Your Summary of Benefits

Harris Mackessy & Brennan, dba HMB, Inc
Lumenos Health Savings Accounts (with Copay)
Effective 01/01/2017

Covered Benefits	Network	Non-Network
Deductible Embedded The single deductible applies to the Family deductible. Once the single deductible has been satisfied, benefits for that member are payable subject to coinsurance. Once the family deductible has been satisfied, benefits for the family are payable subject to coinsurance.	Single: $2,600 Family: $5,200	Single: $5,200 Family: $10,400
Out-of-Pocket Limit	Single: $3,500 Family: $7,000	Single: $7,000 Family: $14,000
Physician Home and Office Services (PCP/SCP) Primary Care Physician(PCP)/Specialty Care Physician (SCP) Including Office Surgeries and allergy serum: • Allergy injections (PCP and SCP) • Allergy testing • MRAs, MRIs, PETS, C-Scans, Nuclear Cardiology Imaging Studies, non-maternity related Ultrasounds and Pharmaceuticals	$30/$60 0% 0% 0%	30%
Preventive Care Services • Routine medical exams, Mammograms, Pelvic Exams, Pap testing, PSA tests, Immunizations, Annual diabetic eye exam, Hearing screenings and Vision screenings which are limited to Screening tests (i.e. Snellen eye chart) and Ocular Photo screening	No cost share	30%
Emergency and Urgent Care **Emergency Room Services** • facility/other covered services (copayment waived if admitted) **Urgent Care Center Services** • MRAs, MRIs, PETS, C-Scans, Nuclear Cardiology Imaging Studies, • Non-Maternity related Ultrasounds and Pharmaceuticals • Allergy injections • Allergy testing	$250 $75 0% 0% 0% 0%	$250 30%
Inpatient and Outpatient Professional Services Include but are not limited to: • Medical Care visits, Intensive Medical Care, Concurrent Care, Consultations, Surgery and administration of general anesthesia and Newborn exams	0%	30%
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Inpatient Facility Services (Network/Non-Network combined) Unlimited days except for: • 60 days for physical medicine/rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis) • 100 days for skilled nursing facility	0%	30%
Outpatient Surgery Hospital/Alternative Care Facility • Surgery and administration of general anesthesia	0%	30%
Other Outpatient Services including but not limited to: • Non Surgical Outpatient Services For example: MRIs, C-Scans, Chemotherapy, Ultrasounds and other diagnostic outpatient services. • Home Care Services 100 visits (excludes IV Therapy) (Network/Non-network combined) • Durable Medical Equipment • Physical Medicine Therapy Day Rehabilitation programs • Hospice Care • Ambulance Services	0% See note below for cost share details. 0% 0%	30% See note below for cost share details. 0% 0%
Accidental Dental Services $3,000 per accident (Network and Non-network combined)	0%	30%
Outpatient Therapy Services (Combined Network & Non-Network limits apply) • Physician Home and Office Visits • Other Outpatient Services @ Hospital/Alternative Care Facility Limits apply to: • Cardio Rehabilitation: 36 visits • Pulmonary Rehabilitation: 20 visits • Physical therapy: 20 visits • Occupational therapy: 20 visits • Speech therapy: 20 visits • Manipulation therapy: 12 visits	 $30/$60 0%	 30% 30%
Behavioral Health Services: Mental Illness and Substance Abuse[1] • Inpatient Facility Services • Physician Home and Office Visits (PCP/SPC) Other Outpatient Services @ Hospital/Alternative Care Facility	 0% $30 0%	 30% 30% 30%
Human Organ and Tissue Transplants Acquisition and transplant procedures, harvest and storage.	0%	30%

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Prescription Drugs • **Network Retail Pharmacies:** (30-day supply) Includes diabetic test strip	$10/$35/$70/25% max $200	50% min $70[2]
• **Home Delivery Service:** (90-day supply) Includes diabetic test strip Specialty medications are limited up to a 30 day supply regardless of whether they are retail or mail service. Member may be responsible for additional cost when not selecting the available generic drug. **Medicare Rx - Wrap**	$10/$88/$175/25% max $200	Not covered

Notes:

- All medical and drug cost shares, deductibles and percentage (%) coinsurance apply toward the out-of-pocket maximum (excluding Non-Network Human Organ and Tissue Transplant (HOTT) Services)
- Deductible(s) apply to covered services listed with a percentage (%) coinsurance and copayment including 0%.
- Deductible applies to all prescription drug expenses. Once the deductible is met the appropriate copayment/ coinsurance applies.
- Once the family deductible is satisfied by either one member or all members collectively, then the additional percentage coinsurance will be required before the family out-of-pocket is satisfied. Does not apply to embedded deductible plans.
- Network and Non-network **Deductible**, copayments, coinsurance and out-of-pocket maximums are separate and do not accumulate toward each other.
- **Dependent Age**: to end of the month which the child 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.
- When allergy injections are rendered with a Physicians Home and Office Visit, only the Office Visit cost share applies. When the Office Visit cost share is a % coinsurance, deductible and coinsurance apply to allergy injections
- 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.
- No Cost Share (NCS): No deductible/copayment/coinsurance up to the maximum allowable amount.
- Live Health Online (LHO) is covered at the PCP costshare.
- Benefit period = calendar year
- Hospital stay for Maternity coverage will not be limited to less than 48 hours for a vaginal delivery or 96 hours for a caesarean section.
- Behavioral Health Services: Mental Health and Substance Abuse benefits provided in accordance with Federal Mental Health Parity.
- Preventive Care Services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits are covered.
- DME at 50% coinsurance (excluding and asthmatic equipment/supplies and prosthetics/orthotics apply the plan's cost share (common deductible/coinsurance) Exclude plans where Ded = OOP.
- Private Duty Nursing – limited to 82 visits/Calendar Year
- Wigs limited to 1 per benefit period.
- Vision limited services – additional vision services are covered when specifically coded as determination of refraction, routine ophthalmological examination including refraction for new and established patients, and a visual functional screening for visual acuity. No additional ophthalmological services are covered as part of the medical coverage.

1 We encourage you to review the Schedule of Benefits for limitations.
2 Rx non-network diabetic/asthmatic supplies not covered except diabetic test strips.

Precertification:

Members are encouraged to always obtain prior approval when using non-network providers. Precertification will help the member know if the services are considered not medically necessary.

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Pre-existing Exclusion Period: None

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 benefit overview is for illustrative purposes and some content may be pending Ohio Department of Insurance approval.

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.

By signing this Summary of Benefits, I agree to the benefits for the product selected as of the effective date indicated.

Authorized group signature (if applicable)	Date
Underwriting signature (if applicable)	Date