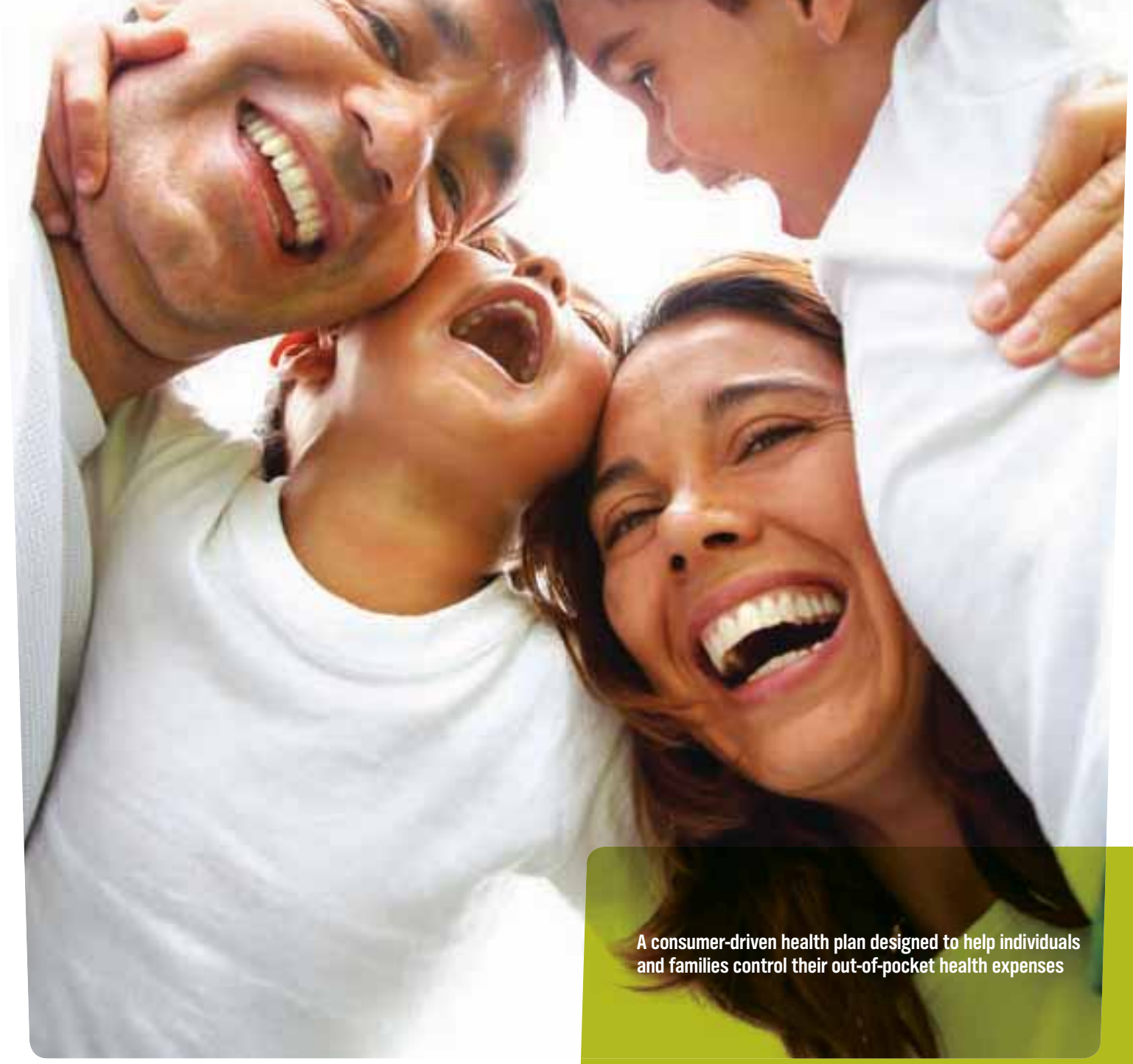


A consumer-driven health plan designed to help individuals and families control their out-of-pocket health expenses

Getting healthy.

Staying healthy.

And saving money while you do it.

Lumenos® HSA

Anthem

CTBR30006XLS (09/10)

Staying healthy is just as important as getting better.

Your health care dollars are too precious to waste. One way we can help you keep those dollars in your pocket is to help you stay as healthy as possible.

