BC Lumenos® Health Savings Account (HSA) Modified LBHSA287H (1500/80/60) Embedded ETSM
The Claremont Colleges

BC PPO 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 proposed benefit summary is subject to the approval of the California Department of Insurance and the California Department of Managed Health Care

This Lumenos plan is an innovative type of coverage that allows an insured person to use a Health Savings Account to pay for routine medical care. The program also includes traditional health coverage, similar to a typical health plan that protects the insured person against large medical expenses.

The insured person can spend the money in the HSA account the way the insured person wants on routine medical care, prescription drugs and other qualified medical expenses. There are no copays or deductibles to satisfy first. Unused dollars can be saved from year to year to reduce the amount the insured person may have to pay in the future. If covered expenses exceed the insured person's available HSA dollars, the traditional health coverage is available after a limited out-of-pocket amount is paid by the insured person.

Certain Covered Services have maximum visit and/or day limits per year. The number of visits and/or days allowed for these services will begin accumulating on the first visit and/or day, regardless of whether your Deductible has been met.

The insured person is responsible for all costs over the plan maximums. Plan maximums and other important information appear in *italics*. Benefits are subject to all terms, conditions, limitations, and exclusions of the Policy.

Subject to Utilization Review

Certain services are subject to the utilization review program. Before scheduling services, the member must make sure utilization review is obtained. If utilization review is not obtained, benefits may be reduced or not paid, according to the plan.

Explanation of Maximum Allowed Amount

Maximum Allowed Amount is the total reimbursement payable under the plan for covered services received from Participating and Non-Participating Providers. It is the payment towards the services billed by a provider combined with any applicable deductible, copayment or coinsurance.

Participating Providers- The rate the provider has agreed to accept as reimbursement for covered services. Members are not responsible for the difference between the provider's usual charges & the maximum allowed amount.

Non-Participating Providers & Other Health Care Providers-(includes those not represented in the PPO provider 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. For Medical Emergency care rendered by a Non-Participating Provider or Non-Contracting Hospital, reimbursement may be based on the reasonable and customary value. Members may be responsible for any amount in excess of the reasonable and customary value. Participating Pharmacies & Mail Service Program-members are not responsible for any amount in excess of the prescription drug maximum allowed amount. Non-Participating Pharmacies-members are responsible for any expense not covered under this plan & any amount in excess of the prescription drug maximum allowed amount.

When using non-participating providers, the insured person is responsible for any difference between the covered expense & actual charges, as well as any deductible & percentage copay.

When using the outpatient prescription drug benefits, the insured person is always responsible for drug expenses which are not covered under this plan, as well as any deductible, percentage or dollar copay.

Calendar year deductible *(In-network/out-of-network deductibles cross apply; applicable to medical care & prescription drug benefits. For subscribers with dependents, this plan contains an embedded deductible, meaning that the cost shares of one family member will be applied to the per member deductible; in addition, amounts for all family members apply to the family deductible. No one member will pay more than the per member deductible*)	
➢ Participating Providers, Participating Pharmacy & Other Health Care Providers	$1,500/single; $2,700/member; $3,000/family
➢ Non-Participating Providers & Non-Participating Pharmacy	$2,500/single; $2,700/member; $5,000/family
Annual Out-of-Pocket Maximums *(in-network/out-of-network out-of-pocket maximums cross apply; applicable to medical care & prescription drug benefits. For subscribers with dependents, this plan contains an embedded out of pocket maximum, meaning that the cost shares of one family member will be applied to the per member out-of-pocket maximum; in addition, amounts for all family members apply to the family out-of-pocket maximum. No one member will pay more than the per member out-of-pocket maximum)*	
➢ Participating Providers, Participating Pharmacy & Other Health Care Providers	$3,000/single; $3,000/member; $6,000/family
➢ Non-Participating Providers & Non-Participating Pharmacy	$6,000/single; $6,000/member; $12,000/family

The following do not apply to out-of-pocket maximums: non-covered expenses. After an annual out-of-pocket maximum is met for medical and prescription drugs during a calendar year, the individual member or family (includes employee & members of the employee's family) will no longer be required to pay a copay or coinsurance for medical and prescription drug covered expenses for the remainder of that year. The member remains responsible for non-covered expenses.

