

# Anthem Blue Cross and Blue Shield Lumenos Health Reimbursement Account (HRA) Plan 46E \$3000/80%

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 04/01/2017 – 03/31/2018  
Coverage for: Individual + Family | Plan Type: CDHP



**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at <https://eoc.anthem.com/eocdbs/fi> or by calling (855) 333-5735.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	\$3,000 single / \$6,000 family for In-Network Providers. Does not apply to Preventive care. \$6,000 single / \$12,000 family for Out-of-Network Providers.	You must pay all costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> starts over (usually, but not always, January 1st). See the chart starting on page 3 for how much you pay for covered services after you meet the <u>deductible</u> .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 3 for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes; \$5,000 single / \$10,000 family for In-Network Providers. \$10,000 single / \$20,000 family for Out-of-Network Providers.	The <u>out-of-pocket limit</u> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <u>out-of-pocket limit</u> ?	Pre-Authorization Penalties, Premiums, Balance-Billed charges, and Health Care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 3 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network of providers</u> ?	Yes, PPO. For a list of In-Network providers, see <a href="http://www.anthem.com">www.anthem.com</a> or call (855) 333-5735.	If you use an in-network doctor or other health care <u>provider</u> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <u>provider</u> for some services. Plans use the term <u>in-network</u> , <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 3 for how this

**Questions:** Call (855) 333-5735 or visit us at [www.anthem.com](http://www.anthem.com) If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [www.ccioo.cms.gov](http://www.ccioo.cms.gov) or call (855) 333-5735 to request a copy.

NV/L/F/LUMENOS HRA 46E \$3000\_80%-CDHP/NA/FB8JF/NA/01-17

Important Questions	Answers	Why this Matters:
Do I need a referral to see a <b>specialist</b> ?	No; you do not need a referral to see a specialist.	plan pays different kinds of <b>providers</b> .
Are there services this plan doesn't cover?	Yes.	You can see the <b>specialist</b> you choose without permission from this plan.  Some of the services this plan doesn't cover are listed on page 7. See your policy or plan document for additional information about <b>excluded services</b> .



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **In-Network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use a Non-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	40% coinsurance	-----none-----
	Specialist visit	20% coinsurance	40% coinsurance	-----none-----
	Other practitioner office visit	Spinal Manipulation 20% coinsurance Acupuncture 20% coinsurance	Spinal Manipulation 40% coinsurance Acupuncture 40% coinsurance	Spinal Manipulation Coverage for In-Network Providers and Non-Network Providers combined is limited to 12 visits per benefit period for Spinal Manipulations. Acupuncture Coverage for In-Network Providers and Non-Network Providers combined is limited to 12 visits per benefit period for Spinal Manipulations and Acupuncture.
If you have a test	Preventive care/screening/immunization	No charge	40% coinsurance	-----none-----
	Diagnostic test (x-ray, blood work)	Lab – Office 20% coinsurance X-Ray – Office 20% coinsurance	Lab – Office 40% coinsurance X-Ray – Office 40% coinsurance	Lab – Office Costs may vary by site of service. X-Ray – Office -----none-----
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Costs may vary by site of service.
If you need drugs to treat	Tier1 - Typically Generic	20% coinsurance (retail and home delivery)	40% coinsurance (retail only)	Covers up to a 30 day supply (retail pharmacy) Covers up to a 90 day