So we created a consumer-driven health plan called Lumenos HSA. Its innovative design helps you lower your coverage costs and control your out-of-pocket health expenses. All while improving your health and well-being. Whether you have a long-term condition, a temporary illness, or general good health, Lumenos HSA puts you in charge of your health.

Getting healthy. Staying healthy. And saving money while you do it.
That's what makes Lumenos special.

Familiar coverage with unfamiliar savings

Lumenos is a different kind of health care plan. But it should also look pretty familiar. You'll recognize many of the benefits you're accustomed to, plus coverage for preventive care services before you have to meet your deductible. Then, after you meet your deductible, you have coverage for office visits, medical care, tests and prescriptions.

The difference is that the Lumenos HSA is offered in an innovative, lower premium/higher deductible package. Many preventive services are covered right away and then all covered services are applied to your deductible. And since Lumenos HSA is compatible with a Health Savings Account (HSA) you can choose to set up an account and fund it with tax deductible contributions to help with qualified expenses while you meet your deductible.

That's right — HSA funds are your health care dollars. Save them or use them to help pay for health expenses. It's your coverage, your HSA money. Lumenos lets you treat it that way.

Like with any PPO plan, you choose your own doctor and never need a referral. Just keep in mind that network providers will probably cost you less.

Plan Features	Lumenos HSA Plan	Typical PPO Plan
Coverage for basic medical care and prescriptions	✓	✓
Personal health savings account can help pay medical expenses	✓	
Traditional health coverage to protect you against large health expenses	✓	✓
100% coverage for preventive care with no deduction from your health account and no out-of-pocket costs when you use in-network providers	✓	✓
Health savings account can be used to help pay your deductible or for medical expenses that aren't covered by the plan	✓	
Savings for using network doctors, hospitals and pharmacies	✓	✓
Interactive online health tools to help you make better health decisions	✓	✓
Personalized programs to address or prevent health problems	✓	✓
Integrated health savings account available with our preferred banking partner	✓	
Unused health savings account funds can be rolled over from year to year	✓	
Health savings account balance belongs to you if you leave the plan	✓	
Tax-deductible contributions mean extra savings	✓	

What makes Lumenos so valuable?

Medical care is covered the same as a traditional health plan

Even though Lumenos is different, you're still covered for the medical services that you've come to expect from your health plan. Preventive services are covered right away and then all covered services are applied to your deductible. But you can also use your personal health savings account to pay for these covered services until you meet your deductible and traditional health coverage kicks in. Some of what Lumenos covers:

- Physician office visits
- Inpatient hospital services
- Outpatient surgery services
- Diagnostic X-rays/lab tests
- Emergency hospital services, urgent care and ambulance
- Durable medical equipment
- Prescription drugs
- Home health care and hospice care
- Physical, speech and occupational therapy services

By offsetting a higher deductible with lower premiums, you're free to set priorities for when and where to spend your health care dollars.

A health savings account can help pay for medical care and prescriptions

Consumer-driven health plans like Lumenos usually have lower premiums and higher deductibles than traditional PPOs. And unlike traditional high-deductible plans, your health savings account can pay for some of that deductible.

Your health savings account is your source of personal funds for health care spending. It gives you extra room to pay for covered health expenses until you meet your deductible.

- Your health savings account is your money. You fund it with your tax-deductible contributions. You decide which qualified health expenses to use your account for.
- Unused funds roll over from year to year so your account can keep growing to help meet future health care costs.
- If you ever leave the Lumenos plan, you can take your health savings account funds with you.

What makes Lumenos so user friendly?

Consumer-driven health plans may be new to many people, but Lumenos is actually pretty simple. Basically, you start by enrolling in an HSA-qualified plan like Lumenos HSA and then fund a personal health savings account with tax-deductible dollars. The account is optional, but it lets you take advantage of some big financial benefits. Then you use that account to help meet your deductible. After that, the plan operates much like traditional health coverage that you're used to, with coinsurance and out-of-pocket maximums. So you get all the tax benefits of an HSA while protecting yourself against big, expensive health problems.

