



New Deductible Options Now Available Effective January 1, 2010

Anthem Blue Cross and Blue Shield is now offering new deductible options for our **Century Preferred Direct** and **Lumenos® HSA** plans.

➤ **New Century Preferred Direct Options:**

- Century Preferred Direct \$1,500 with 20% In Network Coinsurance
 - Offered with and without Rx
- Century Preferred Direct \$3,000 with 0% In Network Coinsurance
 - Offered with and without Rx

➤ **New Lumenos HSA Options:**

- Lumenos HSA \$2,000 with 20% In Network Coinsurance
- Lumenos HSA \$3,500 with 0% In Network Coinsurance
- Lumenos HSA \$5,950 with 0% In Network Coinsurance

Please note that the new Lumenos HSA options listed above offer Preventive Care AFTER the deductible is met. Other Lumenos HSA plans offer Preventive Care at no charge before the deductible.

All other covered services, exclusion, and limitations are described in the enclosed materials. Please review this important information and ask your Anthem Authorized Sales Agent if you have any questions or need a quote.

Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans, Inc. Independent licensee of the Blue Cross and Blue Shield Association. ® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

Lumenos Health Savings Account (HSA)

Outline of Coverage – Major Medical Expense

Underwritten by Anthem Blue Cross and Blue Shield Insurance
370 Bassett Road, North Haven Connecticut 06473 · 1-800-441-6634

This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. Upon enrollment, it is therefore important that you READ YOUR POLICY CAREFULLY.

Major Medical Expense Coverage – Policies of this category are designed to provide, to persons insured, coverage for major hospital, medical, and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services, and out-of-hospital care, subject to any deductibles, copayment provisions, or other limitations which may be set forth in the policy.

A Brief Description of Benefits

Covered Service	In-Network Services (*Out-of-Network Services)			
Single Deductible*	\$1,250	\$2,500	\$2,500	\$5,000
Family Deductible**	\$2,500	\$5,000	\$5,000	\$10,000
Member In-Network Coinsurance	N/A	20%	N/A	N/A
(Member Out-of-Network Coinsurance)	(30%)	(40%)	(30%)	(30%)
Member Out-of-pocket Limit				
<i>Single</i>	\$1,250 (\$2,500)	\$5,000 (\$10,000)	\$2,500 (\$5,000)	\$5,000 (\$10,000)
<i>Family</i>	\$2,500 (\$5,000)	\$10,000 (\$20,000)	\$5,000 (\$10,000)	\$10,000 (\$20,000)
Lifetime Maximum	Unlimited (\$1,000,000)			

*Single Deductible - Lumenos Health Savings Account Direct After the allowance is depleted, the Deductible must be satisfied before any Covered Services are paid by the Plan except for Preventive Services which are not subject to the Deductible.

**Family Deductible – Lumenos Health Savings Account Direct After the allowance is depleted, the family Deductible must be satisfied before any Covered Services are paid by the plan except for Preventive Services which are not subject to the Deductible. The family Deductible may be satisfied by one Member or all Members collectively.

Note: The Deductible may be prorated for Members who begin or change to coverage under this Subscriber Agreement at any time other than at the beginning of the benefit period. Single Out of Pocket Limit – Once the Member Out-of-Pocket Limit is satisfied, no additional Coinsurance will be required for the Member for the remainder of the benefit period except for Out of Network Human Organ and Tissue Transplant services. Family Out of Pocket Limit - Once the family Out-of-Pocket Limit is satisfied, no additional Coinsurance will be required for the Family for the remainder of the benefit period except for Out-of-Network Human Organ and Tissue Transplant services. In Network and Out-of-Network Out-of-Pocket Limits are separate and do not accumulate toward each other.

Hospital Services	
All Inpatient Admissions	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)
Specialty Hospital <i>100 days per Member per Calendar Year (for other than Mental Health and Substance Abuse services only)</i>	Same as Hospital Inpatient Cost-Share (Deductible and Out-of-Network Coinsurance)
Outpatient Surgery <i>In a licensed ambulatory surgical center (including colonoscopy)</i>	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)
Skilled Nursing Facility <i>Up to 100 days per Calendar Year</i>	Same as Hospital Inpatient Cost Share (Deductible and Out-of-Network Coinsurance)

