

# Your Benefits



**Wright State University**  
**Lumenos Health Savings Accounts Option 6**  
**Summary of Benefits , Effective 01/01/2012**

Covered Benefits	Network	Non-Network
<b>Deductible</b> Family coverage requires the family deductible to be met before coinsurance applies. The single deductible does not apply to family coverage. Network and Non-Network deductibles are combined. (This only applies to non-embedded deductible designs.)	Single: \$2,000 Family: \$4,000	Single: \$2,000 Family: \$4,000
<b>Out-of-Pocket Limit</b>	Single: \$2,000 Family: \$4,000	Single: \$4,000 Family: \$8,000
<b>Physician Home and Office Services (PCP/SCP)</b> Primary Care Physician(PCP)/Specialty Care Physician (SCP) · Including Office Surgeries, allergy serum, allergy injections and allergy testing	0%/0%	30%
<b>Preventive Care Services</b> Services include but are not limited to: Routine Exams, Pelvic Exams, Pap testing, PSA tests, Immunizations, Annual diabetic eye exam, Routine Vision and Hearing exams, Routine Mammograms, Diabetic Self Management Training, and Certain Medical Nutritional Therapy (Network only). · Physician Home and Office Visits (PCP/SCP) · Other Outpatient Services @ Hospital/Alternative Care Facility	No Cost Share	30% 30%
<b>Emergency and Urgent Care</b> · Emergency Room Services @Hospital (facility/other covered services) (copayment waived if admitted) · Urgent Care Center Services	0% 0%	0% 0%
<b>Inpatient and Outpatient Professional Services</b> Include but are not limited to: · Medical Care visits (1 per day), Intensive Medical Care, Concurrent Care, Consultations, Surgery and administration of general anesthesia and Newborn exams	0%	30%
<b>Inpatient Facility Services</b> Unlimited days except for: · 60 days Network/Non-Network combined for physical medicine / rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis) · Unlimited days both In-Network/Non-Network for skilled nursing facility	0%	30%
<b>Outpatient Surgery Hospital / Alternative Care Facility</b> · Surgery and administration of general anesthesia	0%	30%
<b>Other Outpatient Services (including but not limited to):</b> · Non Surgical Outpatient Services For example: MRIs, C-Scans, Chemotherapy, Ultrasounds and other diagnostic outpatient services · Home Care Services - unlimited visits Network/30 visits Non-Network  · Durable Medical Equipment and Orthotics (Network/Non-network combined) Unlimited benefit maximum (including Prosthetic Devices and Medical Supplies) · Prosthetic Devices unlimited benefit maximum · Physical Medicine Therapy Day Rehabilitation programs · Hospice Care/Ambulance Services	0%       0%	30%       0%

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<b>Outpatient Therapy Services</b> (Combined Network & Non-Network limits apply) · Physician Home and Office Visits (PCP/SCP) · Other Outpatient Services @ Hospital/Alternative Care Facility Limits apply to: · Physical therapy/Occupational therapy: 60 visits combined  · Manipulation therapy: 12 visits · Speech therapy: 20 visits	0%/0% 0%	30% 30%
<b>Behavioral Health Services:</b>  · Inpatient Facility Services & Inpatient Professional Services · Physician Home and Office Visits (PCP/SCP) · Other Outpatient Services, Outpatient Facility@ Hospital/Alt Care Facility	0% 0%/0% 0%	30% 30% 30%
<b>Human Organ and Tissue Transplants</b> · Acquisition and transplant procedures, harvest and storage.	0%	30%
<b>Prescription Drugs:</b> · <b>Network Retail Pharmacies:</b> (30-day supply) Includes diabetic test strip · <b>Anthem Mail Service:</b> (90-day Supply) Includes diabetic test strip	0% 0%	30%(2) Not Covered
<b>Lifetime Maximum (Combined Network and Non-Network) (3)</b>	Unlimited	Unlimited

**Notes:**

- All deductibles and coinsurance apply toward the out-of-pocket maximum including prescription drugs. (Excludes Non-network Human Organ and Tissue Transplants).
- Deductible(s) apply only to covered medical services listed with a percentage (%) coinsurance including prescription drugs.
- Network and Non-network deductibles are combined. Network and Non-network coinsurance and out-of-pocket maximums are separate and do not accumulate toward each other.
- *Dependent age:* to the end of the month year in which the dependent attains age 26.
- 0% means no coinsurance up to the maximum allowable amount. However, when choosing a Non-network provider, the member is responsible for any balance due after the plan payment. No cost share means no deductible or coinsurance up to the maximum allowable amount.
- PCP is a Network Provider who is a practitioner that specializes in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other Network provider as allowed by the plan.
- SCP is a Network Provider, other than a Primary Care Physician, who provides services within a designated specialty area of practice.
- Benefit period = Calendar Year
- (1) We encourage you to contact Our Mental Health Subcontractor to assure the use of appropriate procedures, setting and medical necessity. Refer to Schedule of Benefits for limitations.
- (2) Rx non-network diabetic/asthmatic supplies not covered except diabetic test strips.

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***Precertification:***

*· Members are encouraged to always obtain prior approval when using Non-network providers. Precertification will help avoid any unnecessary reduction in benefits for non-covered or non-medically necessary services.*

*This summary of benefits is intended to be a brief outline of coverage. The entire provisions of benefits and exclusions are contained in the Group Contract, Certificate, and Schedule of Benefits. In the event of a conflict between the Group Contract and this description, the terms of the Group Contract will prevail.*