Calendar year deductible

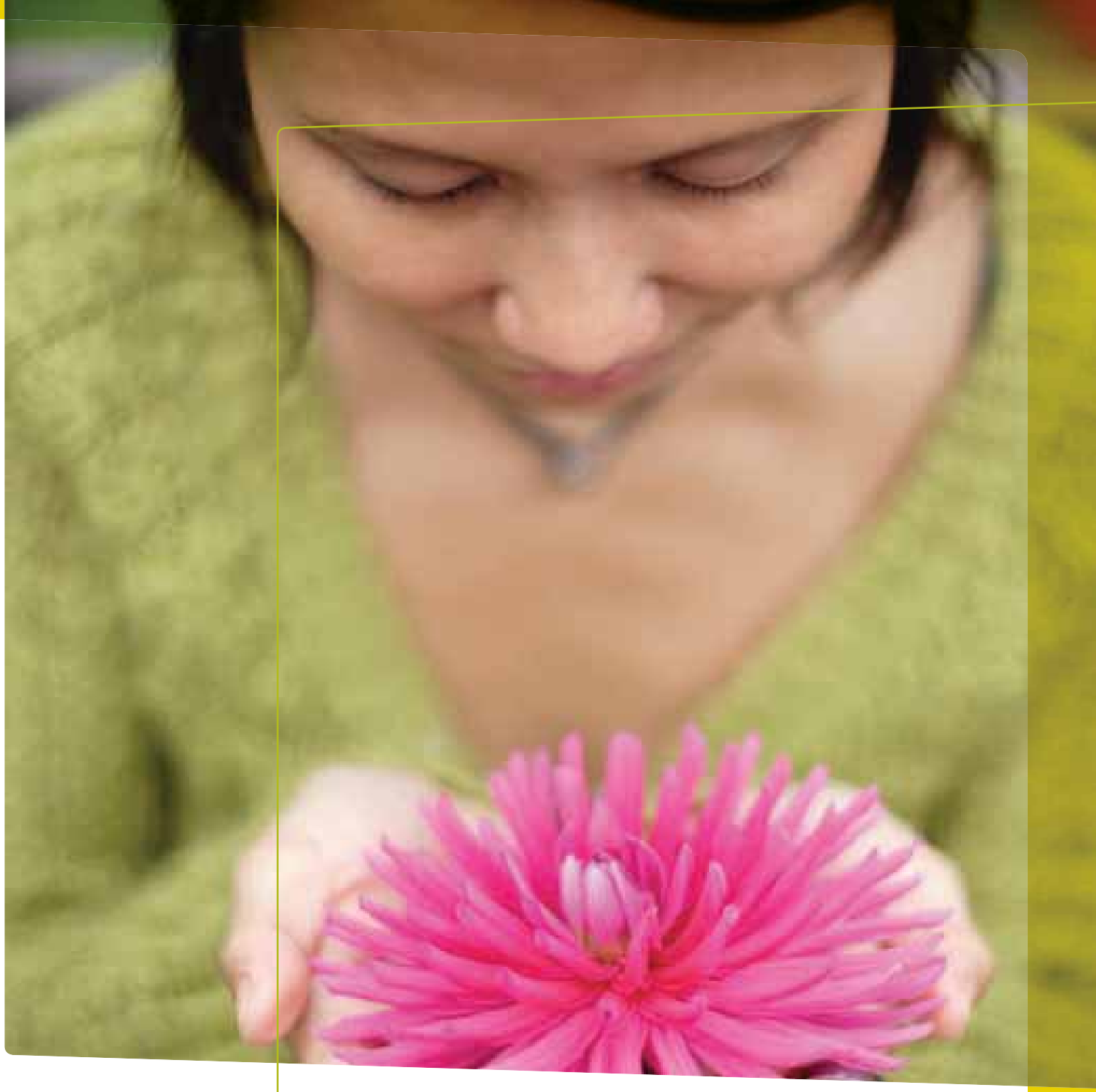
Any time you use your health savings account to cover medical expenses, it applies to your calendar year deductible. (Since preventive care is 100 percent covered by Lumenos when you visit network providers, it doesn't affect your health savings account or deductible.) If you meet your deductible before using up your health savings account, you skip straight to traditional health coverage.* But if you still have some deductible left, you're responsible for the rest.

Coinsurance (Traditional health coverage)

After you meet your deductible and when traditional health coverage begins, the plan pays for most expenses, and you pay a percentage of the cost as coinsurance. (For example, 80/20 means we pay 80 percent of the bill and you pay 20 percent.) Some plans could even cover 100 percent of the approved amount. The percentage you pay will be less for in-network doctors and hospitals, higher for out-of-network. You pay the same coinsurance percentage for most benefits, such as office visits, urgent care, emergency room, and prescription drugs.

