BC/BS Lumenos with HSA
National

# Lumenos® Health Savings Account (HSA) – Preferred Blue®

## COST SHARING SCHEDULE

*This Cost Sharing Schedule is an important part of your Subscriber Certificate. Please keep this schedule with your Certificate, because it contains important information about coverage and limitations.*

| Cost Sharing Summary | YOUR COST | |
|---|---|---|
| | **Network Benefits**<br>*Benefits are limited to the Maximum Allowable Benefit** | **Out-of-Network Benefits**<br>*Benefits are limited to the Maximum Allowable Benefit **|
| **Standard Deductible**<br>If you have a single membership, the Deductible amount is - | $2,000 per Member, per Contract Year | |
| If you have a family membership, the Deductible amount is - | $4,000 per family, per Contract Year | |
| **Standard Coinsurance** | not applicable | 30% |
| **Coinsurance Maximum**<br>If you have a single membership, the Coinsurance Maximum is - | | $2,000 per Member, per Contract Year |
| If you have a family membership, the Coinsurance Maximum is - | | $4,000 per family, per Contract Year |
| **Out of Pocket Limit**<br>If you have a single membership, the Out-of-Pocket Limit is- | $2,000 per Member, per Contract Year | $4,000 per Member, per Contract Year |
| If you have a family membership, the Out-of-Pocket Limit is - | $4,000 per family, per Contract Year | $8,000 per family, per Contract Year |
| **Pharmacy Benefit Cost Sharing**<br>You may purchase up to a 90-day supply of a covered prescription drug at one time, provided that the drug is a Covered Service, the quantity is ordered by your physician and the drug does not require Precertification from Anthem. Please see your Pharmacy Rider for complete information about your share of the cost for Covered Services purchased at a pharmacy. | | |
| **At a Retail Pharmacy or by Mail Order -** | Pharmacy Benefits are subject to the Standard Deductible and Coinsurance shown above | |

*Benefits are limited to the Maximum Allowable Benefit (MAB). If you receive Covered Services from an Out-of-Network Provider, you may be responsible for paying the difference between the MAB and charge.



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**The following is an outline of your coverage. Do not rely on this outline alone. Please read your Subscriber Certificate carefully, because important terms and limitations apply.**

<table>
<tr><th rowspan="2">Coverage Outline</th><th colspan="2">YOUR COST</th></tr>
<tr><th>Network Benefits*</th><th>Out-of-Network Benefits*</th></tr>
<tr><td colspan="3">Medical/Surgical Care</td></tr>
<tr><td colspan="3">I. Inpatient Services</td></tr>
<tr><td>In a Short Term General Hospital<br>(Facility charges for medical, surgical and maternity admissions)</td><td rowspan="4">Standard Deductible</td><td rowspan="4">Standard Deductible and Coinsurance plus any balances</td></tr>
<tr><td>In a Skilled Nursing Facility<br>(Facility charges) Up to 100 Inpatient days per Member, per Calendar Year †</td></tr>
<tr><td>In a Physical Rehabilitation Facility<br>(facility charges) Up to 100 Inpatient days per Member, per Calendar Year †</td></tr>
<tr><td>Inpatient physician and professional services (Such as physician visits, consultations, surgery, anesthesia, delivery of a baby, therapy, laboratory and x-ray tests)<br><br>For Skilled Nursing or Physical Rehabilitation Facility admissions: limited to the number of Inpatient days stated above. †</td></tr>
<tr><td colspan="3">II. Outpatient Services</td></tr>
<tr><td colspan="3">Preventive Care<br>Please Note: Screenings and other services are generally covered as Preventive Care for adults and children with no current symptoms or prior history of a medical condition associated with that screening or service. Members who have current symptoms or have been diagnosed with a medical condition are not considered to require Preventive Care for that condition but instead benefits will be considered under the applicable sections of this Cost Sharing Schedule.</td></tr>
<tr><td>Preventive care and screenings as required by law including, but not limited to:<br>Immunizations for babies, children and adults<br>Cancer screenings such as mammograms and pap smears, lead screening,</td><td>You pay $0</td><td rowspan="2">Standard Deductible and Coinsurance plus any balances</td></tr>
<tr><td>Routine physical exams for babies, children and adults, including an annual gynecological exam<br>Cancer screenings such as routine colonoscopy and sigmoidoscopy screening including fecal occult blood tests, barium enema, and related prep kit and CT colonography (as appropriate)<br>Routine hearing and vision screenings and other preventive care and screenings for infants, children, adolescents and women as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration<br>Any other screening with an "A" or "B" rating from the United States Preventive Services Task Force including, but not limited to: screenings for breast cancer, cervical cancer, colorectal cancer, high blood pressure, type 2 diabetes mellitus, cholesterol, child and adult obesity</td><td>You pay $0</td></tr>
</table>

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† Any combination of Network Benefits and Out-of-Network Benefits counts toward this limit.

