Century Preferred

Summary Booklet

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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.

Anthem BlueCross BlueShield

33903CTMENABS 11/12

Anthem BlueCross BlueShield
108 Leigus Road
Wallingford, CT 06492

CENTURY PREFERRED

SUMMARY BOOKLET

PLEASE READ YOUR SUMMARY BOOKLET

City of Milford
001016-514
HBP#001

"Important: This is not an insured Benefit Plan. The benefits described in this Summary Booklet or any rider or amendments hereto are funded by the Employer who is responsible for their payment. Anthem BCBS provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims."

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PATIENT PROTECTION AND AFFORDABLE CARE ACT AMENDMENT

This Amendment changes provisions in, or adds provisions to, your

Century Preferred
Century Preferred Comprehensive
Century Preferred Comprehensive HSA
Lumenos HSA, HRA, HIA, HIA Plus

including any affected riders, endorsements or other amendments thereto, (hereinafter collectively, "Summary Booklet") issued by "Anthem BCBS" as required by the federal Patient Protection and Affordable Care Act. Except as otherwise provided for in this Amendment, the provisions herein apply to all persons covered under the Summary Booklet, ("Covered Persons"). All of the terms, conditions, and limitations of the Summary Booklet to which this Amendment is attached also apply to this Amendment, except where they are specifically changed by this Amendment. **This Amendment shall take effect on your group's issue date or renewal date on or after September 23, 2010.**

1. **Emergency Services.**

   A. **Emergency Condition Defined.** The definition of Emergency Condition in the Summary Booklet is hereby deleted in its entirety and replaced with the following:

      EMERGENCY CONDITION: A medical or behavioral condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

      1. Placing the health of the person afflicted with such condition (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy;

      2. Serious impairment to such person's bodily functions;

      3. Serious dysfunction of any bodily organ or part of such person; or

      4. Serious disfigurement of such person.

   B. **Emergency Services Defined.** The following definitions are hereby added to the Summary Booklet:

      EMERGENCY SERVICES: A medical screening examination that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate an Emergency Condition; and within the capabilities of the staff and facilities available at the Hospital, such further medical examination and treatment as are required to stabilize the patient. This definition is not intended to limit the scope of services to treat an Emergency Condition otherwise covered under the Benefit Program.

Effective on 07/01/2013
City of Milord 001016-514
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STABILIZE: means, with respect to an emergency medical condition:

To provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility. With respect to a pregnant woman who is having contractions, the term "stabilize" also means to deliver (including the placenta), if there is inadequate time to effect a safe transfer to another Hospital before delivery or transfer may pose a threat to the health or safety of the woman or the unborn child.

C. **Cost Sharing.** Any Copayment or Coinsurance requirement in the Summary Booklet that applies to Emergency Services provided by a Non-Participating Provider that differs from the Copayment or Coinsurance required for Emergency Services provided by a Participating Provider is hereby deleted and replaced with the Copayment or Coinsurance requirement, if any, applicable to Emergency Services provided by Participating Providers. All other cost-sharing and payment terms that apply to Emergency Services remain unchanged.

2. **Preventive Services.** To the extent items and services in the sources referenced below are not already Covered Services under the Benefit Program, benefits for the items and services are hereby added to the Summary Booklet:

Preventive Care services include Outpatient services and Office Services. Screenings and other services are covered as Preventive Care for adults and children with no current symptoms or prior history of a medical condition associated with that screening or service.

Members who have current symptoms or have been diagnosed with a medical condition are not considered to require Preventive Care for that condition but instead benefits will be considered under the Diagnostic Services benefit.

Preventive Care Services in this section shall meet requirements as determined by federal and state law. Many Preventive Care Services are covered by this Benefit Program with no Deductible, Copayments or Coinsurance from the Member when provided by a Network Provider. That means Anthem BCBS pays 100% of the Maximum Allowed Amount. These services fall under four broad categories as shown below:

1. Services with an "A" or "B" rating from the United States Preventive Services Task Force.

   Examples of these services are screenings for:

   - Breast cancer;
   - Cervical cancer;
   - Colorectal cancer;
   - High Blood Pressure;
   - Type 2 Diabetes Mellitus;
   - Cholesterol;
   - Child and Adult Obesity.

2. Immunizations for children, adolescents and adults recommended by the Advisory Committee on Immunization Practices ("ACIP") of the Centers for Disease Control and Prevention;

3. Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and

4. **Women's Preventive:** Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following:.

   - Women's contraceptives, sterilization procedures, and counseling: This includes contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants, as well as injectable contraceptives, are covered at no Cost-Share from an in-network provider. In addition, Generic and single source Brand Name Drugs for oral contraceptives and patches dispensed from an in-network pharmacy are covered at no Cost-Share. Note: Multi-source Brand Name Drugs for oral contraceptives and patches may apply a cost-share.

   - Breastfeeding support, supplies, and counseling: Covered in full when received from an in-network provider. Benefits for breast pumps are limited to one pump per pregnancy.

   - Screenings and/or counseling, where applicable, for: Gestational diabetes, Human Papillomavirus (HPV), sexually transmitted infections (STIs), Human immune-deficiency virus (HIV), and interpersonal and domestic violence.

The preventive services referenced above shall be covered in full when received from Participating; Providers. Cost sharing (Copayments, Deductibles, Coinsurance) may apply to services provided during the same visit as the preventive services set forth above. For example, if a service referenced above is provided during an office visit wherein that service is not the primary purpose of the visit, the cost-sharing amount that would otherwise apply to the office visit will still apply.

You may call Member Services using the number on your ID Card for additional information about these services (or view the federal government's web sites, http://www.healthcare.gov/center/regulations/prevention.html; or http://www.ahrq.gov/clinic/uspstfix.htm; http://www.cdc.gov/vaccines/recs/acip/.

3. **Annual Limits.**

Any annual dollar limit under the Benefit Program that applies to Essential Benefits, whether such annual limit applies only to an Essential Benefit or includes Essential Benefits and other benefits, is hereby deleted. "Essential Benefits" include ambulatory care; emergency services; hospitalization; maternity and newborn care; mental health and substance abuse services; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services; pediatric services, including oral and vision services; and any other services set forth in regulations issued pursuant to the Patient Protection and Affordable Care Act.

Any Covered Services that are not considered "Essential Benefits" will retain their Annual dollar limit.

4. **Pre-Existing Conditions.** Under this Amendment, the provision, if any, in the Summary Booklet that allows us to exclude or otherwise limit coverage for Pre-Existing Conditions until a Covered Person has been continuously covered under the Benefit Program for a stated period is hereby deleted in its entirety with respect to Covered Persons under the age of 19.

5. **Lifetime Dollar Limits Deleted.** Any lifetime dollar limit under the Benefit Program that applies to Essential Benefits, whether such lifetime limit applies only to an Essential Benefit or includes Essential Benefits and other benefits, is hereby deleted in its entirety.

6. **Dependent Children Covered to Age 26**.

   A. The Definitions Section of the Summary Booklet is amended with the deletion of the following:

      DEPENDENT: The term Dependent means a Covered Person's lawful spouse under a legally valid existing marriage; and any unmarried children who meet the eligibility requirements set forth in Section 3: Eligibility.

   B. The Definitions Section of the Summary Booklet is amended with the addition of the following:

      DEPENDENT: The term Dependent means a Covered Person's lawful spouse under a legally valid existing marriage, and any children who meet the eligibility requirements set forth in the Eligibility Section.

   C. The Eligible Dependents subsection of the Eligibility Section of the Summary Booklet is amended to also include **married** dependent children and to remove all **residency** requirements.

   D. The Changes Affecting Eligibility subsection of the Eligibility Section of the Summary Booklet is deleted in its entirety and replaced with the following:

      Anthem BCBS must be told in writing as soon as possible, on a form approved by Anthem BCBS; of any change that may change a Covered Person's eligibility under the Benefit Program. These changes include; but are not limited to:

      1. The marriage of the Covered Person;
      2. The divorce of the Covered Person;
      3. The birth of a child of a Covered Person;
      4. A Dependent child attains the maximum age limit for coverage under the Benefit Program,
      5. A Dependent child obtains group health coverage through their own employer.
      6. A Covered Person's termination of employment; or reduction in work hours;
      7. Loss of eligibility for other reasons shown in the Summary Booklet.

7. **Other Provisions.** All of the terms, conditions, and limitations of the Summary Booklet to which this Amendment is attached also apply to this Amendment, except where they are specifically changed by this Amendment.

This Amendment is to be attached and form a part of your Summary Booklet and any riders; changes; or endorsements to it. This Amendment does not extend, vary, change, or waive any of the terms, benefits, exclusions, limitations, or conditions in the Summary Booklet except as shown in this Amendment.

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INTRODUCTION

This Summary Booklet describes generally this Benefit Program, which is funded by the **City of Milford** and for which Anthem Blue Cross and Blue Shield performs various administrative services.

This Summary Booklet is a description of the Benefit Program only, it is neither intended to describe any other health benefit plans the Employer Group may offer nor by itself intended to be a summary plan description as defined in the Employee Retirement Income Security Act of 1985, as amended (ERISA). In addition, the Employer Group may have requirements with regard to the administration of the Benefit Program.

The Benefit Program is a self-insured health benefit plan. It is not an insurance policy or underwritten program. This Summary Booklet has been prepared by Anthem BCBS on behalf of and at the direction of the Employer Group for the purpose of describing the benefits the Employer Group has agreed to provide to its Employees and their Dependents under the Benefit Program. The Employer Group is responsible for whether the Summary Booklet completely or accurately describes the Benefit Program.

Anthem Blue Cross and Blue Shield is the trade name of Anthem Insurance Companies, Inc., an independent licensee of the Blue Cross and Blue Shield Association, provides administrative claims payment services only and do not assume any financial risk or obligation with respect to claims.

Anthem BCBS performs various administrative services with regard to the Benefit Program as described in the Administrative Services Only Agreement between Anthem BCBS and the Employer Group. The Employer Group has the right to change the benefits under the Benefit Program, subject to the terms specified in the Administrative Services Only Agreement. A change by the Employer Group of the benefits described in this Summary Booklet will not be administered by Anthem BCBS unless the terms of the Administrative Services Only Agreement, including notice to Anthem BCBS of the change, are complied with by the Employer Group. Accordingly, except as specifically required by the terms of the Administrative Services Only Agreement, Anthem BCBS shall have no responsibility to perform certain administrative services with regard to benefit changes made by the Employer Group under the Benefit Program unless they are communicated to Anthem BCBS in the manner prescribed under the Administrative Services Only Agreement. Please be sure to contact the benefits coordinator at the Employer Group for more information concerning the Employer Group's obligations under the Administrative Services Only Agreement; the Employer Group's requirements, if any, regarding participation in the Benefit Program; and to obtain a summary plan description of the employee health care benefit plan.

A Covered Person's rights to benefits under this Benefit Program are subject to all the terms of the Administrative Services Only Agreement and such rights shall terminate in accordance with the terms and provisions as specified therein.

All the defined terms used in this Summary Booklet have the meanings ascribed to them herein without reference to any of the definitions contained in the Administrative Services Only Agreement. The terms of this Summary Booklet shall govern and supersede any previous versions of this Summary Booklet and any outlines or other summaries distributed by the Employer Group or Anthem BCBS with respect to the Benefit Program.

“You” or “your” means the Covered Person; or the Dependent of the Covered Person who is named on the ID Card. The Covered Person is the person for whom the group Contractholder has provided coverage through his or her employment. The Dependent Member is a covered Dependent of the Covered Person. The group Contractholder has contracted with us to provide coverage for its group Covered Persons and their Dependent Members. “We;” “us;” and “our” refer to Anthem Blue Cross and Blue Shield (“Anthem BCBS”). Other terms are defined in the “Definitions” section of the Summary Booklet.

Century Preferred Health Care Benefit Program

This Summary Booklet describes your Century Preferred health care coverage. The Summary Booklet explains the benefits, exclusions, limitations, terms and conditions of Membership and services and the guidelines which must be adhered to in order for you to obtain benefits for Covered Services. This Summary Booklet replaces and supersedes any Summary Booklet, contract, policy or program of the same or similar coverage that Anthem BCBS may have issued to you prior to the issue date of this Policy. Amendments to this Summary Booklet may occur. The Effective Date of such changes shall be designated by Anthem BCBS and the Employer Group.

Century Preferred is a Preferred Provider Organization (PPO) Benefit Program. This Benefit Program provides service throughout the state of Connecticut. The selection of a primary care Physician (PCP) is not required. However, this is a managed care program which requires that you observe all guidelines and procedures for obtaining Covered Services.

This Benefit Program offers you the flexibility to determine how you wish to access benefits and obtain Covered Services. There are two levels of coverage under this Benefit Program; In-Network and Out-of-Network coverage. When you visit an Anthem BCBS PPO Provider for Covered Services, you are responsible for the In-Network Cost-Shares. **Your benefits are highest when you visit an Anthem BCBS PPO Provider.**

If you visit an Out-of-Network Provider for Covered Services, you are responsible for any applicable Cost-Shares or Penalties. You are also responsible for any charges in excess of the Maximum Allowable Amount (MAA).

When establishing the MAA for the Out-of-Network Providers, Anthem BCBS considers industry costs, reimbursement and utilization data indices, including geographically based national reimbursement data.

Please see the Schedule of Benefits for the applicable Cost-Shares and/or Penalties for both options. In addition to listing the Cost-Shares that are your responsibility, this Schedule of Benefits also contains benefit maximums for specific types of coverage.

Century Preferred has a statewide network of Participating Physicians, Providers and Hospitals that you may obtain In-Network services from. For a geographic distribution of these Providers, please refer to the PPO Provider Directory.

Anthem BCBS is not responsible for notifying a Physician's patients when the Provider leaves the Participating Provider network. Although the PPO Provider Directory is updated regularly to keep Members informed of a Provider's participating/non-participating status; we recommend that you verify with the Provider their participating status prior to incurring services.

Your Participating Provider's agreement for providing Covered Services may include financial incentives or risk sharing relationships related to provision of services or referrals to other Providers, including Network Providers and Non-network Providers and disease management programs. If you have questions regarding such incentives or risk sharing relationships, please contact your Provider or Anthem BCBS.

None of Anthem BCBS's employees or the providers with whom it contracts with to make medical management decisions are paid or provided incentives to deny or withhold benefits for services that are Medically Necessary and are otherwise covered under the Plan. In addition, Anthem BCBS requires certain members of our clinical staff to sign an annual statement. This statement verifies that they are not receiving payments that would either encourage or reward them for denying benefits for services that are Medically Necessary and are otherwise covered under the Plan.

The Member is entitled to the Covered Services described in the Benefits Section of the Summary Booklet. The Covered Services therein are subject to the terms; conditions; and limitations of the Benefit Program and the Summary Booklet.

BlueCard PPO Program

Anthem BCBS, like other Blue Cross and Blue Shield Licensees, participates in a program called "BlueCard". See Inter-plan Programs section for additional information.

Member Services / Customer Service

For information and assistance, a Member may call or write Anthem BCBS's Member Services / Customer Service.

Questions?	Member Services / Customer Service is available to explain policies and procedures; and answer questions about available benefits or services. For information and help, a Member may call or write Anthem BCBS. The telephone number for Member Services / Customer Service is printed on the Member's Identification (ID) Card. The address of Anthem BCBS is: Anthem Blue Cross and Blue Shield Member Services / Customer Service P.0. Box 533 North Haven, Connecticut 06473
Suggestions, Concerns, or Complaints:	We hope that you will always be satisfied with the level of service provided to you and your family. We realize, however, that there may be times when problems arise and miscommunications occur which may lead to feelings of dissatisfaction. As a Member, you have the right to express any dissatisfaction, suggestions, or concerns to us. Please contact Member Services / Customer Service to tell us your problem and we will work to resolve it for you as quickly as possible.
Member Services / Customer Service Telephone Number:	Toll free in and outside of Connecticut – 1 (800) 545-0948 The Member Services / Customer Service telephone number is also on your Identification (ID) Card.
Home Office Address:	You may visit our home office during normal business hours Anthem Blue Cross and Blue Shield 108 Leigus Road, Wallingford, CT 06492
Normal Business hours:	Monday through Friday – 8:00 a.m. to 5:00 p.m.

When contacting us, please have your group; and ID numbers from your ID Card available. If your questions involve a claim; we will need to know the date of the service, kind of service, the name of the Provider and the charges involved.

How to Obtain Language Assistance

Anthem BCBS is committed to communicating with our Members about their health plan, regardless of their language. Anthem BCBS employs a language line interpretation service for use by all of our Member Services / Customer Service call centers. Simply call the Member Services / Customer Service phone number on the back of your ID card and a representative will be able to assist you. Translation of written materials about your benefits can also be requested by contacting Member Services / Customer Service. TTY/TDD services also are available by dialing 711. A special operator will contact Anthem to help with member needs.

Your rights and responsibilities as an Anthem BCBS Member

Anthem BCBS Member

As an Anthem BCBS member you have certain rights and responsibilities to help make sure that you get the most from your plan and access to the best care possible. That includes certain things about your care, how your personal information is shared and how you work with us and your doctors. It's kind of like a "Bill of Rights". And helps you know what you can expect from your overall health care experience and become a smarter health care consumer.

You have the right to:

- Speak freely and privately with your doctors and other health professionals about all health care options and treatment needed for your condition, no matter what the cost or whether it's covered under your plan.
- Work with your doctors in making choices about your health care.
- Be treated with respect, dignity, and the right to privacy.
- Privacy, when it comes to your personal health information, as long as it follows state and Federal laws, and our privacy rules.
- Get information about our company and services, and our network of doctors and other health care providers.
- Get more information about your rights and responsibilities and give us your thoughts and ideas about them.
- Give us your thoughts and ideas about any of the rules of your health care plan and in the way your plan works.
- Make a complaint or file an appeal about:
- Your health care plan
- Any care you get
- Any covered service or benefit ruling that your health care plan makes
- Say no to any care, for any condition, sickness or disease, without it affecting any care you may get in the future; and the right to have your doctor tell you how that may affect your health now and in the future
- Participate in matters that deal with the company policies and operations.
- Get all of the most up-to-date information about the cause of your illness, your treatment and what may result from that illness or treatment from a doctor or other health care professional. When it seems that you will not be able to understand certain information that information will be given to someone else that you choose.
- Get help at any time, by contacting your local insurance department.

You have the responsibility to:

- Choose any primary care physician (doctor), also called a PCP, who is in our network if your health care plan says that you to have a PCP.

- Treat all doctors, health care professionals and staff with courtesy and respect.
- Keep all scheduled appointments with your health care providers and call their office if you have a delay or need to cancel.
- Read and understand, to the best of your ability, all information about your health benefits or ask for help if you need it.
- To the extent possible, understand your health problems and work with your doctors or other health care professionals to make a treatment plan that you all agree on.
- Follow the care plan that you have agreed on with your doctors or health care professionals.
- Tell your doctors or other health care professionals if you don't understand any care you're getting or what they want you to do as part of your care plan.
- Follow all health care plan rules and policies.
- Let our Customer Service department know if you have any changes to your name, address or family members covered under your plan.
- Give us, your doctors and other health care professionals the information needed to help you get the best possible care and all the benefits you are entitled to. This may include information about other health care plans and insurance benefits you have in addition to your coverage with us.

For details about your coverage and benefits, please read your "Subscriber Agreement".

SCHEDULE OF BENEFITS

CENTURY PREFERRED

This schedule generally describes the benefits available for Covered Services under this Summary Booklet. For a more detailed explanation of benefits provided, you should refer to the appropriate section of the Summary Booklet. This Schedule of Benefits is subject to all the terms, conditions, and limitations set forth in this Summary Booklet.

COVERED SERVICE	IN-NETWORK SERVICES	OUT-OF-NETWORK SERVICES
Covered Person Annual Deductible	Not Applicable	$200 individual $400 two person $500 family
Covered Person Coinsurance	Not Applicable	20%
Covered Person Cost-Share Maximum	Not Applicable	$600 individual $1,200 two person $1,500 family
Lifetime Maximum	Unlimited	
PREVENTIVE SERVICES		
Well Child Care: 7 exams from birth to 1 year of age 7 exams 1 to 5 years of age 1 exam every Calendar Year 5 to 22 years of age	No Copay	Deductible & Coinsurance
Adult Physical Examinations: 1 exam per Calendar Year 22 years of age and older	No Copay	Deductible & Coinsurance
Routine Gynecological Visit 1 visit per Calendar Year including pap smear	No Copay	Deductible & Coinsurance
Mammography One baseline screening for female 35 through 39 years of age One screening mammogram every Calendar Year for female 40 and older Note: or more frequently if recommended by the woman's Physician (M.D.)	No Copay	Deductible & Coinsurance
Immunizations and Vaccinations Includes those needed for travel	No Copay	Deductible & Coinsurance

COVERED SERVICE	IN-NETWORK SERVICES	OUT-OF-NETWORK SERVICES
Vision Exams 1 vision exam and refraction every 2 Calendar Years	$10 Copay	Deductible & Coinsurance
Hearing Exams 1 hearing exam every 2 Calendar Years	$10 Copay	Deductible & Coinsurance
HOSPITAL SERVICES		
All Inpatient Admissions	No Copay	Deductible & Coinsurance
Specialty Hospital	Same as Hospital Inpatient Cost-Share	Deductible & Coinsurance
Outpatient Surgery (Including colonoscopy) NOTE: A maximum of 1 Cost-Share is applied per Member per Calendar Year for Colonoscopies. Note: See Other Medical Services section also, for Outpatient Surgery rendered in an ambulatory surgical center.	No Copay	Deductible & Coinsurance
DIAGNOSTIC SERVICES		
Diagnostic X-ray Services		
In a Radiologist's Office	No Copay	Deductible & Coinsurance
All other places of service Including Outpatient Hospital	No Copay	Deductible & Coinsurance
High Cost Diagnostic Tests MRI, MRA, CAT, CTA, PET and SPECT scans	No Copay	Deductible & Coinsurance
Laboratory Services:		
Independent Laboratory	No Copay	Deductible & Coinsurance
All other places of service (including Outpatient Hospital Laboratory Services)	No Copay	Deductible & Coinsurance
THERAPY SERVICES		
Outpatient Rehabilitation Outpatient rehabilitative and restorative physical, occupational, speech and chiropractic therapy for up to 50 combined visits per Calendar Year Note: Any visits limits for physical, occupational and speech therapy will not apply to Autism Spectrum Disorder services.	$10 Copay	Deductible & Coinsurance

COVERED SERVICE	IN-NETWORK SERVICES	OUT-OF-NETWORK SERVICES
Autism Services: **Behavioral Therapy** Behavioral Therapy Autism Services are subject to the following maximums per Covered Person: • Children up to age 9: $50,000 per Calendar Year; • Children between ages 9 -13: $35,000 per Calendar Year; and • Children between ages 13 -15: $25,000 per Calendar Year.	No Copay	Deductible & Coinsurance
Other Therapy Services: Outpatient cardiac rehabilitation therapy up to 36 visits per cardiac episode Radiation therapy: Chemotherapy for the treatment of cancer Electroshock Therapy Kidney Dialysis in a Hospital or free-standing dialysis center	No Copay	Deductible & Coinsurance
Allergy Office Visit/Testing	$10 Copay	Deductible & Coinsurance
Allergy Injections Immunotherapy or other therapy treatments Up to a maximum of 80 visits over a 3 Calendar Year period	No Copay	Deductible & Coinsurance
MEDICAL EMERGENCY / URGENT CARE SERVICES		
Emergency Room Treatment Emergency Room Copayment waived if the Covered Person is admitted directly to the Hospital from the emergency room	$25 Copay	Paid as an In-Network Service
Urgent Care Services	$25 Copay	Paid as an In-Network Service
Ambulance Land & Air: Paid according to the Department of Public Health Ambulance Service Rate Schedule.	No Copay	Paid as an In-Network Service

PHYSICIAN MEDICAL/ SURGICAL SERVICES		
Medical Office Visit **Primary Care Services** All services provided by your Primary Care Services/PCP take this Copay. (Including surgical procedures done in the Office) **Specialist Services** (Including surgical procedures done in the Office)	$10 Copay $10 Copay	Deductible & Coinsurance Deductible & Coinsurance
Surgical Services Performed by a Surgeon or Physician (Specialist) in any setting other than an Office Visit	No Copay	Deductible & Coinsurance
Non-Surgical Services of a Physician or Surgeon (Specialist) (Other than a medical office visit) These services may include after care *or* attending medical care	No Copay	Deductible & Coinsurance
Walk-In Center Services	$10 per visit	Deductible & Coinsurance
Retail Health Clinic	$10 per visit	Deductible & Coinsurance
Online Visits	$10 per visit	Deductible & Coinsurance
MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES		
Outpatient Treatment for Mental Health Care and Substance Abuse Care	$10 Copay	Deductible & Coinsurance
Inpatient Hospital Services In a Hospital or Residential Treatment Center for Mental Health Care Per Admission	Same as Hospital Inpatient Cost-Share	Deductible & Coinsurance
Inpatient Rehabilitation Treatment for Substance Abuse Care In a Hospital or Substance Abuse Treatment Facility Per Admission	Same as Hospital Inpatient Cost-Share	Deductible & Coinsurance

OTHER MEDICAL SERVICES		
Outpatient Surgery In a licensed ambulatory surgical center (Not located in a Hospital setting) (Including colonoscopy) NOTE: A maximum of 1 Cost-Share is applied per Member per Calendar Year for Colonoscopies. Note: See the Hospital Services section also for Outpatient Surgery rendered in a Hospital setting.	No Copay	Deductible & Coinsurance
Skilled Nursing Facility Up to 120 days per Calendar Year	Same as Hospital Inpatient Cost-Share	Deductible & Coinsurance
Private Duty Nursing Limited to $15,000 Per Calendar Year	Not Applicable	Deductible & Coinsurance
Prescription Drugs: The maximum supply of a drug for which benefits will be provided when dispensed under any one prescription is a 31-day supply or 100 unit dose, whichever is greater. Diabetic equipment, drugs and supplies	Not Applicable	Deductible & Coinsurance
Human Organ and Tissue Transplant Services Unlimited Lifetime Maximum	No Copay	Deductible & Coinsurance
Home Health Care (Including In-Home Hospice Care) Nursing and therapeutic services limited to 200 visits Home health aide services limited to 80 visits that are applicable to the 200 visit limit **In the Home Hospice Medical Social Services** under the direction of a Physician up to $420 *After a $50 Deductible has been met, the Covered Person shall pay the applicable Coinsurance, plus amounts above the Maximum Allowable Amount. The Deductible for Home Health Care benefits accrues towards the Covered Person's annual Deductible.	No Copay	Deductible* & 20% Coinsurance

Infusion Therapy Unlimited maximum	No Copay	Deductible & Coinsurance
Durable Medical Equipment and Prosthetic Devices Up to an unlimited maximum per Covered Person per Calendar Year **Hearing Aid Coverage** Available for dependent children age 12 years and under	No Copay	Deductible & Coinsurance
Foot Orthotics	No Copay	Deductible & Coinsurance
Ostomy Related Services	No Copay	Deductible & Coinsurance
Wig Up to $350 maximum per Covered Person per Calendar Year.	No Copay	No Cost-Share
Specialized Formula	No Copay	Deductible & Coinsurance
Inpatient Hospice Care 60 days per Calendar Year	No Copay	Deductible & Coinsurance
Infertility Services Please see Maternity/Family Planning Section of this document		
Office Visit	$10 Copay	Deductible & Coinsurance
Outpatient Hospital	Same as Hospital Outpatient Cost-Share	Deductible & Coinsurance
Inpatient Hospital	Same as Hospital Inpatient Cost-Share	Deductible & Coinsurance
Infertility Drugs The maximum supply of a drug for which benefits will be provided when dispensed under any on e prescription is a 30 day supply or 100 unit dose, whichever is greater Note: If this Summary Booklet has a Prescription Drug rider, see rider for infertility drug coverage. Infertility drugs will not apply to the Prescription Drug Rider Maximum. In the absence of a prescription drug rider then the coverage stated in this Schedule of Benefits will apply.	Paid as Out-of-Network	Deductible & Coinsurance
Maternity	$10 Copay first visit only	Deductible & Coinsurance

OTHER		
Penalty for Failure to Prior Authorize Covered Services Please note that the combined penalty amount for Facility Benefit and the Admitting Physician Benefit will be no greater than $500.	$250 Hospital and $250 Physician (of Maximum Allowable Amount (MAA)	$250 Hospital and $250 Physician (of Maximum Allowable Amount (MAA)

Pre-Existing Condition Limitation Exclusion – For Late Enrollees, this Summary Booklet does not cover charges for Pre-Existing Conditions diagnosed or treated during the 6 months immediately preceding the original Effective Date of continuous coverage during the Pre-Existing Condition Limitation Period. 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. You will be notified in writing by Anthem BCBS exactly how many months you will be subject to this exclusion.

Note: Out of Network services applicable after Deductible and Coinsurance. The Covered Person is responsible for the difference between Maximum Allowable Amount (MAA) and total charge.

DEFINITIONS

ACTIVELY AT WORK: The term Actively At Work means the employee must work at the Employer Group's place of business or at such place(s) as normal business requires. The employee must perform all duties of the job as required of a full-time, or part-time or temporary employee working 30 or more hours per week on a regularly scheduled basis. Eligible employees who do not satisfy the criteria, solely due to a health-related reason, are considered Actively At Work for purposes of initial eligibility under the Benefit Program.

