Lumenos® Plan Comparison

for Individuals and Families in California

Your Coinsurance and Maternity Choices	Your Annual Deductible Choices[1]	Lumenos HSA Plan Coinsurance/ Out-of-Pocket Limit[2] Cost to Member In-Network *(your share of costs after deductible)*	Lumenos HSA Plan Out-of-Network	Lumenos HIA Plan Coinsurance/ Out-of-Pocket Limit[2] Cost to Member In-Network *(your share of costs after deductible)*	Lumenos HIA Plan Out-of-Network	Lumenos HIA Plus Plan[3] Coinsurance/ Out-of-Pocket Limit[2] Cost to Member In-Network *(your share of costs after deductible)*	Lumenos HIA Plus Plan[3] Out-of-Network
30% Coinsurance Plans — without Maternity	Individual: $1,500 $3,000	30% / $3,500 30% / $2,000	50% / $8,500 50% / $7,000	30% / $3,500 30% / $2,000	50% / $8,500 50% / $7,000	30% / $3,500 30% / $2,000	40% / $8,500 40% / $7,000
	Family: $3,000 $6,000	30% / $7,000 30% / $4,000	50% / $17,000 50% / $14,000	30% / $7,000 30% / $4,000	50% / $17,000 50% / $14,000	30% / $7,000 30% / $4,000	40% / $17,000 40% / $14,000
0% Coinsurance Plans — without Maternity	Individual: $5,000	0% / $0	30% / $5,000	0% / $0	30% / $5,000	0% / $0	30% / $5,000
	Family: $10,000	0% / $0	30% / $10,000	0% / $0	30% / $10,000	0% / $0	30% / $10,000
0% Coinsurance Plans — with Maternity	Individual: $1,500 $3,000 $5,000	0% / $0 0% / $0 0% / $0	30% / $1,500 30% / $3,000 30% / $5,000	0% / $0 0% / $0 0% / $0	30% / $1,500 30% / $3,000 30% / $5,000	Not Offered 0% / $0 0% / $0	Not Offered 30% / $3,000 30% / $5,000
	Family: $3,000 $6,000 $10,000	0% / $0 0% / $0 0% / $0	30% / $3,000 30% / $6,000 30% / $10,000	0% / $0 0% / $0 0% / $0	30% / $3,000 30% / $6,000 30% / $10,000	Not Offered 0% / $0 0% / $0	Not Offered 30% / $6,000 30% / $10,000
Lifetime Maximum *(the amount the plan pays up to, per member)*		$7 million for plans without maternity $5 million for plans with maternity		$7 million for plans without maternity $5 million for plans with maternity		$7 million for plans without maternity $5 million for plans with maternity	

Covered Services	HSA In-Network *(your share of costs after deductible)*	HSA Out-of-Network	HIA In-Network *(your share of costs after deductible)*	HIA Out-of-Network	HIA Plus In-Network *(your share of costs after deductible)*	HIA Plus Out-of-Network
Doctor's Office Visits	30% or 0%	50% or 30%	30% or 0%	50% or 30%	30% or 0%	40% or 30%
Professional Services *(x-ray, lab, anesthesia, surgeon, etc.)*						
Hospital Inpatient *(overnight hospital stays)*		All charges except $650 per day		All charges except $650 per day		All charges except $650 per day
Hospital Outpatient *(if you don't stay overnight)*		All charges except $380 per day		All charges except $380 per day		All charges except $380 per day
Emergency Room Services						
Maternity *(available if you choose a plan with maternity)*	0%	30%	0%	30%	0%	30%
Preventive Care *(prior to deductible)*	0%	50% or 30%	0%	50% or 30%	0%	40% or 30%
Chiropractic Services	30% or 0%	All charges except $25 per visit	30% or 0%	All charges except $25 per visit	30% or 0%	All charges except $25 per visit
Prescription Drug Coverage	30% or 0%	50% or 30% of drug limited fee schedule and all excess charges	30% or 0%	50% or 30% of drug limited fee schedule and all excess charges	30% or 0%	50% or 30% of drug limited fee schedule and all excess charges

1 In-network and out-of-network deductibles accumulate together. For family coverage, either one or all the members must satisfy the annual calendar-year family deductible collectively before any covered services will be paid by the plan.

2 The annual calendar-year out-of-pocket limit is in addition to the deductible. Once the family out-of-pocket limit 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.

3 The HIA Plus allocation of $125 per individual and $250 per family is contributed to the health account each quarter, for a calendar year total of $500 per individual and $1,000 per family.

Plan benefits effective 12/1/07
MCASH489C Rev. 6/08

Anthem Blue Cross

What the California Individual Lumenos Plans Do Not Cover

Please take a few moments to review the exclusions and limitations. We want you to understand what your coverage does not include before you enroll.

These listings are an overview only. The Lumenos plans Policy booklets contain a comprehensive list of the plans' exclusions and limitations. For a sample copy of a Policy booklet, ask your agent or contact Anthem.

Exclusions and Limitations

- Cosmetic surgery.
- Custodial care.
- Dental care, dental implants or treatment to the teeth, except as specifically stated in the Policy.
- Orthodontic services, braces, and other orthodontic appliances.
- Durable Medical Equipment, except as specifically stated in the Policy.
- Educational services and nutritional counseling, except as specifically provided or arranged by Anthem.
- Any amounts in excess of the maximum amounts stated in the benefit sections of the Policy.
- Experimental or investigative services.
- Food and/or dietary supplements, except for formulas and special food products as specifically stated in the Policy.
- Any services provided by a local, state or federal government agency.
- Hearing aids.
- Infertility services.
- Mental and nervous disorders and substance abuse, except as specifically stated in the benefit sections of the Policy.
- Care or treatment furnished in a non-contracting hospital, except for a Medical Emergency as defined in the Policy.
- Any services received by Medicare benefits without payment of additional premium.
- Services received before your effective date or during an inpatient stay that began before your effective date.
- Services received after your coverage ends.
- Any services or supplies that are not Medically Necessary.
- Orthopedic shoes, except when joined to braces or shoe inserts.
- Outdoor treatment programs.
- Outpatient drugs, medications or other substances dispensed or administered in any outpatient setting.
- Outpatient speech therapy, except as specifically stated in the Policy.
- Personal comfort items.
- Services or supplies related to a pre-existing condition.
- Private duty nursing.
- Routine physical exams, except for preventive care services (e.g., physical exams for insurance, employment, licenses or school are not covered) except as specifically stated in the Policy.
- Services for which no charge would be made if you did not have a health plan or insurance coverage.
- Services from relatives.
- Sex changes.
- Telephone and facsimile machine consultations.
- Services not specifically listed as Covered Services in the Policy.
- Vision care, except as specifically stated in the benefit sections of the Policy.
- Services primarily for weight reduction or treatment of obesity, except Medically Necessary treatment of morbid obesity.
- Conditions covered by workers' compensation law.
- Maternity and pregnancy care (unless the plan selected specifically includes maternity coverage).

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