



O H I O

Health Savings Account Plan

Individual

Lumenos

# PLAN BENEFITS GUIDE

Calendar-year deductible

Out-of-Pocket Maximum (including deductible)

Physician Office Services

Prescription Drugs  
Retail: 30-day supply. Mail service: 90-day supply

Preventive Care

Well Child Care

Diagnostic Services

Inpatient Hospital Services

Outpatient Services

Emergency Room

Urgent Care

Ambulance (includes air)

Maternity Services

Optional Maternity Rider  
Subject to a 270 day waiting period

Outpatient Therapy Services  
Maximum visits per benefit period for network and non-network combined:  
· Physical Therapy - 20 visits maximum  
· Speech Therapy - 20 visits maximum  
· Occupational Therapy - 20 visits maximum  
· Spinal Manipulation - 12 visits maximum

Mental Health and Substance Abuse  
Inpatient - 10 days maximum network and non-network combined  
Outpatient - 10 visits maximum network and non-network combined  
\$550 combined maximum for non-network inpatient and outpatient substance abuse.  
Inpatient and outpatient substance abuse is limited to 2 rehabilitation programs per lifetime

Home Health Care (Maximum visits per benefit period - 60 visits)

Hospice

Durable Medical Equipment

Human Organ and Tissue Transplant Services  
\$1,000,000 Lifetime maximum combined network and non-network transplant provider services. (Kidney and cornea transplants services covered same as any other illness under medical)

Transportation, Lodging and Meals

Lifetime Maximum

Pre-existing Waiting Period

Blue Preferred Term Life Option Available

Dental Blue Option Available

PLAN 1		PLAN 2	
NETWORK YOU PAY	NON-NETWORK YOU PAY	NETWORK YOU PAY	NON-NETWORK YOU PAY
\$1,500 individual / \$3,000 family <sup>2</sup> \$3,000 individual / \$6,000 family <sup>2</sup> \$5,000 individual / \$10,000 family <sup>2</sup>	\$3,000 individual / \$6,000 family <sup>2</sup> \$6,000 individual / \$12,000 family <sup>2</sup> \$10,000 individual / \$20,000 family <sup>2</sup>	\$1,500 individual / \$3,000 family <sup>2</sup> \$3,000 individual / \$6,000 family <sup>2</sup>	\$3,000 individual / \$6,000 family <sup>2</sup> \$6,000 individual / \$12,000 family <sup>2</sup>
\$1,500 individual / \$3,000 family <sup>3</sup> \$3,000 individual / \$6,000 family <sup>3</sup> \$5,000 individual / \$10,000 family <sup>3</sup>	\$4,500 individual / \$9,000 family <sup>3</sup> \$9,000 individual / \$18,000 family <sup>3</sup> \$15,000 individual / \$30,000 family <sup>3</sup>	\$5,000 individual / \$10,000 family <sup>3</sup> \$5,000 individual / \$10,000 family <sup>3</sup>	\$15,000 individual / \$30,000 family <sup>3</sup> \$15,000 individual / \$30,000 family <sup>3</sup>
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Unlimited	Unlimited	Unlimited	Unlimited
12 months	12 months	12 months	12 months
YES	YES	YES	YES
YES	YES	YES	YES

# Lumenos Health Savings Account Plan

<sup>1</sup> Services subject to calendar-year deductible. Network and Non-network deductibles are separate and do not accumulate towards each other.

<sup>2</sup> The family deductible must be satisfied by either one or all members collectively before any covered services will be paid by the plan.

<sup>3</sup> Once the family out-of-pocket maximum is satisfied by either one or all members collectively, no additional coinsurance will be required for the family for the remainder of the benefit period.

These plans are available with the Blue Access PPO network. To find a doctor or local hospital, visit [www.anthem.com](http://www.anthem.com) and select the "Find a Doctor" button for a complete list of providers within the network.

**This Lumenos HSA Plan Benefits Guide is intended to be a brief outline of coverage and is not intended to be a legal contract. The entire provisions of benefits and exclusions are contained in the contract or certificate of coverage. In the event of a conflict between the contract or certificate of coverage and this Lumenos HSA Plan Benefits Guide, the terms of the contract or certificate of coverage will prevail.**

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