continued >

Covered Service	In-Network Services (*Out-of-Network Services)
Mental Health and Substance Abuse Services	
Outpatient Treatment for Mental Health Care and Substance Abuse Care	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)
Inpatient Hospital Services <i>In a Hospital or Residential Treatment Center for Mental Health Care</i>	Same as Hospital Inpatient Cost Share (Deductible and Out-of-Network Coinsurance)
Inpatient Rehabilitation Treatment for Substance Abuse Care <i>In a Hospital or Substance Abuse Treatment Facility</i>	Same as Hospital Inpatient Cost Share (Deductible and Out-of-Network Coinsurance)
Miscellaneous Hospital Services	
Emergency Room Treatment	Deductible and In-Network Coinsurance (Paid as an In-Network Service)
Urgent Care Services	Deductible and In-Network Coinsurance (Paid as an In-Network Emergency Room)
Surgical Services	
Outpatient surgery <i>In a licensed ambulatory surgical center</i>	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)
Medical Office Visit	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)
In-Hospital Medical Services	
Services of a Physician or Surgeon <i>(other than a medical office visit)</i>	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)
Out-of-Hospital Care	
Well Child Care	No cost share In- Network (Deductible and Out-of-Network Coinsurance)
Adult Physical Examinations	No cost share In- Network (Deductible and Out-of-Network Coinsurance)
Other Preventive Screenings <i>Including but not limited to:</i>	No Cost Share In-Network (Deductible and Out-of-Network Coinsurance)
<ul style="list-style-type: none"> · Routine gynecological care: pap smear and pelvic exam · Mammography screening · Flexible sigmoidoscopy · Total Cholesterol screening · Diabetic screening 	<ul style="list-style-type: none"> · Prostate screening · Colorectal Cancer screening · Colonoscopy · Lipid screening and panels
Other Benefits	
Immunizations and Vaccinations <i>(other than those needed for travel)</i>	No Cost Share (Deductible and Out-of-Network Coinsurance)
Immunizations and Vaccinations for Travel	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)
Prescription Drugs <i>The maximum supply of a drug for which benefits will be provided when dispensed under any one prescription is a 30-day supply</i> <i>Diabetic drugs and supplies</i>	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)
Diagnostic Services <i>(Diagnostic, Laboratory, X-ray, MRI, MRA, CAT, CTA, PET and SPECT)</i>	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)

continued >

Covered Service	In-Network Services (*Out-of-Network Services)
Infertility Services <i>Office Visit</i> <i>Outpatient Hospital</i> <i>Inpatient Hospital</i> <i>Infertility drugs (with infertility diagnosis). Maximum drug supply for which benefits will be provided when dispensed under any one prescription is a 30 day supply</i>	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance) Same as Hospital Outpatient Cost-Share (Deductible and Out-of-Network Coinsurance) Same as Hospital Outpatient Cost-Share (Deductible and Out-of-Network Coinsurance) Deductible and In-Network Coinsurance (if applicable) (Deductible and Out-of-Network Coinsurance)
Outpatient Rehabilitation Services <i>Rehabilitative and restorative physical, occupational and speech therapy (\$3,000 combined max. per member per calendar year) Chiropractic therapy (max. 12 visits per calendar year)</i>	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)
Other Therapy Services <i>Outpatient cardiac rehabilitation therapy; Radiation therapy; Chemotherapy for cancer treatment; Electroshock therapy; Kidney Dialysis in a hospital or free standing dialysis center</i>	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)
Allergy Office Visit/Testing <i>Allergy Injections</i> <i>Unlimited Immunotherapy or other therapy treatments</i>	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)
Ambulance Services <i>Land & Air: Paid according to the Department of Public Health Ambulance Service Rate Schedule</i>	Deductible and In-Network Coinsurance (Paid as an In-Network Service)
Human Organ and Tissue Transplant Services <i>Unlimited Lifetime Maximum</i>	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)
Home Health Care <i>Nursing and therapeutic services limited to 100 visits</i>	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)
Infusion Therapy <i>Unlimited Lifetime Maximum</i>	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)
Durable Medical Equipment <i>Hearing Aid Coverage available for dependent children age 12 years and under with a maximum of \$1,000 within a 2 year period.</i>	Deductible and 50% Coinsurance (Deductible and 50% Coinsurance)
Diabetic Equipment <i>Drugs and supplies purchased at a Pharmacy that is not a Durable Medical Equipment supplier</i>	Deductible and In-Network Coinsurance (if applicable) (Deductible and Out-of-Network Coinsurance)
Ostomy Related Services	Deductible and 50% Coinsurance (Deductible and 50% Coinsurance)
Hospice Care (inpatient)	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)
Wig <i>Up to \$500 max. per member per calendar year</i>	Deductible and In-Network Coinsurance (if applicable) (Deductible and Out-of-Network Coinsurance)
Specialized Formula	Deductible and In-Network Coinsurance (if applicable) (Deductible and Out-of-Network Coinsurance)
Nutritional Counseling <i>with a maximum of 3 visits per member per calendar year</i>	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)

*Out-of-Network Services are noted in parentheses.

Note: Services applicable after Deductible and Coinsurance. Member is responsible for the difference between Maximum Allowable Amount (MAA) and total charge.
 The \$2,500/\$5,000 deductible plan with the 20% member in-network coinsurance is the only plan that has in-network coinsurance.

