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%	30%
Coinsurance Limit	see brochure	
Out-of-Pocket Maximum	$0	
Lifetime Maximum	Unlimited	
Office Visit	0% Coinsurance (after deductible)	30% Coinsurance (after deductible)
Prescription Drugs	Retail Drugs (and Mail Order Drugs when available): 0% Coinsurance (after deductible)	Retail Drugs (and Mail Order Drugs when available): 30% Coinsurance (after deductible)
Emergency Room	0% Coinsurance (after deductible)	
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)	30% Coinsurance (Covers all nationally recommended preventive care services, including immunizations, PSA screenings, Pap tests, mammograms, and more)
Child Preventive Care	0% Coinsurance, not subject to deductible (Covers all nationally recommended preventive care services, including well-child care, immunizations, and more)	30% Coinsurance (Covers all nationally recommended preventive care services, including well-child care, immunizations, and more)
Lab/X-ray	0% Coinsurance (after deductible)	30% Coinsurance (after deductible)
Maternity	Not Covered	
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 (after deductible) Inpatient Services (overnight hospital/facility stays): 0% Coinsurance (after deductible) Outpatient Services (without overnight hospital/facility stays): 0% Coinsurance (after deductible)	Professional and Diagnostic Services (X-ray, lab, anesthesia, surgeon, etc.): 30% Coinsurance (after deductible) Inpatient Services (overnight hospital/facility stays): 30% Coinsurance (after deductible) Outpatient Services (without overnight hospital/facility stays): 30% Coinsurance (after deductible)
Included Benefits	see brochure	
Optional Benefits (not included in base rate quotation)		
Fees		
Policy Form Number	see brochure	
Note	Optional Autism Coverage Available - for more information please call Customer Service @ 1-877-494-3089 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.

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

Norvax form #DS-1