Out-of-pocket maximum (Traditional health coverage)

The amount you pay out-of-pocket each year is capped at a maximum amount. Once you reach that max, we pay 100 percent of in-network covered expenses for the rest of the year.* All of your deductible and coinsurance payments count toward your annual out-of-pocket maximum. You have separate out-of-pocket maximums for in-network services and out-of-network services.



When you use network doctors for preventive care, no funds are deducted from your health savings account and you have no out-of-pocket costs. No deductible, no copay, nothing.

*You may have separate in-network and out-of-network deductibles, depending on your plan. Deductibles and out-of-pocket amounts are reset on January 1 of each year.

What makes Lumenos so helpful?

Anthem 360° Health® helps you reach your personal healthy best

Anthem 360° Health surrounds you with resources, tools and guidance to make good health care decisions. Instead of waiting for health problems (and their costs) to crop up, these programs can help you prevent them or keep them from getting worse. Best of all, 360° Health is built into your plan at no extra cost. It includes:

- *MyHealth@Anthem®* — Health assessments, resource centers, and health calculators so you see progress and stay motivated.
- *24/7 NurseLine* — Health information from a registered nurse whenever you need it.
- *ConditionCare* — One-on-one help from trained professionals in managing a chronic condition like asthma, diabetes, coronary artery disease, chronic obstructive pulmonary disease and heart failure.
- *MyHealth Coach* — Personal help with a wide range of health needs, primarily high blood pressure, high cholesterol, low back pain, musculoskeletal issues like arthritis, and certain types of cancer.
- *Healthy Lifestyles Programs* — Our proven "Tobacco-Free" and "Healthy Weight" programs help you adopt new habits for a healthy lifestyle with personalized support and educational resources.
- *SpecialOffers@Anthem℠* — Members-only discounts help you stretch your health savings account even further with savings on services and products that promote a healthy lifestyle.

Prescription drug extras help you control your health — and your wallet

Lumenos not only puts you in charge of your health care dollars, it can also help you spend less of those dollars on prescription drugs. Once traditional health coverage kicks in, prescription drugs are fully covered (less any coinsurance payments). But that doesn't mean you have to wait to save money. Here's how:

With Lumenos, you can go to your local pharmacy or use our mail order service. It's up to you.

- Since you decide how to spend it, your health savings account can be used to pay for prescription drugs.
- We're able to negotiate significant discounts on all types of prescription medicines. If you don't have funds in your account, you still benefit from our discount rate. Just show your health plan ID card at Blue Cross and Blue Shield network pharmacies — that's over 95 percent of pharmacies nationwide.
- To further lower your cost, visit anthem.com to learn about generics or other low-cost alternatives.
- Ordering a 90-day supply through mail order can also save you money. Once you're approved in the plan, you can download a mail order form from anthem.com.

Network discounts pass even more savings on to you

We negotiate special member rates with each network doctor, hospital and pharmacy. When you use a network provider, you get that negotiated rate for services and prescriptions. If you visit an out-of-network provider, you'll still have benefits, but your share of the cost for covered services may be higher.

What makes Lumenos so rewarding?

The Lumenos HSA gives you two financial advantages that traditional plans don't: tax advantages and full ownership of your health savings account. This lets you save now and for the future. While the account is optional with Lumenos, it really helps you make the most of those advantages.

Tax Advantages: Save now

When you open an HSA, you open a separate health savings account that can save on taxes in three ways:

- Contributions to your account may be tax-deductible (within certain IRS limits).
- Money in your account can earn tax-deferred interest.
- Withdrawals to pay for eligible medical expenses are never taxed.

Full ownership: have it for the future

You decide how and when to use your account. If you don't spend it all in a given year, the rest rolls over, so your account keeps growing. A traditional PPO doesn't give you the chance to invest in your health and the future. But with Lumenos, the money in the account is yours to keep — it's never forfeited, even if you leave the health care plan.

As good as these benefits may sound, you should still talk to your tax advisor when trying to maximize financial benefits for your personal situation.

SET UP A HEALTH SAVINGS ACCOUNT IN JUST A FEW STEPS

This is what the IRS requires if you want to open a Health Savings Account:

- You must be covered by an HSA-compatible high deductible health plan (such as the Lumenos HSA plan)
- You must be a U.S. resident over the age of 18, and not a resident of Puerto Rico or American Samoa
- You cannot be covered by any other medical plan that is not an HSA-compatible high deductible health plan
- You cannot be enrolled in Medicare
- You cannot be claimed as a dependent on another individual's tax return
- If you are a veteran, you may not have received veteran's benefits within the last three months
- You cannot be active military

Apply for Lumenos now...it's easy!

