Your Summary of Benefits

Anthem

Synergy Consulting Group Inc
Lumenos Health Savings Accounts Option E55 with Rx Option 9
Effective 12/01/2014

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.

Covered Benefits	Network	Non-Network
Deductible The single deductible applies to the Family deductible. Once the single deductible has been satisfied, benefits for that member are payable subject to coinsurance. Once the family deductible has been satisfied, benefits for the family are payable subject to coinsurance.	Single: $5,000 Family: $10,000	Single: $10,000 Family: $20,000
Out-of-Pocket Limit	Single: $6,050 Family: $12,100	Single: $12,100 Family: $24,200
Physician Home and Office Services · Including Office Surgeries, allergy serum, allergy injections and allergy testing	0%	30%
Preventive Care Services Services included but not limited to: Routine medical exams, Mammograms, Pelvic Exams, Pap testing, PSA tests, Immunizations, Annual diabetic eye exam, Hearing screenings and Vision screenings which are limited to Screening tests (i.e. Snellen eye chart) and Ocular Photo screening.	No Cost Share	30%
Emergency and Urgent Care · **Emergency Room Services @Hospital (facility/other covered services)** *(copayment waived if admitted)* · **Urgent Care Center Services**	0% 0%	0% 30%
Inpatient and Outpatient Professional Services Include but are not limited to: · Medical Care visits (1 per day), Intensive Medical Care, Concurrent Care, Consultations, Surgery and administration of general anesthesia and Newborn exams	0%	30%
Inpatient Facility Services Unlimited days except for: · 60 days Network/Non-Network combined for physical medicine / rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis) · 100 days Network/Non-Network combined for skilled nursing facility	0%	30%
Outpatient Surgery Hospital / Alternative Care Facility · Surgery and administration of general anesthesia	0%	30%
Other Outpatient Services (including but not limited to): · Non Surgical Outpatient Services For example: MRIs, C-Scans, Chemotherapy, Ultrasounds and other diagnostic outpatient services. · Home Care Services (Network/Non-network combined) 100 visits (excludes IV Therapy) · Durable Medical Equipment, Orthotics, and Prosthetics · Physical Medicine Therapy Day Rehabilitation programs · Hospice Care · Ambulance Services	0% 0% 0%	30% 0% 0%

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Covered Benefits	Network	Non-Network
Outpatient Therapy Services **(Combined Network & Non-Network limits apply)** · Physician Home and Office Visits · Other Outpatient Services @ Hospital/Alternative Care Facility Limits apply to: · Physical therapy: 20 visits · Occupational therapy: 20 visits · Manipulation therapy: 12 visits · Speech therapy: 20 visits · Cardiac Rehabilitation: 36 visits · Pulmonary Rehabilitation: 20 visits · Accidental Dental: $3,000 Limit	 0% 0%	 30% 30%
Behavioral Health Services: **Non Biologically Based Mental Illness and Substance Abuse (1) (limits and maximums apply)** · Inpatient Facility Services · Physician Home and Office Visits · Other Outpatient Services @ Hospital/Alternative Care Facility **Inpatient: 30 Network days** (includes inpatient mental health Non-Network) **Outpatient: 30 Network visits** Substance Abuse (non-network) Non-Network limits apply *(Substance abuse rehabilitation programs are limited to one per benefit period.)*	 0% 0% 0%	 30% 30% 30%
Human Organ and Tissue Transplants · Acquisition and transplant procedures, harvest and storage.	0%	30%
Prescription Drugs: · **Network Retail Pharmacies:** (30 day supply) Includes diabetic test strip · **Home Delivery** (90 day supply) Includes diabetic test strip *4th Tier per script max- 30 day supply. Specialty medications are limited to a 30 day supply regardless of whether they are retail or home delivery. -Specialty Medications must be obtained via our Specialty Pharmacy network in order to receive network level benefits. - Member may be responsible for additional cost when not selecting the available generic drug.	 $10 / $35 / $70 / 25% $200 max* out of pocket maximum $10 / $88 / $175 / 25% $200 max* out of pocket maximum	 50% , min $70(2) Not Covered

Notes:
· All deductibles and coinsurance apply toward the out-of-pocket maximum including prescription drug cost shares. (Excludes Non-network Human Organ and Tissue Transplants).
· Deductible(s) apply only to covered medical services listed with a percentage (%) coinsurance.
· Deductible applies to all prescription drug expenses. Once the deductible is met the appropriate copayment/coinsurance applies.
· Network and Non-network deductibles, coinsurance, and out of pocket maximums are separate and do not accumulate towards each other.
· Dependent age: to the end of the month in which the child attains age 26.
· 0% means no coinsurance up to the maximum allowable amount. However, when choosing a Non-network provider, the member is responsible for any balance due after the plan payment. No cost share means no deductible/copayment/coinsurance up to the maximum allowable amount.
· Benefit period = Calendar Year

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· Preventive Care Services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits are covered.
(1) We encourage you to refer to the Schedule of Benefits for limitations.
(2)Rx non-network diabetic/asthmatic supplies not covered except diabetic test strips.
Precertification:
· Members are encouraged to always obtain prior approval when using Non-network providers. Precertification will help avoid any unnecessary reduction in benefits for non-covered or non-medically necessary services.

Pre-Existing Exclusion Period:*None.*

This summary of benefits is intended to be a brief outline of coverage. The entire provisions of benefits and exclusions are contained in the Group Contract, Certificate, and Schedule of Benefits. In the event of a conflict between the Group Contract and this description, the terms of the Group Contract will prevail.

Authorized group signature (if applicable)	*Date*
Underwriting signature (if applicable)	*Date*