ACUTE PSYCHIATRIC CARE: The term Acute Psychiatric Care means psychotherapy provided on an individual or group basis by a Physician or health care team under the supervision of a Physician.

ADMINISTRATIVE SERVICES ONLY AGREEMENT: The term Administrative Services Only Agreement means an administrative agreement between Anthem BCBS and the Employer Group establishing administration fees, remittance of paid claims, benefits to be administered, the Effective Date of the Employer Group and setting forth the duties and responsibilities of the Employer Group and Anthem BCBS.

ADMISSION: The term Admission means the period from the date the Covered Person enters the Hospital, Skilled Nursing Facility, Substance Abuse Treatment Facility, Residential Treatment Facility, Hospice or other Inpatient Facility as an Inpatient until the date of discharge. When counting days of Inpatient services, the date of entry and date of discharge are combined to count together as one day.

> **Elective Admission**: The term Elective Admission means an Inpatient Admission which is Medically Necessary and scheduled in advance where the Covered Person does not require immediate medical treatment to prevent death, disability or serious impairment of bodily part or function.

AMBULANCE SERVICE: The term Ambulance Service means a commercial or municipal Ambulance Service issued a license by the State of Connecticut Office of Emergency Medical Services. If out of state, an Ambulance Service must have equivalent licensure.

ANTHEM BCBS: The term Anthem BCBS means Anthem Health Plans, Inc. doing business as Blue Cross and Blue Shield, an independent licensee of the Blue Cross and Blue Shield Association or its agents, representatives, contractors, subcontractors or affiliates.

APPLIANCE(S): The term Appliance(s) means leg, arm, back or neck braces, or artificial legs, arms or eyes, and any prosthesis with supports, including replacement if a Covered Person's physical condition changes.

AUTHORIZE: The term Authorize (Authorization) means that approval has been obtained from Anthem BCBS for the Emergency Admission of a Covered Person to a Hospital, Skilled Nursing Facility, Substance Abuse Treatment Facility, Residential Treatment Facility or Hospice, when required under the terms of this Benefit Program.

AUTISM BEHAVIORAL THERAPY PROVIDER: means Behavioral Therapy provided or under the supervision of a behavior analyst certified by the Behavior Analyst Certification Board; a licensed physician, or a licensed psychologist. "Supervision" means at least 1 hour of face-to-face supervision of the Autism Services Provider for each ten hours of Behavioral Therapy provided by the supervised certified assistant behavior analyst or behavior therapist.

AUTISM SPECTRUM DISORDERS: "Autism Spectrum Disorders" means the pervasive developmental disorders set forth in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders," including, but not limited to, Autistic Disorder, Rett's Disorder, Childhood Disintegrative Disorder, Asperger's Disorder and Pervasive Developmental Disorder Not Otherwise Specified. The results of an autism spectrum diagnosis shall be valid for a period of twelve months unless the Covered Person's

licensed physician, licensed psychologist, or licensed clinical social worker determines a shorter period is appropriate or changes the results of the Covered Person's diagnosis.

BEHAVIORAL THERAPY: the term Behavioral Therapy means any interactive behavioral therapies derived from evidence-based research, including, but not limited to, applied behavior analysis, cognitive behavioral therapy, or other therapies supported by empirical evidence of the effective treatment of individuals diagnosed with an autism spectrum disorder, that are: (A) Provided to children less than fifteen years of age, and (B) provided or under the supervision of an Autism Behavioral Therapy Provider.

BENEFIT EXCLUSION PERIOD: The term Benefit Exclusion Period means a period of time during which no benefits will be provided for a Pre-Existing Condition.

BENEFIT PERIOD: The term Benefit Period means the consecutive extent of time for which benefits are payable. Unless otherwise defined as a period of days in the Schedule of Benefits.

BENEFIT PROGRAM: The term Benefit Program means the program of health care benefits that is identified on the cover page of the Summary Booklet and described herein.

BIRTHCENTER: The term Birthcenter means a facility separate from a Hospital which provides room, board and Special Services related to the management of normal childbirth. Synonymous terms are Birthing Center and Childbirth Center.

CALENDAR YEAR: The term Calendar Year means a period beginning 12:01 a.m. on January 1 and ending midnight on December 31 of the same year.

CANCER CLINICAL TRIAL: The term Cancer Clinical Trial means an organized, systematic, scientific study of therapies, tests or other clinical interventions for purposes of treatment or palliation or therapeutic intervention for the prevention of cancer in human being except that a clinical trial for the prevention of cancer is eligible for coverage only if it involves a therapeutic intervention and is a Phase III clinical trial that is conducted at multiple institutions. A Cancer Clinical Trial must be conducted under the auspices of an independent peer-reviewed protocol that has been reviewed and approved by:

One of the National Institutes of Health; or
A National Cancer Institute affiliated cooperative group; or
The federal Food and Drug Administration as part of an investigational new drug or device exemption; or
The federal Department of Defense or Veterans Affairs.

CASE MANAGEMENT: The term Case Management means the process of evaluating and arranging for Medically Necessary treatment for patients, identified through the use of one or more managed care programs.

CHRONIC CARE: The term Chronic Care means a condition that continues and/or recurs over a prolonged period of time. The condition is characterized by either a slow progressive loss of function or a static/stationary loss of function in which little or no measurable objective improvement is made despite therapeutic intervention.

COINSURANCE: The term Coinsurance means a fixed percentage of the Maximum Allowable Amount for Covered Services which the Covered Person is required to pay as specified in the Schedule of Benefits.

CONCURRENT REVIEW: The term Concurrent Review means a process to monitor all Inpatient Admissions to determine its continued Medical Necessity, starting from the assignment of the initial Prior Authorization of days and continuing to the Covered Person's discharge.

CONTRACTHOLDER: The term Contractholder means the Employer Group to which the Administrative Services Only Agreement is issued.

COPAYMENT: The term Copayment means a fixed amount which the Covered Person is required to pay for Covered Services. This fee is payable by a Covered Person for certain Covered Services at the time that those services are rendered. Copayments are listed in the Schedule of Benefits.

COST-SHARE: The term Cost-Share means the amount which the Covered Person is required to pay for Covered Services. Where applicable, Cost-Shares can be in the form of Copayments, Coinsurance, and/or Deductibles.

COST-SHARE MAXIMUM: The term Cost-Share Maximum means the Deductible plus Coinsurance amounts which are paid by the Covered Person on a Calendar Year basis.

COVERED EMPLOYEE: The term Covered Employee means an Eligible Person as defined in the Eligibility Section and in whose name an Identification Card is issued.

COVERED PERSON: The term Covered Person means a person who becomes eligible for Covered Services under this Benefit Program through his or her Employer Group, has enrolled in this Benefit Program and in whose name an Identification Card is issued.

COVERED SERVICE(S): The term Covered Service means services, supplies or treatment as described in this Summary Booklet. To be a Covered Service, the service, supply or treatment must be:

a. Medically Necessary or otherwise specifically included as a benefit under this Summary Booklet;
b. Within the scope of the license of the Provider performing the service;
c. Rendered while coverage under this Summary Booklet is in force;
d. Not Experimental or Investigational or otherwise excluded or limited by the Summary Booklet;
e. Authorized in advance by Anthem BCBS if such prior authorization is required under the Summary Booklet.

CREDITABLE COVERAGE (Proof of prior coverage): The term Creditable Coverage means health coverage provided through an individual policy, a self-funded or fully insured group health plan offered by a public or private employer, Medicare, Medical Assistance, General Assistance Medical Care, the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), Federal Employees Health Benefit Plan (FEHBP), Medical Care Program of the Indian Health Service of a tribal organization, a state health benefit risk pool, a State Children's Health Insurance Program (S-CHIP), a qualified Public Health Plan or a Peace Corp health plan.

CUSTODIAL CARE: The term Custodial Care means care primarily for the purpose of assisting the Covered Person in the activities of daily living or in meeting personal rather than medical needs, and which is not specific treatment for an illness or injury. It is care which cannot be expected to substantially improve a medical condition and has minimal therapeutic value. Such care includes, but is not limited to:

assistance with walking, bathing, or dressing;
transfer or positioning in bed;
normally self-administered medicine;
meal preparation;
feeding by utensil, tube, or gastrostomy;
oral hygiene;
ordinary skin and nail care;
catheter care;
suctioning;
using the toilet;
enemas; and
preparation of special diets and supervision over medical equipment or exercises; or
over self-administration of oral medications not requiring constant attention of trained medical personnel.

Care can be custodial whether or not it is recommended or performed by a professional and whether or not it is performed in a facility (e.g. Hospital or Skilled Nursing Facility) or at home.

DATE OF PLACEMENT: The term Date of Placement means the assumption and retention by a person of legal obligation for total or partial support of a child in anticipation of adoption of the child.

DAY/NIGHT VISIT: The term Day/Night Visit means continuous treatment consisting of not less than 4 hours and not more than 12 hours in any 24 hour period when received in a General or Specialty Hospital or in a Substance Abuse Treatment Facility.

DEDUCTIBLE: The term Deductible means the fixed amount which the Covered Person must pay for Covered Services in a Calendar Year prior to the application of Coinsurance when using the Out-of-Network Option.

1. The individual and family Deductible amounts are shown in the Schedule of Benefits
2. The family Deductible amount (2 Covered Person) is met when each Covered Person meets the individual Deductible amount as specified in the Schedule of Benefits.
3. The family Deductible amount (3 or more Covered Persons) is met when one Covered Person meets and the other family Covered Persons collectively meet the difference between the individual Deductible and family Deductible amounts, as specified in the Schedule of Benefits.

DEPENDENT: The term Dependent means a Covered Person's lawful spouse under a legally valid existing marriage and any unmarried children who meet the eligibility requirements set forth in the Eligibility Section.

DESCRIPTION OF BENEFITS: The term Description of Benefits means the document which describes for the Employer the Benefit Program.

DURABLE MEDICAL EQUIPMENT: The terms Durable Medical Equipment means equipment which:

1. is designated for repeated use in the Medically Necessary Care, diagnosis or treatment of an illness or injury;
2. improves the function of a malformed body part or prevents or retards further deterioration of the Covered Person's medical condition; and
3. is not useful in the absence of injury or illness.

EFFECTIVE DATE: The term Effective Date means the date a Covered Person and his or her Dependents, if any, are accepted by Anthem BCBS and eligible to receive benefits for Covered Services under this Benefit Program.

ELIGIBILITY: The term Eligibility means qualifying for coverage according to the Description of Benefits description of Eligible Person and Eligible Dependent.

EMPLOYER GROUP: The term Employer Group means a business entity which meets the underwriting requirements established by Anthem BCBS, and is accepted by Anthem BCBS.

ENROLLMENT DATE: The term Enrollment Date means the first day of coverage or, if there is a Waiting Period, the first day of the Waiting Period.

EXPERIMENTAL OR INVESTIGATIONAL: The term Experimental or Investigational means any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition which Anthem BCBS determines in its sole discretion to be Experimental or Investigational.

A. Anthem BCBS will deem any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply to be Experimental or Investigational if it determines that one or more of the following criteria apply when the service is rendered with respect to the use for which benefits are sought.

   The drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply:

   1. Cannot be legally marketed in the United States without the final approval of the Food and Drug Administration ("FDA") or any other state or federal regulatory agency and such final approval has not been granted; or

2. Has been determined by the FDA to be contraindicated for the specific use; or

3. Is provided as part of a clinical research protocol or clinical trial or is provided in any other manner that is intended to evaluate the safety, toxicity or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply; or

4. Is subject to review and approval of an Institutional Review Board ("IRB") or other body serving a similar function; or

5. Is provided pursuant to informed consent documents that describe the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply as Experimental or Investigational or otherwise indicate that the safety, toxicity or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply is under evaluation.

B. Any service not deemed Experimental or Investigational based on the criteria in subsection A. may still be deemed to be Experimental or Investigational by Anthem BCBS. In determining whether a service is Experimental or Investigational, Anthem BCBS will consider the information described in subsection C. and assess the following:

1. Whether the scientific evidence is conclusory concerning the effects of the service or health outcomes;

2. Whether the evidence demonstrates the service improves the net health outcomes of the total population for whom the service might be proposed by producing beneficial effects that outweigh any harmful effects;

3. Whether the evidence demonstrates the service has been shown to be as beneficial for the total population for whom the service might be proposed as any established alternatives;

4. Whether the evidences demonstrates the service has been shown to improve the net health outcomes of the total population of whom the service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.

C. The information considered or evaluated by Anthem BCBS to determine whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental or Investigational under subsections A. and B. may include one or more items from the following list which is not all inclusive:

1. Published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or

2. Evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or

3. Documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the drug; biologic; device; diagnostic; product; equipment; procedure; treatment; service; or supply; or

4. Documents of an IRB or other similar body performing substantially the same function; or

5. Consent document(s) used by the treating Physicians, other medical professionals, or facilities or by other treating Physicians, other medical professionals or facilities studying substantially the same drug; biologic; device; diagnostic; product; equipment; procedure; treatment; service; or supply; or

6. The written protocol(s) used by the treating Physicians, other medical professionals, or facilities or by other treating Physicians, other medical professionals or facilities studying substantially the same drug; biologic; device; diagnostic; product; equipment; procedure; treatment; service; or supply; or

7. Medical records; or

8. The opinions of consulting Providers and other experts in the field.

D. Anthem BCBS has the sole authority and discretion to identify and weigh all information and determine all questions pertaining to whether a drug; biologic; device; diagnostic; product; equipment; procedure; treatment; service; or supply is Experimental or Investigational.

Notwithstanding the above, services or supplies will not be considered Experimental if they have successfully completed a Phase III clinical trial of the Federal Food and Drug Administration, for the illness or condition being treated, or the diagnosis for which it is being prescribed.

In addition, services and supplies for Routine Patient Care Costs in connection with a Cancer Clinical Trial will not be considered Experimental.

FREE STANDING MAGNETIC RESONANCE IMAGING FACILITY: The term Free Standing Magnetic Resonance Imaging Facility means a facility which has received a certificate of need approval for its magnetic resonance equipment and its services from the State of Connecticut Commission on Hospitals and Health Care. Also, the facility must be accredited as either an Ambulatory Health Care facility by the Joint Commission on Accreditation of Healthcare Organization (JCAHO) or a Magnetic Resonance Imaging Facility by the American College of Radiology (ACR). The term Free-Standing Magnetic Resonance Imaging Facility does not include physician's offices where the primary care is medical services.

HOSPICE: The term Hospice means a facility, organization or agency certified by Medicare that is primarily engaged in providing pain relief, symptom management and supportive services to terminally ill people and their families.

HOSPITAL: The term Hospital means an institution which provides 24 hour continuous services to confined patients and whose chief function is to provide diagnosis and therapeutic facilities for the surgical and medical diagnosis, treatment or care of injured or sick persons. A professional staff of licensed Physicians and surgeons must provide or supervise the services. The institution must provide General Hospital and major surgical facilities and services or specialty services. The following shall not be considered a Hospital:

A convalescent or extended care unit within or affiliated with the Hospital;

A non-Hospital based clinic;

A nursing, rest or convalescent home, or extended care facility;

An institution operated mainly for care of the aged;

A health resort, spa or sanitarium; or

Any facility not having appropriate state licensure and not accredited as a Hospital by the Joint Commission on the Accreditation of Health Care Organizations (JCAHO), except for a Hospital located outside the United States.

1. **General Hospital**: The term General Hospital means a Hospital which is licensed as such by the State of Connecticut and has appropriate accreditation from the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

   If out-of-state, a General Hospital must have equivalent licensure and accreditation.

2. **Specialty Hospital**: The term Specialty Hospital means a Hospital which is not a General Hospital but which is licensed by the State of Connecticut as a certain type of Specialty Hospital and has appropriate accreditation from the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

   If out-of-state, a Specialty Hospital must have equivalent licensure and accreditation.

3. **Participating Hospital**: The term Participating Hospital means a Hospital designated and accepted as a Participating Hospital by Anthem BCBS to provide Covered Services to Covered Persons under the terms of the Summary Booklet.

4. **Non-Participating Hospital:** The term Non-Participating Hospital means any appropriately licensed Hospital which is not a Participating Hospital under the terms of the Summary Booklet.

5. **Mobile Field Hospital:** The term Mobile Field Hospital means a modular, transportable facility used intermittently, deployed at the discretion of the Governor, or the Governor's designee, for the purpose of training or in the event of a public health or other emergency for isolation care purposes or triage and treatment during a mass casualty event; or for providing surge capacity for a hospital during a mass casualty event or infrastructure failure and is licensed as such by the State of Connecticut.

IDENTIFICATION CARD: A card issued by Anthem BCBS to a Covered Person for identification purposes which must be shown by the Covered Person to obtain Covered Services.

INFERTILITY: Infertility is the condition of a presumably healthy individual who is unable to conceive or produce conception or sustain a successful pregnancy during a one year period.

IN-NETWORK OPTION: The term In-Network Option means that Covered Services are obtained from any Participating Physicians, Participating Hospital or Participating Provider.

INPATIENT: The term Inpatient means a Covered Person who occupies a bed in a Hospital or other 24 hour care facility, receives board as well as diagnosis, care or treatment and is counted as an Inpatient at the time of a Hospital or 24 hour care facility census.

INPATIENT FACILITY: The term Inpatient Facility means a facility other than a Hospital that provides board as well as diagnosis, care or treatment on a 24 hour basis to patients such as a Skilled Nursing Facility, Hospice, Substance Abuse Treatment Facility, Sub-acute Care Facility and Residential Treatment Facility.

LATE ENROLLEE: The term Late Enrollee means an eligible employee and/or Dependent who requests health insurance following the Open Enrollment Period Effective Date, if applicable, or more than 31 days after the employee's and/or Dependent's earliest opportunity to enroll for coverage under any health insurance Plan sponsored by the Employer Group.

LEARNING DISABILITY: The term Learning Disability means a disorder in one or more of the basic psychological processes involved in understanding or in using spoken or written language. This may be manifested in disorders of learning, thinking, talking, reading, writing, spelling, arithmetic or social perception.

LICENSED OCCUPATIONAL THERAPIST: The term Licensed Occupational Therapist means a therapist who is licensed by the State of Connecticut. If out of state, a therapist must have equivalent licensure.

LICENSED PHYSICAL THERAPIST: The term Licensed Physical Therapist means a therapist who is licensed by the State of Connecticut. If out of state, a therapist must have equivalent licensure.

LICENSED SPEECH PATHOLOGIST: The term Licensed Speech Pathologist means a therapist who is licensed by the State of Connecticut to render services referred to by Anthem BCBS as Speech Therapy. If out of state, a speech pathologist must have equivalent licensure.

MAINTENANCE CARE: The term Maintenance Care means treatment provided for the Covered Person's continued well-being by preventing deterioration of the Covered Person's chronic clinical condition; and maintenance of an achieved stationary status which is at a point where little or no measurable objective improvement in musculo-skeletal function can be effectuated despite therapy.

MAINTENANCE PRESCRIPTION DRUG: The term Maintenance Prescription Drug means a drug that is used on a continuing basis for the treatment of a chronic illness, such as heart disease, high blood pressure, arthritis and/or diabetes.

MAXIMUM ALLOWABLE AMOUNT (MAA): The term Maximum Allowable Amount (MAA) means for each of the following:

1. Participating Physician and Participating Provider: except as otherwise required by law, an amount agreed upon by Anthem BCBS and a Participating Physician and Participating Provider as full compensation for Covered Services provided to a Covered Person. When applicable, it is the Covered Person's obligation to pay Cost-Shares as a component of this Maximum Allowable Amount. The amount Anthem BCBS will pay for Covered Services will be the Maximum Allowable Amount or the billed charges, whichever is lower.

2. Non-Participating Physician and Non-Participating Provider: except as otherwise required by law, a reasonable amount as determined by Anthem BCBS, after consideration of such industry cost, reimbursement and utilization data and indices, as Anthem BCBS deems appropriate in its sole discretion, which is assigned as reimbursement for Covered Services provided to a Covered Person or an amount negotiated with a Non-Participating Physician and Non-Participating Provider for Covered Services provided to a Covered Person. The amount Anthem BCBS will pay for Covered Services will be the Maximum Allowable Amount or the billed charges, whichever is lower. It is the Covered Person's obligation to pay Cost-Shares as a component of this Maximum Allowable Amount.

3. Participating Hospital: except as otherwise required by law, an amount which a Participating Hospital accepts as full compensation for Covered Services provided to a Covered Person. When applicable, it is the Covered Person's obligation to pay Cost-Shares as a component of this Maximum Allowable Amount.

4. Non-Participating Hospital: except as otherwise required by law, a reasonable amount as determined by Anthem BCBS, after consideration of such industry cost, reimbursement and utilization data and indices, as Anthem BCBS deems appropriate in its sole discretion, which is assigned as reimbursement for Covered Services provided to a Covered Person or an amount negotiated with a Non-Participating Hospital for Covered Services provided to a Covered Person. The amount Anthem BCBS will pay for Covered Services will be the Maximum Allowable Amount or the billed charges, whichever is lower. It is the Covered Person's obligation to pay Cost-Shares and amount in excess of this Maximum Allowable Amount.

Please note that the Maximum Allowable Amount may be greater or less than the Participating Physician's, Participating Provider's, Participating Hospital's, Non-Participating Physician's, Non-Participating Provider's or Non-Participating Hospital's billed charges for the Covered Services.

Anthem BCBS shall have discretionary authority to establish, as it deems appropriate, the Maximum Allowable Amount under the Policy.

Non-Participating Out-of-State Provider Cost Share Calculation

When Covered Services are rendered outside of Connecticut by Non-Participating Physicians, Non-Participating Providers and/or Non-Participating Hospitals, the Covered Person's Cost Share obligation may be calculated based upon one of the following items (note that in the case of items a. and b. the method of Cost-Share calculation must be mandated by the law of the state in which the Covered Person is domiciled pursuant to the exception contained in Ct. General Statute 38a-478j except that in the case of the BlueCard Program, the Cost-Share calculation shall be based on item c.):

a. The Maximum Allowable Amount; or
b. Billed charges; or
c. The Maximum Allowable Amount or billed charges, whichever is lower.

Maximum Allowable Amount: Non-Participating Out-of -State Provider

When Covered Services are rendered outside of Connecticut to a Covered Person by Non-Participating Physicians, Non-Participating Providers and/or Non-Participating Hospitals, (whether or not such physicians, providers or hospitals are Host Plan participating physicians, providers or hospitals), the Maximum Allowable Amount shall be determined by that Blue Cross and/or Blue Shield Plan in that area outside of Connecticut.

The Maximum Allowable Amount may be:

- Under arrangements other than BlueCard, the applicable rate for such services, before deduction of any applicable risk withholds, negotiated with the Provider (Physician, Hospital, other Provider) by that Blue Cross and/or Blue Shield Plan outside of Connecticut which that Blue Cross and/or Blue Shield Plan passes on to Anthem BCBS (which may include fee for service rates, per diem rates, scheduled charges, capitated charges, or other pricing mechanisms in that Blue Cross and/or Blue Shield Plan's discretion); or

- In addition, Anthem BCBS will calculate the Cost-Share obligation (i.e., Coinsurance) for the amount for those Covered Services in some cases based on input from the Blue Cross and/or Blue Shield Plan outside the geographic area we serve where the services were rendered.*

  * Applicable to BlueCard and arrangements other than BlueCard.

MEDICAL EMERGENCY: The term Medical Emergency means the onset of a serious illness or injury which requires emergency medical treatment, or the onset of symptoms of sufficient severity that a Covered Person reasonably believes that emergency medical treatment is needed.

MEDICALLY NECESSARY (MEDICALLY NECESSARY CARE, MEDICAL NECESSITY): The terms Medically Necessary (Medically Necessary Care, Medical Necessity) mean health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

1. In accordance with generally accepted standards of medical practice;

2. clinically appropriate, in terms of type, frequency, extent, site and duration and considered effective for the patient's illness, injury or disease; and

3. not primarily for the convenience of the patient, physician or other health care provider and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For the purposes of this subsection, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community or otherwise consistent with the standards set forth in policy issues involving clinical judgment.

MEDICARE: The term Medicare means Title XVIII of the Social Security Act of 1965, as amended.

MEMBER: The term Member means either a Covered Person or Dependent enrolled in this Benefit Program and eligible for benefits for Covered Services under this Benefit Program.

MENTAL HEALTH CARE: The term Mental Health Care means services provided to treat a mental disorder as defined in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders".

Mental Health Care does not include:

1. mental retardation,
2. learning disorders,
3. motor skills disorder,

4. communication disorders,
5. caffeine-related disorders,
6. relational problems, and
7. additional conditions that may be a focus of clinical attention, that are not otherwise defined as mental disorders in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders'.

OPEN ENROLLMENT PERIOD: The term Open Enrollment Period means the period of time during which an Employer Group allows employees to select group health coverage.

OUT-OF-NETWORK OPTION: The term Out-of-Network Option means that Covered Services are obtained from any Non-Participating Physician, Non-Participating Hospital or Non-Participating Provider. Non-Participating Physician, Non-Participating Hospital or Non-Participating Provider also includes Providers who have not contracted or affiliated with Anthem BCBS's designated Subcontractor(s) for the service they perform under this Benefit Program.

OUTPATIENT: The term Outpatient means that the Covered Person receives services in a Hospital emergency room, Physician's office, or ambulatory surgical facility and leaves in less than 24 hours.

PARTIAL HOSPITALIZATION: The term Partial Hospitalization means continuous treatment in a General Hospital, Specialty Hospital or Residential Treatment Facility consisting of not less than 4 hours and not more than 12 hours in any 24 hour period.

PENALTY (PENALTIES): The term Penalty (Penalties) means that amount the Covered Person must pay when Prior Authorization is not obtained; or for a Medical Emergency Admission which is not authorized by Anthem BCBS within two business days.

PHYSICIAN: The term Physician means any licensed doctor of medicine (M.D.), osteopathic Physician (D.O.), dentist (D.D.S./D.M.D.), podiatrist (Pod. D/D.S.C./D.P.M.), doctor of chiropractic (D.C.), naturopath (N.D.), optometrist (O.D.) or psychologist (Ph.D./Ed.D/PsyD.) who is licensed to practice in the state in which services are rendered.

Participating Physician: The term Participating Physician means any appropriately licensed Physician designated and accepted as a Participating Physician by Anthem BCBS to provide Covered Services to Covered Persons.

Non-Participating Physician: The term Non-Participating Physician means any appropriately licensed Physician who is not a Participating Physician.

PHARMACY: The term Pharmacy means a licensed retail establishment where Prescription Drugs or Maintenance Prescription Drugs are compounded and dispensed by a licensed pharmacist.

PLAN: The term Plan means any Plan which provides benefits or services for Hospital, medical/surgical, or other health care diagnosis or treatment on a group basis. Examples of group Plans include but are not limited to: group or fraternal blanket insurance; group practice; individual practice; other Blue Cross and/or Blue Shield Plans; labor-management trustee Plan; union welfare Plan; employer organization Plan; employee benefit organization Plan.

PRE-EXISTING CONDITION: The term Pre-Existing Condition means a condition, whether physical or mental, regardless of the cause of the condition, for which medical advice, care or treatment was recommended or received within the Pre-Existing Condition Period as specified in the Pre-Existing Schedule of Benefits.

Pre-Existing Condition Period: The term Pre-Existing Condition Period means a specified period of time immediately prior to the Enrollment Date.

Pre-Existing Condition Limitation Period: The term Pre-Existing Condition Limitation Period means a period of time during which no benefits will be provided for a Pre-Existing Condition.

PRESCRIPTION DRUG(S): The term Prescription Drug means drugs, biologicals, and compounds which can be dispensed legally only upon written authorization by a Physician, which are required by law to bear the legend "Caution: Federal Law prohibits dispensing without a prescription," and which are listed in one or more of the following publications: United States Pharmacopeia, The National Formulary, or Accepted Dental Remedies.

PRIMARY CARE SERVICES: The term Primary Care Services means services rendered by a Physician or other appropriately licensed or certified health care professional whose primary medical practice area is: family medicine, general practice, internal medicine or pediatric medicine.

PRIOR AUTHORIZATION (PRIOR AUTHORIZED): The term Prior Authorization means that prior approval has been obtained from Anthem BCBS, which enables a Covered Person to receive benefits for certain Covered Services.

PROOF: The term Proof means any information that may be required by Anthem BCBS in order to satisfactorily determine a Covered Person's eligibility or compliance with any provision of this Benefit Program.

PROSTHETIC DEVICE: The term Prosthetic Device means any device which replaces all or part of a body organ (including contiguous tissues), or replaces all or part of the function of a permanently inoperative, absent, or malfunctioning part of the body.

PROVIDER: The term Provider means any appropriately licensed or certified health care professional or facility providing health care services or supplies to Covered Persons.

Participating Provider: The term Participating Provider means any appropriately licensed or certified health care professional or facility designated and accepted as a Participating Provider by Anthem BCBS to provide Covered Services to Covered Persons.

Non-Participating Provider: The term Non-Participating Provider means any appropriately licensed or certified health care professional or facility which is not a Participating Provider.

RENEWAL INTERVAL: The term Renewal Interval means a consecutive extent of time at which the Benefit Period will be renewed. Unless otherwise defined in the Summary Booklet, Renewal Interval means a period of 12 consecutive months.

