



# Welcome to Our Lumenos<sup>®</sup> Plans Offered by BC Life & Health Insurance Company

Choose from the following Lumenos consumer-driven health plans that give you more control and information to help maintain and improve your health, while also helping you and your family control your health care costs.

## OPTION 1: Lumenos Health Savings Account (HSA) Plans

6 HSA plans are available with different deductibles for individuals and families.	Annual Deductible <sup>1</sup>	Plan Coinsurance <sup>2</sup>		Preventive Care Coverage		Annual Out-of-Pocket Limit <sup>3</sup>	
	Amount you pay before traditional health coverage begins.	The percent the plan pays for covered services. See Page 3 for a brief summary.		The percent the plan pays for covered services. See Page 3 for overview.		The plan pays 100% of covered expenses after you reach this limit.	
	In-Network and Out-of-Network Services Combined Individual/Family	In-Network Services	Out-of-Network Services	In-Network Services	Out-of-Network Services	In-Network Services Individual/Family	Out-of-Network Services Individual/Family
<b>70% Coinsurance Plans</b> (without maternity coverage)	\$1,500/\$3,000	70%	50%	100% (deductible waived)	50%	\$3,500/\$7,000	\$8,500/\$17,000
	\$3,000/\$6,000	70%	50%	100% (deductible waived)	50%	\$2,000/\$4,000	\$7,000/\$14,000
<b>100% Coinsurance Plans</b> (without maternity coverage)	\$5,000/\$10,000	100%	70%	100% (deductible waived)	70%	\$0/\$0	\$5,000/\$10,000
<b>100% Coinsurance Plans</b> (with maternity coverage)	\$1,500/\$3,000	100%	70%	100% (deductible waived)	70%	\$0/\$0	\$1,500/\$3,000
	\$3,000/\$6,000	100%	70%	100% (deductible waived)	70%	\$0/\$0	\$3,000/\$6,000
	\$5,000/\$10,000	100%	70%	100% (deductible waived)	70%	\$0/\$0	\$5,000/\$10,000

## OPTION 2: Lumenos Health Incentive Account (HIA) Plans

6 HIA plans are available with different deductibles for individuals and families.	Annual Deductible <sup>1</sup>	Plan Coinsurance <sup>2</sup>		Preventive Care Coverage		Annual Out-of-Pocket Limit <sup>3</sup>	
	Amount you pay before traditional health coverage begins.	The percent the plan pays for covered services. See Page 3 for a brief summary.		The percent the plan pays for covered services. See Page 3 for overview.		The plan pays 100% of covered expenses after you reach this limit.	
	In-Network and Out-of-Network Services Combined Individual/Family	In-Network Services	Out-of-Network Services	In-Network Services	Out-of-Network Services	In-Network Services Individual/Family	Out-of-Network Services Individual/Family
<b>70% Coinsurance Plans</b> (without maternity coverage)	\$1,500/\$3,000	70%	50%	100% (deductible waived)	50%	\$3,500/\$7,000	\$8,500/\$17,000
	\$3,000/\$6,000	70%	50%	100% (deductible waived)	50%	\$2,000/\$4,000	\$7,000/\$14,000
<b>100% Coinsurance Plans</b> (without maternity coverage)	\$5,000/\$10,000	100%	70%	100% (deductible waived)	70%	\$0/\$0	\$5,000/\$10,000
<b>100% Coinsurance Plans</b> (with maternity coverage)	\$1,500/\$3,000	100%	70%	100% (deductible waived)	70%	\$0/\$0	\$1,500/\$3,000
	\$3,000/\$6,000	100%	70%	100% (deductible waived)	70%	\$0/\$0	\$3,000/\$6,000
	\$5,000/\$10,000	100%	70%	100% (deductible waived)	70%	\$0/\$0	\$5,000/\$10,000

<sup>1</sup> Either one or all members must satisfy the family deductible collectively before any covered services will be paid by the plan.

<sup>2</sup> Services subject to calendar-year deductible. In-Network and Out-of-Network deductibles accumulate together.

<sup>3</sup> The annual out-of-pocket limit is in addition to the deductible. 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.



# Welcome to Our Lumenos® Plans Offered by BC Life & Health Insurance Company

Choose from the following Lumenos consumer-driven health plans that give you more control and information to help maintain and improve your health, while also helping you and your family control your health care costs.