Lumenos Health Incentive Account (HIA)

Outline of Coverage – Major Medical Expense

Underwritten by Anthem Blue Cross and Blue Shield Insurance
370 Bassett Road, North Haven Connecticut 06473 · 1-800-441-6634

This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. Upon enrollment, it is therefore important that you READ YOUR POLICY CAREFULLY.

Major Medical Expense Coverage – Policies of this category are designed to provide, to persons insured, coverage for major hospital, medical, and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services, and out-of-hospital care, subject to any deductibles, copayment provisions, or other limitations which may be set forth in the policy.

A Brief Description of Benefits

Covered Service	In-Network Services (*Out-of-Network Services)
Single Deductible*	\$1,500 \$2,500
Family Deductible**	\$3,000 \$5,000
Member In-Network Coinsurance (Member Out-of-Network Coinsurance)	20% 20% (40%) (40%)
Member Cost-Share Maximum	
Single	\$4,500 (\$9,000) \$5,000 (\$10,000)
Family	\$9,000 (\$18,000) \$10,000 (\$20,000)
Lifetime Maximum	Unlimited (\$1,000,000)

*Single Deductible - Lumenos Health Incentive Account Direct After the allowance is depleted, the Deductible must be satisfied before any Covered Services are paid by the Plan except for Preventive Services which are not subject to the Deductible.

**Family Deductible - Lumenos Health Incentive Account Direct After the allowance is depleted, the family Deductible must be satisfied before any Covered Services are paid by the plan except for Preventive Services which are not subject to the Deductible. The family Deductible may be satisfied by one Member or all Members collectively.

Note: The Deductible may be prorated for Members who begin or change to coverage under this Subscriber Agreement at any time other than at the beginning of the benefit period.

Single Out of Pocket Limit - Once the Member Out-of-Pocket Limit is satisfied, no additional Coinsurance will be required for the Member for the remainder of the benefit period except for Out of Network Human Organ and Tissue Transplant services. Family Out of Pocket Limit - Once the family Out-of-Pocket Limit is satisfied, no additional Coinsurance will be required for the Family for the remainder of the benefit period except for Out-of-Network Human Organ and Tissue Transplant services. In Network and Out-of-Network Out-of-Pocket Limits are separate and do not accumulate toward each other.

Hospital Services

All Inpatient Admissions

Deductible and In-Network Coinsurance
(Deductible and Out-of-Network Coinsurance)

Specialty Hospital

100 days per Member per Calendar Year (for other than Mental Health and Substance Abuse services only)

Same as Hospital Inpatient Cost-Share
(Deductible and Out-of-Network Coinsurance)

Outpatient Surgery

In a licensed ambulatory surgical center (including colonoscopy)

Deductible and In-Network Coinsurance
(Deductible and Out-of-Network Coinsurance)

Skilled Nursing Facility

Up to 100 days per Calendar Year

Same as Hospital Inpatient Cost Share
(Deductible and Out-of-Network Coinsurance)

continued >

Covered Service**In-Network Services (*Out-of-Network Services)**

Covered Service	In-Network Services (*Out-of-Network Services)
Mental Health and Substance Abuse Services	
Outpatient Treatment for Mental Health Care and Substance Abuse Care	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)
Inpatient Hospital Services <i>In a Hospital or Residential Treatment Center for Mental Health Care</i>	Same as Hospital Inpatient Cost Share (Deductible and Out-of-Network Coinsurance)
Inpatient Rehabilitation Treatment for Substance Abuse Care <i>In a Hospital or Substance Abuse Treatment Facility</i>	Same as Hospital Inpatient Cost Share (Deductible and Out-of-Network Coinsurance)
Miscellaneous Hospital Services	
Emergency Room Treatment	Deductible and In-Network Coinsurance (Paid as an In-Network Service)
Urgent Care Services	Deductible and In-Network Coinsurance (Paid as an In-Network Emergency Room)
Surgical Services	
Outpatient surgery <i>In a licensed ambulatory surgical center</i>	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)
Medical Office Visit	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)
In-Hospital Medical Services	
Services of a Physician or Surgeon <i>(other than a medical office visit)</i>	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)
Out-of-Hospital Care	
Well Child Care	No cost share In- Network (Deductible and Out-of-Network Coinsurance)
Adult Physical Examinations	No cost share In- Network (Deductible and Out-of-Network Coinsurance)
Other Preventive Screenings <i>Including but not limited to:</i>	No cost share In- Network (Deductible and Out-of-Network Coinsurance)
<ul style="list-style-type: none"> · Routine gynecological care: pap smear and pelvic exam · Mammography screening · Flexible sigmoidoscopy · Total Cholesterol screening · Diabetic screening 	<ul style="list-style-type: none"> · Prostate screening · Colorectal Cancer screening · Colonoscopy · Lipid screening and panels
Other Benefits	
Immunizations and Vaccinations <i>(other than those needed for travel)</i>	No Cost Share (Deductible and Out-of-Network Coinsurance)
Immunizations and Vaccinations for Travel	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)
Prescription Drugs <i>The maximum supply of a drug for which benefits will be provided when dispensed under any one prescription is a 30-day supply</i> <i>Diabetic drugs and supplies</i>	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)
Diagnostic Services <i>(Diagnostic, Laboratory, X-ray, MRI, MRA, CAT, CTA, PET and SPECT)</i>	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)