RESIDENTIAL TREATMENT FACILITY: The term Residential Treatment Facility means a treatment center, which provides residential care and treatment for emotionally disturbed individuals, and is accredited by the Council on Accreditation or The Joint Commission on the Accreditation of Health Care Organizations as a Residential Treatment Facility.

RIDER: The term Rider means an additional benefit of this Benefit Program, which has been purchased by the Employer Group.

ROUTINE PATIENT CARE COST: The term Routine Patient Care Costs means: Costs for Medically Necessary health care services that are incurred as a result of treatment rendered to a Covered Person for purposes of a Cancer Clinical Trial that would otherwise be covered if such services were not rendered in conjunction with a Cancer Clinical Trial. Such services shall include those rendered by a Physician, diagnostic or laboratory tests, hospitalization or other services provided to the Covered Person during the course of treatment in Cancer Clinical Trial and coverage for Routine Patient Care Costs incurred for off-label drug prescriptions. Hospitalization shall for Routine Patient Care Costs include treatment at an Out-of-Network facility if such treatment is not available In-Network and not eligible for reimbursement by the sponsors of such clinical trial; Out-of Network Hospitalization will be rendered at no greater cost to the insured person than if such treatment was available In-Network, all applicable In-Network cost-shares will apply.

Routine Patient Care Costs shall not include:

1. the cost of an investigational new drug or device that has not been approved for market for any indication by the federal Food and Drug Administration;
2. the cost of a non health care service that a Covered Person may be required to receive as a result of the treatment being provided for the purposes of the Cancer Clinical Trial;
3. facility, ancillary, professional services and drug costs that are paid for by grants or funding for the Cancer Clinical Trial;
4. costs of services that (A) are inconsistent with widely accepted and established regional or national standards of care for a particular diagnosis, or (B) are performed specifically to meet the requirements of the Cancer Clinical Trial;
5. costs that would not be covered under this Plan for non-investigational treatments, including items excluded from coverage under the Plan; and
6. transportation, lodging, food or any other expenses associated with travel to or from a facility providing the Cancer Clinical Trial, for the Covered Person or any family member or companion.

SKILLED NURSING FACILITY: The term Skilled Nursing Facility means any institution that:

a. accepts and charges for patients on an Inpatient basis;
b. is primarily engaged in providing skilled nursing care, rehabilitative and related services to patients requiring medical and skilled nursing care;
c. is under the supervision of a licensed Physician;
d. provides 24 hour a day nursing service under the supervision of a registered nurse; and
e. is not a place primarily for the treatment of nervous-mental disorders, pulmonary tuberculosis, a place of rest, Custodial Care or acute Inpatient level of care.

SPECIAL SERVICES: The term Special Services means services and supplies, rendered by a health care facility in relation to the illness or injury for which a Covered Person is an Inpatient.

SPECIALIZED FORMULA: The term Specialized Formula means a nutritional formula for children up to age twelve that is exempt from the general requirements for nutritional labeling under the statutory and regulatory guidelines of the Federal Food and Drug Administration and is intended for use solely under medical supervision in the dietary management of specific diseases.

SPECIALIST SERVICES: The term Specialist Services means services rendered by a Physician or other appropriately licensed or certified health care professional whose medical practice area is in specialty areas such as cardiology, neurology, surgery and other medical specialties.

SUBACUTE CARE FACILITY: The term Subacute Care Facility means a facility that is generally engaged in providing subacute care services, is licensed by the State of Connecticut as a chronic and convalescent nursing home and has appropriate accreditation from the Joint Commission on Accreditation of Health Care Organizations (JCAHO).

SUBCONTRACTOR: The term Subcontractor means an entity with whom Anthem BCBS may subcontract particular services to, such as organizations or entities that have specialized expertise in certain areas. This may include but is not limited to prescription drugs and mental health/behavioral health and substance abuse services. Such subcontracted organizations or entities may make benefit determinations and/or perform administrative, claims paying, or customer service duties on Anthem BCBS's behalf.

SUBSTANCE ABUSE CARE: The term Substance Abuse Care means services to treat alcoholism or drug dependency.

SUBSTANCE ABUSE TREATMENT FACILITY: The term Substance Abuse Treatment Facility means a facility which is established primarily to provide 24 hour Inpatient treatment of substance abuse and licensed for such care by the State of Connecticut Department of Public Health and Addiction Services.

SUMMARY BOOKLET: The term Summary Booklet means the document provided to each Covered Person which describes the benefits, terms and conditions applicable to the Benefit Program.

TOTALLY DISABLED: The term Totally Disabled means that because of an injury or disease the Covered Person is unable to perform the duties of any occupation for which he or she is suited by reason of education, training or experience.

A Dependent shall be Totally Disabled if because of an injury or disease he or she is unable to engage in substantially all of the normal activities of persons of like age and sex in good health.

Anthem BCBS will determine if a Covered Person is Totally Disabled under the terms of the Benefit Program. The Covered Person must provide Proof of continued disability if Anthem BCBS requests it.

URGENT CARE: The term Urgent Care means care for an illness or injury which is not a Medical Emergency but requires immediate medical attention.

URGENT CARE FACILITY: The term Urgent Care Facility means a Participating Provider from whom Urgent Care services may be obtained when a Participating Physician or covering Physician is not available to treat the Covered Person.

WAITING PERIOD: The term Waiting Period means the period of time which must pass before the first day of coverage under the Benefit Program.

WELL NEWBORN: The term Well Newborn means an infant who:

1. weighs more than 5 pounds; or
2. in the opinion of the attending Physician, does not have any disease, illness, injury or congenital anomaly requiring immediate medical attention during the Hospital stay in which the birth occurred; or
3. is not born of a mother with metabolic, endocrine or other disorders or predisposing factors which are known to cause problems in the care of the infant during the neonatal period.

ELIGIBILITY

The enrollment application and any other forms or statements as requested by Anthem BCBS must be received and accepted by Anthem BCBS before the applicant shall be considered a Covered Person under the Benefit Program. The employee's and Dependent's right to coverage is subject to the condition that all information the employee provides to Anthem BCBS is true, correct and complete to the best of his or her knowledge and belief. The Contractholder is responsible for providing Anthem BCBS with immediate notification of all name, address or phone number changes.

Eligible Employees

Eligible employees may be: current employees; retirees of the Employer Group who meet the Employer Group's criteria for eligibility for participation in the Benefit Program; or former employees who elect to continue enrollment as allowed by either the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, or the Connecticut Continuation Rights Laws .

The following eligibility rules apply to employees and their Dependents:

1. Current employees must be employed full-time, or part-time and working at least 30 hours a week on a regularly scheduled basis and be Actively At Work on the date coverage is to be effective.

2. A newly hired employee must be Actively At Work at least 30 consecutive days (unless a different waiting period has been mutually agreed upon by Anthem BCBS and the Contractholder).

3. If the employee is not Actively At Work on the date upon which coverage would otherwise be effective, the Effective Date of coverage for that employee and any Dependent Covered Persons shall be deferred until the date that the employee is Actively At Work. Benefits under this Plan for the employee and any Dependents are effective for all Covered Services except those for which a prior fully insured health plan is responsible to provide.

4. Retirees who are under age 65 who are former employees of the Employer Group must be entitled to group health coverage under a trust agreement or comparable agreement.

5. If you return from full-time active service following a call to active military duty, no waiting period applies. You and eligible family members can reenroll in the Plan, provided you apply for reemployment within the time period permitted by the Uniformed Services Employment and Reemployment Act. The time period allowed for reemployment depends on the length of your active military duty. To reenroll in the Plan, your application must be received within 31 days of your reemployment date. Coverage will be effective on the effective date of your reemployment.

Eligible Dependents

Dependents are eligible for coverage under the Benefit Program if they meet the Employer Group's eligibility criteria. Enrolled Dependents may also elect to continue coverage in the Benefit Program as allowed by COBRA or the Connecticut Continuation Rights Law.

Your employer determines Dependent eligibility and Effective Dates in accordance with the terms of the Administrative Services Only Agreement Your Dependent must meet all of your employer's Dependent Covered Person's eligibility requirements prior to their Effective Date of coverage.

The following are eligible for membership as Dependents under the Benefit Program:

1. Spouse

   The lawful spouse of the Covered Person under a legally valid; existing marriage or civil union, and who is deemed eligible under the Benefit Program.

2. Unmarried Dependent Child Under Age 26

   The Dependent child under age 26 of the Covered Person or spouse including, a step-child of either, a child legally placed for adoption, a legally adopted child, a child for whom the Covered Person has been appointed a legal guardian, the Dependent child under age 26 of the Covered Person or spouse for whom the Covered Person has been designated as the responsible party under a Qualified Medical Child Support Order (QMCSO).

3. Newborn Dependent Child

   Benefits for Covered Services under the Benefit Program shall be provided for a newborn of the Covered Person from the moment of birth up to and including 61 days immediately following birth.

   With respect to coverage after 61 days following birth, a newborn of a Covered Person may become an enrolled Dependent under the Benefit Program when a completed application is submitted by the Covered Person and accepted by Anthem BCBS. The application must be submitted to Anthem BCBS within 61 days following the date of birth and Anthem BCBS eligibility requirements must be met as specified in this Section.

4. A Newborn of Enrolled Dependent Child

   A newborn of an enrolled Dependent child is eligible for benefits for Covered Services only from the moment of birth up to and including 61 days immediately following birth, but is not eligible for enrollment beyond this 61 day period under the Benefit Program until and unless the Covered Person is appointed by a court as legal guardian and can offer Proof of such legal guardianship.

   Benefits for Covered Services for a newborn shall consist of Covered Services for injury or sickness including Medically Necessary Care and treatment of medically diagnosed congenital defects and birth abnormalities subject to the terms, conditions, exclusions and limitations of this Summary Booklet**.**

5. Disabled Dependent Child

   A disabled Dependent child who is incapable of sustaining employment by reason of physical or mental handicap may continue as an enrolled Dependent or be eligible beyond the age limit set forth in the Benefit Program, provided:

   a. The unmarried disabled Dependent child of the Covered Person or his or her spouse is over the age limit set forth in the Benefit Program; and
   b. The child is incapable of sustaining employment by reason of physical or mental handicap as certified by a Physician and for whom the Covered Person or his or her spouse is chiefly responsible for support and maintenance; and
   c. The child became disabled prior to the limiting age for a Dependent child and he or she had comparable coverage as a Dependent at the time of enrollment.

   Proof acceptable to Anthem BCBS of such incapacity and dependency must be received within 31 days of the date upon which the child's coverage would have terminated in the absence of such incapacity. The disability must be certified at the time of enrollment by a Physician and then no more than annually thereafter.

6. Qualified Medical Child Support Orders

   A Dependent child may become eligible for benefits for Covered Services as a consequence of a domestic relations order issued by a state court to a divorced parent who is a Covered Person. Enrollment may be required even in circumstances in which the child was not previously enrolled in the Benefit Program and might not otherwise be eligible for coverage. For further information concerning medical child support orders, and the Employer Group's procedures for implementing such orders, the Covered Person should contact the Employer Group's benefits coordinator or the administrator of the Employer Group's health care benefits plan.

Effective Date of Coverage

Your employer determines employee eligibility and Effective Dates in accordance with the terms of the Administrative Services Only Agreement. You must meet all your employer's eligibility requirements prior to your Effective Date of coverage.

If an annual Open Enrollment Period is mutually agreed to by Anthem BCBS and the Employer Group, applications from eligible persons and their Dependents received during the Open Enrollment Period shall be effective as of the renewal date, provided such applications are submitted and accepted by Anthem BCBS in advance of the renewal date. Applications received or accepted after the renewal date shall be considered Late Enrollees.

Applications from newly eligible persons and newly eligible Dependents may be submitted in advance of the initial date of eligibility; however, benefits for Covered Services shall not be available prior to the initial date of eligibility. Applications received or accepted by Anthem BCBS more than 31 days from the initial date of eligibility shall be considered Late Enrollees.

Applications for new Covered Persons received and accepted by Anthem BCBS on or before the last working day of the month will be effective the first of the following month.

Effective Dates for group or Covered Person enrollees may be deferred if all required data is not received, or is incomplete.

New spouses and new stepchildren are initially eligible the first of the month following the date of the marriage of the new spouse to the Covered Person.

Newborn children of the Covered Person or lawful spouse are initially eligible as of the moment of birth.

Newly adopted children and children placed for adoption are initially eligible as of the Date of Placement for adoption.

Dependent children for whom the Covered Person has been appointed by the court of law as the responsible party under a Qualified Medical Child Support Order are initially eligible as of the date the court order is in effect.

Dependent children for whom the Covered Person or lawful spouse has been appointed by the court of law as the legal guardian are initially eligible as of the date the court order is in effect.

Employees returning from the military service must reenroll in the Plan within 31 days from the reemployment date. Coverage will be effective upon the date of your reemployment.

Late Enrollee and Special Enrollment Periods

A Late Enrollee is an eligible employee or Dependent of an eligible employee who requests coverage more than 31 days after the earliest opportunity to enroll for coverage as determined by the Benefit Program's eligibility rules, or

after the Employer Group's Open Enrollment Period. Late Enrollees will be subject to a 12-month Pre-Existing Condition limitation period with credit given for prior continuous qualifying coverage. An eligible employee and/or Dependent shall not be considered a Late Enrollee if a request for membership is made and each of the following conditions is satisfied:

1. Coverage was not elected when the employee and/or Dependent was first eligible under the Benefit Program solely because another group health insurance Plan provided coverage for the eligible employee and/or Dependent; and

2. He or she completed any required written waiver of coverage and stated in writing that, at such time, other health insurance coverage was the reason for declining enrollment; and

3. Coverage is lost under other group health insurance due to his or her COBRA or state continuation coverage being exhausted, employment termination, reduction in hours, death of a spouse, or divorce, employer contribution toward the coverage being terminated, an employer no longer offering benefits to a class of individuals such as part time workers, lifetime maximum being met under such insurance or due to that Plan's involuntary termination or cancellation by its carrier; and

4. The Employee and/or Dependent enrolls under the Benefit Program within 31 days after loss of membership under the other Plan.

Special Enrollment Periods

Individuals that meet the above criteria will be eligible to enroll in the Plan at anytime throughout the year. Coverage will be effective the day after the termination of the prior coverage.

In addition, the special enrollment period is available to the Covered Person and the Covered Person's spouse who have not been covered under other group coverage following marriage, a birth or adoption. Dependent children other than the newly born or newly acquired Dependent are eligible for the special enrollment period as a result of the acquisition of new family members.

Eligible employees or Dependents may also enroll under two additional circumstances:

1. The employee's or Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or

2. The employee or Dependent becomes eligible for a subsidy (state premium assistance program under Medicaid or CHIP.

The employee or Dependent must request special enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination. If Anthem BCBS receives an application to add a Dependent or an eligible person and Dependent more than 60 days after the loss of Medicaid/CHIP or of the eligibility determination, that person is only eligible for coverage as a Late Enrollee.

To request a special enrollment or obtain more information, contact Customer Service at (203) 234-1800 or (800) 331-0150.

Changes Affecting Eligibility

Anthem BCBS must be immediately notified in writing, on a form acceptable to Anthem BCBS, of any change that may impact a Covered Person's eligibility under the Benefit Program. These changes include, but are not limited to:

1. The marriage of the Covered Person or an enrolled Dependent child;

2. The divorce of the Covered Person;
3. The birth of a child of a Member;
4. A Dependent child attains the maximum age limit for coverage under the Benefit Program;
5. A Dependent child obtains group health coverage through their own employer;
6. A Covered Person’s termination of employment or reduction in work hours;
7. Loss of eligibility for other reasons specified in the Certificate.

PRE-EXISTING CONDITION EXCLUSION PROVISION

Pre-Existing Condition Exclusion

This Benefit Program does not provide coverage for services that are determined to be related to Pre-Existing Conditions for up to 12 months from your Enrollment Date if you are a Late Enrollee. Credit may be applied toward reducing the Pre-Existing Condition Limitation Period if you have maintained continuous Creditable Coverage. To maintain continuous Creditable Coverage you must not have a break in coverage of more than 120 consecutive days (or 150 consecutive days when coverage was terminated due to involuntary loss of employment). However, the eligible employee must apply for coverage within 30 days of eligibility under this Benefit Program. **Please refer to the Schedule of Benefits for your Benefit Program's specific Pre-Existing Condition Limitation Period**.

For the purpose of identifying a pre-existing condition, claims submitted with a total provider charge under $1,000 (the threshold), are generally not subject to review. Any claim(s) submitted in excess of the threshold, for Covered Persons with pre-existing condition exclusions, may be reviewed to determine if the condition is pre-existing. Once a pre-existing condition has been established, all subsequent claims, regardless of provider charge amount, may be subject to review. As Anthem may apply a threshold in its claims review, the payment of claims with a charge amount below the threshold should not be relied upon as a representation that future claims related to the condition will be paid.

Exceptions to the Pre-Existing Condition exclusion:

- Genetic information can not be treated as a Pre-Existing Condition for the purposes of determining whether a condition meets the definition of a Pre-Existing Condition in the absence of a diagnosis of the condition.
- This Pre-Existing Condition exclusion does not apply to the condition of pregnancy.
- The Pre-Existing Condition exclusion does not apply to children newly born, newly adopted (before the age of 18), or placed for adoption (before the age of 18) provided that such children are enrolled within 30 days following the date of birth, adoption or placement for adoption.
- The Pre-Existing Condition exclusion does not apply to routine follow up care to determine whether a breast cancer has reoccurred in a person who has been previously determined to be breast cancer free, unless evidence of breast cancer is found during or as a result of such follow up.

Certificate of Creditable Coverage

Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), a Certificate of Creditable Coverage must be presented by any employee and his or her Dependents who seek to obtain coverage under this Benefit Program. The information included on the Certificate of Creditable Coverage should include the names of any Covered Persons who terminated from the prior health benefit Plan, the date of coverage and the type of coverage provided under that Plan. The Certificate of Creditable Coverage will provide Anthem BCBS with information regarding previous coverage to assist it in determining any Pre-Existing Condition Limitation Period.

If you do not have a certificate, but you do have prior health coverage, we will help you obtain one from your prior plan or issuer. There are also other ways that you can show you have creditable coverage. Please contact us if you need help demonstrating creditable coverage.

If you have questions about the preexisting condition exclusion and creditable coverage, please contact Customer Service at (800) 843-6096.

MANAGED BENEFITS – MANAGED CARE GUIDELINES

Subject to the terms and conditions of the Benefit Program, a Covered Person is eligible for benefits for Covered Services for Medically Necessary Care when prescribed or ordered by a Physician and when in accordance with the provisions of this Managed Benefits Section.

Introduction

A Covered Person's right to benefits for Covered Services provided under this Summary Booklet is subject to certain policies or guidelines and limitations, including, but not limited to: Anthem Medical Policy; Prior Authorization; Concurrent Review; and Case Management. A description of each of these provisions is described in the Managed Care Guidelines that explains its purpose; requirements; and effects on benefits. Failure to follow the Managed Care Guidelines for obtaining Covered Services will result in a reduction or denial of benefits.

NOTICE: Prior Authorization does NOT guarantee coverage for or the payment of the service or procedure reviewed. The Covered Person should contact his/her Physician and/or Anthem BCBS to be sure that Prior Authorization has been obtained.

The Covered Person should consult his/her Physician concerning courses of treatment and care. Notwithstanding any benefit determination, the Covered Person and the Covered Person's Physician must determine what care and/or treatment is received.

Questions regarding Managed Care Guidelines or to determine which services require Prior Authorization can be addressed by calling the telephone number on the back of the Covered Person's Identification Card or refer to Anthem BCBS's website at: www.Anthem.com.

Anthem Medical Policy

Anthem Medical Policy reflects the standards of practice and medical interventions identified as reflecting appropriate medical practice. The purpose of the Anthem Medical Policy is to assist Anthem BCBS in the determination of Medical Necessity. However, the benefits, exclusions and limitations take precedence over Anthem Medical Policy. Medical technology is constantly changing and Anthem BCBS reserves the right to review and update the Anthem Medical Policy periodically.

Your Responsibilities When Obtaining Health Care – Prior Authorization

Prior Authorization of certain services is required so that we can review the service to verify that it is Medically Necessary and that the treatment provided is the proper level of care. It is the Participating Provider's responsibility to notify Anthem BCBS when Prior Authorization is required for certain services. If the Covered Person decides to receive services from a Non-Participating Physician; Non-Participating Hospital; or Non-Participating Provider the Covered Person must obtain Prior Authorization from Anthem BCBS. Prior Authorization may be obtained by contacting Anthem BCBS at the telephone number located on the back of the Covered Person's Identification Card.

Prior Authorization must be obtained prior to the initial treatment for non-Hospital based services.

With Prior Authorization, we guarantee payment for services that we approve in advance if the services are otherwise covered under the Summary Booklet, the Pre-Existing Condition limitation provision is satisfied, the Coinsurance/Copayment/Deductible requirements are satisfied, and you are covered on the date you receive care. Benefits for Covered Services are subject to the terms, conditions and limitations of the Summary Booklet. The Prior Authorization will indicate a period for approval. Any service not performed in the specified time frame will need to be re-authorized.

Non-Medically Necessary treatment or services for which the necessary Prior Authorization has not been obtained from Anthem BCBS will not be considered services eligible for reimbursement under this Summary Booklet. The Covered Person and Physician or Provider will receive written notification regarding the approval or denial of Prior Authorization.

Requesting Prior Authorization

Most Network Providers know which services require Prior Authorization and will obtain any required Prior Authorization or request a predetermination if they feel it is necessary. Your primary care physician and other Participating Providers have been provided detailed information regarding managed care guideline procedures and are responsible for assuring that the requirements of managed care guidelines are met. The ordering (or "requesting") Provider, facility or attending Physician will contact Us to request a Prior Authorization or predetermination review. We will work directly with the requesting Provider for the Prior Authorization request. However, you may designate an authorized representative to act on your behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older.

Who is responsible for Prior Authorization:

- Services provided by a Network Provider: The Provider is responsible for Prior Authorization
- Services provided by a BlueCard or Non-Participating Provider: The Covered Person is responsible for Prior Authorization

  The Covered Person is financially responsible for services and/or settings that are not covered under the Summary Booklet based on an adverse determination of Medical Necessity or Experimental or Investigational services.

If you have any questions regarding the information contained in this section, you may call the telephone number on the back of your Identification Card or visit www.anthem.com.

Prior Authorization for Specialized Formula

In-Network

Anthem BCBS has a designated In-Network vendor for home delivery of Specialized Formula. To receive In-Network benefits, the Covered Person, Covered Person's representative or Provider should contact the In-Network vendor to initiate the Prior Authorization process. Anthem BCBS can be reached at the number located on the back of the Covered Person's Identification Card for information regarding how to contact the vendor.

Out-of-Network

Prior to obtaining Specialized Formula from other than the designated In-Network vendor, the Covered Person, Covered Person's representative or Provider must obtain Prior Authorization from Anthem BCBS by calling the number on the back of the Covered Person's Identification Card.

Prior Authorization for Admissions

Prior Authorization for Hospital Admissions/Inpatient Facility Admissions, or Admission to a Partial Hospitalization or Day/Night Program.

When a Covered Person is scheduled for an Admission to a Hospital, Skilled Nursing Facility, or Hospice it is the Participating Provider's responsibility to notify Anthem BCBS when Prior Authorization is required for certain services. If the Covered Person decides to receive services from a Non-Participating Physician; Non-Participating Hospital; or Non-Participating Provider the Covered Person must obtain Prior Authorization from Anthem BCBS. **Note: For guidelines regarding an Admission due to a Medical Emergency, please refer to the Medical Emergency Services Section.**

Elective Admissions

It is the Participating Provider's responsibility to notify Anthem BCBS when Prior Authorization is required. If the Covered Person decides to receive services from a Non-Participating Physician; Non-Participating Hospital; or Non-Participating Provider the Covered Person must obtain Prior Authorization from Anthem BCBS. The Participating Provider or Covered Person (as applicable) must call Anthem BCBS for Prior Authorization at the number located on the back of the Covered Person's Identification Card when the Admission is scheduled. This call must be made no later than one business day prior to the Elective Admission day.

a. Once Anthem BCBS has been notified of the Admission, Anthem BCBS will contact the Covered Person's Physician to obtain medical information relating to the Admission.

b. During this process for Elective Admissions, the Admission day of the week will be checked. Friday or Saturday Admissions, or a Sunday Admission when Monday is a holiday will not be Authorized by Anthem BCBS unless the weekend Admission is determined to be Medically Necessary.

c. For an Elective Admission, Anthem BCBS will either: Prior Authorize a number of Inpatient days or advise that Inpatient days cannot be Prior Authorized. The Covered Person, Physician and Hospital will be notified in writing.

Medical Emergency Admissions

This Benefit Program shall provide benefits for Medical Emergency Admissions if the care is determined to be for a Medical Emergency. It is the Participating Provider's responsibility to notify Anthem BCBS within 2 business days of an Inpatient Admission due to a Medical Emergency. If the Covered Person decides to receive services from a Non-Participating Physician; Non-Participating Hospital; or Non-Participating Provider the Covered Person must obtain Prior Authorization from Anthem BCBS within 2 business days of an Inpatient Admission due to a Medical Emergency. When the Covered Person is admitted due to a Medical Emergency and Anthem BCBS is not notified within 2 business days, benefits for Covered Services shall only be provided if the Covered Person's condition at the time of diagnosis, care or treatment is confirmed to have been a Medical Emergency.

Upon receiving proper notification of the Medical Emergency Admission, Anthem BCBS must authorize and manage continued Inpatient or Outpatient care related to the Medical Emergency in order for such care to be covered under this Benefit Program.

Any follow-up diagnosis, care or treatment performed after the cessation of the Medical Emergency must be provided by Participating Physicians in order for benefits to be considered as In Network. Such Covered Services shall be subject to the Cost-Shares specified in the Schedule of Benefits for Participating Physicians, Participating Providers and Participating Hospitals.

Any follow-up diagnosis, care or treatment performed after the cessation of the Medical Emergency and provided by Non-Participating Physicians shall be reimbursed based upon the Out-of-Network Option. Such Covered Services shall be subject to the Cost-Shares specified in the Schedule of Benefits for Non-Participating Physicians, Non-Participating Providers and Non-Participating Hospitals.

Concurrent Review

The availability of benefits for Inpatient Covered Services will be subject to Concurrent Review. Based on the results of the Concurrent Review, Anthem BCBS will determine that:

- There will be additional Inpatient days Prior Authorized; or
- There will be a change in the services, supplies, treatment or setting; or
- There will be no additional Inpatient days Authorized as of a specific date.

If continued Hospitalization can no longer be authorized beyond a specific date, Anthem BCBS will assist the Covered Person, Physician and Hospital to coordinate continued care, where appropriate.

No benefits will be provided under this Summary Booklet or any other policy issued by Anthem BCBS for Inpatient Covered Services billed by the Hospital and the admitting Physician after the specific date indicated in the Anthem BCBS Authorization notice.

Penalties For Not Obtaining Prior Authorization

If the appropriate Prior Authorization is not obtained for Elective Admissions, benefits will be reduced, as shown on the Schedule of Benefits.

No benefits will be payable under the Benefit Program, for Physician Inpatient medical care visits or Hospital room and board charges if you or your Physician fail to obtain the Prior Authorization from Anthem BCBS as stated in this Managed Benefits – Managed Care Guidelines section, and Anthem BCBS determines the Admission is not Medically Necessary for an Inpatient setting. Further, if you elect to be admitted after a determination by Anthem BCBS that Inpatient days cannot be Prior Authorized there will be no payment for benefits.

Case Management

Anthem BCBS may at its discretion, provide benefits supplemental to those Covered Services provided under this Benefit Program as a part of Case Management.

By providing services through Case Management, Anthem BCBS is making an exception only for a specific case and is not committed to providing similar coverage and benefits again for you, nor for other Covered Persons. All other terms and conditions of this Benefit Program shall be strictly administered by Anthem BCBS. Anthem BCBS has the right to alter or discontinue Case Management when it is no longer Medically Necessary. The Covered Person or the Covered Person's representative shall be notified in writing.

Case Management is a program tailored to the Covered Person. Anthem BCBS's case managers work collaboratively with the Covered Person, the Covered Person's family and Providers to coordinate the Covered Person's health care benefits. In certain extraordinary circumstances involving intensive Case Management, Anthem BCBS on behalf of the Employer, may provide benefits for care that is not listed as a Covered Service. Anthem BCBS on behalf of the Employer, may also extend Covered Services beyond the contractual benefits limits of this plan. Anthem BCBS on behalf of the Employer, will make its decisions regarding Case Management on a case-by-case basis.

Appeal Process

If Anthem BCBS denies, reduces or terminates benefits at any time during the review process, the Covered Person, Covered Person's representative, Hospital, Skilled Nursing Facility, Substance Abuse Treatment Facility, Residential Treatment Facility, Hospice or other Inpatient Facility or Physician may request an Appeal review. Please refer to the Covered Person Appeal Process Section for further information regarding this process.

COVERED SERVICES

This Section lists Covered Services and the benefits we pay. This Benefit Program shall provide benefits for the Covered Services described in this section when performed by a Participating Physician, Participating Provider, Participating Hospital, or Non-Participating Physician, Non-Participating Provider or Non-Participating Hospital, and subject to the Managed Benefits Section of this Summary Booklet. The Covered Person is responsible for Copayments if the Covered Services are rendered by a Participating Physician, Participating Provider or Participating Hospital, or the applicable Deductible and Coinsurance if rendered by a Non-Participating Physician, Non-Participating Provider or Non-Participating Hospital. Failure to comply with the guidelines outlined in the Managed Benefits Section of the Summary Booklet will result in Penalties or denial of benefits. Please refer to the Schedule of Benefits for specific Cost-Shares.