Applying for Lumenos couldn't be simpler. Your Anthem Authorized Sales Agent will help you complete the application.

1

Applying through the mail:

Step 1: Complete and return the Enrollment Application.

Step 2: Complete and return the Health Statement and any additional health questionnaires, if applicable.

Step 3: Supply your first month premium payment.

Incomplete paperwork could delay your coverage, so make sure you've filled everything out.

Applying on-line

Can't be bothered with paper forms? Then talk to your Anthem Authorized Sales Agent about applying online.

Don't worry ... we're fanatical about protecting your privacy. That's why our secure website has technical safeguards to help protect your information and keep it confidential.

2

Get a free look with a money-back guarantee

If approved, you'll receive your Lumenos policy by mail. Once you receive your policy, you'll have 10 days to review it. If you decide that Lumenos coverage is not for you, you may cancel your policy within those 10 days and your premiums will be refunded (less any claims that were already paid.)

Important Eligibility Information

To be eligible for membership as a policyholder under Lumenos, the applicant must:

1. Be a resident of Connecticut;
2. Be under age 65;
3. Not have any other type of health insurance. If the applicant has other insurance coverage in-force, he or she must replace that coverage. Please refer to the Replacing Coverage section of this guide;
4. Agree to pay for the cost of premium that Anthem requires; and
5. Satisfy the following requirements to guarantee renewability:
   a) Eligibility criteria continues to be met;
   b) There are no acts, practices or omissions that constitute fraud or misrepresentation of material fact found on the application
   c) Membership has not been terminated by Anthem under the terms of this policy.

If an individual is under 26 years of age and is covered either by his or her parents or guardians as defined by the State of Connecticut, they are eligible for coverage provided they meet eligibility criteria specified in the Eligibility policy stated above. Anthem requires the parent/guardian to sign the applications as the applicant for the insured. Applicants under age 18 are eligible to apply, only requiring a parent or guardian signature on the application. Married couples and domestic partners that meet eligibility requirements may apply. Families with dependent children under age 26 are eligible as well.

(Please note: For HSA-qualified health plans, note that while the health plan recognizes domestic partners, the IRS does not. Therefore, if you want to contribute to an HSA, you will need to enroll in two separate individual health plans.)

Those applying must complete a Health Statement and, if applicable, a Statement of Domestic Partnership. Acceptance into either plan is based on our review of your completed Health Statement.

Utilization Management and Case Management

Our Utilization Management (UM) services offer a structured program that monitors and evaluates member care and services. The UM clinical team, which is made up of health care professionals who hold active professional licenses and certificates, perform the prior authorization, concurrent and retrospective review processes explained below. The UM team follows criteria to assist in decisions regarding requests for health care and other covered benefits, and complies with specific timeframes to ensure requests are handled in a timely manner. Our case management services help you to better understand and manage your health conditions.

Prospective Review / Pre-Admission Review

Prospective review (also known as pre-service or pre-admission review) is the process of reviewing a request for a medical procedure or service before it takes place. The review occurs to ensure that: 1) the procedure is medically necessary and 2) the procedure meets your health care plan's specific guidelines prior to being performed. Requests for prospective review may include but are not limited to:

- inpatient hospitalizations
- outpatient procedures
- diagnostic procedures
- therapy services
- durable medical equipment

Important Eligibility Information (cont.)

Prospective review is required for all elective inpatient admissions and certain outpatient services. The review process evaluates medical necessity and the best level of care and assigns expected length of stay if needed.

Concurrent Review

Concurrent review is an ongoing evaluation of a member's hospital stay, as well as ongoing extensions of services that may be needed (such as acute care facilities, skilled nursing facilities, acute rehabilitation facilities, and home health care services). The review includes physicians, member-assigned health care professionals (or member authorized representative) and takes place by telephone, electronically and/or onsite.

Concurrent review uses pre-set decision criteria in order to approve medical care (deemed to be medically necessary) and assign the right level of care for continued medical treatment. Review decisions are based on the medical information obtained at the time of the review. Concurrent review also helps to coordinate care with behavioral health programs.

Retrospective Review

The retrospective review process consists of obtaining information to determine medical necessity as it relates to services provided without approval or notice ahead of time (e.g. without pre-service notification). Relevant clinical information is required for the retrospective review process. Review decisions are based only on the medical information the doctor or other provider had at the time the member received medical care.