continued >

Covered Service	In-Network Services (*Out-of-Network Services)
Infertility Services <i>Office Visit</i> <i>Outpatient Hospital</i> <i>Inpatient Hospital</i> <i>Infertility drugs (with infertility diagnosis). Maximum drug supply for which benefits will be provided when dispensed under any one prescription is a 30 day supply.</i>	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance) Same as Hospital Outpatient Cost-Share (Deductible and Out-of-Network Coinsurance) Same as Hospital Outpatient Cost-Share (Deductible and Out-of-Network Coinsurance) Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)
Outpatient Rehabilitation Services <i>Rehabilitative and restorative physical, occupational and speech therapy (\$3,000 combined max. per member per calendar year)</i> <i>Chiropractic therapy (max. 12 visits per calendar year)</i>	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)
Other Therapy Services <i>Outpatient cardiac rehabilitation therapy; Radiation therapy; Chemotherapy for cancer treatment; Electroshock therapy; Kidney Dialysis in a hospital or free standing dialysis center</i>	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)
Allergy Office Visit/Testing <i>Allergy Injections</i> <i>Unlimited Immunotherapy or other therapy treatments</i>	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)
Ambulance Services <i>Land & Air: Paid according to the Department of Public Health Ambulance Service Rate Schedule</i>	Deductible and In-Network Coinsurance (Paid as an In-Network Service)
Human Organ and Tissue Transplant Services <i>Unlimited Lifetime Maximum</i>	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)
Home Health Care <i>Nursing and therapeutic services limited to 100 visits</i>	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)
Infusion Therapy <i>Unlimited Lifetime Maximum</i>	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)
Durable Medical Equipment <i>Hearing Aid Coverage available for dependent children age 12 years and under with a maximum of \$1,000 within a 2 year period.</i>	Deductible and 50% Coinsurance (Deductible and 50% Coinsurance)
Diabetic Equipment <i>Drugs and supplies purchased at a Pharmacy that is not a Durable Medical Equipment supplier</i>	Deductible and In-Network Coinsurance (if applicable) (Deductible and Out-of-Network Coinsurance)
Ostomy Related Services	Deductible and 50% Coinsurance (Deductible and 50% Coinsurance)
Hospice Care (inpatient)	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)
Wig <i>Up to \$500 max. per member per calendar year</i>	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)
Specialized Formula	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)
Nutritional Counseling <i>with a maximum of 3 visits per member per calendar year</i>	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)

*Out-of-Network Services are noted in parentheses.

Note: Services applicable after Deductible and Coinsurance. Member is responsible for the difference between Maximum Allowable Amount (MAA) and total charge.

Lumenos Health Incentive Account Plus (HIA)

Outline of Coverage – Major Medical Expense

Underwritten by Anthem Blue Cross and Blue Shield Insurance
 370 Bassett Road, North Haven Connecticut 06473 · 1-800-441-6634

This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. Upon enrollment, it is therefore important that you READ YOUR POLICY CAREFULLY.

Major Medical Expense Coverage – Policies of this category are designed to provide, to persons insured, coverage for major hospital, medical, and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services, and out-of-hospital care, subject to any deductibles, copayment provisions, or other limitations which may be set forth in the policy.

A Brief Description of Benefits

Covered Service	In-Network Services (*Out-of-Network Services)
Single Deductible*	\$2,500
Family Deductible**	\$5,000
Member In-Network Coinsurance (Member Out-of-Network Coinsurance)	20% (40%)
Member Cost-Share Maximum	
<i>Single</i>	\$5,000 (\$10,000)
<i>Family</i>	\$10,000 (\$20,000)
Lifetime Maximum	Unlimited (\$1,000,000)

*Single Deductible Lumenos Health Incentive Account Plus Direct After the allowance is depleted, the Deductible must be satisfied before any Covered Services are paid by the Plan except for Preventive Services which are not subject to the Deductible.

**Family Deductible – Lumenos Health Incentive Account Plus Direct After the allowance is depleted, the family Deductible must be satisfied before any Covered Services are paid by the plan except for Preventive Services which are not subject to the Deductible. The family Deductible may be satisfied by one Member or all Members collectively.