The following conditions apply to the description of Covered Services referenced in this section:

a. All Covered Services and Benefits are subject to the conditions, exclusions, limitations, terms and provisions of this Summary Booklet, including any attachments and riders.

b. To receive maximum benefits for Covered Services, you must follow the terms of the Summary Booklet, including, if applicable, receipt of care from your primary care Physician, use of In-Network Providers, and obtaining any required Prior Authorization.

c. Benefits for Covered Services are based on the Maximum Allowable Amount for such service.

d. If you have an Out-of-Network benefit and use a non-network Provider, you are responsible for the difference between the non-network Provider's charge and the Maximum Allowable Amount, in addition to any applicable Copayment or Deductible. Anthem BCBS cannot prohibit non-network Providers from billing you for the difference in the non-network Provider's charge and the Maximum Allowable Amount.

e. Benefits for Covered Services may be payable subject to an approved treatment plan created under the terms of the Summary Booklet.

f. Anthem BCBS's payment for Covered Services will be limited by any applicable Copayment, Deductible or annual or lifetime payment limit in the Summary Booklet, including the Schedule of Benefits.

g. The fact that a Provider may prescribe, order, recommend or approve a service, treatment or supply does not make it Medically Necessary or a Covered Service and does not guarantee payment.

h. Anthem BCBS bases its decisions about referrals, Prior Authorization, Medical Necessity, experimental services and new technology on medical policy developed by Anthem BCBS. Anthem BCBS may also consider published peer-review medical literature, opinions of experts and the recommendations of nationally recognized public and private organizations which review the medical effectiveness of health care services and technology.

AMBULANCE/MEDICALLY NECESSARY TRANSPORTATION SERVICES

This Summary Booklet Covers:

Medically Necessary Medical transportation services:

Ambulance Services when the Covered Person's condition at the time of the treatment is confirmed to have been a Medical Emergency. If a Covered Person is admitted, any applicable Non-Participating Provider Cost-Share will be waived.

Medical transportation services when Medically Necessary, from a Hospital or Provider where a Covered Person is Inpatient to a Participating Hospital or Participating Provider.

Medical transportation services provided through the Home Health Agency in conjunction with the Home Health Care services as follows:

1. from a Hospital or Provider to Home after discharge;
2. to and from a Hospital or Provider for treatment; or
3. from Home to a Hospital or Provider, if readmission is necessary.

Notes:

Please refer to the Schedule of Benefits for the appropriate Cost-Shares.

Covered Services do not include:

Transportation for Elective Hospital Admissions.

Transportation solely for the convenience of the Covered Person.

Please refer to the Exclusions and Limitations Section of this Summary Booklet for other services not covered under this Benefit Program.

DIAGNOSTIC SERVICES

This Summary Booklet Covers:

Diagnostic x-ray or imaging studies

Magnetic Resonance Imaging (MRI)

Laboratory and pathology tests

Electronic diagnostic medical procedures

Outpatient polysomnography

Laboratory and diagnostic tests, including PSA tests, to screen for prostate cancer

CAT Scan

Services of a Free Standing Magnetic Resonance Imaging Facility with a participating agreement with Anthem BCBS: Maximum Allowable Amount.

Services of a Provider without a participating agreement with Anthem BCBS: Maximum Allowable Amount for Non-Participating Providers.

Colorectal cancer screening, including, but not limited to:

An annual fecal occult blood test; and
Colonoscopy, flexible sigmoidoscopy or radiologic imaging.*

Notes:

*Outpatient Surgical Cost-Shares apply.

Please refer to the Schedule of Benefits for the appropriate Cost-Shares.

Outpatient polysomnograms are covered for the diagnosis of sleep apnea or narcolepsy, when provided in a facility accredited by the Association of Sleep Disorders Centers Clinical Sleep Society

Covered Services do not include:

Please refer to the Exclusions and Limitations Section of this Summary Booklet for other services not covered under this Benefit Program.

DURABLE MEDICAL EQUIPMENT, PROSTHETIC DEVICES, SUPPLIES & APPLIANCES

Please Note: Certain Durable Medical equipment may not require Prior Authorization. Contact Customer Service before any such equipment is obtained to determine if Prior Authorization is required.

This Summary Booklet Covers:

Durable Medical Equipment which improves the function of a malformed body part, or prevents or retards further deterioration of the Covered Person's medical condition.

Prosthetic Devices, when prescribed, whether surgically implanted or worn as an anatomic supplement and subject to the following:

Repair, replacement, fitting, and adjustments are covered when made necessary by normal wear and tear or by body growth or change.

In cases of a tumor of the oral cavity, non-dental Prosthetic Devices, including maxillo-facial Prosthetic Devices used to replace anatomic structures removed during treatment of head or neck tumors, and additional Appliances essential for the support of such Prosthetic Devices.

Appliances such as a leg, arm, back or neck brace or artificial legs, arms or eyes or any prosthesis with supports, including replacement if a Covered Person's physical condition changes

Diabetic equipment and supplies

Ostomy bags, catheters and supplies required for their use, and any other Medically Necessary ostomy-related appliances including; but not limited to: collection devices; irrigation equipment and supplies; and skin barriers and protectors.

External breast prosthesis following mastectomy for malignancy or other disease of breast tissue. Prior authorization is not applicable to prostheses pursuant to the Women's Health and Cancer Rights Act of 1998.

Hypodermic needles or syringes prescribed by a licensed practitioner for the purpose of administering medications for medical conditions, provided such medications are covered under this Summary Booklet.

Hearing aid coverage available for children twelve years of age or younger. Subject to the maximums stated in the Schedule of Benefits.

Wigs if prescribed by a licensed oncologist for a patient who suffers hair loss as a result of chemotherapy.

Wound-care supplies that are Medically Necessary for the treatment of epidermolysis bullosa and are administered under the direction of a Physician. Payment of such services will not be applied against any durable medical equipment Calendar Year dollar maximums or against the maximum lifetime limits specified in this Benefit Program.

Notes:

Please refer to the Schedule of Benefits for the appropriate Cost-Shares.

Anthem BCBS will consider purchase of such durable medical equipment if the cost would be less than rental. In either case, the total benefit will not exceed the cost of the least expensive equipment necessary to meet the medical condition.

Prior Authorization is required. Please refer to the Managed Benefits Section of this Summary Booklet for information on how to obtain Prior Authorization.

Covered Services do not include:

Dental devices, household and personal comfort items, eyeglasses, hearing aids, orthopedic shoes or other supportive or corrective devices for the feet; or any other item not specifically defined in the definition of Appliances.

Repair and replacement of Prosthetic Devices and Appliances made necessary because of loss or damage caused by misuse or mistreatment.

Please refer to the Exclusions and Limitations Section of this Summary Booklet for other services not covered under this Benefit Program.

HOME HEALTH CARE

This Summary Booklet Covers:

Benefit Period:

After an Admission – commencing within 7 days after discharge from the Hospital.

In lieu of an Admission and;

Terminal Illness – upon diagnosis by a Physician

Skilled nursing care by a Registered Nurse (R.N.) or a Licensed Practical Nurse (L.P.N.) under the supervision of a R.N. when the services of a R.N. are not available.

Skilled, progressive and rehabilitative services of a licensed physical therapist.

Other Covered Services

Occupational, speech and respiratory therapy;

Medical and surgical supplies and prescribed Durable Medical Equipment;

Prescription Drugs dispensed from a retail Pharmacy;

Oxygen and its administration;

Home health aide services consisting primarily of patient care of a medical or therapeutic nature;

Laboratory services;

Dietary services;

Transportation to and from a Hospital for treatment, re-admission or discharge by the most safe and cost-effective means available.

Notes:

Please refer to the Schedule of Benefits for the appropriate Cost-Shares.

The Covered Person must be essentially confined at home and home health care services must be rendered for treatment of the same illness or injury for which the Covered Person was hospitalized.

Every four hours of Covered Services rendered by a home health aide will be charged as one visit.

Benefits for Covered Services rendered by a home health aide are provided up to four hours per day for non-terminal Covered Persons and eight hours per day for terminal Covered Persons.

Please refer to the Private Duty Nursing Section of the Benefit Chart for covered private duty nursing services.

Covered Services do not include:

Meals, personal comfort items and housekeeping services.

Nursing services provided in the home by a relative, even if a registered nurse or a licensed practical nurse.

Please refer to the Exclusions and Limitations Section of this Summary Booklet for other services not covered under this Benefit Program.

HOSPICE SERVICES

This Summary Booklet Covers:

Inpatient Hospice services in a Hospice, Hospice unit in a Hospital or Skilled Nursing Facility. Coverage is limited to 60 days per Calendar Year.

Part-time intermittent nursing care by a registered nurse or licensed practical nurse and services of a home health aide for patient care up to 8 hours.

Psychological and dietary counseling.

Consultation or Case Management services by a Physician.

Physical and/or occupational therapy.

Medical supplies, drugs and medicines prescribed by a Physician.

Medical social services under the direction of a Physician up to the maximum shown in the Schedule of Benefits.

Hospice services in the home from a home health care agency.

Part-time or intermittent services of a home health aide for patient care up to 8 hours per day.

Notes:

Please refer to the Schedule of Benefits for the appropriate Cost-Shares.

Physician must certify that patient is terminally ill with 6 months or less to live.

Prior Authorization is required. Please refer to the Managed Benefits Section of this Summary Booklet for information on how to obtain Prior Authorization.

The Hospital Inpatient/Inpatient Facility Coinsurance amount is not subject to Cost-Share Maximums.

Covered Services do not include:

Bereavement counseling, pastoral counseling, financial or legal counseling, or Custodial Care.

Please refer to the Exclusions and Limitations Section of this Summary Booklet for other services not covered under this Benefit Program.

HOSPITAL SERVICES

This Summary Booklet Covers:

Inpatient Hospital Services:

Room and board for a semi-private Hospital room. If a private room is used, this Benefit Program shall only provide benefits for Covered Services up to the cost of the semi-private room rate, unless Anthem BCBS determines that a private room is Medically Necessary.

Following a mastectomy, benefits for Covered Services will be provided as follows:

At least 48 hours after a mastectomy or lymph node dissection unless otherwise agreed upon by the Covered Person and Physician.

Inpatient and Outpatient Hospital services and supplies:

Use of an operating, delivery and treatment room, and equipment (including intensive care);

Prescribed drugs;

Administration of blood and blood processing;

Anesthesia, anesthesia supplies and services;

Medical and surgical dressing, supplies, casts and splints;

Diagnostic services;

Rehabilitative and restorative physical therapy and occupational therapy and speech therapy for treatment expected to result in the reasonable improvement of a Covered Person's condition;

Radiation therapy;

Chemotherapy for treatment of cancer;

Laboratory tests;

X-ray or imaging studies;

Outpatient surgery;

Pre-admission testing;

Tests and studies required in connection with a scheduled Admission for surgery;

Services for hemodialysis or peritoneal dialysis for chronic renal disease, including equipment, training and medical supplies until the Covered Person is eligible for the Medicare End Stage Renal Disease program;

Services associated with accidental consumption or ingestion of a controlled drug or other substance.

Notes:

Please refer to the Schedule of Benefits for the appropriate Cost-Shares.

Outpatient Surgical Cost-Shares apply to colonoscopies performed on an Outpatient basis.

For Outpatient Surgery rendered in a licensed ambulatory surgical center (not located in a hospital setting) see the Other Provisions section.

The Per Admission Copayment is payable by a Covered Person for every Admission, unless otherwise specified in your schedule of Benefits. It does not satisfy any Policy Deductible and is payable whether or not the Cost-Share Maximum has been met.

The benefits for a General Hospital with a participating agreement are unlimited.

The Specialty Hospital benefit period is 60 days per Covered Person per Calendar Year.

Benefits for Non-Participating General Hospitals in and outside of Connecticut are limited to 30 days. Benefits are renewed when 30 consecutive days without Inpatient care have elapsed.

Benefits for services rendered outside of the United States are unlimited days.

The Hospital Inpatient/Inpatient Facility Coinsurance amount is not subject to Cost-Share Maximums.

If a Covered Person is admitted as an Inpatient as a result of Outpatient surgery, the Covered Person must notify Anthem BCBS within 2 business days of the Admission. Please refer to the Managed Benefits Section of this Summary Booklet for information on how to notify us of your Admission.

Pre-Admission testing must be rendered to a Covered Person as an Outpatient prior to the scheduled Admission and not repeated upon Admission for surgery. The Covered Person will be responsible for the charges for Pre-Admission testing if the Covered Person cancels or postpones the scheduled Admission.

Inpatient and Outpatient Hospital Dental Services - Anesthesia, nursing and related Hospital charges for Inpatient dental services; outpatient Hospital dental services; or one day dental services are covered if deemed Medically Necessary by the treating dentist or oral surgeon and the patient's primary care Physician in accordance with Prior Authorization requirements and (1) the patient has been determined by a licensed dentist in conjunction with a licensed primary care Physician to have a dental condition of sufficient complexity that it requires Inpatient services; outpatient Hospital dental services; or one day dental services, or (2) the patient has a developmental disability, as determined by a licensed primary care Physician, that places him or her at serious risk.

Covered Services do not include:

Private duty nursing services during an Inpatient Hospital Admission.

Please refer to the Exclusions and Limitations Section of this Summary Booklet for other services not covered under this Benefit Program.

HUMAN ORGAN AND TISSUE TRANSPLANT SERVICES

Subject to the Exclusions, Conditions and Limitations and Schedules of Eligibility and Benefits of this Description of Benefits, a Covered Person is entitled to benefits for Covered Services as described in this Human Organ and Tissue Transplant Section for Medically Necessary Care when prescribed or ordered by a Physician.

A. COVERED SERVICES:

1. Subject to any Deductible, Coinsurance or Benefit Program maximums, and mandatory Pre-Authorization Guidelines, Anthem will provide on behalf of Employer the benefits of this Benefit Program for the following services:

    a. Kidney transplant;
    b. Heart transplant;
    c. Heart-Lung transplant;
    d. Liver transplant;
    e. Pancreas transplant;
    f. Single Lung transplant;
    g. Bone Marrow transplant - except as specified in Subsection D.

2. The following Covered Services are not subject to the mandatory Pre-Authorization Guidelines Section of the Benefit Program.

    a. Blood transfusion;
    b. Cornea transplant;
    c. Bone and Cartilage grafting; and
    d. Skin grafting.

3. Anthem will only provide on behalf of Employer benefits for the Covered Services which are specified in this Section. All other organ and tissue transplants and related procedures which are not so specified are not covered under this Benefit Program.

B. PRE-AUTHORIZATION GUIDELINES

All Covered Services specified in Subsection A(1)(a-g) and Subsection D are subject to these mandatory pre-authorization guidelines.

When the Physician determines that the Covered Person is a candidate for any of the Covered Services specified in Subsection A(1)(a-g) and Subsection D, the Covered Person or the Covered Person's representative must inform the Physician of this mandatory pre-authorization requirement.

Anthem must be notified by the Covered Person or the Covered Person's representative in order to pre-authorize benefits when any of the Covered Services specified in Subsection A(1)(a-g) are being requested.

All telephone calls must be made during regular business hours from 8:00 a.m. to 6:00 p.m., Eastern Time, Monday through Friday. If a telephone call cannot be made during regular business hours, the caller can leave his/her name, telephone number and a message. This call will be returned on the next business day.

Pre-authorization is based upon the clinical criteria and guidelines established in the sole discretion of consultant(s) designated by Anthem.

The authorization of any of the Covered Services specified in Subsection A(1)(a-g) and Subsection D as Medically Necessary Care does not constitute a promise of benefits and does not guarantee payment of benefits. Actual coverage will be determined at the time a claim is submitted.

The final decision concerning treatment remains with the Covered Person and the Covered Person's Physician. Anthem is responsible for determining, within the terms and conditions of this Benefit Program, what benefits, if any, will be provided on behalf of Employer.

Any penalty amounts imposed under this Human Organ and Tissue transplant Section will not be counted toward annual out-of-pocket expense limits and are not reimbursable as a Covered Service under any other provision or section of this Benefit Program or any other benefit plan administered by Anthem.

1. PRE-AUTHORIZATION REVIEW

    a. The Covered Person or the Covered Person's representative must notify Anthem's Managed Benefits Unit of the Utilization Review Programs Department by telephone as soon as the Physician determines that the Covered Person is a candidate for any of the Covered Services specified in Subsection A(1)(a-g) and Subsection D. This notification must be received prior to the Covered Services being performed.

    b. Once Anthem has been notified of the determination that the Covered Person is a candidate for any of the Covered Services specified here in Subsection A(1)(a-g) and Subsection D or upon notification of the scheduled admission, Anthem will contact the Covered Person's Physician to obtain medical information relating to the Covered Services.

c. If this Benefit Program includes the Admission Planning Services Amendment or the Managed Benefits Section, the Covered Person or Covered Person's representative must make additional calls in accordance with the applicable terms of the Admission Planning Services Amendment and/or the Managed Benefits Section of this Benefit Program.

d. In the event that the Covered Services must be performed on an emergency basis, the Covered Person or Covered Person's representative must notify Anthem's Managed Benefits Unit no later than two business days after the admission.

e. Anthem will notify the Covered Person, Physician and Hospital that the Covered Services are either authorized or are not authorized.

2. RE-AUTHORIZATION

The Covered Person or the Covered Person's representative must notify Anthem's Managed Benefits Unit of the Utilization Review Programs Department by telephone for re-authorization for any of the Covered Services specified here in Subsection A(1)(a-g) and Subsection D if:

a. The Covered Person does not have the Covered Service performed within 90 days from the date of Anthem's written notice sent to the Covered Person or the Covered Person's representative that the Covered Service is authorized; or

b. The Hospital in which the Covered Service is to be performed is different from the Hospital identified on Anthem's written notice sent to the Covered Person or Covered Person's representative.

3. No benefits will be provided for Covered Services, billed by the Hospital and any Physician in the event that the Covered Service is not authorized by Anthem.

4. PENALTIES

Benefits will be reduced $10,000 if the Covered Person or Covered Person's representative fails to notify Anthem by telephone prior to any of the Covered Services specified in Subsection A(1)(a-g) and Subsection D being performed, and Anthem subsequently authorizes such Covered Services after the procedure has been performed.

C. <u>OTHER ORGAN AND TISSUE TRANSPLANT PROVISIONS</u>

1. In order to receive benefits of this Benefit Program for the Covered Services specified in Subsection A(1)(a-g) and Subsection D, the Covered Person or Covered Person's representative must comply with the mandatory Pre-Authorization Guidelines specified in Subsection B of this Organ and Tissue Transplant Section.

2. If a human organ or tissue transplant is provided from a donor to a human organ or tissue transplant recipient, benefits for the Covered Services specified herein will be subject to the following terms and conditions. As used in this Subsection, the term donor means a person who furnishes the organ or tissue for transplantation in a histo-compatible recipient.

a. When both the recipient and the donor are Covered Persons, each is entitled to the benefits of this Benefit Program;

b. When only the recipient is a Covered Person, both the donor and the recipient are entitled to the benefits of this Benefit Program. The donor benefits are limited to only those not provided or available to the donor from any other source. This includes, but is not limited to, other insurance coverage, or other Blue Cross & Blue Shield coverage or any government program. Benefits provided to the donor will be charged against the recipient Covered Person's coverage under this Benefit Program;

c. Benefits under this Benefit Program for services directly related to the procurement of a donor organ or tissue used for any of the Covered Services specified herein such as hospital, medical/surgical, storage and transportation costs, will be subject to a maximum of $15,000. No benefits will be provided for procurement of a donor organ or tissue which is not used for a Covered Service specified herein unless the transplant is cancelled due to the recipient's medical condition or death and the organ cannot be transplanted to another person. No benefits will be provided for procurement of a donor organ or tissue which has been sold rather than donated. No benefits will be provided for transportation costs of the recipient.

d. When the recipient is uninsured and the donor is a Covered Person, Anthem will only provide on behalf of Employer benefits related to the procurement of the donor organ or tissue up to the $15,000 maximum.

e. When a Covered Person fails to meet the clinical criteria and guidelines established in the sole discretion of consultant(s) designated by Anthem, no coverage will be extended for any procedure or service related to that Covered Service for a period of three hundred sixty-five days following the date of that Covered Service.

D. SPECIAL EXCLUSIONS AND LIMITATIONS

The following is a list of services 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. All Allogeneic or Syngeneic Bone Marrow Transplants or other forms of stem cell rescue or stem cell infusion (with or without high dose chemotherapy and/or radiation) are not considered Covered Services EXCEPT when:

   a. At least five out of six major histo-compatibility 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 nonlymphocyic 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 hypoplasis
      * Diamond Blackfan syndrome
      * Thalassemia
      * Sickle cell anemia
      * Primary thrombocytopathy including

* Glanzmann's syndrome
* Gaucher's 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 Allergenic 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 Services.

2. ALL Autologous Bone Marrow Transplants 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 considered Covered Services 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. Non-Hodgkin's lymphoma, low grade with conversion to high grade. No morphological evidence of bone marrow involvement should be evident.

   c. Hodgkin's disease as defined above with an absence of bone marrow involvement.

   d. Acute nonlymphocytic leukemia in second remission, in which no HLA matched donor exists or an allogeneic transplant is inappropriate.

   e. Acute lymphocytic leukemia in second remission, in which no HLA matched donor exists or an allegeneic transplant is inappropriate.

   f. Retinoblastoma, adjuvant setting after successful induction (consolidation).

   g. Neuroblastoma, adjuvant setting after successful induction (consolidation).

   ALL other Autologous Bone Marrow Transplants or other forms of stem cell rescue and stem cell infusion (with high dose chemotherapy and/or radiation), are not considered Covered Services.

3. Tissue Matching is not a Covered Service.

MATERNITY/FAMILY PLANNING SERVICES

This Summary Booklet Covers:

Obstetrical care or pregnancy, delivery, prenatal and postpartum care. Care related to complications of pregnancy including surgery and interruptions of pregnancy.

Hospital Services including room, board and Special Services, specified in this Section: Hospital Services of this Summary Booklet.

Abortions and Miscarriages.

Infertility services

Infertility drugs (with an infertility diagnosis)

Note: If this certificate has a Prescription Drug rider, see rider for infertility drug coverage. Infertility drugs will not apply to the Prescription Drug Rider Maximum. In the absence of a prescription drug rider then the coverage stated in this Schedule of Benefits will apply.

Notes:

The Hospital/Inpatient Facility amount is not subject to the Cost-Share Maximums.

Birthcenter services are available only when the Provider has a participating agreement with Anthem BCBS.

Inpatient care for a female Covered Person and newborn will be provided for a minimum of 48 hours following a vaginal delivery, and for a minimum of 96 hours following a cesarean delivery, unless otherwise agreed upon by the Covered Person and the attending Provider. The attending Provider is restricted to an individual who is licensed under applicable state law to provide maternal or pediatric care and who is directly responsible for providing such care to a mother or newborn child. The term attending Provider does not include a plan, hospital, managed care organization, or other issuer.

If the Covered Person and the attending Provider agree to an earlier discharge time, benefits for Covered Services shall be provided for a follow-up home visit within 48 hours of discharge and an additional follow-up visit within 7 days. The time period shall commence at the time of delivery.

Infertility services are the Medically Necessary expenses of the diagnosis and treatment of infertility, including, but not limited to, ovulation induction, intrauterine insemination, in-vitro fertilization (IVF), uterine embryo lavage, embryo transfer, gamete intra-fallopian transfer (GIFT), zygote intra-fallopian transfer (ZIFT) and low tubal ovum transfer.

Covered Services do not include:

Please refer to the Exclusions and Limitations Section of this Summary Booklet for other services not covered under this Benefit Program.

MEDICAL EMERGENCY

This Summary Booklet Covers:

Ambulance services when the Covered Person's condition at the time of the treatment is confirmed to have been a Medical Emergency.

Medical Emergency services provided at a Hospital's emergency room.

Medical Emergency services provided by a Physician.

Notes:

Please refer to the Schedule of Benefits for any applicable Cost-Shares.

This Benefit Program shall only provide benefits for Medical Emergency services if the care is determined to be for a Medical Emergency. All Admissions resulting from a Medical Emergency must be approved by Anthem BCBS within 2 business days of the diagnosis, care or treatment of the Medical Emergency.

If the emergency requires that the Covered Person be taken to the Hospital, this Benefit Program shall provide benefits for Covered Services for the Medical Emergency regardless of whether the Hospital is a Participating Hospital or Non-Participating Hospital.

If the emergency requires that the Covered Person receive diagnosis, care or treatment from the first available Physician or Provider, this Benefit Program shall provide benefits for Covered Services for the Medical Emergency regardless of whether the Physician or Provider is a Participating Physician or Provider or Non-Participating Physician or Provider.

If the Medical Emergency requires a Covered Person's Admission to a Non-Participating Hospital, this Benefit Program shall provide benefits for Covered Services as if the services were received at a Participating Hospital only through the day when the Covered Person can be transferred to a Participating Hospital, as determined by Anthem BCBS. If the Covered Person chooses to remain in the Non-Participating Hospital, the Covered Person will be responsible for Non-Participating Hospital Cost-Shares in accordance with the Schedule of Benefits.

Claims for services rendered to the Covered Person shall be subject to review by Anthem BCBS. Based on Anthem BCBS's review, the Covered Person may be liable for Cost-Shares, or the full cost of all services rendered if Anthem BCBS determines that the services provided were not for a Medical Emergency. Medical Emergency Covered Services are limited to the treatment rendered during the initial visit only.

All services deemed by Anthem BCBS to be Medical Emergencies are eligible for benefits as if rendered by Participating Physicians, Participating Providers or Participating Hospitals as specified in the Schedule of Benefits and Benefit Chart.

Covered Services do not include:

Please refer to the Exclusions and Limitations Section of this Summary Booklet for other services not covered under this Benefit Program.

MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

This Summary Booklet Covers:

Outpatient treatment for Mental Health Care and Substance Abuse Care

Inpatient Hospital Services in a Hospital or Residential Treatment Center Facility for Mental Health Care

Inpatient rehabilitation treatment for Substance Abuse Care in a Hospital or Substance Abuse Treatment Facility

Partial Hospitalization sessions and Day/Night Visits

Notes:

Please refer to the Schedule of Benefits for the appropriate Cost-Shares.

Prior Authorization is required. Please refer to the Managed Benefits Section for how to obtain Prior Authorization.

Outpatient care for mental illness includes services rendered in the following locations: a non-profit community mental health center, a non-profit licensed adult mental health center, a non-profit licensed adult psychiatric clinic operated by an accredited Hospital or in a Residential Treatment Facility when provided by or under the supervision of a Physician practicing as a Psychiatrist, licensed psychologist, Certified Independent Social Worker, Certified Marriage and Family Therapist or a Licensed or Certified Alcohol and Drug Counselor; or appropriately licensed professional counselor.

Outpatient care for mental illness includes services by a person with a master's degree in social work when such person renders service in a child guidance clinic or in a Residential Treatment Facility under the supervision of a

Physician practicing as a Psychiatrist, licensed Psychologist, Certified Independent Social Worker, Certified Marriage and Family Therapist or a Licensed or Certified Alcohol and Drug Counselor or appropriately licensed professional counselor.

Benefits for confinement in a Residential Treatment Facility shall be provided only in the following situations:

1. the Covered Person has a Medically Necessary, serious mental or nervous condition that substantially impairs the Covered Person's thoughts, perception of reality, emotional process or judgment or grossly impairs the behavior of the Covered Person, and, upon an assessment of the Covered Person by a physician, psychiatrist, psychologist or clinical social worker, cannot appropriately, safely or effectively be treated in an acute care, partial hospitalization, intensive outpatient or outpatient setting; and
2. An individual Treatment Plan must be prescribed by a Physician with certain specific attainable goals and objectives appropriate to both the patient and the treatment modality of the program.

Covered Services do not include:

Please refer to the Exclusions and Limitations Section of this Summary Booklet for other services not covered under this Benefit Program.

ORAL SURGERY

This Summary Booklet Covers:

For office based services see Physician Medical/ Surgical Section

For Hospital based services see Hospital Service Section

Oral Surgery Services

The following are Covered Services, as determined by Anthem BCBS:

1. An initial visit for the prompt immediate repair of trauma, due to an accident or injury, to the jaw, natural teeth, cheeks, lips, tongue and/or the roof of the mouth. Benefits available for services provided during the initial visit, include but are not limited to the following:

   - Evaluation;
   - Radiology to evaluate extent of injury;
   - Treatment of the wound; tooth fracture or evulsion.

   No additional benefits will be provided for any services rendered after the initial visit, including but not limited to: follow-up care, replacement of sound natural teeth, crowns, bridges, and prosthetic devices.

2. Oral surgical services for treatment of lesions, tumors and cysts on or in the mouth. Oral surgery services for treatment related to tumors of the oral cavity, treatment of fractures of the jaw and/or facial bones, and dislocation of the jaw.

Notes:

Please refer to the Schedule of Benefits for the appropriate Cost-Shares.

The Hospital Inpatient/Inpatient Facility Coinsurance amount is not subject to Cost-Share Maximums.

Covered Services do not include:

In the case of injury to the oral cavity, non-covered Prosthetic Devices include, but are not limited to, plates, bridges, dentures or caps/crowns.