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use a Non-Network Provider	Limitations & Exceptions
<p>your illness or condition</p> <p>More information about <b>prescription drug coverage</b> is available at <a href="http://www.anthem.com/pharmacyinformation/">http://www.anthem.com/pharmacyinformation/</a></p>				<p>supply (home delivery program)</p> <p>Specialty drug networks must be used for in-network coverage. If the member selects a brand drug when generic equivalent is available the member is responsible for the generic copay + the cost difference between the generic and brand equivalent. You pay additional copays or coinsurance on all tiers for retail fills that exceed 30 days.</p>
	Tier2 - Typically Preferred / Brand	20% coinsurance (retail and home delivery)	40% coinsurance (retail only)	<p>Covers up to a 30 day supply (retail pharmacy) Covers up to a 90 day supply (home delivery program)</p> <p>Specialty drug networks must be used for in-network coverage. If the member selects a brand drug when generic equivalent is available the member is responsible for the generic copay + the cost difference between the generic and brand equivalent.</p>
	Tier3 - Typically Non-Preferred / Specialty Drugs	20% coinsurance (retail and home delivery)	40% coinsurance (retail only)	<p>Covers up to a 30 day supply (retail pharmacy) Covers up to a 90 day supply (home delivery program)</p> <p>Specialty drug networks must be used for in-network coverage. If the member selects a brand drug when generic equivalent is available the member is responsible for the generic copay + the cost difference between the generic and brand equivalent.</p>
	Tier4 - Typically Specialty Drugs	20% coinsurance (retail and home delivery)	40% coinsurance (retail only)	<p>Covers up to a 30 day supply (retail pharmacy) Specialty drug networks must be used for in-network coverage. If the member selects a brand drug when generic equivalent is available the member is responsible for the generic copay + the cost difference between the generic and brand equivalent.</p>

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use a Non-Network Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	genetic copay + the cost difference between the generic and brand equivalent.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Costs may vary by site of service.
	Emergency room services	20% coinsurance	Covered as In-Network	-----none----- -----none-----
If you need immediate medical attention	Emergency medical transportation	20% coinsurance for ground	Covered as In-Network	There may be other levels of cost share that are contingent on how services are provided.
	Urgent care	20% coinsurance	40% coinsurance	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Coverage for In-Network Providers and Non-Network Providers combined is limited to 30 day limit per calendar Year for Inpatient Rehabilitation.
	Physician/surgeon fee	20% coinsurance	40% coinsurance	-----none-----
	Mental/Behavioral health outpatient services	Mental/Behavioral Health Office Visit 20% coinsurance Mental/Behavioral Health Facility Visit - Facility Charges 20% coinsurance	Mental/Behavioral Health Office Visit 40% coinsurance Mental/Behavioral Health Facility Visit - Facility Charges 40% coinsurance	Mental/Behavioral Health Office Visit -----none----- Mental/Behavioral Health Facility Visit - Facility Charges -----none-----
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health inpatient services	20% coinsurance	40% coinsurance	-----none-----
	Substance use disorder outpatient services	Substance Use Office Visit 20% coinsurance Substance Use Facility Visit - Facility Charges 20% coinsurance	Substance Use Office Visit 40% coinsurance Substance Use Facility Visit - Facility Charges 40% coinsurance	Substance Use Office Visit -----none----- Substance Use Facility Visit - Facility Charges -----none-----
	Substance use disorder inpatient services	20% coinsurance	40% coinsurance	-----none-----
If you are pregnant	Prenatal and postnatal care	20% coinsurance	40% coinsurance	Your doctor's charge for delivery are part of prenatal and postnatal care



Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use a Non-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Delivery and all inpatient services	20% coinsurance	40% coinsurance	Applies to inpatient facility. Other cost shares may apply depending on services provided.
	Home health care	20% coinsurance	40% coinsurance	Coverage for In-Network Providers and Non-Network Providers combined is limited to 100 visits per calendar Year.
	Rehabilitation services	20% coinsurance	40% coinsurance	Coverage is limited to 20 visits per calendar Year for Physical Therapy. Coverage is limited to 20 visits per calendar Year for Occupational Therapy. Coverage is limited to 20 visits per calendar Year for Speech Therapy. Apply to In-Network Providers and Non-Network Providers combined. Costs may vary by site of service.
	Habilitation services	20% coinsurance	40% coinsurance	Habilitation visits count towards your rehabilitation limit. Costs may vary by site of service.
	Skilled nursing care	20% coinsurance	40% coinsurance	Coverage for In-Network Providers and Non-Network Providers combined is limited to 100 day limit per calendar Year.
	Durable medical equipment	20% coinsurance	40% coinsurance	-----none-----
	Hospice service	20% coinsurance	40% coinsurance	-----none-----
	Eye exam	Not covered	Not covered	-----none-----
	Glasses	Not covered	Not covered	-----none-----
	Dental check-up	Not covered	Not covered	-----none-----
If your child needs dental or eye care				

