



# City of Chico Lumenos<sup>®</sup> Health Savings Account (HSA) Embedded EPID CGHSA773

This Summary of Benefits is a brief overview of your plan's benefits only. The benefits listed are for both in state and out of state members, there may be differences in benefits depending on where you reside. For more detailed information about the benefits in your plan, please refer to your Certificate of Insurance or Evidence of Coverage (EOC), which explains the full range of covered services, as well as any exclusions and limitations for your plan.

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.

### Explanation of Covered Expense

Plan payments are based on covered expense, which is the lesser of the charges billed by the provider or the following:

**Participating Providers** — Negotiated rates. Insured persons are not responsible for the difference between the provider's usual charges and the negotiated amount.

**Non-Participating Providers & Other Health Care Providers** (*includes those not represented in the PPO provider network*) — The customary and reasonable charge for professional services or the reasonable charge for institutional services.

**Participating Pharmacies & Mail Service Program** — Prescription drug negotiated rates. Insured persons are not responsible for any amount in excess of the prescription drug maximum allowed amount.

**Non-Participating Pharmacies** — Drug limited fee schedule amount. Insured persons are responsible for any expense not covered under this plan and 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 and actual charges, as well as any deductible and 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 for all providers (*applicable to medical care & prescription drug benefits*)

- Individual insured person \$3,000/individual insured person
- Insured family \$6,000/insured family  
(*Each insured person only needs to satisfy his or her individual deductible, not the entire family deductible, prior to receiving plan benefits*)

### Annual Out-of-Pocket Maximums (*in-network/out-of-network out-of-pocket maximums are exclusive of each other; includes calendar year deductible & prescription drug maximum allowed amount*)

- Participating Providers, Participating Pharmacy & Other Health Care Providers \$3,000/individual insured person; \$6,000/insured family/year
- Non-Participating Providers & Non-Participating Pharmacy \$5,000/individual insured person; 10,000/insured family/year

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	
	In-Network	Insured Person Copay Out-of-Network <i>(Insured is also responsible for charges in excess of covered expense.)</i>
<b>Hospital Medical Services</b> <i>(subject to utilization review for inpatient services; waived for emergency admissions)</i>		
➤ Semi-private room, meals & special diets, & ancillary services	No copay	50%
➤ Outpatient medical care, surgical services & supplies <i>(hospital care other than emergency room care)</i>	No copay	50%
<b>Ambulatory Surgical Centers</b>		
➤ Outpatient surgery, services & supplies	No copay	50% <i>(benefit limited to \$350/visit)</i>
<b>Hemodialysis</b>		
➤ Outpatient hemodialysis services & supplies	No copay	50% <i>(benefit limited to \$350/visit)</i>
<b>Skilled Nursing Facility</b> <i>(subject to utilization review)</i>		
➤ Semi-private room, services & supplies <i>(limited to 100 days/calendar year)</i>	No copay	No copay
<b>Hospice Care</b>		
➤ Inpatient or outpatient services; family bereavement services	No copay	No copay
<b>Home Health Care</b>		
➤ Services & supplies from a home health agency <i>(limited to 100 visits/calendar year, one visit by a home health aide equals four hours or less; not covered while insured person receives hospice care)</i>	No copay	No copay
<b>Home Infusion Therapy</b>		
➤ Includes medication, ancillary services & supplies; caregiver training & visits by provider to monitor therapy; durable medical equipment; lab services	No copay	No copay <i>(benefit limited to \$600/day)</i>
<b>Physician Medical Services</b>		
➤ Office & home visits	No copay	50%
➤ Hospital & skilled nursing facility visits	No copay	50%
➤ Surgeon & surgical assistant; anesthesiologist or anesthesiologist	No copay	50%
<b>Diagnostic X-ray &amp; Lab</b>		
➤ MRI, CT scan, PET scan & nuclear cardiac scan <i>(subject to utilization review)</i>	No copay	50%
➤ Other diagnostic X-ray & lab	No copay	50%
<b>Preventive Care Services</b>		
<i>Preventive Care Services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits</i>		
➤ Routine physical examinations <i>(birth through age six)</i>	No copay <i>(deductible waived)</i>	Not covered
➤ Immunizations <i>(birth through age six)</i>	No copay <i>(deductible waived)</i>	Not covered
➤ Routine physical exams, immunizations, diagnostic X-ray & lab for routine physical exam (members 7 years old and older)	No copay <i>(deductible waived)</i>	Not covered
➤ Adult preventive services <i>(including mammograms, Pap smears, prostate cancer screenings &amp; colorectal cancer screenings)</i>	No copay <i>(deductible waived)</i>	Not covered
<b>Physical Therapy, Physical Medicine &amp; Occupational Therapy</b> <i>(limited to 24 visits/calendar year)</i>	No copay	50%
<b>Chiropractic Services</b> <i>(limited to 20 visits/calendar year)</i>	No copay	50%
<b>Speech Therapy</b>		
➤ Outpatient speech therapy following injury or organic disease	No copay	50%