Injury to teeth or soft tissue as a result of chewing or biting shall not be considered an accidental injury.

Please refer to the Exclusions and Limitations Section of this Summary Booklet for other services not covered under this Benefit Program.

OTHER PROVISIONS

This Summary Booklet Covers:

Outpatient Surgery in a licensed ambulatory surgical center (not located in a Hospital setting) (including colonoscopy) Note: See the Hospital Service section also for Outpatient Surgery rendered in a Hospital setting.

Blood and blood plasma

Blood derivatives when purchased through a blood derivative supplier.

Blood lead screenings and clinically indicated risk assessments.

Amino acid modified preparations and low protein modified food products for the treatment of inherited metabolic diseases.

Coverage for Specialized Formulas when such specialized formulas are medically necessary for the treatment of a disease or condition and are administered under the direction of a physician.

Outpatient self-management training for the treatment of diabetes including medical nutrition therapy.

Intravenous and oral antibiotic therapy for the treatment of Lyme Disease.

Medically Necessary Pain Management medications and procedures when ordered by a pain management specialist.

Routine Patient Care Costs in connection with Cancer Clinical Trial.

A Cancer Clinical Trial must be conducted under the auspices of an independent peer-reviewed protocol that has been reviewed and approved by:

- One of the National Institutes of Health; or
- A National Cancer Institute affiliated cooperative group; or
- The federal Food and Drug Administration as part of an investigational new drug or device exemption; or
- The federal Department of Defense or Veterans Affairs.

Hospitalization for Routine Patient Care Costs in connection with Cancer Clinical Trials shall include treatment at an Out-of-Network facility if such treatment is not available In-Network and not eligible for reimbursement by the sponsors of such clinical trial; Out-of Network Hospitalization will be rendered at no greater cost to the insured person than if such treatment was available In-Network, all applicable In-Network cost-shares will apply.

Birth to Three Program:

Services from birth to age three for early intervention Covered Services for a Covered Person and his/her family members provided as part of an individualized family service plan. A maximum of $6,400 over a three year period per child, up to a lifetime maximum of $19,200. Payment of such services shall not be applied against the maximum lifetime limits specified in this Benefit Program.

Autism Spectrum Disorders:

Coverage shall be provided for the Medically Necessary diagnosis and treatment of Autism Spectrum Disorders based on an approved treatment plan. A treatment plan will be reviewed not more than once every six months unless the Member's licensed Physician, licensed psychologist or licensed clinical social worker agrees that a more frequent review is necessary or as a result of changes in the Member's treatment plan.

Covered Services include:

- Behavior Therapy rendered by an Autism Behavioral Therapy Provider and ordered by a licensed physician, psychologist or clinical social worker in accordance with a treatment plan developed by a licensed Physician, psychologist or licensed clinical social worker;
- Direct psychiatric or consultative services provided by a licensed psychiatrist;
- Direct psychiatric or consultative services provided by a licensed psychologist;
- Physical therapy provided by a licensed physical therapist;
- Speech therapy provided by a licensed speech and language pathologist; and
- Occupational therapy provided by a licensed occupational therapist.

As applicable, any visit limits for physical, speech and occupational therapy, will not apply to Autism Spectrum Disorder services. Please see the Schedule of Benefits for applicable Cost-Shares, age and dollar maximums.

Voluntary Wellness Incentive Programs

We may offer health or fitness related program options for purchase by your employer Group. If your Group has selected this option, You may receive incentives such as gift cards by participating in or completing such voluntary wellness promotion programs as health assessments, weight management or tobacco cessation coaching. (Use of gift cards for purposes other than for qualified medical expenses may result in taxable income to you. For additional guidance, please consult your tax advisor.) These programs are not Covered Services under Your Group Health Plan but are a value added component of your plan benefits; these program features are not guaranteed under your Summary Booklet and could be discontinued at any time.

Notes:

Please refer to the Schedule of Benefits for the appropriate Cost-Shares.

Prior Authorization is required for the purchase of Specialized Formula. Please refer to the Managed Benefits Section of the Summary Booklet for information on how to obtain Prior Authorization.

Outpatient diabetes self-management training is covered if prescribed by a licensed health care professional and performed by a certified, licensed or registered health care professional trained in diabetes care and operating within

the scope of their licensure. Benefits are provided for 10 hours of initial training, 4 hours of additional training because of changes in the individual's condition and four hours of training required by new developments in the treatment of diabetes. Please refer to your directory for a listing of Participating Providers and Hospitals where Covered Services may be obtained.

Coverage is provided for up to 30 days of intravenous antibiotic therapy, or 60 days of oral antibiotic therapy, or both, for the treatment of Lyme Disease. Further treatment is covered if recommended by a board-certified rheumatologist, infectious disease specialist or neurologist.

Covered Services do not include:

Please refer to the Exclusions and Limitations Section of this Summary Booklet for other services not covered under this Benefit Program.

PHYSICIAN MEDICAL/SURGICAL SERVICES

This Summary Booklet Covers:

Medical services for the treatment of an illness or injury.

Medical office visits, specialist consultations, injections, and home visits by a Physician to examine, diagnose, and treat an illness or injury.

Chiropractic services, evaluation and treatment.

Allergy testing.

Inpatient Hospital/Inpatient Facility visits during a covered Admission.

Acute Psychiatric Care while an Inpatient at a Hospital or Inpatient Facility - 1 session per Inpatient day

Inpatient consultations by other than the attending Physician - 2 per 30 day period

Coverage for Medically Necessary orthodontic processes and appliances for the treatment of craniofacial disorders for individuals eighteen years of age or younger if such processes and appliances are prescribed by a craniofacial team recognized by the American Cleft Palate-Craniofacial Association.

Surgical Procedures:

If more than one surgical procedure is performed during the same operation, we will calculate the allowable charge for all the services combined by adding:

- The allowable charge for the service with the highest allowable charge; plus
- A reduced percentage of what the allowable charge would have been for each of the additional surgical services if these services had been performed alone. The amount of the reduced percentage will be on file with Anthem BCBS and available for inspection upon request.

Surgical assistant services.

Reconstructive surgeries, procedures and services:

In addition to the Exclusions and Limitations stated elsewhere in this Summary Booklet, the following limitations apply:

Benefits are available for Medically Necessary reconstructive surgeries, procedures and services only if at least one of the following criteria is met. Reconstructive surgeries, procedures and services must be:

1. Medically Necessary due to accidental injury; or
2. Medically Necessary for reconstruction or restoration of a functional part of the body following a covered surgical procedure for disease or injury; or
3. Medically Necessary to restore or improve a bodily function; or
4. Medically Necessary to correct a birth defect for covered dependent children who have functional physical deficits due to a birth defect. Corrective surgery for children who do not have functional physical deficits due to a birth defect is not covered under any portion of this Summary Booklet; or
5. Medically Necessary due to a mastectomy in accordance with the Women's Health and Cancer Rights Act of 1998 (see below).

Reconstructive surgeries, procedures, and services that do not meet at least one of the above criteria are not covered under any portion of this Benefit Program.

In addition to the above criteria, benefits are available for certain reconstructive surgery, procedures or services subject to Anthem Medical Policy coverage criteria. Some examples of reconstructive surgeries, procedures and services eligible for consideration based on Anthem Medical Policy coverage criteria are:

1. Mastectomy for Gynecomastia;
2. Mandibular/Maxillary orthognathic surgery;
3. Adjustable Band for Treatment of Non-synostotic plagiocephaly and Brachycephaly in infants and
4. Port Wine Stain surgery.

Breast Reconstruction Surgery Benefits and the Women's Health and Cancer Rights Act of 1998

If you are receiving covered benefits for a mastectomy, you should know that the Women's Health and Cancer Rights Act of 1998 provides for:

- reconstruction of the breast(s) on which a covered mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- prostheses and treatment of physical complications related to all stages of a covered mastectomy, including lymphedema (swelling). Prior authorization is not applicable to such prostheses.

The manner in which services are provided is between you and your physician. Coverage is subject to all of the terms and conditions stated in this Summary Booklet, including any applicable deductible, co-payment and coinsurance. You may be entitled to additional benefits as mandated by state law. Contact Member Services at the number located on the back of your Identification Card for additional information.

Removal of breast implants

For breast implants which were surgically implanted as a result of a mastectomy; benefits for Covered Services for the Medically Necessary removal of such implants due to a medical complication of a mastectomy will be covered the same as any other illness or injury. As to all other breast implants; benefits for Covered Services for the Medically Necessary removal of any breast implant without regard to the reason for implantation, will be provided for at least $1,000 per Member per Calendar YearPlan Year.

Walk-In Center Services

Office visit for services limited to routine care and treatment of common illnesses for adults and children. You do not have to be an existing patient or have an appointment to use a walk-in Doctor's office.

Retail Health Clinic Visit

When available in your area, your coverage will include Retail Health Clinic Visits. Visits for limited basic health care services to Members on a "walk-in" basis will be provided. These clinics are normally found in major pharmacies or retail stores. Health care services are typically given by Physician's Assistants or Nurse Practitioners. Services are limited to routine care and treatment of common illnesses for adults and children.

Online Visits

When available in your area, your coverage will include online visit services. Covered Services include a medical visit with a Doctor using the internet by a webcam, chat or voice. See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment and benefit limitation information.

Online visits do not include:

- Reporting normal lab or other test results,
- requesting office visits ,
- getting answers to billing, insurance coverage or payment questions,
- asking for referrals to doctors outside the online care panel,
- Benefit prior authorization,
- Physician to Physician consultation, or
- Doctor to Doctor discussions.

Notes:

Please refer to the Schedule of Benefits for the appropriate Cost-Shares.

Anthem BCBS will pay for the services of only one Physician in a given specialty if the surgery reasonably could be expected to be performed by one Physician.

Services of surgical assistants are payable as a surgery benefit based on approved surgical assistant procedures when a Hospital or ambulatory surgical facility does not provide surgical assistants through a residential or surgical assistant program.

Covered Services do not include:

Initial medical care for scheduled Admissions for surgery. This means the first non-surgical services rendered to a Member as an Inpatient by the attending Physician.

Separate charges for pre and post-operative care.

Please refer to the Exclusions and Limitations Section of this Summary Booklet for other services not covered under this Benefit Program.

PRESCRIPTION DRUG

This Summary Booklet Covers:

Prescription Drugs dispensed by a Pharmacy.

The maximum supply of a drug for which benefits will be provided when dispensed under any one prescription is a 31-day supply or 100 unit dose, whichever is greater, except for insulin for which the maximum per prescription is 4 vials.

Diabetic equipment, drugs and supplies.
Prescription drugs prescribed by a licensed Physician, advanced practice registered nurse, or licensed physician assistant for the treatment of symptoms and comorbidities of Autism Spectrum Disorders.

Notes:

If a Prescription Drug Rider has been added to this Summary Booklet, the Maximum Allowable Amount for drug benefits will be paid under this Summary Booklet after the Rider's benefits have been exhausted.

Anthem BCBS has the right to deny benefits for any Prescription Drug that in its judgment is not prescribed or dispensed in a manner consistent with normal medical practice.

Covered Services do not include:

Prescription Drugs which are not required for the treatment or prevention of an illness or injury.

Antibacterial soaps, detergents, shampoos, toothpaste/gels, and mouthwashes/rinses.

Parenteral nutritional products.

Prescription Drugs dispensed in a Hospital, clinic, Skilled Nursing Facility, nursing home or other institution.

A contraceptive or contraceptive device that has not been approved by the Federal Food and Drug Administration, and is not prescribed by a licensed Physician.

Please refer to the Exclusions and Limitations Section of this Summary Booklet for other services not covered under this Benefit Program.

PREVENTIVE SERVICES

This Summary Booklet Covers:

Screenings and other services are generally covered as preventive care for adults and children with no current symptoms or prior history of a medical condition associated with that screening or service. Covered Persons who have current symptoms or have been diagnosed with a medical condition are not considered to require Preventive Care for that condition but instead benefits will be considered under the diagnostic services benefit.

Coverage for hearing examinations that includes screening to determine the Medical Necessity for hearing correction when performed by a Participating Physician or Non-Participating Physician certified as an otolaryngologist or a legally qualified audiologist holding a Certificate of Clinical Competence in Audiology from the American Speech and Hearing Association in the absence of any applicable licensing requirements.

Notes:

Please refer to the Schedule of Benefits for the appropriate Cost-Shares.

Covered Services do not include:

Please refer to the Exclusions and Limitations Section of this Summary Booklet for other services not covered under this Benefit Program.

PRIVATE DUTY NURSING

This Summary Booklet Covers:

Private Duty Nursing Services.

Limited to Calendar Year maximum as shown in the Schedule of Benefits.

Notes:

Please refer to the Schedule of Benefits for the appropriate Cost-Shares.

Covered Services do not include:

Private duty nursing care services for the convenience of the Covered Person or while the Covered Person is an Inpatient in a Hospital or Skilled Nursing Facility.

Care primarily to provide room and board (with or without routine nursing care), training in personal hygiene, and other forms of self-care.

Please refer to the Exclusions and Limitations Section of this Summary Booklet for other services not covered under this Benefit Program.

SKILLED NURSING FACILITIES

This Summary Booklet Covers:

Coverage includes:

1. Skilled nursing care;
2. Rehabilitative and related services; and
3. Semiprivate room and board.

Notes:

Please refer to the Schedule of Benefits for the appropriate Cost-Shares.

Prior Authorization is required. Please refer to the Managed Benefits Section of this Summary Booklet for how to obtain Prior Authorization.

The Hospital Inpatient/Inpatient Facility Coinsurance amount is not subject to Cost-Share Maximums.

Covered Services do not include:

Please refer to the Exclusions and Limitations Section of this Summary Booklet for other services not covered under this Benefit Program.

Room and board charges exceeding the Skilled Nursing Facility's most common semi-private rate shall be excluded.

THERAPY SERVICES

This Summary Booklet Covers:

Outpatient Rehabilitation

Outpatient physical, occupational, speech and chiropractic therapy;

Outpatient cardiac rehabilitation therapy;

Other Therapy Services

Radiation therapy;

Chemotherapy for the treatment of cancer;

Electroshock Therapy;

Kidney Dialysis in a Hospital or free-standing dialysis center;

Infusion Therapy – Benefit will be provided for Outpatient Hospital; Physician office, ambulatory infusion suite or home Infusion Therapy regimens under the following conditions:

1. A plan of care for such services is prescribed in writing by a Physician (M.D.);

2. The plan of care is reviewed and recertified by the Physician (M.D.);

3. Infusion Therapy is limited to:

    a. Chemotherapy (including gamma globulin);
    b. intravenous antibiotic therapy;
    c. total parenteral nutrition;
    d. enteral therapy when nutrients are only available by a Physician's prescription;
    e. intravenous pain management;

4. Covered Services will include supplies, solutions, and pharmaceuticals and nursing.

Notes:

Please refer to the Schedule of Benefits for the appropriate Cost-Shares.

Speech therapy is a Covered Service when prescribed by a Physician (M.D.) and provided by a licensed speech pathologist.

Whether Infusion Therapy is provided in an: ambulatory infusion suite; or Physician office, Outpatient Hospital program; or a combined Outpatient Hospital; and home program covered under this Policy; the benefits will not be more than the amount shown on the Schedule of Benefits.

Infusion Therapy benefits, covered under this Policy will not exceed the amount shown on the Schedule of Benefits.

Coinsurance amounts for Out-of-Network Providers for infusion therapy do not accrue toward the Cost-Share Maximum.

Covered Services do not include:

Please refer to the Exclusions and Limitations Section of this Summary Booklet for other services not covered under this Benefit Program.

URGENT CARE SERVICES

This Summary Booklet Covers:

Urgent Care services received at a designated Urgent Care Facility or provided by a Participating Physician.

Notes:

Please refer to the Schedule of Benefits for the appropriate Cost-Shares.

Urgent Care Services are only available in Connecticut. Please refer to the BlueCard PPO program section of this Summary Booklet for obtaining emergency services out of Connecticut by utilizing the BlueCard Program.

Urgent Care services will be covered only if the Covered Person's signs and symptoms at the time of treatment are such that Urgent Care services are Medically Necessary as determined by Anthem BCBS.

Covered Services do not include:

Please refer to the Exclusions and Limitations Section of this Summary Booklet for other services not covered under this Benefit Program.

EXCLUSIONS AND LIMITATIONS

In addition to the other limitations, conditions and exclusions set forth elsewhere in this Summary Booklet, 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 Summary Booklet. 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 BCBS 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 Summary Booklet.

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

1. Benefits for services which are not:
    a. specifically described in the Summary Booklet
    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 Covered Person.
2. Benefits may be reduced or denied subject to the Managed Benefits – Managed Care Guidelines. Any reduced or denied benefits paid by the Covered Person do not apply toward the Cost Share Maximums shown in the Schedule of Benefits.
3. Any reduction in benefits, including but not limited to Penalties, imposed by another Plan, which are similar to those stated in the Managed Benefits – Managed Care Guidelines, are not reimbursable as a Covered Service.
4. Benefits for services rendered before the Covered Person's Effective Date under this Benefit Program.
5. 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.
6. Care for conditions which are required by State or Local law to be treated in a public facility.
7. Services and care in a Veteran's Hospital or any Federal Hospital, except as may be otherwise required by law.
8. Services covered in whole or in part by public or private grants.
9. Services required by third parties, including but not limited to: school, employment, summer camp and premarital physicals and related tests.
10. Studies related to pregnancy except for significant medical reasons.
11. Simplified or self-administered tests and multiphasic screening.
12. Cosmetic surgeries, procedures and services performed primarily to improve appearance and not otherwise determined by Anthem BCBS to meet the coverage criteria for reconstructive surgeries, procedures and services set forth in this Summary Booklet.
13. 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 Benefit Program.

14. Sperm collection and preservation, all services related to surrogate parenting arrangements and preparatory treatment.
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 BCBS will not provide benefits unless otherwise provided for by an Amendatory Rider to this Benefit Program.
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. Including without limitation, Methadone and Suboxone maintenance or any other similar maintenance therapy program and its related testing, supplies, visits and treatment.
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 Covered Person's room and board when the Covered Person has a leave of absence from the Hospital, Substance Abuse Treatment Facility or other Inpatient Facility.
20. Evaluation, treatment, procedures and Prescription Drugs related to and performance of sex-change operations including follow-up treatment, care and counseling.
21. Vaccines other than routine immunizations or those needed for travel.
22. 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.
23. 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.
24. 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.
25. 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.
26. Services which the Covered Person or Anthem BCBS is not legally required to pay.
27. Wigs, except as noted in the Covered Services section.
28. Inpatient services which can be properly rendered as Outpatient services.
29. Disease contracted or injuries resulting from war.
30. Charges after the Provider's or Hospital's regular discharge hour on the day indicated for the Covered Person's discharge by his/her Physician.
31. Charges in excess of the Maximum Allowable Amount.
32. Eyeglasses and contact lenses.
33. Supervisory care by a Physician for a Covered Person 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.

34. Travel, whether or not recommended by a Physician.
35. Certain pulmonary function tests which in the opinion of Anthem BCBS do not meet the definition of a covered diagnostic laboratory test.
36. Services or procedures rendered without regard for specific clinical indications, routinely for groups or individuals or which are performed solely for research purposes.
37. Services or procedures which have become obsolete or are no longer medically justified as determined by appropriate medical specialties.
38. Radiation therapy as a treatment for acne vulgaris.
39. Services rendered by a Physician in the employ of a Home (e.g. Skilled Nursing Facility) do not qualify as Home & Office Care.
40. 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.

RIGHT OF RECOVERY

To the extent permissible by law, Anthem BCBS shall have a right of recovery against third parties for benefits for Covered Services provided under the terms of this Benefit Program, where the Covered Person has a right of recovery against third parties for the cost of Covered Services. Acceptance of Covered Services will constitute consent by the Covered Person to Anthem BCBS's right of recovery. The Covered Person agrees to take all further action to execute and deliver such additional instruments and to take such other action as Anthem BCBS shall require to implement this provision. Anthem BCBS will have the right to bring suit against such third party in the name of the Covered Person and in its own name as subrogee. The Covered Person shall do nothing to prejudice the rights given to Anthem BCBS by this provision without its consent.

If a Covered Person received payment from a third party by suit or settlement for the cost of Covered Services, such Covered Person is obligated to reimburse Anthem BCBS less Anthem BCBS's pro rata share of the reasonable attorney's fees and cost the Covered Person sustained in obtaining the recovery.

We have established recovery policies to determine which recoveries are to be pursued, when to incur costs and expenses and settle or compromise recovery amounts. We will not pursue recoveries for overpayments if the cost of collection exceeds the overpayment amount. We may not provide you with notice of overpayments made by Us or you if the recovery method makes providing such notice administratively burdensome.

WORKERS' COMPENSATION

To the extent permissible by law no benefits shall be provided for Covered Services paid, payable or eligible for coverage under any Workers' Compensation Law, employer's liability or occupational disease law, denied under a managed Workers' Compensation program as Out-of-Network services or which, by law, were rendered without expense to the Covered Person.

Anthem BCBS shall be entitled to the following:

1. To charge the entity obligated under such law for the dollar value of those benefits to which the Covered Person is entitled.

2. To charge the Covered Person for such dollar value, to the extent that the Covered Person has been paid for the Covered Services.

3. To reduce any sum owing to the Covered Person by the amount that the Covered Person has received payment.

4. To place a lien on any sum owing to the Covered Person for the amount Anthem BCBS has paid for Covered Services rendered to the Covered Person, in the event that there is a disputed and/or controverted claim between the Covered Person's Employer Group and the designated Workers' Compensation insurer as to whether or not the Covered Person is entitled to receive Workers' Compensation benefits payments.

5. To recover any such sum owing as described above, in the event that the disputed and/or controverted claim is resolved by monetary settlement to the full extent of such settlement.

6. If a Covered Person is entitled to benefits under Workers' Compensation, employer's liability or occupational disease law, it is necessary to follow all of the guidelines in the Managed Benefits Section in order for this Benefit Program to continue to provide benefits for Covered Services when the Workers' Compensation benefits are exhausted.

AUTOMOBILE INSURANCE

To the extent permissible by law, benefits shall not be provided by this Benefit Program for Covered Services paid, payable or required to be provided as basic reparations benefits under any no-fault or other automobile insurance policy.

Anthem BCBS shall be entitled:

- To charge the insurer obligated under such law for the dollar value of those benefits to which a Covered Person is entitled;

- To charge the Covered Person for such dollar value, to the extent that the Covered Person has received payment from any and all sources, including but not limited to, first party payment.

- To reduce any sum owing to the Covered Person by the amount that the Covered Person has received payment from any and all sources, including but not limited to, first party payment.

- Benefits shall be subject to Coordination of Benefits as described in the Coordination of Benefits Section of this Summary Booklet, for Covered Services a Covered Person receives under an automobile insurance policy which provides benefits without regard to fault.

- A Covered Person who fails to secure no-fault insurance required by applicable law shall be deemed to be his or her own insurer and Anthem BCBS shall reduce his or her benefits for Covered Services by the amount of basic reparations benefits or other benefits provided for injury if such a no-fault policy had been obtained.

- If a Covered Person is entitled to benefits under a no-fault or other automobile insurance policy, benefits for Covered Services will only be provided when a Covered Person follows all of the guidelines stated in the Managed Benefits Section of the Summary Booklet. It is necessary to follow all the guidelines in the Managed Benefits Section in order for Anthem BCBS to continue to provide benefits for Covered Services when the no-fault or other automobile insurance policy benefits are exhausted.

COORDINATION OF BENEFITS

All benefits provided under this Benefit Program are subject to the Coordination of Benefits provision as described in this Section.

Applicability

1. The Coordination of Benefits (COB) provision applies to this Benefit Program when a Covered Person has health care coverage under more than one Plan as defined below.

2. If the Covered Person is covered by this Benefit Program and another Plan; the Order of Benefit Determination Rules in this Section shall decide which Plan is the Primary Plan. The benefits of this Plan:

   a. Shall not be reduced when under the Order of Benefit Determination Rules this Benefit Program is the Primary Plan; but

   b. May be reduced or the reasonable cash value of any Covered Service may be recovered from the Primary Plan when under the Order of Benefit Determination Rules another Plan is the Primary Plan. The above reduction is described in the Effect Of This Benefit Program On The Benefits Policy Subsection;

   c. Penalties imposed on a Covered Person by the primary carrier are not subject to COB;

   d. The Covered Person must submit the explanation of benefits from the Primary Plan to Anthem BCBS within two years of the date of service; in order to be eligible for payment under this Coordination of Benefits Section.

Definitions

In addition to the defined terms listed in the Definitions Section of this Benefit Program, the following also apply to this Coordination of Benefits Section.

ALLOWABLE EXPENSE: The term Allowable Expense means a Medically Necessary Allowable Expense, for an item of expense for health care, when the item of expense, including any Copayment amounts, is covered at least in part by one or more Plans covering the Covered Person for whom the claim is made. Allowable Expense does not include coverage for: dental care; vision care; Prescription Drugs; or hearing aid programs. When this Benefit Program provides Covered Services, the reasonable cash value of each Covered Service is the Allowable Expense; and is a benefit paid.

The difference between the cost of a private Hospital room and the cost of a semi-private Hospital room is not considered an Allowable Expense under the above definition; unless the patient's stay in a private Hospital room is Medically Necessary.

CLAIM DETERMINATION PERIOD: The term Claim Determination Period means a Calendar Year. However, it does not include any part of a Calendar Year during which a person has no coverage under this Benefit Program; or any part of a Calendar Year before the date this COB provision or a like provision takes effect.

PLAN: For the purpose of this Section, the term Plan means any of the following which provides benefits or services for, or because of, medical care or treatment:

a. Group health insurance; group-type coverage; whether fully insured or self-insured, or any other contract or arrangement where a health benefit is provided. This includes prepayment; staff or group practice association health maintenance organization coverage.

b. Coverage under a governmental Plan or required or provided by law. This does not include: a state Plan under Medicaid (Title XIX; Grants to States for Medical Assistance Programs; or the United States Social Security Act as amended from time to time). It also does not include any Plan when, by law, its benefits are more than those of any private insurance program or other non-governmental program.

c. Medical benefits coverage of: no-fault and traditional automobile fault contracts, as provided in this Section.

Each contract; or other arrangement for coverage under: (a); (b); or (c) is a separate Plan. Also, if an arrangement has two parts; and COB rules apply only to one of the two; each of the parts is a separate Plan.

PRIMARY PLAN: The term Primary Plan means a Plan whose benefits for a person's health care coverage must be determined without taking the existence of any other plan into consideration. A Plan is a Primary Plan if either a or b below is true:

a. The Plan either has no Order of Benefit Determination rules; or it has rules which differ from those stated in this Section; or

b. All Plans which cover the person use the Order of Benefit Determination rules as shown in this Section; and under those rules the Plan decides its benefits first. There may be more than one Primary Plan (for example: two Plans which have no Order of Benefit Determination rules).

When this Benefit Program is the Primary Plan, Covered Services are provided or covered without considering the other Plan's benefits.

SECONDARY PLAN: The term Secondary Plan means a Plan which is not a Primary Plan. If a person is covered by more than one Secondary Plan, the Order of Benefit Determination rules of this Section decide the order in which the benefits are determined in relation to each other. The benefits of the Secondary Plan may take into account the benefits of the Primary Plan or Plans and the benefits of any other Plan which, under the rules of this Section, has its benefits determined before those of the Secondary Plan.

When this Benefit Program is the Secondary Plan, benefits for Covered Services under the Benefit Program may be reduced and Anthem BCBS may recover from the: Primary Plan; the Provider of Covered Services, or the Covered Person, the reasonable cash value of the Covered Services provided by this Benefit Program.

Order Of Benefit Determination Rules

1. General Rule

   When a Covered Person receives Covered Services by or through this Benefit Program or is otherwise entitled to claim benefits under this Benefit Program; and has followed all Anthem BCBS guidelines and procedures; including: Prior Authorization requirements as shown in this Benefit Program; and the Covered Services are a basis for a claim under another Plan; this Benefit Program is a Secondary Plan which has its benefits determined after those of the other Plan, unless:

   a. The other Plan has rules coordinating its benefits with those described in the Summary Booklet; and
   b. Both the other Plan's rules; and this Benefit Program's coordination rules; as described below, require that this Benefit Program's benefits be determined before those of the other Plan.

2. Coordination Rules:

   Anthem BCBS decides its order of benefits using the following rules:

a. Other than a Dependent

The benefits of the Plan which covers the person as a Covered Person (that is, other than as a Dependent) are primary to those of the Plan which covers the person as a Dependent.

b. Dependent Child/Parents Not Separated or Divorced:

When this Benefit Program and another Plan cover the same child as a Dependent of different persons, called "parents", the Plan of the parent whose birthday falls earlier in a year is primary to the Plan of the parent whose birthday falls later in that year; but if both parents have the same birthday; the Plan which covered a parent longer is primary. Only the month and day of the birthday are considered.

c. Dependent Child/Separated or Divorced Parents:

In the case of a Covered Person for whom claim is made as a Dependent child:

i. When the parents are separated or divorced; and the parent with legal custody of the child has not remarried; the benefits of a Plan which covers the child as a Dependent of the parent with legal custody of the child shall be determined before the benefits of a Plan which covers the child as a Dependent of the parent without legal custody;

ii. When the parents are divorced; and the parent with legal custody of the child has remarried; the benefits of a Plan which covers the child as a Dependent of the parent with custody shall be determined before the benefits of a Plan which covers that child as a Dependent of the step-parent; and

The benefit of a Plan which covers that child as a Dependent of the step-parent shall be determined before the benefits of a Plan which covers that child as a Dependent of the parent without legal custody.