Lifetime Maximum	Unlimited

Covered Services	Traditional Health Coverage Insured Person Copay In-Network	Out-of-Network *(Insured is also responsible for charges in excess of covered expense.)*
Hospital Medical Services *(subject to utilization review for inpatient services; waived for emergency admissions)*		
➢ Semi-private room, meals & special diets, & ancillary services	20%	40%
➢ Outpatient medical care, surgical services & supplies *(hospital care other than emergency room care)*	20%	40%
Ambulatory Surgical Centers		
➢ Outpatient surgery, services & supplies	20%[1]	40%[1] *(benefit limited to $350/day)*
Hemodialysis		
➢ Outpatient hemodialysis services & supplies	20%[1]	40%[1] *(benefit limited to $350/day)*
Skilled Nursing Facility *(subject to utilization review)*		
➢ Semi-private room, services & supplies *(limited to 100 days/calendar year; limit does not apply to mental health and substance abuse)*	20%[1]	40%[1]
Hospice Care		
➢ Inpatient or outpatient services for insured persons; family bereavement services	20%[1]	
Home Health Care		
➢ Services & supplies from a home health agency *(limited to combined maximum of 100 visits/calendar year, one visit by home health aide equals four hours or less; not covered while insured person receives hospice care)*	20%[1]	40%[1]
Home Infusion Therapy		
➢ Includes medication, ancillary services & supplies; caregiver training & visits by provider to monitor therapy; durable medical equipment; lab services	20%[1]	40%[1] *(benefit limited to $600/day)*
Physician Medical Services		
➢ Office & home visits	20%	40%
➢ Hospital & skilled nursing facility visits	20%	40%
➢ Surgeon & surgical assistant; anesthesiologist or anesthetist	20%	40%
Diagnostic X-ray & Lab		
➢ MRI, CT scan, PET scan & nuclear cardiac scan *(subject to utilization review)*	20%[1]	40%[1]
➢ Other diagnostic x-ray & lab,	20%[1]	40%[1]
Preventive Care Services Preventive Care Services including*, physical exams, preventive screenings (including screenings for cancer, HPV, diabetes, cholesterol, blood pressure, hearing and vision, immunizations, health education, intervention services, HIV testing), and additional preventive care for women provided for in the guidelines supported by the Health Resources and Services Administration. *This list is not exhaustive. This benefit includes all Preventive Care	No copay *(deductible waived)*	40%
Physical Therapy, Physical Medicine & Occupational Therapy, including Chiropractic Services *(limited to 24 visits/calendar year)*	20%	40%
Speech Therapy	20%	40%
Acupuncture		
➢ Services for the treatment of disease, illness or injury *(limited to 12 visits/calendar year)*	20%[2]	40%[2]
Temporomandibular Joint Disorders		
➢ Splint therapy & surgical treatment	20%	40%
Pregnancy & Maternity Care		
➢ Physician office visits	20%	40%
➢ Prescription drug for abortion *(mifepristone)*	20%	40%
Normal delivery, cesarean section, complications of pregnancy & abortion		
➢ Inpatient physician services	20%	40%
➢ Hospital & ancillary services	20%	40%

[1] These providers may not be represented in the PPO network in the state where the insured person receives services. If such provider is not available in the service area, the insured person's copay is 20%. If such provider is available in the service area and the insured person receives services from a PPO provider, the insured person's copay is 20%. However, if the insured person chooses to receive services from a non-PPO provider when such provider is available in the service area, the insured person's copay is 40%. All copays are in addition to applicable deductibles.

[2] Acupuncture services can be performed by a certified acupuncturist (C.A.), a doctor of medicine (M.D.), a doctor of osteopathy (D.O.), a podiatrist (D.P.M.), or a dentist (D.D.S.).

Covered Services	Traditional Health Coverage Insured Person Copay In-Network	Out-of-Network *(Insured is also responsible for charges in excess of covered expense.)*
Organ & Tissue Transplants *(subject to utilization review; specified transplants covered only when performed at Centers of Medical Excellence [CME] for California; Blue Distinction Centers for Specialty Care [BDCSC] for out of California)*		
Inpatient services provided in connection with non-investigative organ or tissue transplants	20%	40%
Bariatric Surgery *(subject to utilization review; medically necessary surgery for weight loss, only for morbid obesity, covered only when performed at Centers of Medical Excellence [CME])*		
➢ Inpatient services provided in connection with medically necessary surgery for weight loss, only for morbid obesity	20%	
➢ Bariatric travel expense when insured person's home is 50 miles or more from the nearest bariatric *CME (insured person's transportation to & from CME limited to $130/person/trip for 3 trips [pre-surgical visit, initial surgery & one follow-up visit]; one companion's transportation to & from CME limited to $130/person/trip for 2 trips [initial surgery & one follow-up visit]; hotel for insured person & one companion limited to one room double occupancy & $100/day for 2 days/trip, or as medically necessary, for pre-surgical & follow-up visit; hotel for one companion limited to one room double occupancy & $100/day for duration of insured person's initial surgery stay for 4 days; other reasonable expenses limited to $25/day/person for 4 days/trip)*	20%	
Diabetes Education Programs *(requires physician supervision)*		
➢ Teach insured persons & their families about the disease process, the daily management of diabetic therapy & self-management training	20%	40%
Prosthetic Devices		
➢ Coverage for breast prostheses; prosthetic devices to restore a method of speaking; surgical implants; artificial limbs or eyes; the first pair of contact lenses or eyeglasses when required as a result of eye surgery; wigs for alopecia resulting from chemotherapy or radiation therapy; & therapeutic shoes & inserts for insured persons with diabetes	20%	40%
Durable Medical Equipment		
➢ Rental or purchase of DME including hearing aids, dialysis equipment & supplies *(hearing aids benefit available for one hearing aid per ear every three years breast pump and supplies are covered under preventive care at no charge)*	20%[1]	40%[1]
Related Outpatient Medical Services & Supplies		
➢ Ground or air ambulance transportation, services & disposable supplies	20%[1]	
➢ Blood transfusions, blood processing & the cost of unreplaced blood & blood products	20%[1]	
➢ Autologous blood *(self-donated blood collection, testing, processing & storage for planned surgery)*	20%[1]	
Emergency Care		
➢ Emergency room services & supplies	20%	20%
➢ Inpatient hospital services & supplies	20%	20%
➢ Physician services	20%	20%
Mental or Nervous Disorders and Substance Abuse		
➢ Inpatient facility care *(subject to utilization review; waived for emergency admissions)*	20%	40%
➢ Inpatient physician visits	20%	40%
➢ Outpatient facility care	20% *(after deductible is met)*	40% *(after deducible is met)*
➢ Physician office visits *(Behavioral Health treatment for Autism or Pervasive Development disorders require pre-service review)*	20% *(after deductible is met)*	40% *(after deductible is met)*