Note: The Deductible may be prorated for Members who begin or change to coverage under this Subscriber Agreement at any time other than at the beginning of the benefit period. Single Out of Pocket Limit – Once the Member Out-of-Pocket Limit is satisfied, no additional Coinsurance will be required for the Member for the remainder of the benefit period except for Out of Network Human Organ and Tissue Transplant services. Family Out of Pocket Limit - Once the family Out-of-Pocket Limit is satisfied, no additional Coinsurance will be required for the Family for the remainder of the benefit period except for Out-of-Network Human Organ and Tissue Transplant services. In Network and Out-of-Network Out-of-Pocket Limits are separate and do not accumulate toward each other.

Hospital Services	
All Inpatient Admissions	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)
Specialty Hospital <i>100 days per Member per Calendar Year (for other than Mental Health and Substance Abuse services only)</i>	Same as Hospital Inpatient Cost-Share (Deductible and Out-of-Network Coinsurance)
Outpatient Surgery <i>In a licensed ambulatory surgical center (including colonoscopy)</i>	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)
Skilled Nursing Facility <i>Up to 100 days per Calendar Year</i>	Same as Hospital Inpatient Cost Share (Deductible and Out-of-Network Coinsurance)

continued >

Covered Service	In-Network Services (*Out-of-Network Services)
Mental Health and Substance Abuse Services	
Outpatient Treatment for Mental Health Care and Substance Abuse Care	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)
Inpatient Hospital Services <i>In a Hospital or Residential Treatment Center for Mental Health Care</i>	Same as Hospital Inpatient Cost Share (Deductible and Out-of-Network Coinsurance)
Inpatient Rehabilitation Treatment for Substance Abuse Care <i>In a Hospital or Substance Abuse Treatment Facility</i>	Same as Hospital Inpatient Cost Share (Deductible and Out-of-Network Coinsurance)
Miscellaneous Hospital Services	
Emergency Room Treatment	Deductible and In-Network Coinsurance (Paid as an In-Network Service)
Urgent Care Services	Deductible and In-Network Coinsurance (Paid as an In-Network Emergency Room)
Surgical Services	
Outpatient surgery <i>In a licensed ambulatory surgical center</i>	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)
Medical Office Visit	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)
In-Hospital Medical Services	
Services of a Physician or Surgeon <i>(other than a medical office visit)</i>	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)
Out-of-Hospital Care	
Well Child Care	No cost share In- Network (Deductible and Out-of-Network Coinsurance)
Adult Physical Examinations	No cost share In- Network (Deductible and Out-of-Network Coinsurance)
Other Preventive Screenings <i>Including but not limited to:</i>	No Cost Share In-Network (Deductible and Out-of-Network Coinsurance)
<ul style="list-style-type: none"> · Routine gynecological care: pap smear and pelvic exam · Mammography screening · Flexible sigmoidoscopy · Total Cholesterol screening · Diabetic screening 	<ul style="list-style-type: none"> · Prostate screening · Colorectal Cancer screening · Colonoscopy · Lipid screening and panels
Other Benefits	
Immunizations and Vaccinations <i>(other than those needed for travel)</i>	No Cost Share (Deductible and Out-of-Network Coinsurance)
Immunizations and Vaccinations for Travel	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)
Prescription Drugs <i>The maximum supply of a drug for which benefits will be provided when dispensed under any one prescription is a 30-day supply</i> <i>Diabetic drugs and supplies</i>	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)
Diagnostic Services <i>(Diagnostic, Laboratory, X-ray, MRI, MRA, CAT, CTA, PET and SPECT)</i>	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)

continued >

Covered Service	In-Network Services (*Out-of-Network Services)
Infertility Services <i>Office Visit</i> <i>Outpatient Hospital</i> <i>Inpatient Hospital</i> <i>Infertility drugs (with infertility diagnosis). Maximum drug supply for which benefits will be provided when dispensed under any one prescription is a 30 day supply.</i>	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance) Same as Hospital Outpatient Cost-Share (Deductible and Out-of-Network Coinsurance) Same as Hospital Outpatient Cost-Share (Deductible and Out-of-Network Coinsurance) Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)
Outpatient Rehabilitation Services <i>Rehabilitative and restorative physical, occupational and speech therapy (\$3,000 combined max. per member per calendar year) Chiropractic therapy (max. 12 visits per calendar year)</i>	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)
Other Therapy Services <i>Outpatient cardiac rehabilitation therapy; Radiation therapy; Chemotherapy for cancer treatment; Electroshock therapy; Kidney Dialysis in a hospital or free standing dialysis center</i>	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)
Allergy Office Visit/Testing <i>Allergy Injections</i> <i>Unlimited Immunotherapy or other therapy treatments</i>	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)
Ambulance Services <i>Land & Air: Paid according to the Department of Public Health Ambulance Service Rate Schedule</i>	Deductible and In-Network Coinsurance (Paid as an In-Network Service)
Human Organ and Tissue Transplant Services <i>\$1,000,000 Lifetime Maximum</i>	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)
Home Health Care <i>Nursing and therapeutic services limited to 100 visits</i>	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)
Infusion Therapy <i>Unlimited Lifetime Maximum</i>	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)
Durable Medical Equipment <i>Hearing Aid Coverage available for dependent children age 12 years and under with a maximum of \$1,000 within a 2 year period.</i>	Deductible and 50% Coinsurance (Deductible and 50% Coinsurance)
Diabetic Equipment <i>Drugs and supplies purchased at a Pharmacy that is not a Durable Medical Equipment supplier</i>	Deductible and In-Network Coinsurance (if applicable) (Deductible and Out-of-Network Coinsurance)
Ostomy Related Services	Deductible and 50% Coinsurance (Deductible and 50% Coinsurance)
Hospice Care (inpatient)	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)
Wig <i>Up to \$500 max. per member per calendar year</i>	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)
Specialized Formula	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)
Nutritional Counseling <i>with a maximum of 3 visits per member per calendar year</i>	Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)

