

# CONSUMER DIRECTED PLANS<sup>†</sup>

## Benefit Summaries

Medical Benefits	Lumenos HSA 1800		Lumenos HSA 2500	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Deductible / Family Maximum	\$1,800 / \$3,600 <sup>4</sup> (medical and pharmacy combined)	\$1,800 / \$3,600 <sup>4</sup> (medical and pharmacy combined)	\$2,500 / \$5,000 <sup>4</sup> (medical and pharmacy combined)	\$2,500 / \$5,000 <sup>4</sup> (medical and pharmacy combined)
<b>DR. OFFICE VISITS</b>	<b>80%</b>	<b>50%</b>	<b>80%</b>	<b>50%</b>
Annual Physical Exam	100% (ded. waived)	50%	100% (ded. waived)	50%
Lab And X-Ray	80%	50% (Max \$800 Benefit for Advanced Imaging)	80%	50% (Max \$800 Benefit for Advanced Imaging)
<b>HOSPITAL SERVICES</b>	<b>80%</b>	<b>50% (Up to \$650 Per Day)<sup>5</sup></b>	<b>80%</b>	<b>50% (Up to \$650 Per Day)<sup>5</sup></b>
Inpatient Physician Fees	80%	50%	80%	50%
Emergency Room	\$150 (waived if admitted)-80%	\$150 (waived if admitted)-80%	\$150 (waived if admitted)-80%	\$150 (waived if admitted)-80%
<b>Rx BENEFITS</b>				
Generic Formulary	<b>\$15 Copay</b> (after deductible)	<b>\$15 Copay</b> (after deductible) <sup>6</sup>	<b>\$15 Copay</b> (after deductible)	<b>\$15 Copay</b> (after deductible) <sup>6</sup>
Formulary Brand <sup>2</sup>	<b>\$30 Copay</b> (after deductible)	<b>\$30 Copay</b> (after deductible) <sup>6</sup>	<b>\$30 Copay</b> (after deductible)	<b>\$30 Copay</b> (after deductible) <sup>6</sup>
Non-Formulary Brand <sup>2</sup>	<b>\$50 Copay</b> (after deductible)	<b>\$50 Copay</b> (after deductible) <sup>6</sup>	<b>\$50 Copay</b> (after deductible)	<b>\$50 Copay</b> (after deductible) <sup>6</sup>
Oral Contraceptives	Covered	Covered	Covered	Covered
Maternity	Covered as any illness	Covered as any illness	Covered as any illness	Covered as any illness
Physical/Occupational Therapy and Chiropractic Care	80% Maximum 24 visits per year	50% (Up to \$25 Per Visit) <sup>5</sup> Maximum 24 visits per year	80% Maximum 24 visits per year	50% (Up to \$25 Per Visit) <sup>5</sup> Maximum 24 visits per year
Out-of-Pocket Max.–Ind./Fam. <sup>1</sup>	\$3,000 / \$5,500 (Includes Ded)	\$3,000 / \$5,500 (Includes Ded)	\$4,000/\$6,000 (Includes Ded)	\$4,000/\$6,000 (Includes Ded)
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited
Outpatient Surgery	80%	50% (Up to \$380 Per Admission) <sup>5</sup>	80%	50% (Up to \$380 Per Admission) <sup>5</sup>
Hospital Pre-Authorization	Required	Required	Required	Required
Hospice	80%	50%	80%	50%
Skilled Nursing Facility	80% Maximum 100 days per year	50% (Up to \$150 Per Day) <sup>5</sup> Maximum 100 days per year	80% Maximum 100 days per year	50% (Up to \$150 Per Day) <sup>5</sup> Maximum 100 days per year
Ambulance	80%	50%	80%	50%
Drug & Alcohol Benefits, Mental & Nervous Benefits <sup>3</sup> (severe and non-severe)				
Outpatient	80%	50%	80%	50%
Inpatient	80%	50% (Up to \$650 Per Day) <sup>5</sup>	80%	50% (Up to \$650 Per Day) <sup>5</sup>

See footnotes on back page



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**Note: For non-emergency care, out-of-network reimbursement amount is based on: an Anthem Blue Cross rate or fee schedule, a rate negotiated with the provider, information from a third party vendor, or billed charges. Members are responsible for the difference between the provider's usual charges & the maximum allowed amount. Non-participating hospitals are covered at a reduced benefit but there are no benefits for care in non-contracting hospitals, except for medical emergencies. For medical emergency care rendered by a non-participating provider or non-contracting hospital, reimbursement is based on the reasonable and customary value. Members may be responsible for any amount in excess of the reasonable and customary value. Plans exclude coverage for pre-existing conditions (except for members under age 19, a child acquired through legal guardianship if the child is added within 31 days of final court decree or order, a child born to or newly adopted by an enrolled subscriber or spouse, or conditions of pregnancy) for the first six months of coverage unless replacing prior creditable coverage.**

† These plans are offered by Anthem Blue Cross Life and Health Insurance Company

<sup>1</sup> The following do not apply to the out of pocket maximum: charges paid for acupuncture/acupressure by non-participating providers and non-covered expenses. The insured remains responsible for these amounts even after the out of pocket maximum has been met. In-network and out-of-network out-of-pocket maximums are exclusive of each other; includes calendar year deductible & prescription drug covered expense.

<sup>2</sup> If a member selects a brand-name drug when a generic-equivalent is available, even if the physician writes a "dispense as written" or "do not substitute", the member will be responsible for the generic copay plus the difference in cost between the brand-name drug and the generic-equivalent drug.

<sup>3</sup> Pre-service review is required for the following mental or nervous disorders and substance abuse services: 1) Facility-based treatment; and 2) Outpatient professional services after twelve visits.

<sup>4</sup> Employees enrolling for single coverage must satisfy the single deductible; for employees enrolling with Dependent coverage, the family deductible must be met before any member receives benefits. In-network and out-of-network deductibles are exclusive of each other; they are applicable to medical care & prescription drug benefits.

<sup>5</sup> The coverage amount listed is the maximum allowed charge for non-emergency services received from a Non-Participating Hospital or Non-Participating Provider. Members are responsible for all charges in excess of the covered amount. Physician Services are covered separately at 50% of Allowable Amounts.

<sup>6</sup> Benefits apply to prescriptions filled at participating pharmacies. Please see Health Plan & Formulary Comparison Guide for non-participating pharmacy benefits.

This summary of benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits. This summary of benefits, as updated, is subject to the approval of the California Department of Insurance and the California Department of Managed Health Care (as applicable).

Please refer to the CaliforniaChoice® Program brochure for more detailed plan benefit information.