Case Management

Case managers are licensed healthcare professionals who work with you to help you understand your benefits and support your health care needs. The case manager works with you and your doctor to help you better understand and manage your health conditions.

Limitations and exclusions

This is not a complete list of non-covered services. Please review your Subscriber Certificate (including any riders, endorsements or amendments) for a complete description of coverage, limitations and exclusions. The Subscriber Certificate will be mailed to you once you are a member. Anthem Blue Cross and Blue Shield's internal appeal process is also described in the Subscriber Certificate.

The following is a list of services that are not covered. Benefits are not available for:

- Any service that is not medically necessary
- Any service required by a third party (court ordered services are covered if all of the other terms of the plan are met)
- Artificial insemination, assisted reproductive technologies, and infertility drugs
- Biofeedback services
- Blood and blood products
- Care furnished by a family member
- Claims for services received more than 12 months ago
- Chelating agents
- Chiropractic services
- Cosmetic surgery

continued >

Important Eligibility Information (cont.)

- Custodial or convalescent care
- Disease or injury as a result of war, riot or civil disobedience
- Educational testing and therapy
- Experimental and/or investigational services
- Food or food supplements except as required by law
- Hospitalization or other services for conditions that are not covered
- Care required due to conditions or complications arising from non-covered services
- Human organ transplants other than those listed in the Subscriber Certificate as covered benefits
- Mental health services which do not usually result in favorable modification through short-term therapy
- Miscellaneous devices, materials, and supplies, including, but not limited to, breast pumps, routine hearing exams and hearing aids (except for children under 19), eyeglasses, contact lenses (except after cataract surgery), dentures and support devices for the feet and corrective shoes
- Permanent dental restoration, orthognathic and most oral surgery
- Personal comfort items
- Radial keratotomy or other surgery to correct vision
- Routine podiatry
- Sclerosing solutions
- Services covered by government programs to the extent permitted by law
- Services for work-related illness or injury that are covered by workers' compensation unless you have waived coverage in accordance with state law
- Sex changes
- Sterilization reversal
- Weight reduction management and control except diabetes education and nutritional counseling
- Wigs except as required by law

Pre-existing conditions

For applicants age nineteen (19) and older this plan does not cover Pre-Existing Conditions diagnosed or treated during the 6 months immediately preceding your Effective Date. The Pre-Existing Condition Limitation Period may last up to 12 months from your Enrollment Date. Credit from prior Creditable Coverage will be applied if applicable to reduce your specific Pre-Existing Condition Limitation Period. If applicable, you will be notified in writing by Anthem Blue Cross and Blue Shield exactly how many months you will be subject to this exclusion.

Renewal/termination of coverage

Membership will not be terminated solely due to medical risk factors such as health status, current or past medical conditions. We may not renew your coverage for the following reasons:

1. Nonpayment of required premiums
2. Any act, practice or omission that constitutes fraud or misrepresentation of material fact found on the application

Your Rights and Responsibilities

We are committed to:

- *Recognizing and respecting you as a member.*
- *Encouraging your open discussions with your health care professionals and providers.*
- *Providing information to help you become an informed health care consumer.*
- *Providing access to health benefits and our network providers.*
- *Sharing our expectations of you as a member.*

You have the right to:

- Participate with your health care professionals and providers in making decisions about your health care.
- Receive the benefits for which you have coverage.
- Be treated with respect and dignity.
- Privacy of your personal health information, consistent with state and federal laws, and our policies.
- Receive information about our organization and services, our network of health care professionals and providers, and your rights and responsibilities.
- Candidly discuss with your physicians and providers appropriate or medically necessary care for your condition, regardless of cost or benefit coverage.
- Make recommendations regarding the organization's members' rights and responsibilities policies.
- Voice complaints or appeals about: our organization, any benefit or coverage decisions we (or our designated administrators) make, your coverage, or care provided.
- Refuse treatment for any condition, illness or disease without jeopardizing future treatment, and be informed by your physician(s) of the medical consequences.
- Participate in matters of the organization's policy and operations.
- For assistance at any time, contact your local insurance department:
  CONNECTICUT
  Phone: (800) 203-3447
  Write: State of Connecticut Insurance Department
  P.O. Box 816
  Hartford, CT 06142-0816

You have the responsibility to:

