

Prepared For:	0360
Prepared By:	Med
Phone Number:	800.
Date Prepared:	4/29
Zip Code:	0360
Effective Date:	5/1/2
Applicant:	Male



Company		
Plan Name	Lumenos HSA Plus	
Apply	Apply	
Estimated Monthly Premium	\$161.13	
Plan Type	PPO	
Networks	See provider details	
	Network	Non-Network
Copay	N/A	
Deductible	\$5,950 (individual only)	
Coinsurance	0%	30%
Coinsurance Limit	see brochure	
Out-of-Pocket Maximum	\$0 (Add your chosen deductible to the amount - individual only)	\$5,950 (Add your chosen deductible to the amount - individual only)
Lifetime Maximum	None	
Office Visit	0% Coinsurance	30% Coinsurance
Prescription Drugs	Retail Drugs (and Mail Order Drugs when available) - Generic drugs required if available. If a brand name drug is purchased when generic was available, member pays the applicable copay/coinsurance plus the difference between the brand-name and generic (Retail 90-day supply or Mail Order 90-day supply): 0% Coinsurance	Retail Drugs (and Mail Order Drugs when available) - Generic drugs required if available. If a brand name drug is purchased when generic was available, member pays the applicable copay/coinsurance plus the difference between the brand-name and generic (Retail 90-day supply or Mail Order 90-day supply): 30% Coinsurance
Emergency Room	0% Coinsurance	
Adult Preventive Care	0% Coinsurance, not subject to deductible (Covers nationally recommended preventive care for adults, PSA screenings, Pap tests, mammograms and more)	30% Coinsurance (Covers nationally recommended preventive care for adults, PSA screenings, Pap tests, mammograms and more)
Child Preventive Care	0% Coinsurance, not subject to deductible (Covers nationally recommended preventive care for children including immunizations and more)	30% Coinsurance (Covers nationally recommended preventive care for children immunizations and more)
Lab/X-ray	0% Coinsurance	30% Coinsurance
Maternity	Not Covered (optional benefit available)	
Physical Therapy	0% Coinsurance (20 visits per year per person, in and out-of-network combined)	30% Coinsurance (20 visits per year per person, in and out-of-network combined)
Skilled Nursing	0% Coinsurance (100 day limit per year per person, in and out-of-network combined)	30% Coinsurance (100 day limit per year per person, in and out-of-network combined)
Home Health Care	Home Health Care: 0% Coinsurance (100 visit limit per person, in and out-of-network combined) Hospice: 0% Coinsurance (Coverage if member is diagnosed as terminal with life expectancy of 6 months or less and who elect to receive palliative rather than curative care)	Home Health Care: 30% Coinsurance (100 visit limit per person, in and out-of-network combined) Hospice: 30% Coinsurance (Coverage if member is diagnosed as terminal with life expectancy of 6 months or less and who elect to receive palliative rather than curative care)
Mental Health	Not Covered	
Hospital Care	Professional and Diagnostic Services (X-ray, lab, anesthesia, surgeon, etc.): 0% Coinsurance Inpatient Services (overnight hospital/facility stays): 0% Coinsurance Outpatient Services (without overnight hospital/facility stays): 0% Coinsurance	Professional and Diagnostic Services (X-ray, lab, anesthesia, surgeon, etc.): 30% Coinsurance Inpatient Services (overnight hospital/facility stays): 30% Coinsurance Outpatient Services (without overnight hospital/facility stays): 30% Coinsurance
Included Benefits	see brochure	
Optional Benefits (not included in base rate quotation)		
Fees		
Policy Form Number	see brochure	
Note	Network and non-network deductibles are separate and do not accumulate toward each other. Network and non-network out-of-pocket maximums are separate and do not accumulate toward each other. 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 Blue Cross and Blue Shield of New Hampshire

Other plan options and less expensive plan designs may be available. Please contact us, or your broker, for details.

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