If the terms of a court order state that one of the parents is financially responsible for the health care expenses of the child; then the Plan which covers the child as a Dependent of the financially responsible parent shall be determined before the benefits of any other Plan which covers the child as a Dependent child. The provisions of this Subsection do not apply with respect to any Claim Determination Period or Plan year during which any benefits are actually paid or provided before the payor has that actual knowledge.

d. Active/Inactive Employee

A Plan which covers a person as an employee who is neither: laid off; nor retired (or as that employee's Dependent) is primary to a Plan which covers that person as a: laid-off; or retired employee (or as that employee's Dependent). If the other Plan does not have this rule; and if, as a result, the Plans do not agree on the order of benefits; this rule (d) is ignored.

e. Longer/Shorter Length of Coverage

If none of the above rules decides the order of benefits; the Plan which covered a Covered Person longer is primary to the Plan which covered that person for the shorter time.

f. Medicare

If a Covered Person is eligible for Medicare; and still covered under this Benefit Program; Anthem BCBS will provide the benefits of this Benefit Program; except as obliged by law. However, these benefits will be reduced to an amount which; when added to the benefits received pursuant to Medicare; may equal; but not be more than the actual charges for services covered in whole; or in part by either this Benefit Program; or Parts A and B of Medicare.

(Note: Certain services may not require Prior Authorization when it is determined that Anthem BCBS is the Secondary Plan. Contact Customer Service before any services are rendered to determine if such services require Prior Authorization. In the event that a later determination finds that Anthem BCBS is the Primary Plan, any services that were obtained without Prior Authorization while Anthem BCBS was administering benefits as a Secondary Plan will not require Prior Authorization as would be required under a Primary Plan.)

Effect Of This Benefit Program On The Benefits

1. This Subsection applies when; in accordance with the Order of Benefit Determination Rules; this Benefit Program is a Secondary Plan as to one or more other Plans. In that event, the benefits of this Benefit Program may be reduced under this Subsection. Such other Plan or Plans are referred to as "the other Plans."

2. Reduction in this Benefit Program's benefits. When the Benefit Program is the Secondary Plan; Anthem BCBS will provide benefits under the Benefit Program; so that the sum of the reasonable cash value of any Covered Service provided by the Benefit Program; and the benefits payable under the other Plans shall not total more than the Allowable Expense. Benefits will be provided by the Secondary Plan at the lesser of: the amount that would have been paid had it been the Primary Plan or the balance of the bill. Anthem BCBS shall never pay more than it would have paid as the Primary Plan.

If another Plan provides that its benefits are "excess;" or "always secondary;" and if this Benefit Program is determined to be secondary under this Benefit Program's COB provisions; the amount of benefits paid under this Benefit Program shall be determined on the basis of this Benefit Program being secondary.

Right To Receive And Release Needed Information

Certain data is needed to apply these COB rules. Anthem BCBS has the right to decide which data it needs. By enrolling in the Benefit Program; the Covered Person allows the release of data needed to apply the COB rules. Any Covered Person claiming benefits under this Benefit Program must give data to Anthem BCBS; which Anthem BCBS decides is necessary for the coordination of benefits.

Facility Of Payment

A payment made; or a service provided under another Plan may include: an amount which should have been paid; or provided under this Benefit Program. If it does, Anthem BCBS may pay that amount to the group which made that payment. Such amount shall then be considered as though it were a benefit paid under this Benefit Program.

Right Of Recovery

If the amount of the payments made by Anthem BCBS is more than it should have paid under this COB provision; or if it has provided services which should have been paid by the Primary Plan; Anthem BCBS may recover the excess or the reasonable cash value of the Covered Services; from one or more of the persons it has paid; or for whom it has paid insurance companies, or other groups.

The right of Anthem BCBS to recover from a Covered Person shall be limited to the Allowable Expense that the Covered Person has received from another Plan. Acceptance of Covered Services will make up consent by the Covered Person to Anthem BCBS's right of recovery. The Covered Person agrees to take all further action to: execute; and deliver such documents as may be needed; and do whatever else is needed to secure Anthem BCBS's rights to recover excess payments. If the Covered Person does not comply; it may result in a withdrawal of benefits already provided; or a denial of benefits requested.

TERMINATION

This Section describes how coverage for a Member can be: cancelled; rescinded; suspended; or not renewed.

Termination of the Covered Person

The Covered Person's enrollment in the Benefit Program shall terminate:

1. The date the Group Contractholder's contract with us terminates;

2. The last day of the month that required charges are paid for your coverage if we do not receive payment when due. Your payment of charges to the Group Contractholder does not guarantee coverage unless we receive full payment when due;

3. The last day of the month you enter military service for duty lasting more than 30 days;

4. At the Covered Person's option during an Employer Group's Open Enrollment Period; and shall be effective as of the renewal date of the Benefit Program;

5. The day following the Covered Person's death. When a Covered Person dies, Dependents shall be terminated the first of the month following the Covered Person's death;

6. The first day of the month following the loss of eligibility due to:

   - Loss of employment with the Employer Group; or
   - a reduction in work hours; or
   - He or she no longer meets the eligibility requirements of the Benefit Program as defined in the Eligibility Section of this Summary Booklet;

7. Following the effective date of the Benefit Program, Anthem BCBS may rescind, cancel or limit the Benefit Program; if the Covered Person has submitted false information to Anthem BCBS, or omitted information during the application and enrollment process concerning eligibility, insurability or health status and such information was material to the underwriting of the application at the time submitted and acceptance by Anthem BCBS of that application for coverage.

   Anthem BCBS may also initiate and conduct a review on a post claim basis to obtain information when the information sought is:

   - in relation to a medical condition not disclosed on the application, or;
   - when the information on the claim or the facts and circumstances of the medical treatment for which a claim is submitted clearly indicate the response or responses to the questions on the application, or the information provided on the application, might be suspect in any way.

   The Benefit Program may not be rescinded, cancelled or limited more than 2 years after the effective date of the policy. The date of rescission shall be the Effective Date of the Benefit Program.

8. When a Member ceases to be a Covered Person or Dependent, or the required contribution, if any, is not paid, the Member's coverage will terminate at the end of the last day for which payment was made;

9. Termination of an enrolled Dependent Spouse's Coverage (as defined in the Eligibility section) will occur as follows:

- On the first day of the month following a divorce or legal separation of the spouse;
- On the first day of the month following when other enrolled Dependent's criteria are no longer met by the spouse;
- Enrollment in the Benefit Program shall be terminated on the day after the death of an enrolled Dependent Spouse.

It is the sole responsibility of the covered employee to notify Anthem BCBS of any changes in the Dependent Spouse's status.

10. Termination of an enrolled Dependent child's coverage (as defined in the Eligibility section) will occur as follows:

    - Coverage shall terminate on the first day of the month following when a enrolled Dependent reaches the limiting age allowed under the Benefit Program, unless the child is physically or mentally handicapped; or
    - Coverage shall terminate on the first day of the month following when a enrolled criteria are no longer met by the child;
    - On the day after the death of an enrolled Dependent child.

    It is the sole responsibility of the covered employee to notify Anthem BCBS of any changes in the Dependent child's status.

11. A Covered Person will cease to be covered under the Benefit Program, on the first day of the month in which he or she attains age 65 and is eligible for Medicare, except as required by law. If a Covered Person is covered by law, he or she will automatically terminate from the Benefit Program on the first day of the month in which such eligibility ceases. The Covered Person who certifies before this termination date that he or she is not enrolled in Part B of Medicare will be reinstated under the Medical/Surgical Section without interruption of membership. Applications are available upon request, but Anthem BCBS is not responsible for notifying the Covered Person of the necessity for applying.

Termination of the Employer Group

1. The Benefit Program may be terminated in accordance with applicable law as follows:

    - At the option of the Employer Group; without cause upon delivery of 15 days prior written notice to the other party, to be effective the first of the month following the end of the 15 day notice period;

    - By Anthem BCBS, at its option; in the event the Employer Group receives 30 days prior written notice from Anthem BCBS of the Employer Group's failure to satisfy any other condition in the Benefit Program or any underwriting requirement adopted by Anthem BCBS. Such termination will go into effect on the first day of the month following such 30 day notice period;

    - Anthem BCBS may not renew the entire contract in the event the Contractholder fails to meet the participation or contributory requirements stated in the Administrative Services Only Agreement.

2. During the first two years following the effective date of the Benefit Program, Anthem BCBS may rescind, cancel, or limit the Benefit Program if Anthem BCBS determines after completing underwriting, there was false, misleading or fraudulent information submitted by or information omitted, during the initial application and enrollment process, and such information was material to the acceptance of the application at the time submitted to Anthem BCBS. Such information may include, but is not limited to, information regarding the eligibility of the Employer Group or any Members to receive coverage under the Benefit Program. The date of rescission shall be the Effective Date of the Benefit Program.

3. The termination, expiration, non-renewals, or cancellation of the Administrative Services Only Agreement by the Contractholder or Anthem BCBS will automatically result in the termination of each Covered Person's or Dependent's right to coverage and benefits under this Administrative Services Agreement.

Consent

No event of termination, expiration, non-renewal, or cancellation of the Benefit Program shall affect the rights and obligations of the parties arising out of any transactions occurring prior to the Effective Date of any such event. The Member hereby acknowledges that the termination, expiration, non-renewal, or cancellation of the contract will automatically result in the termination of the Benefit Program.

Rescission of the Benefit Program by Anthem BCBS will cause the Benefit Program and any other contracts or agreements between Anthem BCBS and the Employer Group to be null and void.

Covered Person Notification

If the Covered Person's Employer Group or Anthem BCBS cancels or discontinues this Benefit Program with respect to the entire group or a class of employees; the Employer Group must send the Covered Person written notice of cancellation or discontinuation of this Benefit Program at least 15 days before the Effective Date of cancellation or discontinuation. Coverage will be terminated regardless of whether the notice was given. Failure to furnish such notice results in the Employer Group's liability for benefits to the same extent to which Anthem BCBS would have been liable if coverage had not been canceled or discontinued.

Certificates of Creditable Coverage

Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA); a Certificate of Coverage must be issued to a Covered Person and his or her covered Dependents who terminate from this Benefit Program. The information included on the Certificate of Creditable Coverage will include: the names of any Members terminating; the date coverage under this Benefit Program ended; and the type of coverage provided under this Benefit Program. This Certificate of Creditable Coverage will provide a subsequent insurer or group Plan with information regarding prior coverage to help in determining any Pre-Existing Condition exclusion period or Affiliation Period. This Certificate of Creditable Coverage should be presented by the Member to his or her next Employer Group; and/or when applying for subsequent group health insurance. A Certificate of Creditable Coverage will be issued to terminating Members 14 days after the date Anthem BCBS is notified of his or her termination. In addition, a terminated Member may request an additional copy of the Certificate of Creditable Coverage by contacting Member Services.

GENERAL PROVISIONS

Benefits To Which Covered Persons Are Entitled

1. Anthem BCBS's sole obligation is to administer on behalf of Employer the benefits specified herein

2. No person other than a Covered Person is entitled to receive benefits under the Benefit Program. All benefits (including payments) due or to become due are personal to the Covered Person and are not assignable or transferable by the Covered Person to any other person.

3. Benefits for Covered Services specified herein will be provided only for services and supplies that are rendered by a Physician, Provider or Hospital and regularly included in such Physician's, Provider's or Hospital's charges.

Disclosure

The Covered Person hereby expressly acknowledges its understanding that the Agreement constitutes a contract solely between the Employer Group and Anthem Blue Cross and Blue Shield, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans ("the Association") permitting Anthem BCBS to use the Blue Cross and Blue Shield service marks in the State of Connecticut, and that Anthem BCBS is not contracting as an agent of the Association. The Covered Person further acknowledges and agrees that he or she has not enrolled under this agreement based upon representations by any person other than the Employer Group or Licensee and that no person, entity or organization other than the Employer Group or Licensee shall be held accountable or liable to the Covered Person for any of the Employer Group or Licensee's obligations to the Covered Person created under the Agreement. This paragraph shall not create any additional obligations whatsoever on the part of the Employer Group or Licensee other than those obligations created under other provisions of this Summary Booklet.

Authority for Discretionary Decisions

Anthem BCBS, or anyone acting on its behalf, shall determine the administration of benefits and eligibility for participation in such a manner that has a rational relationship to the terms set forth herein. However, Anthem BCBS, or anyone acting on its behalf, has complete discretion to determine the administration of the Covered Person's benefits. Anthem BCBS's determination shall be final and conclusive and may include, without limitations, determination of whether the services, care, treatment, or supplies are Medically Necessary, Investigational/Experimental-Investigative, whether surgery is cosmetic, and whether charges are consistent with its Maximum Allowable Amount. However, a Covered Person may utilize all applicable Member Appeals procedures.

Anthem BCBS, or anyone acting on Our behalf, shall have all the powers necessary or appropriate to enable it to carry out its duties in connection with the operation and administration of the Summary Booklet. This includes, without limitation, the power to construe the Contract, to determine all questions arising under the Summary Booklet and to make, establish and amend the rules, regulations and procedures with regard to the interpretation and administration of the provisions of this Summary Booklet. However, these powers shall be exercised in such a manner that has reasonable relationship to the provisions of the Summary Booklet, Provider agreements, and applicable state or federal laws. A specific limitation or exclusion will override more general benefit language.

Records of Covered Person Eligibility and Changes in Covered Person Eligibility

Clerical errors or reasonable delays in recording or reporting dates will not invalidate coverage which would otherwise be in force or continue coverage which would otherwise terminate.

Notice of Claim

1. Anthem BCBS will not be obligated to process on behalf of the Employer any claim for benefits for Covered Services under the Benefit Program unless proper notice is furnished to Anthem BCBS that Covered Services have been rendered to a Covered Person. Written notice must be given within 60 days after completion of the Covered Services. The notice must include the data necessary for Anthem BCBS to determine benefits. An expense will be considered incurred on the date the service or supply was received.

2. Failure to give notice to Anthem BCBS within the time specified will not reduce any benefit if it is shown that the notice was given as soon as reasonably possible, but in no event will Anthem BCBS be required to accept notice more than two years after Covered Services are received.

Information Practices Notice

The purpose of this Information Practices notice is to provide a notice to Covered Persons regarding Anthem BCBS's standards for the collection, use, and disclosure of information gathered in connection with Anthem BCBS's business activities.

- Anthem BCBS may collect personal information about a Covered Person from persons or entities other than the Covered Person.

- Anthem BCBS may disclose Covered Person information to persons or entities outside of Anthem BCBS without Covered Person authorization in certain circumstances.

- A Covered Person has a right of access and correction with respect to all personal information collected by Anthem BCBS.

- A more detailed notice will be furnished to you upon request.

Limitation of Actions

No legal action may be taken to recover benefits within 60 days after Notice of Claim has been given as specified above. No legal proceeding may be brought under the Benefit Program after a two-year period from the date services are received.

Payment of Benefits

1. Anthem BCBS is authorized to make payments on behalf of the Employer directly to Physicians, Providers or Hospitals furnishing Covered Services for which benefits are provided under the Benefit Program. However, except as otherwise provided for in any Physician, Provider or Hospital agreement, Anthem BCBS reserves the right to make payments on behalf of the Employer directly to the Covered Person or the Covered Person's Dependents at Anthem BCBS's discretion. In the absence of a participating agreement, and one parent or custodian who has custody of a minor child Dependent, Anthem BCBS will make payments on behalf of the Employer to that custodial parent or custodian.

2. Once Covered Services are rendered by a Physician, Provider or Hospital, Anthem BCBS will reject the Covered Person's request not to pay the claims submitted by the Physician, Provider or Hospital. Anthem BCBS will have no liability to any person because of its rejection of the request.

3. The Covered Person must advise the Physician, Provider or Hospital that he or she is covered under the Benefit Program when arrangements for services are made or as soon as reasonably possible thereafter.

4. Anthem BCBS will not routinely issue a benefit payment on behalf of the Employer under the Benefit Program of less than $1.00 except upon a written request from the Covered Person.

5. Claims for benefits for Covered Services provided to a Covered Person will be processed within thirty (30) days of the date the claim is received by Anthem BCBS. If a claim decision cannot be made within the 30-day period, an extension of up to fifteen (15) days may be requested. Before the end of the initial thirty (30)-day period, Anthem BCBS will send the Covered Person written notice of the reason(s) for the delay.

   If the time to process a health claim is extended because the Covered Person has not submitted requested information, the time period requirements for claim processing will be tolled from the date the notice of requested information is sent to the Covered Person until the date Anthem BCBS receives the Covered Person's response. Anthem BCBS will make a claim decision within fifteen (15) days after receipt of the requested information. Covered Persons should submit the requested information within forty-five (45) days of receipt of the request.

6. When Anthem BCBS has made payments for Covered Services either in error or in excess of the maximum amount of payment necessary to satisfy the provisions of this Benefit Program, Anthem BCBS has the right to recover these payments from one or more of the following as may be appropriate. Anthem BCBS will not attempt to recover from any Covered Person or Provider, overpayments not made to or held by such Covered Person or Provider. Overpayments may be recovered from:

   - Any person to or for whom such payments were made;
   - Any insurance companies, or
   - Any other organizations.

   Anthem BCBS's right to recover may include subtracting from future benefits payments the amount Anthem BCBS has paid in error or in excess. The Covered Person personally and on behalf of his or her Dependents will, upon request, execute and deliver such documents as may be required and do whatever is necessary to secure Anthem BCBS's right to recover any erroneous or excess payments.

   Under BlueCard, recoveries made from a Blue Cross and/or Blue Shield plan in the BlueCard program or from participating providers of a Blue Cross and/or Blue Shield plan in the BlueCard program can arise in several ways, including, but not limited to, anti-fraud and abuse audits, Provider/Hospital audits, credit balance audits, utilization review refunds, and unsolicited refunds. In some cases, the Blue Cross and/or Blue Shield plan will engage third parties to assist in discovery or collection of recovery amounts. The fees of such a third party are netted against the recovery. Recovery amounts, net of fees, if any, will be applied in accordance with applicable BlueCard policies, which generally require correction on a claim-by-claim or prospective basis.

Claim Denials

If benefits are denied, in whole or in part, Anthem BCBS will send the Covered Person a written notice within the established time periods described in the section Payment of Benefits. The Covered Person or the Covered Person's duly authorized representative may appeal the denial as described in the Covered Person Appeal Process. The adverse determination notice will include the reason(s) for the denial, reference to the Plan provision(s) on which the denial is based, whether additional information is needed to process the claim and why the information is needed, the claim appeal procedures and time limits, and if applicable, the Covered Person's right to bring civil action under ERISA 502(a).

If the denial involves a utilization review determination, the notice will also specify:

a. whether an internal rule, guideline, protocol or other criterion was relied upon in making the claim decision and that this information is available to the Covered Person upon request and at no charge;
b. that an explanation of the scientific or clinical judgment for a decision based on Medical Necessity, Experimental or Investigational treatment or similar limitation is available to the Covered Person upon request and at no charge.

Covered Person/Physician/Provider/Hospital Relationship

1. The choice of a Physician, Provider or Hospital network is solely the Employer's.

2. The choice of a Physician, Provider or Hospital is solely the Covered Person's.

3. Anthem BCBS does not furnish Covered Services but only provides benefits on behalf of the Employer for Covered Services received by Covered Persons. Anthem BCBS is not liable for any act or omission of any Physician, Provider or Hospital. Anthem BCBS administers the Benefit Program for the Employer and has no responsibility for a Physician's, Provider's or Hospital's failure or refusal to render Covered Services to a Covered Person.

4. The use or non-use of an adjective such as "Participating" or "Non-Participating" in modifying the term Physician, Provider or Hospital is not a statement as to the ability of the Physician, Provider or Hospital.

5. Anthem BCBS does not make medical judgments. Anthem BCBS only administers the benefits available under the Benefit Program on behalf of the Employer.

6. Anthem BCBS's sole obligation is to administer the Benefit Program in accordance with the agreement between Anthem BCBS and the Employer. No action at law based upon or arising out of the Provider-patient relationship will be maintained against Anthem BCBS.

Agency Relationships

The Employer is the agent of the Covered Person, not Anthem BCBS.

Time Periods

When the time of day is important for benefits or determining when coverage starts and ends, a day begins at 12:01 a.m. and ends at 12:00 a.m. eastern standard time.

GRIEVANCE AND EXTERNAL REVIEW PROCESS

You may have questions about your Health benefit plan. Since questions can often be handled informally, these questions may be addressed by contacting Member Services / Customer Service, please call the number on the back of your Identification Card. In addition, information about the following the Grievance and External Review Procedures, also known as the Appeal Process, may be obtained by contacting Member Services/Customer Service.

We reserve the right to modify the policies, procedures and timeframes in this section upon further clarification from the Department of Health and Human Services and Department of Labor.

Rights Available to Members

If you don't agree with our adverse determination you have the right to ask for a grievance. You must ask for a grievance within 180 calendar days from the date you were notified of our adverse determination. You, your provider, or any other person you choose, may ask for a grievance on your behalf. They may also help you during the grievance process. If you ask someone to represent or help you, please give them a signed authorization to include with the grievance.

Whether or not you use the grievance rights available to you, you may contact the Consumer Affairs Unit of the Connecticut Insurance Department or the Connecticut Office of the Health Care Advocate at any time. You may contact the Consumer Affairs Unit of the Connecticut Insurance Department at the following address: P.O. Box 816, Hartford, CT 06142-0816. You may also reach them by phone locally at 860-297-3900, toll free at 800-203-3447 or by e-mail at cid.ca@ct.gov. You may contact the Connecticut Office of the Health Care Advocate at the following address: P.O. Box 1543, Hartford, CT 06144. You may also reach them by phone at 866-466-4446 or by e-mail at Healthcare.advocate@ct.gov.

How do I ask for a standard grievance?

You may ask for a grievance for services you have not had (prospective or pre-service), for services you are receiving (concurrent) or for services you have received (retrospective or post-service). You may also ask for a grievance about a rescission of coverage. You must ask for a standard grievance by writing to the following address:

Grievances and Appeals
P.O. Box 1038
North Haven, CT 06473-4201

Grievances of medical necessity determinations are resolved within 30 calendar days from the date we receive the request. Grievances not based on medical necessity are resolved within 20 business days from the date we receive the request. We'll respond to all grievances in writing.

How do I ask for an expedited grievance?

If you have not yet had services, or if you are now receiving services, a grievance may be handled in an expedited manner if you, or your provider, believe that the condition:

- could seriously jeopardize your life, health, or ability to regain maximum function; or
- would subject you to severe pain that cannot be adequately managed without care or treatment by waiting for the grievance to be resolved using standard grievance time frames.

To ask for an expedited grievance, you, your provider or your authorized representative can call Member Services / Customer Service at the phone number on your health plan identification card. A written request may also be sent to the following address:

Grievances and Appeals
P.O. Box 1038
North Haven, CT 06473-4201

We'll respond to expedited grievance requests within 72 hours by phone, fax, or any other available means.

If you are a member of a self-funded non-grandfathered health plan, as defined by the Patient Protection and Affordable Care Act (PPACA), you may request an expedited external review instead of, or at the same time as, requesting an expedited internal grievance with us. To request this review, you, your provider or your representative can call Member Services / Customer Service at the phone number on your health plan identification card. If you prefer, you may send your written request, and any additional supporting documentation, to the following address: Grievances and Appeals, Expedited External Grievances, P.O. Box 1038, North Haven, CT 06473-4201.

What should my grievance include?

You may include, if available, the following information with your grievance: the member's name and identification number; the name of the provider or facility who will or has provided care; date(s) of service; the claim or reference number for the specific determination with which you don't agree; and the specific reason(s) why you don't agree with the determination. You have the right, and we encourage you, to submit written comments, documents or other relevant information with your grievance.

How will my grievance be handled?

The appropriate administrative and/or clinical specialists will review your grievance. Relevant information submitted by you or on your behalf will be reviewed even if it was considered at the time the initial determination was made. We may contact providers who may have additional information to support your grievance. The reviewers will not have been involved in the initial determination. They also will not be a subordinate of the person who made the initial adverse determination. Before issuing a determination on a grievance of an adverse determination based upon medical necessity, we'll provide you, free of charge, with any new or additional evidence relied upon or scientific or clinical rationale. It will be provided in advance of the grievance resolution date. This will allow you a reasonable amount of time to respond before that date.

If I don't agree with my grievance determination, what other rights do I have?

You may ask for a voluntary second level grievance. You don't have to complete this voluntary level of review prior to asking for external review. If you don't ask for a voluntary second level grievance, the first level grievance response will be the final level of the internal grievance process. You have 60 calendar days from the date you receive the written first level grievance determination to ask for a voluntary second level grievance. To ask for this review, please send a written request, and any additional supporting documentation, to the following address: Grievances and Appeals, Second Level Grievance Panel, P.O. Box 1038, North Haven, CT 06473-4201. In your written request, please let us know that you are asking for a voluntary grievance review. You may ask for an in-person presentation, phone conference, videoconference or conference by other form of acceptable technology. Voluntary grievances of medical necessity determinations are resolved within 30 calendar days from the date we receive the request. Voluntary grievances not based on medical necessity are resolved within 20 business days from the date we receive the request. The written determination will state the specific reason(s) for the determination and will reference the specific health benefit plan provisions on which the determination is based, if applicable. It will also include general information about other voluntary alternative dispute resolution options.

If you are a member of a self-funded non-grandfathered health plan, as defined by PPACA, you may have the right to ask for an independent external review if our coverage determination was based on medical judgment. Please refer to the External Review subsection below.

Please call Member Services / Customer service at the phone number on your health plan identification card for detailed information about the entire grievance process.

How do I get access to and copies of documents?

You are entitled to receive reasonable access to and copies of all documents including criteria, benefit provisions or guidelines, records and other information relied upon or used in connection with the adverse determination that is the subject of your benefit request. This information will be given to you for free upon request. If you prefer, any other person you authorize may ask for this information. We'll provide this information by fax, electronic means, or any other expeditious method within five business days after receiving a request. We'll provide this information using these methods within one calendar day after receiving a request regarding a final adverse determination about:

1. an admission, availability of care, continued stay, or health care service for which you received emergency services but have not been discharged from a facility; or
2. a denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational and your treating provider certifies in writing that this care service or treatment would be significantly less effective if not promptly initiated.

External Review

If the outcome of all mandatory appeals is adverse to you and it was based on medical judgment, you may be eligible for an independent External Review pursuant to federal law.

You must submit your request for External Review to the Claims Administrator within four (4) months of the notice of your final internal adverse determination.

A request for an External Review must be in writing unless the Claims Administrator determines that it is not reasonable to require a written statement. You do not have to re-send the information that you submitted for internal appeal. However, you are encouraged to submit any additional information that you think is important for review.

For pre-service claims involving urgent/concurrent care, you may proceed with an Expedited External Review without filing an internal appeal or while simultaneously pursuing an expedited appeal through our internal appeal process. You or your authorized representative may request it orally or in writing. All necessary information, including the Claims Administrator's decision, can be sent between the Claims Administrator and you by telephone, facsimile or other similar method. To proceed with an Expedited External Review, you or your authorized representative must contact the Claims Administrator at the number shown on your identification card and provide at least the following information:

- the identity of the claimant;
- the date(s) of the medical service;
- the specific medical condition or symptom;
- the provider's name;
- the service or supply for which approval of benefits was sought; and
- any reasons why the appeal should be processed on a more expedited basis.

All other requests for External Review should be submitted in writing unless the Claims Administrator determines that it is not reasonable to require a written statement. Such requests should be submitted by you or your authorized representative to:

Anthem Blue Cross and Blue Shield
ATTN: Grievance & Appeals/External Appeals
P.O. Box 1038
North Haven, CT 06473

This is not an additional step that you must take in order to fulfill your appeal procedure obligations described above. Your decision to seek External Review will not affect your rights to any other benefits under this health care plan. There is no charge for you to initiate an independent External Review. The External Review decision is final and binding on all parties except for any relief available through applicable state laws.

Requirement to file an Appeal before filing a lawsuit

No lawsuit or legal action of any kind related to a benefit decision may be filed by you in a court of law or in any other forum, unless it is commenced within three years of the Plan's final decision on the claim or other request for benefits. If the Plan decides an appeal is untimely, the Plan's latest decision on the merits of the underlying claim or benefit request is the final decision date. You must exhaust the Plan's internal Appeals Procedure but not including a voluntary level of appeal, before filing a lawsuit or taking other legal action of any kind against the Plan.

CLAIMS PROVISIONS

Anthem BCBS reserves the right to review any submitted claims for services; and has complete discretion to interpret; and apply the terms of the Benefit Program; and to decide which services are eligible for payment.

Claim Procedures

Participating Physician, Providers and Hospitals

When you receive Covered Services from a Participating Physician; Provider; or Hospital the Physician; or Provider shall file the claim with Anthem BCBS. Any payment due under this Benefit Program shall be made to the Participating Physician; Provide; or Hospital.

If further review of a claim is requested; the Covered Person should first contact Member Services. If resolution is not met; the Covered Person should follow the guidelines set forth in the Covered Person Appeal Process Section of this Summary Booklet.

Benefits for Covered Services will be paid based on the Maximum Allowable Amount for Participating Physicians; Providers; or Hospitals.