- Choose a participating primary care physician if required by your health benefit plan.
- Treat all health care professionals and staff with courtesy and respect.
- Keep scheduled appointments with your doctor, and call the doctor's office if you have a delay or cancellation.
- Read and understand to the best of your ability all materials concerning your health benefits or ask for help if you need it.
- Understand your health problems and participate, along with your health care professionals and providers in developing mutually agreed upon treatment goals to the degree possible.
- Supply, to the extent possible, information that we and/or your health care professionals and providers need in order to provide care.
- Follow the plans and instructions for care that you have agreed on with your health care professional and provider.
- Tell your health care professional and provider if you do not understand your treatment plan or what is expected of you.
- Follow all health benefit plan guidelines, provisions, policies and procedures.
- Let our Customer Service Department know if you have any changes to your name, address, or family members covered under your policy.
- Provide us with accurate and complete information needed to administer your health benefit plan, including other health benefit coverage and other insurance benefits you may have in addition to your coverage with us.

We are committed to providing quality benefits and customer service to our members. Benefits and coverage for services provided under the benefit program are governed by the Subscriber Agreement and not by this Member Rights and Responsibilities statement.

Notices of Privacy Practices

Every year, we're required to send you specific information about your rights, your benefits and more. This can use up a lot of trees, so we've combined a couple of these required annual notices. Please take a few minutes to read about:

- State notice of privacy practices
- HIPAA notice of privacy practices
- Breast reconstruction surgery benefits

Want to save more trees? Go to www.anthem.com/medicare and sign up to receive these types of notices by e-mail.

State Notice of Privacy Practices

As mentioned in our Health Insurance Portability and Accountability Act (HIPAA) notice, we must follow state laws that are stricter than the federal HIPAA privacy law. This notice explains your rights and our legal duties under state law. This applies to life insurance benefits, in addition to health, dental and vision benefits that you may have.

Your Personal Information

We may collect, use and share your nonpublic personal information (PI) as described in this notice. PI identifies a person and is often gathered in an insurance matter.

We may collect PI about you from other persons or entities, such as doctors, hospitals or other carriers. We may share PI with persons or entities outside of our company — without your OK in some cases. If we take part in an activity that would require us to give you a chance to opt out, we will contact you. We will tell you how you can let us know that you do not want us to use or share your PI for a given activity.

You have the right to access and correct your PI. Because PI is defined as any information that can be used to make judgements about your health, finances, character, habits, hobbies, reputation, career and credit, we take reasonable safety measures to protect the PI we have about you. A more detailed state notice is available upon request.

Please call the phone number printed on your ID card.

HIPAA Notice of Privacy Practices

This notice describes how health, vision and dental information about you may be used and disclosed, and how you can get access to this information with regard to your health benefits. Please review it carefully.

We keep the health and financial information of our current and former members private, as required by law, accreditation standards and our rules. This notice explains your rights. It also explains our legal duties and privacy practices. We are required by federal law to give you this notice.

Your Protected Health Information

We may collect, use and share your Protected Health Information (PHI) for the following reasons and others as allowed or required by law, including the HIPAA Privacy rule:

For payment: We use and share PHI to manage your account or benefits; or to pay claims for health care you get through your plan. For example, we keep information about your premium and deductible payments. We may give information to a doctor's office to confirm your benefits.

For health care operations: We use and share PHI for our health care operations. For example, we may use PHI to review the quality of care and services you get. We may also use PHI to provide you with case management or care coordination services for conditions like asthma, diabetes or traumatic injury.

For treatment activities: We do not provide treatment. This is the role of a health care provider, such as your doctor or a hospital. But, we may share PHI with your health care provider so that the provider may treat you.

To you: We must give you access to your own PHI. We may also contact you to let you know about treatment options or other health-related benefits and services. When you or your dependents reach a certain age, we may tell you about other products or programs for which you may be eligible. This may include individual coverage. We may also send you reminders about routine medical checkups and tests.

To others: You may tell us in writing that it is OK for us to give your PHI to someone else for any reason. Also, if you are present and tell us it is OK, we may give your PHI to a family member, friend or other person. We would do this if it has to do with your current treatment or payment for your treatment. If you are not present, if it is an emergency, or you are not able to tell us it is OK, we may give your PHI to a family member, friend or other person if sharing your PHI is in your best interest.

