| | | |
|---|---|---|
| **Company** | Anthem. | |
| **Plan Name** | Lumenos HSA Plus | |
| **Apply** | Apply | |
| **Estimated Monthly Premium** | Varies By Deductible | |
| **Plan Type** | PPO | |
| **Networks** | See provider details | |
| | Network | Non-Network |
| **Copay** | N/A | |
| **Deductible** | Individual: 3000, 4500, 5950 Family: 3500, 5500, 7500, 11,900 | |
| **Coinsurance** | 0% | 40% |
| **Coinsurance Limit** | see brochure | |
| **Out-of-Pocket Maximum** | $0 | |
| **Lifetime Maximum** | Unlimited | |
| **Office Visit** | 0% coinsurance | 40% coinsurance |
| **Prescription Drugs** | 0% coinsurance | 40% coinsurance |
| **Emergency Room** | 0% coinsurance | |
| **Adult Preventive Care** | 0% coinsurance, not subject to deductible (Covers all nationally recommended preventive care services, including immunizations, PSA screenings, Pap tests, mammograms, and more) | Routine Mammogram, Pap, PSA and Colorectal screenings, covered at no cost to member, deductible waived All other covered Services: $30 copay, deductible waived |
| **Child Preventive Care** | 0% coinsurance, not subject to deductible (Covers all nationally recommended preventive care services, including well-child care, immunizations, and more) | Immunizations (children under age 13) covered at no cost to member, deductible waived |
| **Lab/X-ray** | 0% coinsurance | 40% coinsurance |
| **Maternity** | 0% coinsurance | 40% coinsurance |
| **Physical Therapy** | Benefits Included, see brochure for more coverage details | |
| **Skilled Nursing** | Benefits Included, see brochure for more coverage details | |
| **Home Health Care** | Benefits Included, see brochure for more coverage details | |
| **Mental Health** | Benefits Included, see brochure for more coverage details | |
| **Hospital Care** | Professional and Diagnostic Services (X-ray, lab, anesthesia, surgeon, etc.): 0% coinsurance Inpatient Services (overnight hospital/facility stays): 0% coinsurance Outpatient (overnight hospital/facility stays): 0% coinsurance | Professional and Diagnostic Services (X-ray, lab, anesthesia, surgeon, etc.): 40% coinsurance Inpatient Services (overnight hospital/facility stays): 40% coinsurance Outpatient (overnight hospital/facility stays): 40% coinsurance |
| **Included Benefits** | see brochure | |
| **Optional Benefits (not included in base rate quotation)** | | |
| **Fees** | | |
| **Policy Form Number** | see brochure | |
| **Note** | To view your Summary of Benefits and Coverage please visit www.healthcare.gov. | |
| **Product Brochure** | Brochure | |
| **Summary of Benefits and Coverage** | | |
| **Optional Riders included in the quote** | | |
| **Optional Riders not included in the quote** | | |

## General Disclaimers

The quotes shown above are estimates only, and are subject to change based on the proposed insured's medical history, the underwriting practices of the health plan, the selection of the appropriate Provider Network, the optional benefits selected, occupation (where allowed by state), if any, and other relevant factors. The insurance company reserves the right to change the terms of a policy upon proper notification.

The quotes shown above are for the requested effective date ONLY. If the actual effective date of coverage is different from the requested effective date, the actual cost may differ from the quote above due to rate increases or policy changes from the insurance company and/or one or more family members having a birthday. (Rates are highly dependent on age.) The carrier selected may not guarantee its rates for any period of time.

Applicants should not cancel any in-force health coverage until written formal approval from the insurance company selected is received.

This is not a complete solicitation of health insurance coverage. Please refer to sales brochure and applicable inserts for further information. Sales brochures and applicable inserts may be downloaded or can be obtained by calling our contact number near the top of this page.

The benefits shown in the details summary are not guaranteed. Please refer to the sales brochure and applicable inserts for further information.

**Carrier Specific Disclaimers**

**Anthem**

Please note that any premium rates quoted may be subject to changed based on actual effective date, responses to applications questions, age of applicant(s) on actual effective date, geographic location, risk tier adjustments, scheduled rate adjustments and/or rate guarantee periods or anniversary month, if applicable.

Premium quotes do not include administrative fees that may apply upon approval of your application and enrollment.

The premium does not include any provision for CoverColorado assessment. In the event that Anthem is assessed by CoverColorado for 2013, we reserve the right to pass along a charge to recoup the amount assessed.

For information on Anthem CO Child Only, please click here.

To view the standard Summary of Benefits & Coverage (SBC) which is required by Health Care Reform and the Colorado Supplement to the Summary of Benefits and Coverage, please visit Colorado SBC and Supplement

To view your Summary of Benefits and Coverage please visit www.healthcare.gov (Not applicable for Short Term plans)