Non-Participating Physicians, Providers and Hospitals

Claims must be submitted by the Covered Person when a Covered Person receives Covered Services from a Non-Participating Physician, Provider or Hospital. The Covered Person should get a complete itemized bill for services (charge card receipts; and "balance due" statement are not acceptable) from the Physician; Provider; or Hospital. The itemized bill; along with your name; and ID number should be submitted in as explained in the Payment of Covered Services Section of the Summary Booklet.

In some instances: the Non-Participating Hospital may file the claim to Anthem BCBS; and any payment due under the Benefit Program shall be made to the Non-Participating Hospital.

Benefits for Covered Services will be paid based on the Maximum Allowable Amount for Non-Participating Physicians; Providers; or Hospitals. Hospitals outside the United States are eligible to receive the Maximum Allowable Amount based on the rate of exchange.

If further review of a claim is requested; the Covered Person should first contact the Member Services. If resolution is not met; the Covered Person should follow the guidelines set forth in Covered Person Appeal Process Section of the Summary Booklet.

Payment For Covered Services

Payment by Anthem BCBS for Covered Services shall be made to the Participating Physician, Participating Provider or Participating Hospital. Payment by Anthem BCBS for Covered Services provided by a Non-Participating Physician or Non-Participating Provider shall be made to the Covered Person who shall be responsible for payment to the Provider. In certain situations where a Dependent child receives Covered Services from a Non-Participating Physician or Non-Participating Provider, Anthem BCBS will send payment directly to the custodial parent when Anthem BCBS is notified in writing, even if that parent is not a Covered Person.

In order to be considered for payment, claims submitted by a Covered Person for payment for Covered Services provided by Non-Participating Physicians, Non-Participating Providers and Non-Participating Hospitals must be received by Anthem BCBS within 120 days from the date the Covered Services were performed. Claims for

Covered Services more than 120 days after the date the services were performed shall not be covered or paid. Claims for Covered Services must be submitted to:

Anthem Blue Cross and Blue Shield
P.O. Box 533
North Haven, CT 06473

Anthem BCBS will not routinely issue a benefit payment of less than $1.00 except upon written request from the Covered Person.

Claims for benefits for Covered Services provided to a Covered Person will be processed within thirty (30) days of the date the claim is received by Anthem BCBS. If a claim decision cannot be made within the 30-day period, an extension of up to fifteen (15) days may be requested. Before the end of the initial thirty (30)-day period, Anthem BCBS will send the Covered Person written notice of the reason(s) for the delay.

If the time to process a health claim is extended because the Covered Person has not submitted requested information, the time period requirements for claim processing will be tolled from the date the notice of requested information is sent to the Covered Person until the date Anthem BCBS receives the Covered Person's response. Anthem BCBS will make a claim decision within fifteen (15) days after receipt of the requested information. Covered Persons should submit the requested information within forty-five (45) days of receipt of the request.

Claim Overpayments

When Anthem BCBS has made payments for Covered Services either in error or in excess of the maximum amount of payment necessary to satisfy the provisions of this Benefit Program, Anthem BCBS has the right to recover these payments from one or more of the following as may be appropriate. Anthem BCBS will not attempt to recover from any Covered Person or Provider overpayments not made to or held by such Covered Person or Provider. Overpayments may be recovered from:

- Any person to or for whom such payments were made;
- Any insurance companies; or
- Any other organizations.

Anthem BCBS's right to recover may include subtracting from future benefits payments the amount Anthem BCBS has paid in error or in excess. The Covered Person personally and on behalf of his or her Dependents will, upon request, execute and deliver such documents as may be required and do whatever is necessary to secure Anthem BCBS's right to recover any erroneous or excess payments.

Under BlueCard, recoveries made from a Blue Cross and/or Blue Shield plan in the BlueCard program or from participating providers of a Blue Cross and/or Blue Shield plan in the BlueCard program can arise in several ways, including, but not limited to, anti-fraud and abuse audits, provider/hospital audits, credit balance audits, utilization review refunds, and unsolicited refunds. In some cases, the Blue Cross and/or Blue Shield plan will engage third parties to assist in discovery or collection of recovery amounts. The fees of such a third party are netted against the recovery. Recovery amounts, net of fees, if any, will be applied in accordance with applicable BlueCard policies, which generally require correction on a claim-by-claim or prospective basis.

Claim Denials

If benefits are denied, in whole or in part, Anthem BCBS will send the Covered Person a written notice within the established time periods described in the Section Payment for Covered Services. The Covered Person or the Covered Person's duly authorized representative may appeal the denial as described in the Covered Person Appeal Process Section below. The adverse determination notice will include the reason(s) for the denial, reference to the Plan provisions(s) on which the denial is based, whether additional information is needed to process the claim and why the information is needed, the claim appeal procedures and time limits, and if applicable, the Covered Person's right to bring civil action under ERISA section 502(a).

If the denial involves a utilization review determination, the notice will also specify:

- whether an internal rule, guideline, protocol or other criterion was relied upon in making the claim decision and that this information is available to the Covered Person upon request and at no charge;

- that an explanation of the scientific or clinical judgment for a decision based on Medical Necessity, Experimental or Investigational treatment or a similar limitation is available to the Covered Person upon request and at no charge.

INTER-PLAN PROGRAMS

Out-of-Area Services

Anthem BCBS has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever you obtain healthcare services outside of Anthem BCBS service area, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard Program and may include negotiated National Account arrangements available between Anthem BCBS and other Blue Cross and Blue Shield Licensees.

Typically, when accessing care outside Anthem BCBS service area, you will obtain care from healthcare providers that have a contractual agreement (i.e., are "participating providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, you may obtain care from nonparticipating healthcare providers. Anthem BCBS payment practices in both instances are described below.

BlueCard® Program

Under the BlueCard® Program, when you access covered healthcare services within the geographic area served by a Host Blue, Anthem BCBS will remain responsible for fulfilling Anthem BCBS contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare providers.

Whenever you access covered healthcare services outside Anthem BCBS service area and the claim is processed through the BlueCard Program, the amount you pay for covered healthcare services is calculated based on the lower of:

- The billed covered charges for your covered services; or
- The negotiated price that the Host Blue makes available to Anthem BCBS.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price Anthem BCBS uses for your claim because they will not be applied retroactively to claims already paid.

Laws in a small number of states may require the Host Blue to add a surcharge to your calculation. If any state laws mandate other liability calculation methods, including a surcharge, we would then calculate your liability for any covered healthcare services according to applicable law.

Under certain circumstances, if we pay the healthcare provider amounts that are your responsibility, such as deductibles, co-payments or co-insurance, we may collect such amounts directly from you. You agree that we have the right to collect such amounts from you.

Non-Participating Healthcare Providers Outside Anthem BCBS Service Area

Your Liability Calculation

When covered healthcare services are provided outside of our service area by non-participating healthcare providers, the amount you pay for such services will generally be based on either the Host Blue's nonparticipating healthcare provider local payment or the pricing arrangements required by applicable state law. In these situations, you may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment we will make for the covered services as set forth in this paragraph.

Exceptions

In certain situations, we may use other payment bases, such as billed covered charges, the payment we would make if the healthcare services had been obtained within our service area, or a special negotiated payment, as permitted under Inter-Plan Programs Policies, to determine the amount we will pay for services rendered by nonparticipating healthcare providers. In these situations, you may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment we will make for the covered services as set forth in this paragraph.

BlueCard Worldwide

BlueCard Worldwide® allows access to providers and hospitals internationally. When Urgent Care services are needed out-of-country; the Member should call 1-800-810-BLUE or collect at 804-673-1177 to locate a Provider. If you are hospitalized, please call 1-800-810-BLUE or collect 804-673-1177 to arrange for cashless access at a Participating Hospital. You will be responsible for any applicable Cost-Shares at the time of discharge. The Participating Hospital will submit your claim to the BlueCard Worldwide Service Center.

The BlueCard Worldwide® Physician should be paid in full at the time of the service and the Member will be reimbursed by Anthem BCBS upon receipt of the claim (minus any applicable Cost-Shares).

CONTINUATION OF COVERAGE

You may continue this coverage if your current coverage ends because of any of the following qualifying events. You must be covered under this Benefit Program before the qualifying event in order to continue coverage. In all cases, continuation ends if the Administrative Services Only Agreement terminates.

Qualifying Event	**Who May Continue**	**Maximum Continuation Period**
Employment ends, retirement, leave of absence, or reduction in hours (except gross misconduct dismissal)	Group Covered Person and Dependent Covered Persons	Earliest of: 1. 18 months, or 2. Enrollment Date in other group coverage or Medicare, or 3. Date Coverage would otherwise end.
Divorce or Legal Separation	Former spouse and child Dependent Covered Persons.	Earliest of: 1. 36 months, or 2. Enrollment Date in other group coverage or Medicare, or 3. Date Coverage would otherwise end.
Death of Group Covered Person	Surviving spouse and child Dependent Covered Persons.	Earliest of: 1. 36 months, or 2. Enrollment Date in other group coverage or Medicare, or 3. Date Coverage would otherwise end.
Child Dependent Covered Person loses eligibility	Child Dependent Covered Person.	Earliest of: 1. 36 months, or 2. Enrollment Date in other group coverage or Medicare, or 3. Date Coverage would otherwise end.
Total Disability of Group Covered Person	Group Covered Person and Dependent Covered Persons	Earliest of: 1. 29 months after the Group Covered Person leaves employment, or 2. Date total disability ends, or 3. Enrollment Date in other Group coverage or Medicare, or 4. Date Coverage would otherwise end.
Employment ends, retirement, leave of absence, or reduction in hours (except gross misconduct dismissal) as a result of a Covered Person's eligibility to receive Social Security income	Group Covered Person and Dependents Covered Persons	Until midnight of the day preceding such Covered Person's eligibility for benefits under Title XVIII of the Social Security Act
Retirees of Group Contractholder filing Chapter 11 bankruptcy (includes substantial reduction in coverage within 1 year of filing)	Retiree and Dependent Covered Persons	Lifetime Continuation
Surviving Dependent Covered Persons of a retiree on lifetime continuation due to bankruptcy of Group Contractholder	Surviving spouse and child Dependent Covered Persons.	36 months following retiree's death.
Employee leaves for duty in the military service	Group Member and Dependent Members	The 24 months continuation beginning on the first date of your absence from work; or the day after the date on which you fail to apply for or return to a position of employment.

Who May Elect to Continue Coverage?

Qualified Beneficiaries are eligible to elect to continue coverage. Qualified beneficiaries are individuals who had coverage under the Benefit Program immediately prior to the qualifying event and are either covered employees, spouses or Dependent children of covered employees. A qualified beneficiary also includes a child born to or placed for adoption with the covered employee during the continuation period.

Continuation Options

Continuation options will be provided under each of the following circumstances for the period indicated or until the Covered Person becomes eligible for other group insurance, except as otherwise stated in this Section.

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) P.L. 99-272

1. Covered Persons in groups subject to the Consolidated Omnibus Budget Reconciliation Act of 1985, P.L. 99-272(COBRA) may continue membership in this Benefit Program to the extent permitted by law. The Employer is responsible for notifying the Covered Person regarding whether the Employer or Anthem BCBS will be administering the program. Coverage shall also be available to a child born to or placed for adoption with the Covered Person while the Covered Person is continuing coverage pursuant to COBRA.

    a. Continuation of coverage for up to 36 months shall be available for an enrolled Dependent following:

        (i) The death of the Covered Person;
        (ii) The legal separation or divorce from the Covered Person;
        (iii) The Covered Person's entitlement for Medicare;
        (iv) The attainment of the limiting age for an enrolled Dependent child or student.

    b. Continuation of coverage for up to 18 months shall be available to a Covered Person and his or her enrolled Dependents following:

        (i) The Covered Person's reduction in work hours;
        (ii) The Covered Person's voluntary resignation;
        (iii) Lay-off or termination of the Covered Person for any reason (other than gross misconduct).

2. An additional 11 months shall be available to a Covered Person and an enrolled Dependent who is; determined to be disabled under Title II or Title XVI of the Social Security Act at the time he or she becomes eligible for extended continuation of coverage under COBRA, or becomes disabled at any time during the first 60 days of COBRA continuation coverage. The Covered Person or enrolled Dependent must provide notice of the disability determination to Anthem BCBS no later than 60 days after the date of the Social Security Administration's determination and before the end of the initial 18 months of COBRA continuation coverage.

    If it is determined that the Covered Person is no longer disabled, the extended continuation of coverage period can be terminated on the first of the month following 30 days after the final determination notice.

3. The continuation of coverage must be equal to the benefits available to currently employed Covered Persons. A Covered Person who is eligible for continuation of coverage must be provided with at least 60 days in which to elect such coverage. A Covered Person's eligibility for such continuation of coverage ends earlier than the above periods if:

    a. The Covered Person becomes eligible for benefits under another group health plan as a result of employment, re-employment, or marriage, except when the new plan contains any exclusion or limitation relating to any pre-existing condition of the Covered Person; or
    b. The premium for continuation of coverage is not paid on time; or
    c. The Covered Person becomes entitled to Medicare benefits; or

d. The Employer no longer provides group health coverage for any of its employees.

Continuation of Coverage Due To Military Service

In the event you are no longer Actively At Work due to military service in the Armed Forces of the United States, you may elect to continue health coverage for yourself and your Dependents (if any) under this Benefit Plan in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.

"Military service" means performance of duty on a voluntary or involuntary basis, and includes active duty, active duty for training, initial active duty for training, inactive duty training, and full-time National Guard duty.

You may elect to continue to cover yourself and your eligible Dependents (if any) under this Benefit Program and upon payment of any required contribution for health coverage. This may include the amount the employer normally pays on your behalf. If your military service is for a period of time less than 31 days, you may not be required to pay more than the active employee contribution, if any, for continuation of health coverage. If continuation is elected under this provision, the maximum period of health coverage under this Benefit Program shall be the lesser of:

The 24 months beginning on the first date of your absence from work; or
The day after the date on which you fail to apply for or return to a position of employment.

Regardless whether you continue your health coverage, if you return to your position of employment your health coverage and that of your eligible Dependents (if any) will be reinstated under this Benefit Program.

Conversion

1. If a person ceases to be a Covered Person under this Benefit Program, the person is eligible for coverage under a conversion contract then available from Anthem BCBS. The coverage may be different from the coverage provided under this Benefit Program.

2. Direct payment for coverage under the conversion contract must be made from the date the person ceases to be a Covered Person under this Benefit Program.

3. The Covered Person will be allowed to continue membership in the direct pay plan currently available in accordance with Anthem BCBS's underwriting regulations. Not all coverages available on a group basis are available on a direct pay basis.

4. A conversion option will not be available if the Employer terminates this Benefit Program for another Plan.

Certificate of Creditable Coverage

Pursuant to the Connecticut Health Insurance Portability and Extended Health Insurance Act; and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), a Certificate of Creditable coverage must be issued to a Covered Person and his or her covered Dependents who terminate from this Benefit Program. The information included on the Certificate of Creditable coverage will include the names of any Covered Persons terminating, the date coverage under this Benefit Program ended, and the type of coverage provided under this Benefit Program. This Certificate of Creditable coverage will provide a subsequent insurer or group Plan with information regarding previous coverage to assist it in determining any Pre-Existing Condition exclusion period or Affiliation Period. This Certificate of Creditable coverage should be presented by the Covered Person to his or her next employer group and/or when applying for subsequent group health insurance. A Certificate of Creditable coverage will be issued to terminating Covered Persons 14 days after the date Anthem BCBS is notified of his or her termination. In addition, a terminated Covered Person may request an additional copy of the Certificate of Creditable Coverage by contacting Member Services.

Assignment of Benefits for Dentists and Oral Surgeons

Notwithstanding the terms of any provision regarding the payment of benefits payable for a Covered Service, a Covered Person may assign the benefits to a dentist or oral surgeon, who performs such services.

OPTIONAL PROVISION(S)

Optional Provisions refer to Preferred Provider Program addenda for benefits for Covered Services which are provided in addition to, or to supersede, Preferred Provider Program Covered Services. The Schedules of Benefits of these Optional Provision Sections are not subject to the Preferred Provider Program Schedule of Benefits.

A Covered Person is entitled to benefits for Covered Services as described in these Optional Provision Sections and related Schedules of Benefits.

These Optional Provision Sections are subject to the terms and conditions of the following Preferred Provider Program Benefits Sections: Acceptance, Eligibility, Exclusions, Conditions and Limitations, Coordination of Benefits and General Provisions.

These Optional Provision Sections are not subject to the terms and conditions of the Preferred Provider Program of Benefits Section: Preferred Provider Program Description.

Optional Provision benefits prevail until a per Covered Person maximum has been reached. Preferred Provider Program benefits will become effective after a Covered Person's Optional Provision maximum is reached, if applicable.

2 TIER PRESCRIPTION DRUG RIDER

Pharmacy Benefits Management

The Pharmacy benefits available to you under this rider are managed by Anthem BCBS's affiliate. The Pharmacy benefits manager is a Pharmacy benefits management company with which Anthem BCBS contracts to manage Pharmacy benefits. The Pharmacy benefits manager has a nationwide network of retail Pharmacies, a mail service Pharmacy, and clinical services that include formulary management.

The management and other services the Pharmacy benefits manager provides include, among others: managing a network of retail Pharmacies and operating a mail service Pharmacy. The Pharmacy benefits manager, in consultation with Anthem BCBS, also provides services to promote and assist Covered Persons in the appropriate use of Pharmacy benefits, such as review for possible excessive use, proper dosage, drug interactions or drug/pregnancy concerns.

From time to time we may initiate various programs to encourage Covered Persons to utilize more cost-effective or clinically-effective drugs including, but not limited to, generic drugs, mail order drugs, OTC, or preferred products. Such programs may involve reducing or waiving Copayments or Coinsurance for certain drugs or preferred products for a limited period of time.

The Half-Tablet Program will allow Covered Persons to pay a reduced Copayment on selected "once daily dosage" medications. The Half-Tablet Program allows a Covered Person to obtain a 30-day supply (15 tablets) of the higher strength medication when written by the Physician to take "1/2 tablet daily" of those medications on the approved list. The National Pharmacy and Therapeutics Committee will determine additions and deletions to the approved list. The Half-Tablet Program is strictly voluntary and the Covered Person's decision to participate should follow consultation with and the concurrence of his/her Physician. To obtain a list of the products available on this program contact Member Services.

You may contact the Pharmacy benefits manager through Member Services at the number located on the back of your Identification Card or online at the Anthem BCBS website: www.Anthem.com.

SCHEDULE OF PRESCRIPTION DRUG BENEFITS

Participating Pharmacy

COPAYMENT – Retail Pharmacy

$5 per prescription - Generic Prescription Drugs
$10 per prescription - Brand Name Prescription Drugs

COPAYMENT – Mail Order (Maintenance Drugs)

$0 per prescription - Generic Prescription Drugs
$0 per prescription - Brand Name Prescription Drugs

NOTES:

- The Covered Person will be responsible for the applicable Copayment shown on this schedule for up to a 100 day supply of any Prescription Drug purchased through a Retail Pharmacy or the designated Mail Order vendor.

- The Covered Person's Prescription Drug Copayment will be the lesser of the Copayment amount or the amount charged for the Prescription Drug by the Pharmacy or the Pharmacy benefits manager.

Non-Participating Pharmacy

COINSURANCE*

20% per prescription - Generic or Brand Name Prescription Drugs

* When applicable, the accumulated Coinsurance for Non-Participating Pharmacy benefits shall not apply to a Covered Person's Cost-Share Maximum.

Prescription Drug Rider

MAXIMUM

$1,500 per Covered Person per Calendar Year

RENEWAL INTERVAL

Calendar Year

COVERED SERVICES

Prescription Drugs
Maintenance Prescription Drugs

NOTES:

- No additional benefits are available for Cost-Share amounts under the Century Preferred Master Description of Benefits issued by Anthem BCBS.

- Your Copayment(s) and/or Coinsurance and/or annual Prescription Drug Maximum will not be reduced by any discounts, rebates or other funds received by Anthem BCBS's designated Pharmacy benefits manager from drug manufacturers, wholesalers, distributors, similar vendors and/or funds received by Anthem BCBS from the Pharmacy benefits manager.

Participating Pharmacy Benefits

When a Medically Necessary Prescription Drug or Maintenance Prescription Drug is dispensed by a Participating Pharmacy, the Participating Pharmacy shall accept Anthem BCBS's payment on behalf of Employer in full and shall make no charge to the Covered Person except for any applicable Copayment amounts or amounts exceeding the maximum benefits.

Payment shall be made directly to the Participating Pharmacy.

Non-Participating Pharmacy Benefits

When a Medically Necessary Prescription Drug or Maintenance Prescription Drug is dispensed by a Non-Participating Pharmacy, the Covered Person shall be responsible for his or her Deductible and the applicable Coinsurance. Anthem BCBS shall pay on behalf of Employer the Maximum Allowable Amount that is payable to a Non-Participating Provider. The Covered Person shall be responsible for any difference between the Maximum Allowable Amount and the amount charged by the Non-Participating Pharmacy.

Claims must be filed with Anthem BCBS within two years after the Prescription Drug or Maintenance Prescription Drug has been filled. Claims must include the Covered Person's name, Identification Card number, an original itemized bill and explanation including the name and quantity of the Prescription Drug or Maintenance Prescription Drug. Covered Persons may contact the Member Services/Customer Service Department at the toll-free number listed on their Identification Card to obtain instructions on how to file a Non-Participating Pharmacy claim.

Anthem BCBS shall reimburse to the Covered Person the Maximum Allowable Amount for Non-Participating Providers for Covered Drugs after review and approval of the claim.

NOTE:
Pre-existing conditions, if applicable, shall not apply to Prescription Drug and Maintenance Prescription Drug benefits.

PRESCRIPTION DRUG BENEFITS

Subject to the Exclusions, Conditions and Limitations, and Schedules of Eligibility and Benefits of the Description of Benefits and this Rider, a Covered Person is entitled to benefits for Covered Drugs as described in this Prescription Drug Benefits Section.

Definitions

In addition to the defined terms listed in the Definitions Section of the Description of Benefits, the following also apply to this Rider:

COVERED DRUG: The term Covered Drug means a Medically Necessary Prescription Drug or Maintenance Prescription Drug. A Covered Person's rights to benefits for a Covered Drug are subject to the terms and conditions of the Description of Benefits and this Rider.

A Covered Drug includes any of the following:

a. Any legend Prescription Drug or Maintenance Prescription Drug which is not excluded under the Description of Benefits or this Rider;
b. Injectable insulin; or
c. Any medicine which a Pharmacy compounds (at least one ingredient must be a legend drug) and which is not excluded under the Description of Benefits or this Rider. This includes refills of Covered Drugs.
d. Oral chemotherapy

In addition, all of the following conditions must be met:

a. A Prescription Drug order or Maintenance Prescription Drug order must always be made by a duly licensed Physician or Provider; and
b. A separate charge equal to, or more than, the Copayment is usually made for it.

Any drug that requires federal or other governmental agency approval not granted at the time the drug was prescribed, or any drug that is approved by the Food and Drug Administration for controlled studies only, is not a Covered Drug.

Notwithstanding the above, benefits will be available for those Prescription Drugs that have successfully completed a Phase III clinical trial of the FDA, for the illness or condition being treated, or the diagnosis for which it is being prescribed.

MAINTENANCE PRESCRIPTION DRUG: The term Maintenance Prescription Drug means a Prescription Drug which is used on a continuing basis for the treatment of a chronic Illness.

MAXIMUM ALLOWABLE AMOUNT: The Maximum Allowed Amount for Prescription Drugs is the amount determined by Anthem BCBS using prescription drug cost information provided by the Pharmacy Benefits Manager (PBM).

NEW FDA APPROVED DRUG PRODUCT OR TECHNOLOGY: The term New FDA Approved Drug Product or Technology means the first release of the brand name product or technology upon the initial FDA New Drug Approval or other applicable FDA approval for its biochemical composition and initial availability in the marketplace for the indicated treatment and use.

New FDA Approved Drug Product or Technology does not include:

- New formulations: A new dosage form or new formulation of an active ingredient already on the market;

- Already marketed drug product but new manufacturer: A product that duplicates another firm's already marketed drug product, same active ingredient, formulation, or combination;
- Already marketed drug product, but a new use: A new use for a drug product already marketed by the same or different firm; or
- Newly introduced generic medications (generic medications contain the same active ingredient as their counterpart brand-name medications).

NON-PARTICIPATING PHARMACY: The term Non-Participating Pharmacy means any appropriately licensed Pharmacy that is not a Participating Pharmacy under the terms of this Rider.

ORAL CONTRACEPTIVE: The term Oral Contraceptive means a hormonal compound taken orally in order to block ovulation and prevent the occurrence of pregnancy.

PHARMACY: The term Pharmacy means a licensed retail establishment where Prescription Drugs are compounded and dispensed by a licensed pharmacist.

PARTICIPATING PHARMACY: The term Participating Pharmacy means a Pharmacy acceptable as a Participating Pharmacy by Anthem BCBS, or its pharmacy benefits manager designee, to provide Covered Drugs to Covered Persons under the terms of this Rider.

PRIOR AUTHORIZATION: The term Prior Authorization (Prior Authorized) means that prior approval has been obtained from Anthem BCBS, which enables a Covered Person to receive benefits for certain Covered Drugs.

RIDER: The term Rider means an amendment or modification to the Benefit Program which has been selected by the Employer group and is described in this Description of Benefits.

Other Prescription Drug Benefits Provisions

1. The amounts payable on behalf of Employer for Prescription Drugs and Maintenance Prescription Drugs are on file at Anthem BCBS's Home Office.

2. The Covered Person agrees to furnish to Anthem BCBS all information as to the illness or injury and the nature and quantity of drugs prescribed as Anthem BCBS may consider necessary in the processing of the claim.

3. Anthem BCBS shall not be liable for any claims, injury, demand or judgment based on tort, product liability, or other grounds (including warranty of merchantability), arising out of the sale, compounding, dispensing, manufacturing, or use of any Prescription Drug or Maintenance Prescription Drug dispensed under the provisions of this Rider.

4. If the Physician does not specify "No Substitution" for a brand name Prescription Drug or Maintenance Prescription Drug, Anthem BCBS requires that the Pharmacy or mail order vendor dispense to the Covered Person the Federally approved Generic equivalent medication.

5. If the Physician does not specify "No Substitution" and the Prescription Drug is filled with a Brand Name Prescription Drug at the request of the Covered Person, even though a Federally approved Generic equivalent medication is available, the Covered Person shall be responsible for the Brand Name Copayment amount, or the Coinsurance amount, whichever is applicable, as shown on the Schedule of Prescription Drug Benefits, as well as the difference in cost between the Generic equivalent and the Brand Name drug.

6. Where no Generic Prescription Drug or Generic Maintenance Prescription Drug is available, the Member is responsible for the applicable Brand Name Prescription Drug, or Brand Name Maintenance Prescription Drug Copayment, as shown on the Schedule of Prescription Drug Benefits.

7. A Physician may decide that a brand name Prescription Drug or Maintenance Prescription Drug is Medically Necessary to identify or treat a Covered Person's specific injury or illness. If the Physician writes "No Substitution", for a particular Prescription Drug for the Covered Person, the Covered Person is required to pay the Brand Name Copayment amount, or the Coinsurance amount, whichever is applicable, for that particular Prescription Drug as shown on the Schedule of Prescription Drug Benefits.

8. In the event that there is no Generic equivalent for the dispensing of a Brand Name Prescription Drug, the Covered Person is required to pay the Brand Name Copayment amount, or the Coinsurance amount, whichever is applicable, as shown on the Schedule of Prescription Drug Benefits.

9. Benefits for up to 6 pill(s)/unit(s)/dose(s) per month are available for a Covered Drug related to the treatment of male or female sexual dysfunctions or inadequacies or erectile dysfunctions or inadequacies.

10. Infertility drugs will not apply to the Prescription Drug Rider Maximum.

NOTE: General Conditions 5, 6 and 7 are not applicable to the Mail Order Program described in this Rider.

Covered Services

Medically Necessary Prescription Drugs or Maintenance Prescription Drugs dispensed by a Pharmacy.

The maximum supply of a Prescription Drug or Maintenance Prescription Drug, for which benefits shall be provided on behalf of Employer when dispensed under any one prescription by a retail establishment or the Mail Order Vendor, is a 100 day supply.*

*Certain Covered Drugs have specific quantity limits as determined by Anthem BCBS in its sole discretion to which the general guidelines described above are not applicable. These quantity limits may include limitations imposed by State and Federal Statutes, FDA approved labeling for use and/or drug utilization review. Drug utilization review may include but is not limited to: drug-to-drug interaction screening, dosage-range screening, drug-of-preference screening, therapy protocol screening, gender and age-benefit screening, duration of use and monitoring of refills. The Covered Person should contact the Member Services/Customer Service Department at the number located on his or her identification card to determine the applicable specific quantity for certain Covered Drugs.

In addition to benefits for Covered Drugs for the treatment of diabetes, benefits are also available for Medically Necessary equipment and supplies for the treatment of diabetes.

