

**Truman State University Plan C
Lumenos Health Savings Accounts
Summary of Benefits, Effective 1/1/2009**

Covered Benefits	Network	Non-Network
Deductible The single deductible applies to family coverage. Network and Non-Network deductibles are combined. <i>(This only applies to embedded deductible designs).</i>	Single: \$3,000 Family: \$6,000	Single: \$3,000 Family: \$6,000
Out-of-Pocket Limit	Single: \$5,000 Family: \$10,000	Single: \$10,000 Family: \$20,000
Physician Home and Office Services (PCP/SCP) Primary Care Physician (PCP)/Specialty Care Physician (SCP) • Including Office Surgeries, allergy serum, allergy injections and allergy testing	20%	40%
Preventive Care Services 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 • Immunizations through age 5	No Cost Share No Cost Share	40% No Cost Share
Emergency and Urgent Care • Emergency Room Services (facility/other covered services) <i>(copayment waived if admitted)</i> • Urgent Care Center Services	20% 20%	20% 40%
Inpatient and Outpatient Professional Services 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	20%	40%
Inpatient Facility Services Unlimited days except for: • 60 days Network/Non-Network combined for physical medicine/rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis) • 100 days Network/Non-Network combined for skilled nursing facility	20%	40%
Outpatient Surgery Hospital/Alternative Care Facility • Surgery and administration of general anesthesia	20%	40%
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 (Network/Non-network combined) 100 visits (excludes IV Therapy) • Durable Medical Equipment and Orthotics (Network/Non-network combined) \$10,000 benefit maximum (excluding Prosthetic Devices and Medical Supplies) • Prosthetic Devices \$10,000 benefit maximum • Physical Medicine Therapy Day Rehabilitation programs • Hospice Care • Ambulance Services	20% 20%	40% 20%

Covered Benefits	Network	Non-Network
Outpatient Therapy Services (Combined Network & Non-Network limits apply) <ul style="list-style-type: none"> Physician Home and Office Visits (PCP/SCP) Other Outpatient Services @ Hospital/Alternative Care Facility Limits apply to: <ul style="list-style-type: none"> Physical/Manipulation therapy excludes Chiropractic Services: 60 visits Occupational therapy: 60 visits Chiropractic Services: 26 visits (Speech therapy: 26 visits 	20% 20%	40% 40%
Behavioral Health Services: (Network and Non-Network) Mental Health and Substance Abuse <ul style="list-style-type: none"> Inpatient Facility Services Physician Home and Office Visits (PCP/SCP) Other Outpatient Services @ Hospital/Alternative Care Facility Substance Abuse limits <ul style="list-style-type: none"> Inpatient: 30 days, 6 separate days for detox Outpatient Facility: 30 visits Outpatient Office Visits: 30 visits (Substance abuse rehabilitation programs are limited to 10 episodes per lifetime Network and Non-Network combined.)	20% 20% 20%	40% 40% 40%
Human Organ and Tissue Transplants <ul style="list-style-type: none"> Acquisition and transplant procedures, harvest and storage. 	20%	40%
Prescription Drugs <ul style="list-style-type: none"> Network Retail Pharmacies: (30-day supply) Includes diabetic test strip Anthem Rx Direct Mail Service: (90-day supply) Includes diabetic test strip Medicare Rx <SELECT>	20% 20%	40% ¹ Not covered
Lifetime Maximum²	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 to covered 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 calendar year which the child attains age 25
- 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.
- 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

¹Rx non-network diabetic/asthmatic supplies not covered except diabetic test strips.

²Prescription Drugs do not accumulate toward the Medical Lifetime Maximum (if applicable). However, once the Medical Lifetime Maximum is met (if applicable), no additional Prescription Drug claims will be paid.

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.

Pre-existing Exclusion Period:

We will not provide benefits for services, supplies or charges for any pre-existing condition for the time period specified below (subject to HIPAA portability requirements):
12 months after the member's enrollment date

A pre-existing condition is a condition (mental or physical) which was present and for which medical advice, diagnosis, care or treatment was recommended or received within the 6 month period ending on the member's enrollment date. Pregnancy and domestic violence are not considered a pre-existing condition. Genetic information may not be used as a condition in the absence of a diagnosis.

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.

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