Covered Services	Traditional Health Coverage Insured Person Copay	
	In-Network	Out-of-Network <i>(Insured is also responsible for charges in excess of covered expense.)</i>
<b>Acupuncture</b>		
➤ Services for the treatment of disease, illness or injury	Not covered	Not covered
<b>Temporomandibular Joint Disorders</b>		
➤ Splint therapy & surgical treatment	No copay	50%
<b>Pregnancy &amp; Maternity Care</b>		
➤ Physician office visits	No copay	50%
➤ Prescription drug for elective abortion ( <i>mifepristone</i> )	No copay	50%
Normal delivery, cesarean section, complications of pregnancy & abortion ( <i>newborn routine nursery care covered when natural mother is insured employee or spouse/domestic partner</i> )		
➤ Inpatient physician services	No copay	50%
➤ Hospital & ancillary services	No copay	50%
<b>Organ &amp; Tissue Transplants</b> ( <i>subject to utilization review; specified organ transplants covered only when performed at Centers of Medical Excellence [CME]</i> )		
➤ Inpatient services provided in connection with non-investigative organ or tissue transplants		No copay
➤ Transplant travel expense for an authorized, specified transplant at a CME ( <i>recipient and companion transportation limited to 6 trips/episode and \$250/person/trip for round-trip coach airfare hotel limited to 1 room double occupancy and \$100/day for 21 days/trip, other expenses limited to \$25/day/person for 21 days/trip; donor transportation limited to 1 trip/episode and \$250 for round-trip coach airfare, hotel limited to \$100/day for 7 days, other expenses limited to \$25/day for 7 days</i> )		No copay
<b>Bariatric Surgery</b> ( <i>subject to utilization review; medically necessary surgery for weight loss, only for morbid obesity, covered only when performed at Centers of Medical Excellence [CME]</i> )		
➤ Inpatient services provided in connection with medically necessary surgery for weight loss, only for morbid obesity		No copay
➤ Bariatric travel expense when insured person's home is 50 miles or more from the nearest bariatric CME ( <i>Our maximum payment will not exceed \$3,000 per surgery for the following travel expenses incurred by the insured person and/or one companion: Transportation for the insured person and/or one companion to and from the CME. Lodging, limited to one room, double occupancy. Other reasonable expenses. Tobacco, alcohol, drug and meal expenses are excluded from coverage.</i> )		No copay
<b>Diabetes Education Programs</b> ( <i>requires physician supervision</i> )		
➤ Teach insured persons & their families about the disease process, the daily management of diabetic therapy & self-management training	No copay	50%