| Coverage Outline | Network Benefits* | Out-of-Network Benefits* |
|---|---|---|
| **Preventive care (continued)** | | |
| **As required by law:**<br>Outpatient/office contraceptive services as required by law<br>Nutrition counseling including nutrition counseling for eating disorders | You pay $0 | Standard Deductible and Coinsurance plus any balances |
| **Other preventive care:**<br>Rabies immunizations<br>Prostatic specific antigen (PSA) screening] | You pay $0 | Standard Deductible and Coinsurance plus any balances |
| Routine hearing exams<br>Routine vision exams - One exam each Contract Year † | You pay $0 | Standard Deductible and Coinsurance plus any balances |
| **Prescription Eyewear** - Anthem covers $100 per Member every other Contract Year toward the cost of prescription eyewear (frames, lenses and contact lenses). | You pay any amount that exceeds Anthem's $100 allowance. | |
| Diabetes management program | Standard Deductible | Standard Deductible and Coinsurance plus any balances |
| **Medical/Surgical Care in a Physician's Office (in addition to the "Preventive Care" listed in II above)** | | |
| Medical exams, consultations, office surgery and anesthesia, injections (including allergy injections), medical treatments, telemedicine visits and physician services at a walk-in center | Standard Deductible | Standard Deductible and Coinsurance plus any balances |
| laboratory and x-ray tests (including allergy testing and ultrasound) | Standard Deductible | Standard Deductible and Coinsurance plus any balances |
| CT Scan, MRI, chemotherapy, medical supplies and drugs | Standard Deductible | Standard Deductible and Coinsurance plus any balances |
| Contraceptive drugs and devices that must be administered in a provider's office (such as IUDs) | You pay $0 | Standard Deductible and Coinsurance plus any balances |
| maternity care (prenatal and postpartum visits) Please see Section 7, "Covered Services" II, B, 5 in your Subscriber Certificate for information about total "maternity care." | Your share of the cost for delivery of a baby is the same as shown above in I for "Inpatient Services" and in II below for "Outpatient Facility Care". | |
| **Outpatient Facility Care in the Outpatient Department of a Hospital, Ambulatory Surgical Center, Hemodialysis Center or Birthing Center (in addition to the "Preventive Care" listed in II above)** | | |
| medical exams and consultations by a physician and telemedicine visits | Standard Deductible | Standard Deductible and Coinsurance plus any balances |
| operating room for surgery or delivery of a baby | Standard Deductible | Standard Deductible and Coinsurance plus any balances |
| physician and professional services: surgery, anesthesia, delivery of a baby or management of therapy<br>hemodialysis, chemotherapy, radiation therapy, infusion therapy, CT Scan, MRI<br>facility charges, medical supplies, drugs, other ancillaries, observation | Standard Deductible | Standard Deductible and Coinsurance plus any balances |
| laboratory and x-ray tests (including ultrasounds) | Standard Deductible | Standard Deductible and Coinsurance plus any balances |

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| Coverage Outline | Network Benefits* | Out-of-Network Benefits* |
|---|---|---|
| **Emergency Room Visits and Urgent Care Facility Visits** | | |
| Use of the emergency room<br>- Emergency room physician's fee, surgery, CT Scan, MRI, medical supplies and drugs, laboratory and x-ray tests<br>- | Standard Deductible* | Covered under Network Benefits* |
| Use of a licensed hospital Urgent Care Facility<br>- Urgent care physician's fee, surgery, CT Scan, MRI, medical supplies and drugs, laboratory and x-ray tests | Standard Deductible | Standard Deductible and Coinsurance plus any balances |
| **Ambulance Services** Transport by ambulance must be Medically Necessary. | Standard Deductible* | Covered under Network Benefits* |
| **III. Outpatient Physical Rehabilitation Services** | | |
| **Physical Therapy and Occupational Therapy and Speech Therapy** - Up to a combined maximum of 60 visits per Member, per Contract Year †<br>**Cardiac Rehabilitation Visits**<br>**Early Intervention Services** Available from birth to a covered child's third birthday.<br>**Chiropractic Care**<br>• Office visits (limited to 12 visits per Member, per Contract Year) †<br>• Laboratory and x-ray tests furnished by a chiropractor | Standard Deductible | Standard Deductible and Coinsurance plus any balances |
| **IV. Home Care (in addition to the "Preventative Care" listed in II above)** | | |
| **Physician services** Medical exams, consultations, office surgery and anesthesia, injections (including allergy injections), medical treatments and telemedicine visits<br>**Home Health Agency services** limited to 100 visits per Member, per Calendar Year †<br>**Hospice**<br>**Infusion Therapy**<br>**Medical Equipment, Medical Supplies and Prosthetics** | Standard Deductible | Standard Deductible and Coinsurance plus any balances |

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| Coverage Outline | Network Benefits* | Out-of-Network Benefits* |
|---|---|---|
| **V. Behavioral Health Care (Mental Health and Substance Use Care)** | | |
| **Outpatient/office visits and telemedicine visits**<br>**For Mental Disorders:** Unlimited Medically Necessary visits<br>**For Substance Use Disorders** (including detoxification and substance use rehabilitation combined) - Unlimited Medically Necessary visits | Standard Deductible | Standard Deductible and Coinsurance plus any balances |
| **Partial Hospitalization and Intensive Outpatient Treatment Programs**<br>**For Mental Disorders:** Unlimited Medically Necessary care<br>**For Substance Use Disorders** - Unlimited Medically Necessary care. | Standard Deductible | Standard Deductible and Coinsurance plus any balances |
| **Inpatient Care**<br>**Benefits for Mental Disorders:** Unlimited Medically Necessary Inpatient days<br>**Benefits for Substance Use Disorders** – Unlimited Medically Necessary Inpatient Days for:<br>• Medical detoxification (limits are stated above), and<br>• Substance use rehabilitation | Standard Deductible | Standard Deductible and Coinsurance plus any balances |
| **Scheduled ambulance transport** limited to Medically Necessary transport from one facility to another | Standard Deductible* | Covered under Network Benefits* |

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