*Out-of-Network Services are noted in parentheses.

Note: Services applicable after Deductible and Coinsurance. Member is responsible for the difference between Maximum Allowable Amount (MAA) and total charge.

Lumenos Exclusions and Limitations

In addition to the other limitations, conditions and exclusions set forth elsewhere in this Certificate, no benefits will be provided for expenses related to the services, supplies, conditions or situations described in this section. These items and services are not covered even if you receive them from your Provider or according to your Provider's Referral.

Please remember, this plan does not cover any service or supply not specifically listed as a Covered Service in this Certificate. The following list of exclusions is not a complete list of all services, supplies, conditions or situations that are not Covered Services. If a service is not covered, then all services performed in conjunction with that service are not covered. Anthem Blue Cross and Blue Shield (Anthem) is the final authority for determining if services or supplies are Medically Necessary.

The listed exclusions below are in addition to those set forth elsewhere in the Certificate.

The following services are not Covered Services under this Benefit Program, except when approved by Anthem as part of Case Management.

1. Benefits for services which are not:
 - a. specifically described in the Subscriber Agreement
 - b. rendered or ordered by a Physician
 - c. within the scope of the Physician's, Provider's or Hospital's licensure; and
 - d. Medically Necessary Care for the proper diagnosis and treatment of the Member.
2. Benefits may be reduced or denied if subject to the Managed Benefits – Managed Care Guidelines. Any reduced or denied benefits paid by the Member do not apply toward the Cost Share Maximums shown in the Schedule of Benefits.
3. Routine hearing exams are not covered, with the exception of child hearing screening which is covered under Preventive Care.
4. Private Duty Nursing is not a Covered Service, unless otherwise stated in this Subscriber Agreement.
5. Benefits for services rendered before the Member's Effective Date under this Benefit Program.
6. Benefits for services rendered after the person's Benefit Program has been rescinded, suspended, cancelled, interrupted or terminated. Any person obtaining services after his or her Benefit Program is rescinded, suspended, cancelled, interrupted or terminated for any reason will be solely responsible for payment of such services.
7. Care for conditions which are required by State or Local law to be treated in a public facility.
8. Services and care in a Veteran's Hospital or any Federal Hospital, except as may be otherwise required by law.
9. Services covered in whole or in part by public or private grants.
10. Services required by third parties, including but not limited to: school, employment, summer camp and premarital physicals and related tests.
11. Studies related to pregnancy except for significant medical reasons.
12. Simplified or self-administered tests and multiphasic screening.
13. Cosmetic Surgery or services performed primarily to improve appearance and not designed to restore body function or to correct deformity resulting from the treatment of malignancy or physical trauma.
14. Dental diagnosis, care, treatment, x-rays, or Appliances, for any of the diseases or lesions of the oral cavity, its contents or contiguous structures, the extraction of teeth, the correction of malpositions of the teeth and jaw, or for pain, deformity, deficiency, injury or physical condition of teeth, unless otherwise provided for in this Subscriber Agreement.
15. Surgical and non-surgical examination, diagnosis, including invasive (internal) and non-invasive (external) procedures and tests, and all services related to diagnosis and treatment, both medical and surgical, of temporomandibular joint dysfunction or syndrome also called myofascial pain dysfunction or craniomandibular pain syndrome. This exclusion includes but is not limited to the following: contrast and non-contrast imaging, arthroscopic and open surgical procedures, physical therapy, and appliance therapy such as occlusal Appliances (splints) or adjustments. Anthem will not provide benefits unless otherwise provided for by an Amendatory Rider to this Subscriber Agreement.