<sup>1</sup> 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.)
<b>Prosthetic Devices</b>		
➤ 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	No copay	50%
<b>Durable Medical Equipment</b>		
➤ Rental or purchase of DME including hearing aids, dialysis equipment & supplies ( <i>hearing aids benefit is available for one hearing aid per ear every three years</i> )	No copay	50%
<b>Related Outpatient Medical Services &amp; Supplies</b>		
➤ Ground or air ambulance transportation, services & disposable supplies		No copay <sup>1</sup>
➤ Blood transfusions, blood processing & the cost of unreplaced blood & blood products		No copay <sup>1</sup>
➤ Autologous blood ( <i>self-donated blood collection, testing, processing &amp; storage for planned surgery</i> )		No copay <sup>1</sup>
<b>Specialty Pharmacy Drugs</b> ( <i>utilization review may be required</i> )		
➤ Specialty pharmacy drugs filled through the specialty pharmacy program ( <i>limited to 30-day supply; not covered if benefits are provided through prescription drug benefits, if applicable</i> )	No copay	Not covered <sup>2</sup>
<p><b>If insured person does not get specialty pharmacy drugs from the specialty pharmacy program, insured person will not receive any specialty pharmacy drug benefits under this plan, unless the insured person qualifies for an exception as specified in the Certificate.</b></p>		
<b>Emergency Care</b>		
➤ Emergency room services & supplies	No copay	No copay
➤ Inpatient hospital services & supplies	No copay	No copay
➤ Physician services	No copay	No copay
<b>Mental or Nervous Disorders and Substance Abuse</b>		
<b>Inpatient Care</b>		
➤ Facility-based care ( <i>subject to utilization review; waived for emergency admissions</i> )	No copay	50%
➤ Inpatient physician visits	No copay	50%
<b>Outpatient Care</b>		
➤ Facility-based care ( <i>subject to utilization review; waived for emergency admissions</i> )	No copay	50%
➤ Outpatient physician visits ( <i>pre-service review required after the 12th visit</i> )	No copay	50%

<sup>1</sup> These providers are not represented in the Anthem Blue Cross PPO Network.

<sup>2</sup> 10% if insured person or non-PPO physician obtains drug from Specialty Pharmacy Program; otherwise, not covered.

Covered Services (For Outpatient Prescription Drugs)	Traditional Health Coverage Per Insured Person Copay for Each Prescription or Refill
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### Outpatient Prescription Drug Benefits

*(Until the calendar year deductible is satisfied, the insured person pays the prescription drug maximum allowed amount, and not the copays listed below.)*

<b>Retail Pharmacy</b>	
➤ Generic drugs	No copay
➤ Brand name formulary drugs <sup>1</sup>	No copay
➤ Brand name non-formulary drugs <sup>1</sup>	No copay
➤ Compound drugs <sup>1</sup>	No copay
➤ Self-administered injectable drugs, except insulin	No copay
<b>Mail Service</b>	
➤ Generic drugs	No copay
➤ Brand name formulary drugs <sup>1</sup>	No copay
➤ Brand name non-formulary drugs <sup>1</sup>	No copay
➤ Self-administered injectable drugs, except insulin	No copay
<b>Specialty Pharmacy Drugs</b> <i>(may only be obtained through the specialty pharmacy program)</i>	
➤ Generic drugs	No copay
➤ Brand name formulary drugs <sup>1</sup>	No copay
➤ Brand name non-formulary drugs <sup>1</sup>	No copay
➤ Self-administered injectable drugs, except insulin	No copay
<b>Non-participating Pharmacies</b> <i>(compound drugs &amp; specialty pharmacy drugs not covered at a retail pharmacy)</i>	<b>Not covered</b>
<b>Supply Limits<sup>2</sup></b>	
➤ Retail Pharmacy <i>(participating and non-participating)</i>	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)
➤ Mail Service	90-day supply
➤ Specialty Pharmacy	30-day supply

<sup>1</sup> **Preferred Generic Program** If a member requests a formulary or non-formulary brand name drug when a generic drug substitution exists, the member pays the difference in cost between the prescription drug maximum allowed amount for the generic drug and the brand name drug dispensed, but not more than 50% of our cost of the prescription drug. The Preferred Generic Program does not apply when the physician has specified "dispense as written" (DAW) or when it has been determined that the brand name drug (formulary or non-formulary) is medically necessary for the member. In such case, the applicable copay for the dispensed drug will apply.

<sup>2</sup> Supply limits for certain drugs may be different. Please refer to the Certificate for complete information.

#### The Outpatient Prescription Drug Benefit covers the following:

- 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
- Prescription oral contraceptives; contraceptive diaphragms. Contraceptive diaphragms are limited to one per year.
- Injectable drugs which are self-administered by the subcutaneous route (under the skin) by the patient or insured person. 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.

**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.**

# Lumenos HSA Embedded Plan — Exclusions and Limitations

**Benefits are not provided for expenses incurred for or in connection with the following items:**

**Not Medically Necessary.** Services or supplies that are not medically necessary, as defined.

**Experimental or Investigative.** Any experimental or investigative procedure or medication. But, if insured person is denied benefits because it is determined that the requested treatment is experimental or investigative, the insured person may request an independent medical review, as described in the Certificate.

**Outside the United States.** Services or supplies furnished and billed by a provider outside the United States, unless such services or supplies are furnished in connection with urgent care or an emergency.

**Crime or Nuclear Energy.** Conditions that result from (1) the insured person's commission of or attempt to commit a felony, as long as any injuries are not a result of a medical condition or an act of domestic violence; or (2) any release of nuclear energy, whether or not the result of war, when government funds are available for the treatment of illness or injury arising from the release of nuclear energy.

**Not Covered.** Services received before the insured person's effective date. Services received after the insured person's coverage ends, except as specified as covered in the Certificate.

**Excess Amounts.** Any amounts in excess of covered expense or any Medical Benefit Maximum.

**Work-Related.** Work-related conditions if benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any workers' compensation, employer's liability law or occupational disease law, whether or not the insured person claims those benefits. If there is a dispute of substantial uncertainty as to whether benefits may be recovered for those conditions pursuant to workers' compensation, we will provide the benefits of this plan for such conditions, subject to a right of recovery and reimbursement under California Labor Code Section 4903, as specified as covered in the Certificate.

**Government Treatment.** Any services the insured person actually received that were provided by a local, state or federal government agency, except when payment under this plan is expressly required by federal or state law. We will not cover payment for these services if the insured person is not required to pay for them or they are given to the insured person for free.

**Services of Relatives.** Professional services received from a person living in the insured person's home or who is related to the insured person by blood or marriage, except as specified as covered in the Certificate.

**Voluntary Payment.** Services for which the insured person has no legal obligation to pay, or for which no charge would be made in the absence of insurance coverage or other health plan coverage, except services received at a non-governmental charitable research hospital. Such a hospital must meet the following guidelines:

1. it must be internationally known as being devoted mainly to medical research;
2. at least 10% of its yearly budget must be spent on research not directly related to patient care;
3. at least one-third of its gross income must come from donations or grants other than gifts or payments for patient care;
4. it must accept patients who are unable to pay; and
5. two-thirds of its patients must have conditions directly related to the hospital's research.

**Not Specifically Listed.** Services not specifically listed in the plan as covered services.

**Private Contracts.** Services or supplies provided pursuant to a private contract between the insured person and a provider, for which reimbursement under Medicare program is prohibited, as specified in Section 1802 (42 U.S.C. 1395a) of Title XVIII of the Social Security Act.

**Inpatient Diagnostic Tests.** Inpatient room and board charges in connection with a hospital stay primarily for diagnostic tests which could have been performed safely on an outpatient basis.

**Mental or Nervous Disorders.** Academic or educational testing, counseling, and remediation. Mental or nervous disorders or substance abuse, including rehabilitative care in relation to these conditions, except as specified as covered in the Certificate.

**Nicotine Use.** Smoking cessation programs, except as specified as covered in the Certificate, or treatment of nicotine or tobacco use. Smoking cessation drugs, except as specified as covered in the Certificate.

**Orthodontia.** Braces, other orthodontic appliances or orthodontic services.

**Dental Services or Supplies.** Dental plates, bridges, crowns, caps or other dental prostheses, dental implants, dental services, extraction of teeth, treatment to the teeth or gums, or treatment to or for any disorders for the temporomandibular (jaw) joint, except as specified as covered in the Certificate. Cosmetic dental surgery or other dental services for beautification.

**Hearing Aids or Tests.** Hearing aids, except as specified as covered in the Certificate. Routine hearing tests, except as specified as covered in the Certificate.

**Optometric Services or Supplies.** Optometric services, eye exercises including orthoptics. Routine eye exams and routine eye refractions, as specified as covered in the Certificate. Eyeglasses or contact lenses, except as specified as covered in the Certificate.

**Outpatient Occupational Therapy.** Outpatient occupational therapy, except by a home health agency, hospice, or home infusion therapy provider, as specified as covered in the Certificate.

**Outpatient Speech Therapy.** Outpatient speech therapy, except as specified as covered in the Certificate.

**Cosmetic Surgery.** Cosmetic surgery or other services performed solely for beautification or to alter or reshape normal (including aged) structures or tissues of the body to improve appearance. This exclusion does not apply to reconstructive surgery (that is, surgery performed to correct deformities caused by congenital or developmental abnormalities, illness, or injury for the purpose of improving bodily function or symptomatology or to create a normal appearance), including surgery performed to restore symmetry following mastectomy. Cosmetic surgery does not become reconstructive surgery because of psychological or psychiatric reasons.

**Scalp Hair Prostheses.** Scalp hair prostheses, including wigs or any form of hair replacement, except as specified as covered in the Certificate.

**Commercial Weight Loss Programs.** Weight loss programs, whether or not they are pursued under medical or *physician* supervision, unless specifically listed as covered in this *plan*.

This exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

This exclusion does not apply to *medically necessary* treatments for morbid obesity or dietary evaluations and counseling, and behavioral modification programs for the treatment of anorexia nervosa or bulimia nervosa. Surgical treatment for morbid obesity is covered as described in the Certificate.

**Sex Transformation.** Procedures or treatments to change characteristics of the body to those of the opposite sex.

**Sterilization Reversal.**

**Infertility Treatment.** Any services or supplies furnished in connection with the diagnosis and treatment of infertility, including, but not limited to diagnostic tests, medication, surgery, artificial insemination, in vitro fertilization, sterilization reversal and gamete intrafallopian transfer.

**Surrogate Mother Services.** For any services or supplies provided to a person not covered under the plan in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

**Orthopedic Supplies.** Orthopedic supplies, orthopedic shoes (other than shoes joined to braces), or non-custom molded and cast shoe inserts, except for therapeutic shoes and inserts for the prevention and treatment of diabetes-related foot complications as specified as covered in the Certificate.

**Air Conditioners.** Air purifiers, air conditioners or humidifiers.

**Custodial Care or Rest Cures.** Inpatient room and board charges in connection with a hospital stay primarily for environmental change or physical therapy. Custodial care or rest cures, except as specified as covered in the Certificate. Services provided by a rest home, a home for the aged, a nursing home or any similar facility. Services provided by a skilled nursing facility, except as specified as covered in the Certificate.

**Chronic Pain.** Treatment of chronic pain, except as specified as covered in the Certificate.

**Health Club Memberships.** Health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment or facilities used for developing or maintaining physical fitness, even if ordered by a *physician*. This exclusion also applies to health spas.

**Personal Items.** Any supplies for comfort, hygiene or beautification.

**Education or Counseling.** Educational services or nutritional counseling, except as specified as covered in the Certificate. This exclusion does not apply to counseling for the treatment of anorexia nervosa or bulimia nervosa.

**Food or Dietary Supplements.** Nutritional and/or dietary supplements, except as provided in this *plan* or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either a written prescription or dispensing by a licensed pharmacist.

**Telephone and Facsimile Machine Consultations.** Consultations provided by telephone, except as specified as covered in the Certificate, or facsimile machine.

**Routine Exams or Tests.** Routine physical exams or tests which do not directly treat an actual illness, injury or condition, including those required by employment or government authority, except as specified as covered in the Certificate.

**Acupuncture.** Acupuncture treatment, except as specified as covered in the Certificate. Acupressure or massage to control pain, treat illness or promote health by applying pressure to one or more specific areas of the body based on dermatomes or acupuncture points.

**Eye Surgery for Refractive Defects.** Any eye surgery solely or primarily for the purpose of correcting refractive defects of the eye such as nearsightedness (myopia) and/or astigmatism. Contact lenses and eyeglasses required as a result of this surgery.

**Physical Therapy or Physical Medicine.** Services of a physician for physical therapy or physical medicine, except when provided during a covered inpatient confinement or as specified as covered in the Certificate.

**Outpatient Prescription Drugs and Medications.** Outpatient prescription drugs or medications and insulin, except as specified as covered in the Certificate. Non-prescription, over-the-counter patent or proprietary drug or medicines, except as specified as covered in the Certificate. Cosmetics, health or beauty aids.

**Specialty Pharmacy Drugs.** Specialty pharmacy drugs that must be obtained from the specialty pharmacy program, but, which are obtained from a retail pharmacy, are not covered by this plan. **Insured person will have to pay the full cost of the specialty pharmacy drugs obtained from a retail pharmacy that should have been obtained from the specialty pharmacy program.**

**Contraceptive Devices.** Contraceptive devices prescribed for birth control except as specified as covered in the Certificate.

**Diabetic Supplies.** Prescription and non-prescription diabetic supplies except as specified as covered in the Certificate.

**Private Duty Nursing.** Inpatient or outpatient services of a private duty nurse.

**Lifestyle Programs.** Programs to alter one's lifestyle which may include but are not limited to diet, exercise, imagery or nutrition, except as specified as covered in the Certificate. This exclusion will not apply to cardiac rehabilitation programs approved by us.

**Clinical Trials.** Services and supplies in connection with clinical trials, except as specified as covered in the Certificate.

# Lumenos HSA Embedded Rx Copay after Deductible Plan — Exclusions and Limitations (Continued)

## Outpatient prescription drug services and supplies are not provided for or in connection with the following:

Immunizing agents, biological sera, blood, blood products or blood plasma

Hypodermic syringes &/or needles, except when dispensed for use with insulin & other self-injectable drugs or medications

Drugs & medications used to induce spontaneous & non-spontaneous abortions

Drugs & medications dispensed or administered in an outpatient setting, including outpatient hospital facilities and physicians' offices

Professional charges in connection with administering, injecting or dispensing drugs

Drugs & medications that may be obtained without a physician's written prescription, except insulin or niacin for cholesterol lowering and certain over-the-counter drugs approved by the Pharmacy and Therapeutics Committee to be included in the prescription drug formulary.

Drugs & medications dispensed by or while confined in a hospital, skilled nursing facility, rest home, sanatorium, convalescent hospital or similar facility

Durable medical equipment, devices, appliances & supplies, even if prescribed by a physician, except contraceptive diaphragms, as specified as covered in the Certificate

Services or supplies for which the insured person is not charged

Oxygen

Cosmetics & health or beauty aids.

Drugs labeled "Caution, Limited by Federal Law to Investigational Use," or Non-FDA approved investigational drugs. Any drugs or medications prescribed for experimental indications

Any expense for a drug or medication incurred in excess of the prescription drug maximum allowed amount.

Drugs which have not been approved for general use by the State of California Department of Health Services or the Food and Drug Administration. This does not apply to drugs that are medically necessary for a covered condition.

Drugs to eliminate or reduce dependency on, or addiction to, tobacco and tobacco products. This does not apply to medically necessary drugs that the insured person can only get with a prescription under state and federal law.

Drugs used primarily for cosmetic purposes (e.g., Retin-A for wrinkles). However, this will not apply to the use of this type of drug for medically necessary treatment of a medical condition other than one that is cosmetic.

Drugs used primarily to treat infertility (including, but not limited to, Clomid, Pergonal and Metrodin), unless medically necessary for another covered condition.

Anorexiant and drugs used for weight loss, except when used to treat morbid obesity (e.g., diet pills & appetite suppressants)

Drugs obtained outside the U.S. unless they are furnished in connection with urgent care or an emergency.

Allergy desensitization products or allergy serum

Infusion drugs, except drugs that are self-administered subcutaneously

Herbal supplements, nutritional and dietary supplements except for formulas for the treatment of phenylketonuria.

Prescription drugs with a non-prescription (over-the-counter) chemical and dose equivalent except insulin. This does not apply if an over-the-counter equivalent was tried and was ineffective.

Compound medications unless:

- There is at least one component in it that is a prescription drug; and
- It is obtained from other than a participating pharmacy. **Insured person will have to pay the full cost of the compound medications if insured person obtains drug at a non-participating pharmacy.**

Specialty pharmacy drugs that must be obtained from the specialty pharmacy program, but, which are obtained from a retail pharmacy are not covered by this plan. **Insured person will have to pay the full cost of the specialty pharmacy drugs obtained from a retail pharmacy that insured person should have obtained from the specialty pharmacy program.**

**Third Party Liability** – Anthem Blue Cross Life and Health Insurance Company is entitled to reimbursement of benefits paid if the insured person recovers damages from a legally liable third party.

**Coordination of Benefits** – The benefits of this plan may be reduced if the insured person has any other group health or dental coverage so that the services received from all group coverages do not exceed 100% of the covered expense.

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