

Lumenos[®] Plan Comparison

for Individuals and Families in Nevada



		Lumenos HSA Plan		Lumenos HIA Plan		Lumenos HIA Plus Plan ³	
Coinsurance	Annual Deductible ¹	Coinsurance ² / Out-of-Pocket Maximum ³ Cost to Member		Coinsurance ² / Out-of-Pocket Maximum ³ Cost to Member		Coinsurance ² / Out-of-Pocket Maximum ³ Cost to Member	
	In-Network / Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
70% Coinsurance	Individual: \$1,500 / \$3,000	30% / \$5,000	50% / \$10,000	30% / \$4,500	50% / \$9,000	not offered	
	Family: \$3,000 / \$6,000	30% / \$10,000	50% / \$20,000	30% / \$9,000	50% / \$18,000		
80% Coinsurance	Individual: \$2,500 / \$5,000	20% / \$5,000	40% / \$10,000	20% / \$5,000	40% / \$10,000	20% / \$5,000	40% / \$10,000
	Family: \$5,000 / \$10,000	20% / \$10,000	40% / \$20,000	20% / \$10,000	40% / \$20,000	20% / \$10,000	40% / \$20,000
100% Coinsurance	Individual: \$5,000 / \$10,000	0% / \$5,000	30% / \$15,000	0% / \$5,000	30% / \$15,000	0% / \$5,000	30% / \$15,000
	Family: \$10,000 / \$20,000	0% / \$10,000	30% / \$30,000	0% / \$10,000	30% / \$30,000	0% / \$10,000	30% / \$30,000
Lifetime Maximum <i>(the amount the plan pays up to per member)</i>		\$2 Million		\$2 Million		\$2 Million	

Covered Services	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
	<i>(your share of costs after deductible)</i>		<i>(your share of costs after deductible)</i>		<i>(your share of costs after deductible)</i>	
Doctors' Office Visits						
Professional Services <i>(x-ray, lab, anesthesia, surgeon, etc.)</i>						
Hospital Inpatient <i>(overnight hospital stays)</i>	30% / 20% / 0%	50% / 40% / 30%	30% / 20% / 0%	50% / 40% / 30%	20% / 0%	40% / 30%
Hospital Outpatient <i>(if you don't stay overnight)</i>						
Emergency Room Services						
Maternity	not covered		not covered		not covered	
Preventive Care	0% (deductible waived)		20% / 0% (deductible waived)		0% (deductible waived)	
Chiropractic Services		50% / 40% / 30%		50% / 40% / 30%		40% / 30%
Prescription Drug Coverage	30% / 20% / 0%		30% / 20% / 0%		20% / 0%	

1 Either one or all members must satisfy the family deductible collectively before any covered services will be paid by the plan.
2 Services subject to calendar-year deductible. In-Network and out-of-network deductible accumulate separately.

3 The annual calendar year out-of-pocket maximum includes 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 calendar year.

What the Nevada individual Lumenos plans do not cover

This listing is an overview only. Your plan's Summary of Benefits and Certificate contain a comprehensive list of the plan's exclusions and limitations. You can request a copy of the Summary of Benefits and Certificate from your agent.

Exclusions and Limitations

- Alternative or complementary medicines
- Artificial conception, except as provided in the member's Certificate
- Services received before the member's plan effective date
- Biofeedback
- The first three pints of blood, blood plasma and blood derivatives.
- Chelating agent, except for providing treatment of heavy metal poisoning
- Services or supplies provided as part of clinic research, except where required by law or allowed by Anthem Blue Cross and Blue Shield
- Complications arising from non-covered services and supplies
- Convalescent care
- Services and supplies used primarily for the member's personal comfort or convenience
- Cosmetic services
- Services that are required under court order, parole or probation unless those services would otherwise be covered under this certificate
- Custodial care
- Dental services, except as otherwise covered under this certificate
- Inpatient care received after the date Anthem, using managed care guidelines, determines discharge is appropriate
- Domiciliary care such as care provided in a residential, non-treatment institution, halfway house or school.
- Experimental/investigative procedures
- Genetic testing/counseling
- Government operated facility, including a veterans administration facility
- Hair loss drugs, hair pieces, artificial hairpieces, hair or cranial prosthesis, hair transplants or implants
- Hearing aids or routine hearing tests
- Hypnosis, whether for medical or anesthesia purposes
- Any loss to which a contributing cause was the member's commission of or attempt to commit a felony which they are convicted of
- Services or supplies for the treatment of intractable pain and/or chronic pain.
- Therapies for learning deficiencies and/or behavioral problems, maintenance therapy
- Services and supplies that are not medically necessary
- Charges for treatment of non-severe mental illness, regardless of where they are furnished
- Charges for the member's failure to keep scheduled appointments
- Neuropsychiatric testing, unless allowed by Anthem's medical policy
- Non-covered providers or facilities
- Non-medical expenses
- Upper or lower jaw augmentation or reductions (orthognathic surgery)
- Any items available without a prescription
- Care received after coverage is terminated
- Services related to a pre-existing conditions as defined in the member's Certificate
- Services related to normal pregnancy including prenatal and deliver services
- Private duty nursing services
- Private room expenses, except as noted in the member's Certificate
- Ultrafast CT scan and peripheral bone density testing
- Charges for the preparation of medical reports or itemized bills or charges for duplication of medical records from the provider when requested by the member
- Services or supplies necessitated by injuries which a member intentionally self inflicted, except where the law prohibits such an exclusion
- Services or supplies related to sex-change operations, reversals of such procedures, complications of such procedures, or services received prior to any such operation
- Services, supplies, or prescription drugs for the treatment of sexual dysfunction or impotence
- Services provided in or by a skilled nursing facility
- Routine eye examinations, routine refractive examinations, eyeglasses, frames, contact lenses (even if there is a medical diagnosis which prevents the member from wearing contact lenses), or prescriptions for such services and supplies
- Services or supplies necessary to treat disease or injury resulting from war, civil war, insurrection, rebellion, or revolution
- Weight loss services except as provided in the Certificate under Healthy Rewards
- Services and supplies for a work- related accident or illness
- A maximum payment of \$2,500 per member's benefit year for special food products that are prescribed or ordered by a physician as medically necessary is allowed