## Excluded Services & Other Covered Services:

### Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Bariatric surgery
- Cosmetic surgery
- Dental care (adult)
- Hearing aids
- Long- term care
- Preauthorization - You may have to pay for all or a portion of any test, equipment, service or procedure that is not preauthorized. To find out which services require Preauthorization and to be sure that Preauthorization has been given, you may contact us.
- Private-duty nursing
- Routine eye care (adult)
- Routine foot care unless you have been diagnosed with diabetes.
- Weight loss programs

### Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture
- Spinal Manipulation
- Infertility treatment Limited to surgical treatment for correction, replacement of deficient naturally occurring hormones, and artificial insemination.
- Most coverage provided outside the United States. See [www.bcbs.com/bluecardworldwide](http://www.bcbs.com/bluecardworldwide)

## Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at (855) 333-5735. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).

## Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

ATTN: Grievances and Appeals P.O. Box 10330 Reno, NV 89520	Department of Labor, Employee Benefits Security Administration (866) 444-EBSA (3272) <a href="http://www.dol.gov/ebsa/healthreform">www.dol.gov/ebsa/healthreform</a>	Nevada Division of Insurance 2501 East Sahara Ave., Suite 302 Las Vegas, NV 89104 (702) 486-4009 (888) 872-3234 Nevada Division of Insurance 1818 E. College Pkwy., Suite 103 Carson City, NV 89706 (775) 687-0700 (888) 872-3234
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### **Does this Coverage Provide Minimum Essential Coverage?**

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy does provide minimum essential coverage.**

### **Does this Coverage Meet the Minimum Value Standard?**

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

### **Language Access Services:**

如果您是非會員並需要中文協助，請聯絡您的銷售代表或小組管理員。如果您已參保，則請使用您 ID 卡上的號碼聯絡客戶服務人員。

Doo bee a'tah n'i'ligoo e' dooda'i, shikaa adookwol i'ni'zinigo t'aa' diné k'éjigo, t'aa' shoodí ba na'afnhi' ya sidahi' bich'i naabidifikiid. Eí doo bi'gha daago ni ba'nija'go ho'aalagú bich'i hodiilini. Hai'daa' iini'taago e'ya, t'aa' shoodí diné ya atáh halne'igú ni béesh bee hane'i wólta' bi'ki si'núligú bi'kéhgo bich'i hodiilini.

Si no es miembro todavía y necesita ayuda en idioma español, le suplicamos que se ponga en contacto con su agente de ventas o con el administrador de su grupo. Si ya está inscrito, le rogamos que llame al número de servicio de atención al cliente que aparece en su tarjeta de identificación.

Kung hindi ka pa miyembro at kailangan ng tulong sa wikang Tagalog, mangyaring makipag-ugnayan sa iyong sales representative o administrator ng iyong pangkat. Kung naka-enroll ka na, mangyaring makipag-ugnayan sa serbisyo para sa customer gamit ang numero sa iyong ID card.