continued >

16. Routine foot care in the absence of systemic or vascular disease affecting the foot, including hygienic care, treatment of corns or calluses, services performed in conjunction with fitting of supportive or comfort devices for the foot or other foot care.
17. Services for Custodial Care, Chronic Care and/or Maintenance Care.
18. Prenatal medical conferences with a pediatrician regarding an unborn child unless the visit is the result of a medical referral.
19. Charges for the Member's room and board when the Member has a leave of absence from the Hospital, Substance Abuse Treatment Facility or other Inpatient Facility.
20. Drugs or medications, legend and over-the-counter, prescribed for use as an Outpatient, except as otherwise stated herein.
21. Sperm collection and preservation, all services related to surrogate parenting arrangements and preparatory treatment.
22. Evaluation, treatment, procedures and Prescription Drugs related to and performance of sex-change operations including follow-up treatment, care and counseling.
23. Obstetrical care or pregnancy, delivery, prenatal and postpartum care, including Inpatient care for a female Member.
24. No benefits are available for reversal of sterilization.
25. Vaccines other than routine immunizations or those needed for travel.
26. Services, medical supplies or supplies not specifically listed as Covered Services. These include but are not limited to educational therapy, marital counseling, sex therapy, weight control programs, nutritional programs and exercise programs.
27. No benefits are available for any service, care, procedure or program for weight or appetite control, weight loss, weight management or for control of obesity even if the weight or obesity aggravates another condition.
28. Experimental or Investigational treatment, procedure, facility, equipment, drugs, devices or supplies. Any services associated with or as follow-up to any of the above is not a Covered Service.
29. Any treatment, procedure, facility, equipment, drug, device or supply which requires Federal or other governmental agency approval not granted at the time services are rendered. Any service associated with, or as follow-up to, any of the above is not a Covered Service.
30. Any services by a Physician or Provider to himself or herself or for services rendered to his or her parent, spouse, children, grandchildren or any other immediate family Member or relation, even if a Participating Physician or Participating Provider.
31. Services which the Member or Anthem is not legally required to pay.
32. Wigs, except as noted in the Covered Services Section.
33. Inpatient services which can be properly rendered as Outpatient services.
34. Disease contracted or injuries resulting from war.
35. Charges after the Provider's or Hospital's regular discharge hour on the day indicated for the Member's discharge by his/her Physician.
36. Charges in excess of the Maximum Allowable Amount.
37. Supervisory care by a Physician for a Member who is mentally or physically disabled and who is not under specific medical, surgical or psychiatric treatment to reduce the disability to the extent necessary to enable the patient to live outside an institution providing medical care; or when despite such treatment, there is no reasonable likelihood that the disability will be so reduced.
38. Travel, whether or not recommended by a Physician.
39. Certain pulmonary function tests which in the opinion of Anthem do not meet the definition of a covered diagnostic laboratory test.
40. Services or procedures rendered without regard for specific clinical indications, routinely for groups or individuals or which are performed solely for research purposes.
41. Services or procedures which have become obsolete or are no longer medically justified as determined by appropriate medical specialties.
42. Radiation therapy as a treatment for acne vulgaris.
43. Services rendered by a Physician in the employ of a Home (e.g. Skilled Nursing Facility) do not qualify as Home & Office Care.

continued >

44. The following is a list of procedures which are not covered:

1. Allogeneic or Syngeneic Bone Marrow Transplant or other forms of stem cell rescue and stem cell infusion (with or without high dose chemotherapy and/or radiation) are those with a donor other than the patient. They are not covered except in the following cases:
 - a. When at least five out of six histocompatibility complex antigens match between the patient and the donor.
 - b. The mixed leukocyte culture is non-reactive.
 - c. One of the following conditions is being treated:
 - Severe aplastic anemia
 - Acute nonlymphocytic leukemia in first or subsequent remission or early first relapse
 - Myelodysplastic syndrome
 - Secondary acute nonlymphocytic leukemia as initial therapy
 - Acute lymphocytic leukemia in second or subsequent remission
 - Acute lymphocytic leukemia in first remission
 - Chronic myelogenous leukemia in chronic and accelerate phase
 - Non-Hodgkin's lymphoma, high grade, in first or subsequent remission
 - Hodgkin's lymphoma low grade, which has undergone conversion to high grade
 - Neuroblastoma, stage 3 or relapsed stage 4
 - Ewing's sarcoma
 - Severe combined immunodeficiency syndrome
 - Wiskott-Aldrich syndrome
 - Osteopetrosis, infantile malignant
 - Chediak-Higashi syndrome
 - Congenital life-threatening neutrophil disorders to include Kostmann's syndrome, chronic granulomatous disease, and cartilage hair hypoplasia

- Diamond Blackfan syndrome
- Thalassemia
- Sickle cell anemia
- Primary thrombocytopathy including Glanzmann's syndrome
- Gaucher disease
- Mucopolysaccharidoses and lipidoses to include Hurler's syndrome, Sanfilippo's syndrome, Maroteaux-Lamy syndrome, Morquio's syndrome, Hunter's syndrome, and metachromatic leukodystrophy.