[1] These providers may not be represented in the PPO network in the state where the insured person receives services. If such provider is not available in the service area, the insured person's copay is 20%. If such provider is available in the service area and the insured person receives services from a PPO provider, the insured person's copay is 20%. However, if the insured person chooses to receive services from a non-PPO provider when such provider is available in the service area, the insured person's copay is 40%. All copays are in addition to applicable deductibles.

Covered Services (For Outpatient Prescription Drugs)	Traditional Health Coverage Per Insured person Copay for Each Prescription or Refill	
Outpatient Prescription Drug Benefits		
➢ Preventive immunizations administered by a retail pharmacy	No copay *(deductible waived)*	40% up to $250 per prescription
➢ Female oral contraceptives generic and single source brand	No copay *(deductible waived)*	40% up to $250 per prescription
➢ Retail pharmacy prescription drug maximum allowed amount	20% *(maximum $250 for a 30-day supply)*	40%[1] up to $250 per prescription
➢ Home Delivery prescription drug maximum allowed amount	20% *(maximum $250 for a 30-day supply)*	Not applicable
➢ Specialty pharmacy drugs *(obtained through specialty pharmacy program)*	20% *(maximum $250 for a 30-day supply)*	Not applicable
Supply Limits[2]		
➢ Retail Pharmacy *(participating and non-participating)*	30-day supply; 60-day supply for federally classified Schedule II attention deficit disorder drugs that require a triplicate prescription form, but require a double copay; 6 tablets or units/30-day period for impotence and/or sexual dysfunction drugs (available only at retail pharmacies); 90-day supply for eligible prescriptions obtained through a retail pharmacy, but will require a triple copay	
➢ Home Delivery	90-day supply	
➢ Specialty Pharmacy	30-day supply	

[1] Insured person remains responsible for the costs in excess of the prescription drug maximum amount allowed.

[2] Supply limits for certain drugs may be different. Please refer to the Certificate for complete information.

The Outpatient Prescription Drug Benefit covers the following:

- All eligible immunizations administered by a participating retail pharmacy
- Outpatient prescription drugs and medications which the law restricts to sale by prescription. Formulas prescribed by a physician for the treatment of phenylketonuria.
- Insulin
- Syringes when dispensed for use with insulin and other self-injectable drugs or medications
- All FDA-approved contraceptives for women, including oral contraceptives; contraceptive diaphragms and over-the-counter contraceptives prescribed by a doctor
- Injectable drugs which are self-administered by the subcutaneous route (under the skin).
- Drugs that have Food and Drug Administration (FDA) labeling for self-administration
- All compound prescription drugs that contain at least one covered prescription ingredient
- Diabetic supplies (i.e., test strips and lancets)
- Prescription drugs for treatment of impotence and/or sexual dysfunction are limited to organic (non-psychological) causes.
- Inhaler spacers and peak flow meters for the treatment of pediatric asthma.
- Smoking cessation products requiring a physician's prescription.
- Certain over-the-counter drugs approved by the Pharmacy and Therapeutics Committee to be included in the prescription drug formulary.

In addition to the benefits described above, coverage may include additional benefits, depending upon the insured person's home state. The benefits provided in this summary are subject to federal and California laws. There are some states that require more generous benefits be provided to their residents, even if the master policy was not issued in their state. If the insured person's state has such requirements, we will adjust the benefits to meet the requirements.

This Summary of Benefits is a brief review of benefits. Once enrolled, insured persons will receive a Certificate of Insurance, which explains the exclusions and limitations, as well as the full range of covered services of the plan, in detail.

For additional information on limitations and exclusions and other disclosure items that apply to this plan, go to https://le.anthem.com/pdf?x=CA_LG_CDHP