As allowed or required by law: We may also share your PHI, as allowed by federal law, for many types of activities. PHI can be shared for health oversight activities. It can also be shared for judicial or administrative proceedings, with public health authorities, for law enforcement reasons, and with coroners, funeral directors or medical examiners (about decedents). PHI can also be shared with organ donation groups for certain reasons, for research, and to avoid a serious threat to health or safety. It can be shared for special government functions, for Workers' Compensation, to respond to requests from the U.S. Department of Health and Human Services, and to alert proper authorities if we reasonably believe that you may be a victim of abuse, neglect, domestic violence or other crimes. PHI can also be shared as required by law. If you are enrolled with us through an employer-sponsored group health plan, we may share PHI with your group health plan. We and/or your group health plan may share PHI with the sponsor of the plan. Plan sponsors that receive PHI are required by law to have controls in place to keep it from being used for reasons that are not proper.

Authorization: We will get an OK from you in writing before we use or share your PHI for any other purpose not stated in this notice. You may take away this OK at any time, in writing. We will then stop using your PHI for that purpose. But, if we have already used or shared your PHI based on your OK, we cannot undo any actions we took before you told us to stop.

Genetic Information: If we use or disclose PHI for underwriting purposes, we are prohibited from using or disclosing PHI that is genetic information of an individual for such purposes.

Your Rights

Under federal law, you have the right to:

- Send us a written request to see or get a copy of certain PHI, or ask that we correct your PHI that you believe is missing or incorrect. If someone else (such as your doctor) gave us the PHI, we will let you know so you can ask him or her to correct it.
- Send us a written request to ask us not to use your PHI for treatment, payment or health care operations activities. We are not required to agree to these requests.
- Give us a verbal or written request to ask us to send your PHI using other means that are reasonable. Also, let us know if you want us to send your PHI to an address other than your home if sending it to your home could place you in danger.
- Send us a written request to ask us for a list of certain disclosures of your PHI. Call Customer Service at the phone number printed on your identification (ID) card to use any of these rights. Customer Service representatives can give you the address to send the request. They can also give you any forms we have that may help you with this process.

How We Protect Information

We are dedicated to protecting your PHI, and have set up a number of policies and practices to help make sure your PHI is kept secure.

We keep your oral, written and electronic PHI safe using physical, electronic, and procedural means. These safeguards follow federal and state laws. Some of the ways we keep your PHI safe include securing offices that hold PHI, password-protecting computers, and locking storage areas and filing cabinets. We require our employees to protect PHI through written policies and procedures. These policies limit access to PHI to only those employees who need the data to do their job. Employees are also required to wear ID badges to help keep people who do not belong out of areas where sensitive data is kept. Also, where required by law, our affiliates and nonaffiliates must protect the privacy of data we share in the normal course of business. They are not allowed to give PHI to others without your written OK, except as allowed by law.

Potential Impact Of Other Applicable Laws

HIPAA (the federal privacy law) generally does not preempt, or override, other laws that give people greater privacy protections. As a result, if any state or federal privacy law requires us to provide you with more privacy protections, then we must also follow that law in addition to HIPAA.

Complaints

If you think we have not protected your privacy, you can file a complaint with us. You may also file a complaint with the Office for Civil Rights in the U.S. Department of Health and Human Services. We will not take action against you for filing a complaint.

Contact Information

Please call Customer Service at the phone number printed on your ID card. Representatives can help you apply your rights, file a complaint or talk with you about privacy issues.

Copies and Changes

You have the right to get a new copy of this notice at any time. Even if you have agreed to get this notice by electronic means, you still have the right to a paper copy. We reserve the right to change this notice.

A revised notice will apply to PHI we already have about you, as well as any PHI we may get in the future. We are required by law to follow the privacy notice that is in effect at this time. We may tell you about any changes to our notice in a number of ways. We may tell you about the changes in a member newsletter or post them on our website. We may also mail you a letter that tells you about any changes.

Breast Reconstruction Surgery Benefits

If you ever need a benefit-covered mastectomy, we hope it will give you some peace of mind to know that your Anthem benefits comply with the Women's Health and Cancer Rights Act of 1998, which provides for:

- Reconstruction of the breast(s) that underwent a covered mastectomy.
- Surgery and reconstruction of the other breast to restore a symmetrical appearance.
- Prostheses and coverage for physical complications related to all stages of a covered mastectomy, including lymphedema.

All applicable benefit provisions will apply, including existing deductibles, copayments and/or co-insurance. Contact your Plan administrator for more information.

QUESTIONS?

Call your Anthem Authorized Sales Agent.

Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente que aparece al dorso de su tarjeta de identificación o en el folleto de inscripción.

This summary of benefits complies with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits.