Your Summary of Benefits

Paulding
Lumenos Health Savings Accounts
Effective **October 1, 2018**

Covered Benefits	Network	Non-Network
Deductible Family coverage requires the family deductible to be met before coinsurance applies. The single deductible does apply to family coverage.	Single: $2,700 Family: $5,000	Single: $5,000 Family: $10,000
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	0% 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	0% 0% 0% 0% 0% 0%	0% 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) • 90 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, Orthotics and Prosthetics • Physical Medicine Therapy Day Rehabilitation programs • Hospice Care • Ambulance Services	0% 0% 0%	30% 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	 0% 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% 0% 0%	 30% 30% 30%
Human Organ and Tissue Transplants Acquisition and transplant procedures, harvest and storage.	0%	30%

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Prescription Drugs: Administered by CVS/Caremark	See Your Prescription Benefit Plan Summary	See Your Prescription Benefit Plan Summary

Notes:

- All medical 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%.
- Network and Non-network Deductible, copayments, coinsurance and out-of-pocket maximums are separate and do not accumulate toward each other.
- Dependent Age: to the end of the calendar year 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.
- 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.
- No Cost Share (NCS): No deductible/copayment/coinsurance up to the maximum allowable amount.
- 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.

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 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.

Here's an overview of your CVS Caremark benefits.

Paulding HSA Plan 10/01/2018

If you have any questions about your prescription plan or costs, call us at 1-888-202-1654. We can help any time after your plan starts. For TDD assistance, please call 1-800-863-5488.

	Short-Term Medicines CVS Caremark Retail Pharmacy Network (Up to a 30-day supply)	**Long-Term Medicines** CVS Caremark Mail Service or CVS Pharmacy locations (up to a 90-day supply)
Generic Medicines Always ask your doctor if there's a generic option available. It could save you money.	**$10 after deductible** for a generic medicine	**$10 after deductible** for a generic medicine
Preferred Brand-Name Medicines If a generic is not available or appropriate, ask your doctor to prescribe from your plan's preferred drug list.	**$35 after deductible** for a preferred brand-name medicine	**$88 after deductible** for a preferred brand-name medicine
Non-Preferred Brand-Name Medicines Drugs that aren't on your plan's preferred list will cost more.	**$70 after deductible** for a non-preferred brand-name medicine	**$175 after deductible** for a non-preferred brand-name medicine
Refill Limit	**None**	**None**
Annual Deductible	**$2,700 per individual / $5,000 per family**	
Maximum Out-of-Pocket	**$3,500 per individual / 7,000 per family**	
Out-of-Network Claims	Prescriptions filled at out-of-network pharmacies will be reimbursed at 50% of the cost of the claim.	
Prior Authorization	Certain medications may require prior authorization. Please contact Customer Care toll-free at 1-888-202-1654 or visit www.caremark.com for verification of prior authorization requirements.	
Specialty Medicines	Specialty medications are required to be filled through CVS Specialty Mail Order Pharmacy or at a retail CVS/pharmacy. Please contact Customer Care toll-free at 1-888-202-1654 for questions or to get started today.	

Please Note: When a generic is available, but the pharmacy dispenses the brand-name medication for any reason other than doctor or other prescriber indicates "dispense as written," you will pay the difference between the brand-name medication and the generic plus the generic copayment.

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Copayment, copay or coinsurance means the amount a plan member is required to pay for a prescription in accordance with a Plan which may be a deductible, a percentage of the prescription price, a fixed amount or other charge, with the balance, if any, paid by a Plan.
Your feedback is important as it helps us improve our service. Please contact us with any questions or concerns at 1-888-202-1654.
Your privacy is important to us. Our employees are trained regarding the appropriate way to handle private health information.