All other uses of Allogeneic or Syngeneic Bone Marrow Transplants or other forms of stem cell rescue and stem cell infusion (with or without high dose chemotherapy or radiation) are not covered.

2. Autologous Bone Marrow Transplantation or other forms of stem cell rescue and stem cell infusion (in which the patient is the donor) with high dose chemotherapy or radiation are not covered except for the following:
 - a. Non-Hodgkin's lymphoma, high grade, first or subsequent remission. No morphological evidence of bone marrow involvement should be evident.
 - b. Hodgkin's disease as defined above with an absence of bone marrow involvement.
 - c. Acute nonlymphocytic leukemia in second remission, in which no HLA matched donor exists or an allogeneic transplant is inappropriate.
 - d. Acute lymphocytic leukemia in second remission, in which no HLA matched donor exists or an allogeneic transplant is inappropriate.
 - e. Retinoblastoma, adjuvant setting after successful induction (consolidation).
 - f. Neuroblastoma, adjuvant setting after successful induction (consolidation).

Autologous Bone Marrow Transplants or other forms of stem cell rescue and stem cell infusion (with high dose chemotherapy and/or radiation), for all other cases are not covered.

Know Your Rights and Responsibilities

You have the right to:

- Receive quality health care from your primary care provider in a timely manner and in a medically appropriate setting.
- Participate with your health care professionals and providers in making decisions about your health care.
- Select a participating primary care physician and change your selection at any time without the need for stating a reason.
- Receive all benefits for which you have coverage.
- Be treated with respect and recognition of your dignity and right to privacy, consistent with state and federal laws, and our policies.
- Receive information about our organization and services, our participating health care professionals and providers, and your rights and responsibilities.
- A candid discussion of appropriate or medically necessary treatment options for your condition, regardless of cost or benefit coverage.
- Make recommendations regarding the organization's members' rights and responsibilities policies.

Connecticut members may voice complaints or appeals about our company, any decisions we (or our designated administrators) make, your coverage, or the quality of care provided.

You have the responsibility to:

- 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.
- Provide, to the extent possible, any information that we and/or our health care professionals and providers need so care can be provided to you.
- 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.
- Refuse treatment and be informed by your health care professional and provider of the medical consequences.
- Know how and when to access care in routine, urgent and emergency situations.
- Follow all plan 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 benefit plan, including other health coverage and other insurance benefits you may have in addition to your coverage.

We are committed to providing quality service to our members and participating health care professionals. To further that goal, this Member Bill of Rights and Responsibilities will serve as an example of our commitment to you. Benefits and coverage for services provided under the benefit program are governed by the Subscriber Agreement and not by this statement.

If you are a Connecticut member, contact:

State of Connecticut
Insurance Department
P.O. Box 816
Hartford, CT 06142-0816
Phone: 1-860-297-3800

We promise to:

- Recognize and respect your needs
- Encourage your open discussions with all health care professionals and providers
- Help you become an informed health care consumer
- Assist you in receiving appropriate health care services
- Share our expectations of your responsibilities

And we stand by our promises.

continued >

Eligibility

To become eligible for membership as a Subscriber under this Benefit Program the applicant must:

1. Be a resident of the State of Connecticut
2. Be under age 65.

Renewability of Coverage

We will renew your Policy each time you send us the premium. Payment must be made on or before the due date or during the month that follows. Your Policy stays in force during this time. We can refuse to renew your Policy only when we refuse to renew all form number N1369 Policies in our state. Nonrenewal will not affect an existing claim.

Premium Rates

The amount, time and manner of payment of Premiums shall be determined by Anthem BCBS and shall be subject to the approval of the State of Connecticut Insurance Department.

In the event of any change in Premium, the Subscriber will be given notice of at least 30 days prior to such change. Payment of the Premium by the Subscriber of contributions shall serve as notice of the Subscriber's acceptance of the change.

HIPAA notice of privacy practices

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 to coroners, funeral

continued >

directors or medical examiners (about decedents). PHI can also be shared for certain reasons with organ donation groups, 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.

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 them 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. They 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. We 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 offices that are kept secure, computers that need passwords, and locked storage areas and filing cabinets. We require our employees to protect PHI through written policies and procedures. The 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 non-affiliates 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.

continued >

Contact Information

Please call Customer Service at the phone number printed on your ID card. They 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 web site. We may also mail you a letter that tells you about any changes.

State Notice Of Privacy Practices

As we told you in our HIPAA notice, we must follow state laws that are more strict than the federal HIPAA privacy law. This notice explains your rights and our legal duties under state law.

Your Personal Information

- We may collect, use and share your non-public personal information (PI) as described in this notice. PI identifies a person and is often gathered in an insurance matter. PI could also be used to make judgments about your health, finances, character, habits, hobbies, reputation, career, and credit.
- 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.
- 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.

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.