## OPTION 3: Lumenos Health Incentive Account Plus (HIA Plus) Plans

5 HIA Plus plans are available with different deductibles for individuals and families.	HIA Plus Quarterly Health Account Allocation*	Annual Deductible <sup>1</sup> Amount you pay before traditional health coverage begins.	Plan Coinsurance <sup>2</sup> The percent the plan pays for covered services. See Page 3 for a brief summary.		Preventive Care Coverage The percent the plan pays for covered services. See Page 3 for overview.		Annual Out-of-Pocket Limit <sup>3</sup> The plan pays 100% of covered expenses after you reach this limit.	
			In-Network and Out-of-Network Services Combined Individual/Family	In-Network and Out-of-Network Services Combined Individual/Family	In-Network Services	Out-of-Network Services	In-Network Services	Out-of-Network Services
<b>70% Coinsurance Plans</b> (without maternity coverage)	\$125/\$250	\$1,500/\$3,000	70%	60%	100% (deductible waived)	60%	\$3,500/ \$7,000	\$8,500/ \$17,000
	\$125/\$250	\$3,000/\$6,000	70%	60%	100% (deductible waived)	60%	\$2,000/ \$4,000	\$7,000/ \$14,000
<b>100% Coinsurance Plans</b> (without maternity coverage)	\$125/\$250	\$5,000/\$10,000	100%	70%	100% (deductible waived)	70%	\$0/\$0	\$5,000/ \$10,000
<b>100% Coinsurance Plans</b> (with maternity coverage)	\$125/\$250	\$3,000/\$6,000	100%	70%	100% (deductible waived)	70%	\$0/\$0	\$3,000/ \$6,000
	\$125/\$250	\$5,000/\$10,000	100%	70%	100% (deductible waived)	70%	\$0/\$0	\$5,000/ \$10,000

<sup>1</sup> Either one or all members must satisfy the family deductible collectively before any covered services will be paid by the plan.

<sup>2</sup> Services subject to calendar-year deductible. In-Network and Out-of-Network deductibles accumulate together.

<sup>3</sup> The annual out-of-pocket limit is in addition to the deductible. 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.

\* The HIA Plus allocation of \$125 per individual and \$250 per family is contributed to the health account each quarter, for a calendar year total of \$500 per individual and \$1,000 per family.



# Welcome to Our Lumenos® Plans Offered by BC Life & Health Insurance Company

## Summary of Covered Services

### Preventive Care

Blue Cross' Lumenos plans cover preventive services recommended by the U.S. Preventive Services Task Force, the American Cancer Society, the Advisory Committee on Immunization Practices and the American Academy of Pediatrics. The preventive care benefits include screening tests, immunizations and counseling services designed to detect and prevent medical conditions in advance and help keep you healthier in the long run.

All preventive services received from an in-network provider are covered at the coinsurance listed in the benefits comparison chart and are not subject to your deductible. If you see an out-of-network provider, then your deductible and out-of-network coinsurance responsibility will apply. If you receive any of these services for diagnostic purposes – for example, colonoscopy when symptoms are present – the appropriate plan deductible and coinsurance will apply and available health account dollars may be used to cover these costs.

The following is an overview of the types of preventive services covered:

#### Well Baby and Well Child Preventive Care

##### Office Visits for preventive services

**Screening Tests** for vision (eye chart), hearing, and lead exposure. Also includes pelvic exam, Pap test and contraceptive management for females who are age 18, or have been sexually active.

##### Immunizations:

Hepatitis A  
 Hepatitis B  
 Diphtheria, Tetanus, Pertussis (DtaP)  
 Varicella (chicken pox)  
 Influenza - flu shot  
 Pneumococcal Conjugate (pneumonia)  
 Human Papilloma Virus (HPV) - cervical cancer  
 H. Influenza type b  
 Polio  
 Measles, Mumps, Rubella (MMR)  
 Meningococcal Polysaccharide  
 Rotavirus

#### Adult Preventive Care

##### Office Visits for preventive services

**Screening Tests** for vision (eye chart), hearing, coronary artery disease, colorectal cancer, prostate cancer, diabetes, and osteoporosis. Also includes mammogram, as well as pelvic exam, Pap test and contraceptive management.