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*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*

## About These Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



### This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

### Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$3,554
- Patient pays \$3,986

#### Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
<b>Total</b>	<b>\$7,540</b>

#### Patient pays:

Deductibles	\$3,000
Copays	\$0
Coinsurance	\$836
Limits or exclusions	\$150
<b>Total</b>	<b>\$3,986</b>

### Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$2,177
- Patient pays \$3,223

#### Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
<b>Total</b>	<b>\$5,400</b>

#### Patient pays:

Deductibles	\$3,000
Copays	\$0
Coinsurance	\$183
Limits or exclusions	\$40
<b>Total</b>	<b>\$3,223</b>

# Questions and answers about the Coverage Examples:

## What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

## What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, co payments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

## Does the Coverage Example predict my own care needs?

**No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

## Does the Coverage Example predict my future expenses?

**No.** Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

## Can I use Coverage Examples to compare plans?

**Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

## Are there other costs I should consider when comparing plans?

**Yes.** An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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## Language Access Services:

(TTY/TDD: 711)

**Albanian (Shqip):** Nëse keni pyetje në lidhje me këtë dokument, keni të drejtë të merrni falas ndihmë dhe informacion në gjuhën tuaj. Për të kontaktuar me një përkthyes, telefononi (855) 333-5735

**Amharic (አማርኛ):-** ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በነጻ የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር (855) 333-5735 ይደውሉ።

(855) 333-5735 اتصل على مترجم، التحدث إلى مترجم. للمساعدة والمعلومات بلغاتك نون مقابل. للتحدث إلى مترجم، اتصل على (855) 333-5735. (العربية) Arabic

**Armenian (հայերեն).** Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (855) 333-5735:

**Bassa (Bāsō wūdū):** M̄ d̄yí d̄yí-diè-d̄è b̄è b̄édé bá céé-d̄è nià ke d̄yí ní, ɔ mò nì d̄yí-b̄èd̄èin-d̄è b̄é m̄ ké gbo -kpá-kpá ké b̄ō kp̄ō dé m̄ b̄íqí-wùd̄ūn b̄ó pídyi. B̄é m̄ ké wūdu-z̄iin-nyò d̄ò gbo wùd̄ù ke, d̄á (855) 333-5735.

**Bengali (বাংলা):** যদি এই নথিপত্রের বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষায় বিগাম্ভা সাহায্য পাওয়ার ও তথ্য পাওয়ার অধিকার আপনার আছে। একজন দোভাষীর সাথে কথা করার জন্য (855) 333-5735 - তে কল করুন।

**Burmese (ပြန်စာ):** ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အချက်အလက်များနှင့် အကူအညီကို အကြောင်းပေးပေးရမလိမ့်။ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖုန်း (855) 333-5735 သို့ ခေါ်ဆိုပါ။

**Chinese (中文):** 如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需用譯員通話，請致電 (855) 333-5735。

**Dinka (Dinka):** Na naq thiéc né ke de ya thore, ke yin naq loq bé yi kuony ku wer aieú bé geer yic yin ne thog du ke cin wéu tááúé ke piny. Te kor yin ba jam wéné ran ye thok genic, ke yin col (855) 333-5735.

**Dutch (Nederlands):** Bij vragen over dit document hebt u recht op hulp en informatie in uw taal zonder bijkomende kosten. Als u een tolk wilt spreken, belt u (855) 333-5735.

**French (Français):** Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (855) 333-5735.



## Language Access Services:

**German (Deutsch):** Wenn Sie Fragen zu diesem Dokument haben, haben Sie Anspruch auf kostenfreie Hilfe und Information in Ihrer Sprache. Um mit einem Dolmetscher zu sprechen, bitte wählen Sie (855) 333-5735.

**Greek (Ελληνικά):** Αν έχετε τυχόν απορίες σχετιζά με το παρόν έγγραφο, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας δωρεάν. Για να μιλήσετε με κάποιον διερμηνέα, τηλεφωνήστε στο (855) 333-5735.

**Gujarati (ગુજરાતી):** જો આ દસ્તાવેજ અંગે આપને કોઈપણ પ્રશ્નનો હોય તો, કોઈપણ ખર્ચ વગર આપની ભાષામાં મદદ અને માહિતી મેળવવાનો તમને અધિકાર છે. દુભાષણિ સહાય વાદ કરવા માટે, કોલ કરો (855) 333-5735.

**Haitian Creole (Kreyòl Ayisyen):** Si ou gen nespòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (855) 333-5735.

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