##### Immunizations:

Hepatitis A  
 Hepatitis B  
 Diphtheria, Tetanus, Pertussis (DtaP)  
 Varicella (chicken pox)  
 Influenza - flu shot  
 Pneumococcal Conjugate (pneumonia)  
 Human Papilloma Virus (HPV) - cervical cancer  
 Herpes Zoster (shingles)

### Medical Care

Blue Cross' Lumenos plans cover a wide range of medical services. You can use your available health account funds to pay for these covered services. Once you spend up to your deductible amount shown in the benefits comparison chart for covered services, you will have traditional health coverage with the coinsurance listed in the benefits comparison chart to help pay for additional covered services. The following is a summary of covered medical services under Blue Cross' Lumenos plans:

Physician Office Visits

Inpatient Hospital Services

Outpatient Surgery Services

Diagnostic X-rays/Lab Tests

Emergency Hospital Services, Urgent Care and Ambulance (in-network coinsurance applies both in-network and out-of-network)

Inpatient and Outpatient Mental Health and Substance Abuse Services

Durable Medical Equipment

Prescription Drugs (Retail: 30-day supply, Mail Service: 90-day supply)

Home Health Care and Hospice Care

Physical, Speech and Occupational Therapy Services

Maternity (if included with plan)

For the Lumenos plans without maternity coverage, the Lifetime Maximum (the maximum amount the plan pays per member) is \$7,000,000.

For the Lumenos plans with maternity coverage, the Lifetime Maximum (the maximum amount the plan pays per member) is \$5,000,000.



# Welcome to Our Lumenos® Plans Offered by BC Life & Health Insurance Company

## Exclusions and Limitations

Please take a few moments to review the exclusions and limitations. We want you to understand what your coverage does not include before you enroll. These listings are an overview only. The Lumenos plans Policy booklets contain a comprehensive list of the plans' exclusions and limitations. For a sample copy of a Policy booklet, ask your agent or contact BC Life & Health Insurance Company.

- Cosmetic surgery.
- Custodial care.
- Dental care, dental implants or treatment to the teeth, except as specifically stated in the Policy.
- Orthodontic services, braces, and other orthodontic appliances.
- Durable Medical Equipment, except as specifically stated in the Policy.
- Educational services and nutritional counseling, except as specifically provided or arranged by Blue Cross.
- Any amounts in excess of the maximum amounts stated in the benefit sections of the Policy.
- Experimental or investigative services.
- Food and/or dietary supplements, except for formulas and special food products as specifically stated in the Policy.
- Any services provided by a local, state or federal government agency.
- Hearing aids.
- Infertility services.
- Mental and nervous disorders and substance abuse, except as specifically stated in the benefit sections of the Policy.
- Care or treatment furnished in a non-contracting hospital, except for a Medical Emergency as defined in the Policy.
- Any services received by Medicare benefits without payment of additional premium.
- Services received before your effective date or during an inpatient stay that began before your effective date.
- Services received after your coverage ends.
- Any services or supplies that are not Medically Necessary.
- Orthopedic shoes, except when joined to braces or shoe inserts.
- Outdoor treatment programs.
- Outpatient drugs, medications or other substances dispensed or administered in any outpatient setting.
- Outpatient speech therapy, except as specifically stated in the Policy.
- Personal comfort items.
- Services or supplies related to a pre-existing condition.
- Private duty nursing.
- Routine physical exams, except for preventive care services (e.g., physical exams for insurance, employment, licenses or school are not covered) except as specifically stated in the Policy.
- Services for which no charge would be made if you did not have a health plan or insurance coverage.
- Services from relatives.
- Sex changes.
- Telephone and facsimile machine consultations.
- Services not specifically listed as Covered Services in the Policy.
- Vision care, except as specifically stated in the benefit sections of the Policy.
- Services primarily for weight reduction or treatment of obesity, except medically necessary treatment of morbid obesity.
- Conditions covered by workers' compensation law.
- Maternity and pregnancy care (unless the plan selected specifically includes maternity coverage).

### Questions?

For more information about Individual Lumenos plans, contact your agent.

Si necesita asistencia o materiales de venta en español, por favor contacte a su agente Blue Cross.

This brochure 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 Policy booklet. In the event of a conflict between the contract or Policy booklet and this brochure, the terms of the contract or Policy booklet will prevail.

[bluecrossca.com](http://bluecrossca.com)