Therapeutic Substitution of Drugs

Your pharmacy benefit includes a therapeutic drug substitution program approved by Anthem BCBS and managed by the Pharmacy benefits manager. This voluntary program designed to inform Covered Persons and Physicians about formulary or Generic alternatives to Non-Formulary and Formulary Brand Name Prescription Drugs. The Pharmacy benefits manager may contact the Covered Person, the Covered Person’s representative, or the prescribing Physician to make the Covered Person aware of Formulary or Generic Drug substitution options. Therapeutic substitution may also be initiated at the time the Prescription Drug is dispensed. Only the Covered Person and the Covered Person’s Physician can determine whether the therapeutic substitution is appropriate.

For a list of therapeutic drug substitutions that have been identified, contact a customer service representative by calling the telephone number on the back of the ID Card. The Covered Person may also review the list of therapeutic drug substitutions on the Pharmacy benefits manager’s website at www.Anthem.com. The therapeutic drug substitution list is subject to periodic review and amendment.

National Pharmacy Network

Covered Persons covered under this Rider may obtain Prescription Drugs or Maintenance Prescription Drugs out-of-state at any Pharmacy participating in the National Pharmacy Network servicing Anthem Blue Cross and Blue Shield of Connecticut's Covered Persons.

Covered Persons may locate an out-of-state Participating Pharmacy by calling the toll-free number listed on their Identification Card.

To obtain benefits, Covered Persons should show the out-of-state Participating Pharmacy pharmacist their Identification Card. All Prescription Drugs and Maintenance Prescription Drugs are subject to the applicable Cost-Share amounts as shown on the Schedule of Prescription Drug Benefits.

Voluntary Mail Order Program

Covered Persons may order a 1-100 day supply of a Maintenance Prescription Drug from the designated mail order vendor, subject to the applicable Cost-Share amount as shown on the Schedule of Prescription Drug Benefits. Covered Persons should refer to the mail order program brochure included with their Covered Person materials for more information on this program, or call their Anthem Blue Cross and Blue Shield Member Services/Customer Service Department.

Special Exclusions and Limitations

Anthem BCBS has the right to deny benefits on behalf of Employer for any medication that in its judgment is not prescribed or dispensed in a manner consistent with normal medical practice.

Prescription Drugs and Maintenance Prescription Drugs which are not required for the treatment or prevention of an illness or injury are not covered.

Parenteral nutritional products are not covered.

In addition, this Rider provides no benefits for any Prescription Drug or Maintenance Prescription Drug that is/has been:

1. Dispensed before the Covered Person's Effective Date or after the termination date.
2. Refills which exceed the number the prescription order calls for; or refills after one year from the date of such order.
3. A Pharmacy charge that is less than the applicable Copayment amount as shown on the Schedule of Prescription Drug Benefits.
4. Used solely to improve appearance or for cosmetic purposes.
5. Covered by Workers' Compensation law or similar laws, or covered by Workers' Compensation coverage, even if the Covered Person chooses not to claim such benefits.
6. Furnished by the U.S. Veterans' Administration, unless a charge is made.
7. Covered in whole or in part by public or private grants.
8. Dispensed or prescribed in a manner contrary to accepted medical and professional standards of practice.
9. Considered Experimental or Investigational in nature, which includes any drug that requires Federal or other governmental agency approval not granted at the time the drug was prescribed, or any drug that is

approved by the Food and Drug Administration for controlled studies only. However, Prescription Drugs will not be considered Experimental if they have successfully completed a Phase III clinical trial of the FDA, for the illness or condition being treated, or the diagnosis for which it is being prescribed.

10. An over-the-counter drug or non-legend drug, even if written as a prescription.
11. Provided in connection with a Hospital, clinic, Skilled Nursing Facility, nursing home or other institution.
12. Used prior to or after sex transformation surgery.
13. Used in connection with weight control.
14. A contraceptive or contraceptive device, that has not been approved by the FDA, and is not prescribed by a licensed Physician.
15. An antibacterial soap/detergent, shampoo, toothpaste/gel, or mouthwash/rinse.
16. An appliance or device.
17. Hypodermic needles, syringes, or similar devices, except when prescribed by a Physician for the administration of Prescription Drugs or Maintenance Prescription Drugs, which are covered under the terms and conditions of this Prescription Drug Benefits Section.
18. An allergenic extract or vaccine.
19. All other services and items of care not listed in this Rider.

2013 IMPORTANT CHANGES AMENDMENT

This Amendment changes provisions in, or adds provisions to, your

Century Preferred
Century Preferred Comprehensive
Century Preferred Comprehensive HSA
Lumenos HRA
Lumenos HIA
Lumenos HIA Plus

including any affected riders, endorsements or other amendments thereto, (hereinafter collectively, "Summary Booklet") issued by "Anthem BCBS". This Amendment is to be attached and forms a part of your Summary Booklet. This Amendment does not extend, vary, change, or waive any of the terms, benefits, exclusions, limitations, or conditions in the Certificate except as shown in this Amendment.

1. **Patient Protection and Affordable Care Act Amendment:** The *Preventive Services* subsection of the *Patient Protection and Affordable Care Act Amendment* of your Summary Booklet is amended with the deletion of bullet #4 and replaced with the following:

    4. **Women's Preventive:** Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following:~~.~~

        - Women's contraceptives, sterilization procedures, and counseling: This includes contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants, as well as injectable contraceptives, are covered at no Cost-Share from an in-network provider. In addition, Generic and single source Brand Name Drugs for oral contraceptives and patches dispensed from an in-network pharmacy are covered at no Cost-Share. Note: Multi-source Brand Name Drugs for oral contraceptives and patches may apply a cost-share.

        - Breastfeeding support, supplies, and counseling: Covered in full when received from an in-network provider. Benefits for breast pumps are limited to one pump per pregnancy.

        - Screenings and/or counseling, where applicable, for: Gestational diabetes, Human Papillomavirus (HPV), sexually transmitted infections (STIs), Human immune-deficiency virus (HIV), and interpersonal and domestic violence.

2. **Introduction:**

    A. **Introduction - BlueCard PPO Program**: The *BlueCard PPO Program* subsection in the *Introduction* section of your Summary Booklet is deleted and replaced with the following subsection:

    ## BlueCard PPO Program

    Anthem BCBS, like other Blue Cross and Blue Shield Licensees, participates in a program called "BlueCard". See Inter-Plan Programs section for additional information.

B. **Introduction – Member Services / Customer Service**: The *Customer Service* subsection in the *Introduction* section of your Summary Booklet is deleted and replaced with the following subsection:

Member Services / Customer Service

For information and assistance, a Member may call or write Anthem BCBS's Member Services / Customer Service.

Questions?

Member Services / Customer Service is available to explain policies and procedures; and answer questions about available benefits or services.

For information and help, a Member may call or write Anthem BCBS. The telephone number for Member Services / Customer Service is printed on the Member's Identification (ID) Card. The address of Anthem BCBS is:

Anthem Blue Cross and Blue Shield
Member Services / Customer Service
P.0. Box 533
North Haven, Connecticut 06473

Suggestions, Concerns, or Complaints:

We hope that you will always be satisfied with the level of service provided to you and your family. We realize, however, that there may be times when problems arise and miscommunications occur which may lead to feelings of dissatisfaction. As a Member, you have the right to express any dissatisfaction, suggestions, or concerns to us. Please contact Member Services / Customer Service to tell us your problem and we will work to resolve it for you as quickly as possible.

Member Services / Customer Service Telephone Number:

Toll free in and outside of Connecticut – 1 (800) 545-0948

The Member Services / Customer Service telephone number is also on your Identification (ID) Card.

Home Office Address:

You may visit our home office during normal business hours

Anthem Blue Cross and Blue Shield
108 Leigus Road, Wallingford, CT 06492

Normal Business hours:

Monday through Friday – 8:00 a.m. to 5:00 p.m.

When contacting us, please have your group; and ID numbers from your ID Card available. If your questions involve a claim; we will need to know the date of the service, kind of service, the name of the Provider and the charges involved.

C. **Introduction - How to Obtain Language Assistance**: The *Introduction* section of your Summary Booklet is changed with the addition of the following subsection:

How to Obtain Language Assistance

Anthem BCBS is committed to communicating with our Members about their health plan, regardless of their language. Anthem BCBS employs a language line interpretation service for use by all of our Member Services / Customer Service call centers. Simply call the Member Services / Customer Service phone number on the back of your ID card and a representative will be able to assist you. Translation of written materials about your benefits can also be requested by contacting Member Services / Customer Service. TTY/TDD services also are available by dialing 711. A special operator will contact Anthem to help with member needs.

D. **Introduction - Your rights and responsibilities as an Anthem BCBS Member**: The *Introduction* section of your Summary Booklet is changed with the addition of the following subsection:

Your rights and responsibilities as an Anthem BCBS Member

Anthem BCBS Member

As an Anthem BCBS member you have certain rights and responsibilities to help make sure that you get the most from your plan and access to the best care possible. That includes certain things about your care, how your personal information is shared and how you work with us and your doctors. It's kind of like a "Bill of Rights". And helps you know what you can expect from your overall health care experience and become a smarter health care consumer.

You have the right to:

- Speak freely and privately with your doctors and other health professionals about all health care options and treatment needed for your condition, no matter what the cost or whether it's covered under your plan.
- Work with your doctors in making choices about your health care.
- Be treated with respect, dignity, and the right to privacy.
- Privacy, when it comes to your personal health information, as long as it follows state and Federal laws, and our privacy rules.
- Get information about our company and services, and our network of doctors and other health care providers.
- Get more information about your rights and responsibilities and give us your thoughts and ideas about them.
- Give us your thoughts and ideas about any of the rules of your health care plan and in the way your plan works.
- Make a complaint or file an appeal about:
- Your health care plan
- Any care you get
- Any covered service or benefit ruling that your health care plan makes
- Say no to any care, for any condition, sickness or disease, without it affecting any care you may get in the future; and the right to have your doctor tell you how that may affect your health now and in the future
- Participate in matters that deal with the company policies and operations.
- Get all of the most up-to-date information about the cause of your illness, your treatment and what may result from that illness or treatment from a doctor or other

health care professional. When it seems that you will not be able to understand certain information, that information will be given to someone else that you choose.
- Get help at any time, by contacting your local insurance department.

You have the responsibility to:

- Choose any primary care physician (doctor), also called a PCP, who is in our network if your health care plan says that you to have a PCP.
- Treat all doctors, health care professionals and staff with courtesy and respect.
- Keep all scheduled appointments with your health care providers and call their office if you have a delay or need to cancel.
- Read and understand, to the best of your ability, all information about your health benefits or ask for help if you need it.
- To the extent possible, understand your health problems and work with your doctors or other health care professionals to make a treatment plan that you all agree on.
- Follow the care plan that you have agreed on with your doctors or health care professionals.
- Tell your doctors or other health care professionals if you don't understand any care you're getting or what they want you to do as part of your care plan.
- Follow all health care plan rules and policies.
- Let our Customer Service department know if you have any changes to your name, address or family members covered under your plan.
- Give us, your doctors and other health care professionals the information needed to help you get the best possible care and all the benefits you are entitled to. This may include information about other health care plans and insurance benefits you have in addition to your coverage with us.

For details about your coverage and benefits, please read your "Subscriber Agreement".

3. Schedule of Benefits:

A. **Schedule of Benefits:** The *Schedule of Benefits* section of the Summary Booklet, is changed where applicable by adding the following:

A maximum of 1 Cost-Share is applied per Member per Calendar Year for Colonoscopies.

B. **Schedule of Benefits – Early Intervention (Cost-Sharing):**

Cost-Sharing: No Cost-Shares apply for Birth to Three Program services.

C. **Schedule of Benefits – Walk-In Center Services, Retail Health Clinic, and Online Visits:** The *PHYSICIAN MEDICAL / SURGICAL SERVICES* subsection in the *Schedule of Benefits* section of your Summary Booklet is amended with the addition of the following:

Walk-In Center Services	$10 Copay	Deductible & Coinsurance
Retail Health Clinic	$10 Copay	Deductible & Coinsurance
Online Visits	$10 Copay	Deductible & Coinsurance

4. Definitions:

A. **Clinical Trial Defined:** The term Clinical Trial in the *Definitions* section of your Summary Booklet is deleted and replaced with the following definition:

> **CLINICAL TRIAL**: The term Clinical Trial means an organized, systematic, scientific study of therapies, tests or other clinical interventions for purposes of treatment, or palliation, or therapeutic intervention for the prevention of cancer, or disabling, or life-threatening chronic disease, in human beings ,except that a clinical trial for the prevention of cancer, or disabling, or life-threatening chronic disease, is eligible for coverage only if it involves a therapeutic intervention and is a Phase III clinical trial that is conducted at multiple institutions. A Clinical Trial must be conducted under the auspices of an independent peer-reviewed protocol that has been reviewed and approved as outlined in the "Covered Services" section of your Summary Booklet.

B. **Maximum Allowable Amount (MAA) Defined:** The *Definitions* section of your Summary Booklet is changed with the addition or the deletion and replacement of the following definition:

> **MAXIMUM ALLOWABLE AMOUNT (MAA)**: The term Maximum Allowable Amount (MAA) means for each of the following:
>
> 3. Participating Physician and Participating Provider: except as otherwise required by law, an amount agreed upon by Anthem BCBS and a Participating Physician and Participating Provider as full compensation for Covered Services provided to a Covered Person. When applicable, it is the Covered Person's obligation to pay Cost-Shares as a component of this Maximum Allowable Amount. The amount Anthem BCBS will pay for Covered Services will be the Maximum Allowable Amount or the billed charges, whichever is lower.
>
> 4. Non-Participating Physician and Non-Participating Provider: except as otherwise required by law, a reasonable amount as determined by Anthem BCBS, after consideration of such industry cost, reimbursement and utilization data and indices, as Anthem BCBS deems appropriate in its sole discretion, which is assigned as reimbursement for Covered Services provided to a Covered Person or an amount negotiated with a Non-Participating Physician and Non-Participating Provider for Covered Services provided to a Covered Person. The amount Anthem BCBS will pay for Covered Services will be the Maximum Allowable Amount or the billed charges, whichever is lower. It is the Covered Person's obligation to pay Cost-Shares as a component of this Maximum Allowable Amount.
>
> 5. Participating Hospital: except as otherwise required by law, an amount which a Participating Hospital accepts as full compensation for Covered Services provided to a Covered Person. When applicable, it is the Covered Person's obligation to pay Cost-Shares as a component of this Maximum Allowable Amount.
>
> 6. Non-Participating Hospital: except as otherwise required by law, a reasonable amount as determined by Anthem BCBS, after consideration of such industry cost, reimbursement and utilization data and indices, as Anthem BCBS deems appropriate in its sole discretion, which is assigned as reimbursement for Covered Services provided to a Covered Person or an amount negotiated with a Non-Participating Hospital for Covered Services provided to a Covered Person. The amount Anthem BCBS will pay for Covered Services will be the Maximum Allowable Amount or the billed charges, whichever is lower. It is the Covered Person's obligation to pay Cost-Shares and amount in excess of this Maximum Allowable Amount.

Please note that the Maximum Allowable Amount may be greater or less than the Participating Physician's, Participating Provider's, Participating Hospital's, Non-Participating Physician's, Non-Participating Provider's or Non-Participating Hospital's billed charges for the Covered Services.

Anthem BCBS shall have discretionary authority to establish, as it deems appropriate, the Maximum Allowable Amount under the Policy.

Non-Participating Out-of-State Provider Cost Share Calculation

When Covered Services are rendered outside of Connecticut by Non-Participating Physicians, Non-Participating Providers and/or Non-Participating Hospitals, the Covered Person's Cost Share obligation may be calculated based upon one of the following items (note that in the case of items a. and b. the method of Cost-Share calculation must be mandated by the law of the state in which the Covered Person is domiciled pursuant to the exception contained in Ct. General Statute 38a-478j except that in the case of the BlueCard Program, the Cost-Share calculation shall be based on item c.):

d. The Maximum Allowable Amount; or
e. Billed charges; or
f. The Maximum Allowable Amount or billed charges, whichever is lower.

Maximum Allowable Amount: Non-Participating Out-of -State Provider

When Covered Services are rendered outside of Connecticut to a Covered Person by Non-Participating Physicians, Non-Participating Providers and/or Non-Participating Hospitals, (whether or not such physicians, providers or hospitals are Host Plan participating physicians, providers or hospitals), the Maximum Allowable Amount shall be determined by that Blue Cross and/or Blue Shield Plan in that area outside of Connecticut.

The Maximum Allowable Amount may be:

- Under arrangements other than BlueCard, the applicable rate for such services, before deduction of any applicable risk withholds, negotiated with the Provider (Physician, Hospital, other Provider) by that Blue Cross and/or Blue Shield Plan outside of Connecticut which that Blue Cross and/or Blue Shield Plan passes on to Anthem BCBS (which may include fee for service rates, per diem rates, scheduled charges, capitated charges, or other pricing mechanisms in that Blue Cross and/or Blue Shield Plan's discretion); or

- In addition, Anthem BCBS will calculate the Cost-Share obligation (i.e., Coinsurance) for the amount for those Covered Services in some cases based on input from the Blue Cross and/or Blue Shield Plan outside the geographic area we serve where the services were rendered.*

* Applicable to BlueCard and arrangements other than BlueCard.

C. **Primary Care Services Defined:** The *Definitions* section of your Summary Booklet is changed with the addition or the deletion and replacement of the following definition:

PRIMARY CARE SERVICES: The term Primary Care Services means services rendered by a Physician, or Advanced Practice Registered Nurse (APRN), or other appropriately licensed or certified health care professional whose primary medical practice area is: family medicine, general practice, internal medicine or pediatric medicine. Primary Care Services includes any reference to Primary Care Physician found throughout your certificate.

D. **Routine Patient Care Costs Defined:** The term Routine Patient Care Costs in the *Definitions* section of your Summary Booklet is deleted and replaced with the following definition:

> **ROUTINE PATIENT CARE COSTS:** Routine Patient Care Costs in connection with Clinical Trials shall include Medically Necessary health care services that are incurred as a result of treatment rendered to a Member for purposes of a Clinical Trial that would otherwise be covered if such services were not rendered in conjunction with a Clinical Trial. Please see the "Covered Services" section for details.

5. Eligibility:

A. **Eligibility – Eligible Dependents:** The *Eligible Dependents* subsection of the *Eligibility* section of your Certificate is hereby amended with the deletion of the following:

> Newborn Dependent Child
>
> Benefits for Covered Services under the Benefit Program shall be provided for a newborn of the Covered Person from the moment of birth up to and up to the 31 days following birth.
>
> With respect to coverage after 31 days from birth, a newborn of a Covered Person may become an enrolled Dependent under the Benefit Program when a completed application is submitted by the Covered Person; and accepted by Anthem BCBS. The application must be submitted to Anthem BCBS within 31 days from the date of birth; and Anthem BCBS eligibility requirements must be met as specified in this section.

B. **Eligibility – Eligible Dependents:** The *Eligible Dependents* subsection of the *Eligibility* section of your Certificate is hereby amended with the addition of the following:

> Newborn Dependent Child
>
> Benefits for Covered Services under the Benefit Program shall be provided for a newborn of the Covered Person from the moment of birth up to and up to the 61 days following birth.
>
> With respect to coverage after 61 days from birth, a newborn of a Covered Person may become an enrolled Dependent under the Benefit Program when a completed application is submitted by the Covered Person; and accepted by Anthem BCBS. The application must be submitted to Anthem BCBS within 61 days from the date of birth; and Anthem BCBS eligibility requirements must be met as specified in this section.

C. **Eligibility – Eligible Dependents:** The *Eligible Dependents* subsection of the *Eligibility* section of your Certificate is hereby amended with the deletion of the following:

> A Newborn of Enrolled Dependent Child
>
> A newborn of an enrolled Dependent child is eligible for Covered Services only from the moment of birth; up to and including the 31 days immediately following birth; but is not eligible for enrollment beyond this 31 day period under the Benefit Program; until and unless the Covered Person is appointed by a court as legal guardian; and can offer Proof of such legal guardianship.
>
> Benefits for Covered Services for a newborn shall consist of Covered Services for injury or sickness; including Medically Necessary Care and treatment of medically diagnosed congenital defects and birth abnormalities; subject to the terms, conditions, exclusions, and limitations of this Certificate.

D. **Eligibility – Eligible Dependents:** The *Eligible Dependents* subsection of the *Eligibility* section of your Certificate is hereby amended with the addition of the following:

A Newborn of an Enrolled Dependent Child

A newborn of an enrolled Dependent child is eligible for Covered Services only from the moment of birth; up to and including the 61 days immediately following birth; but is not eligible for enrollment beyond this 61 day period under the Benefit Program; until and unless the Covered Person is appointed by a court as legal guardian; and can offer Proof of such legal guardianship.

Benefits for Covered Services for a newborn shall consist of Covered Services for injury or sickness; including Medically Necessary Care and treatment of medically diagnosed congenital defects and birth abnormalities; subject to the terms, conditions, exclusions, and limitations of this Certificate.

6. Covered Services:

A. **Covered Services - Clinical Trials:** The *Covered Services* section is amended with the addition of the following subsection:

CLINICAL TRIALS

Benefits include coverage for services given to you as a participant in an approved clinical trial if the services are Covered Services under this Benefit Program. An "approved clinical trial" means a phase I, phase II, phase III, or phase IV clinical trial that studies the prevention, detection, or treatment of cancer or other life-threatening conditions. The term life-threatening condition means any disease or condition from which death is likely unless the disease or condition is treated.

Benefits are limited to the following trials:

1. Federally funded trials approved or funded by one of the following:

    a. The National Institutes of Health.

    b. The Centers for Disease Control and Prevention.

    c. The Agency for Health Care Research and Quality.

    d. The Centers for Medicare & Medicaid Services.

    e. Cooperative group or center of any of the entities described in (a) through (d) or the Department of Defense or the Department of Veterans Affairs.

    f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.

    g. Any of the following in i-iii below if the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines 1) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and 2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

        - The Department of Veterans Affairs.
        - The Department of Defense.
        - The Department of Energy.

2. Studies or investigations done as part of an investigational new drug application reviewed by the Food and Drug Administration;

3. Studies or investigations done for drug trials which are exempt from the investigational new drug application.

Your Benefit Program may require you to use an In-Network Provider to maximize your benefits.

When a requested service is part of an approved clinical trial, it is a Covered Service even though it might otherwise be Investigational as defined by this Benefit Program. All other requests for clinical trials services that are not part of approved clinical trials will be reviewed according to our Clinical Coverage Guidelines, related policies and procedures.

Your Benefit Program is not required to provide benefits for the following services. We reserve our right to exclude any of the following services:

1. The Investigational item, device, or service, itself; or

2. Items and services that given only to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or

3. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;

4. Any item or service that is paid for, or should have been paid for, by the sponsor of the trial.

Routine Patient Care Costs in connection with Clinical Trials shall include Medically Necessary health care services that are incurred as a result of treatment rendered to a Member for purposes of a Clinical Trial that would otherwise be covered if such services were not rendered in conjunction with a Clinical Trial. Such services shall include those rendered by a Physician, diagnostic or laboratory tests, hospitalization, or other services provided to the Member during the course of treatment in Clinical Trial and Coverage for Routine Patient Care Costs incurred for off-label drug prescriptions in accordance with Connecticut Law. Hospitalization shall, for Routine Patient Care Costs, include treatment at an Out-of-Network facility if such treatment is not available In-Network and not eligible for reimbursement by the sponsors of such clinical trial; Out-of Network Hospitalization will be rendered at no greater cost-share to the insured person than if such treatment was available In-Network, all applicable In-Network cost-shares will apply.

Routine Patient Care Costs shall not include:

1. The cost of an investigational new drug or device that has not been approved for market for any indication by the federal Food and Drug Administration;

2. The cost of a non health care service that an insured person may be required to receive as a result of the treatment being provided for the purposes of the Clinical Trial;

3. Facility, ancillary, professional services and drug costs that are paid for by grants or funding for the Clinical Trial;

4. Costs of services that (A) are inconsistent with widely accepted and established regional or national standards of care for a particular diagnosis, or (B) are performed specifically to meet the requirements of the Clinical Trial;

5. Costs that would not be covered under this Plan for non-investigational treatments, including items excluded from coverage under the Plan; and

6. Transportation, lodging, food or any other expenses associated with travel to or from a facility providing the Clinical Trial, for the insured person or any family member or companion.

B. **Covered Services – Diagnostic Services:** The *Diagnostic Services* subsection of the *Covered Services* section of your Summary Booklet is hereby amended with the following changes for **Colorectal Cancer Screenings**:

- The *Diagnostic Services* chapter is amended with the deletion of the following:

  Colorectal cancer screening, including, but not limited to:

  - An annual fecal occult blood test; and
  - Colonoscopy, flexible sigmoidoscopy or radiologic imaging.*

- The *Diagnostic Services* chapter is amended with the addition of the following:

  Colorectal cancer screening, including, but not limited to:

  - An annual fecal occult blood test; and
  - Colonoscopy, flexible sigmoidoscopy or radiologic imaging, in accordance with the recommendations established by the American Cancer Society, based on the ages, family histories and frequencies provided in the recommendations. *

C. **Covered Services – Diagnostic Services:** The *Diagnostic Services* chapter is amended with the following addition regarding **Breast MRIs**:

Coverage for Magnetic resonance imaging (MRI) of an entire breast or breasts, in accordance with the guidelines established by the American Cancer Society.

D. **Covered Services – Oral Surgery:** The *Oral Surgery* subsection of the *Covered Services* section of your Certificate is hereby amended with the addition of the following under Notes:

IMPORTANT: If you opt to receive dental services or procedures that are not covered benefits under this plan, a participating dental provider may charge you his or her usual and customary rate for such services or procedures. Prior to providing you with dental services or procedures that are not covered benefits, the dental provider should provide you with a treatment plan that includes each anticipated service or procedure to be provided and the estimated cost of each such service or procedure. To fully understand your coverage, you may wish to review your evidence of coverage document.

E. **Covered Services - Other Provisions (Routine Patient Care Costs in connection with Clinical Trial):** In the *Other Provisions* subsection of the *Covered Services section* of your Summary Booklet, Routine Patient Care Costs in connection with Clinical Trial is hereby removed:

Routine Patient Care Costs in connection with Clinical Trial.

A Clinical Trial must be conducted under the auspices of an independent peer-reviewed protocol that has been reviewed and approved by:

- One of the National Institutes of Health; or
- A National Cancer Institute affiliated cooperative group; or
- The federal Food and Drug Administration as part of an investigational new drug or device exemption; or
- The federal Department of Defense or Veterans Affairs; or

- Qualified to receive Medicare coverage of its routine costs under the Medicare Clinical Trial Policy established under the September 19, 2000, Medicare National Coverage Determination, as amended from time to time.

Hospitalization for Routine Patient Care Costs in connection with Clinical Trials shall include treatment at an Out-of-Network facility if such treatment is not available In-Network and not eligible for reimbursement by the sponsors of such clinical trial; Out-of Network Hospitalization will be rendered at no greater cost-share to the insured person than if such treatment was available In-Network, all applicable In-Network cost-shares will apply.

F. **Covered Services - Other Provisions (Voluntary Wellness Incentive Programs):** In the *Other Provisions* subsection of the *Covered Services section* of your Summary Booklet, Voluntary Wellness Incentive Programs is hereby added:

Voluntary Wellness Incentive Programs

We may offer health or fitness related program options for purchase by your employer Group. If your Group has selected this option, You may receive incentives such as gift cards by participating in or completing such voluntary wellness promotion programs as health assessments, weight management or tobacco cessation coaching. (Use of gift cards for purposes other than for qualified medical expenses may result in taxable income to you. For additional guidance, please consult your tax advisor.) These programs are not Covered Services under Your Group Health Plan but are a value added component of your plan benefits; these program features are not guaranteed under your Summary Booklet and could be discontinued at any time.

G. **Covered Services – Physician Medical / Surgical Services:** The *Physician Medical / Surgical Services* subsection in the *Covered Services* section of your Summary Booklet is hereby amended with the addition of the following:

Walk-In Center Services

Office visit for services limited to routine care and treatment of common illnesses for adults and children. You do not have to be an existing patient or have an appointment to use a walk-in Doctor's office.

Retail Health Clinic Visit

When available in your area, your coverage will include Retail Health Clinic Visits. Visits for limited basic health care services to Members on a "walk-in" basis will be provided. These clinics are normally found in major pharmacies or retail stores. Health care services are typically given by Physician's Assistants or Nurse Practitioners. Services are limited to routine care and treatment of common illnesses for adults and children.

Online Visits

When available in your area, your coverage will include online visit services. Covered Services include a medical visit with a Doctor using the internet by a webcam, chat or voice. See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment and benefit limitation information.

Online visits do not include:

- Reporting normal lab or other test results,
- requesting office visits ,

- getting answers to billing, insurance coverage or payment questions,
- asking for referrals to doctors outside the online care panel,
- Benefit prior authorization,
- Physician to Physician consultation, or
- Doctor to Doctor discussions.

H. Covered Services – Preventive Services: The *Preventive Services* subsection in the *Covered Services* section of your Summary Booklet is hereby amended with the addition of the following:

Screenings and other services are generally covered as preventive care for adults and children with no current symptoms or prior history of a medical condition associated with that screening or service. Covered Persons who have current symptoms or have been diagnosed with a medical condition are not considered to require Preventive Care for that condition but instead benefits will be considered under the diagnostic services benefit.

7. Right of Recovery: The *Right of Recovery* section of your Summary Booklet is deleted and replaced with the following section:

RIGHT OF RECOVERY

To the extent permissible by law, Anthem BCBS shall have a right of recovery against third parties for benefits for Covered Services provided under the terms of this Benefit Program, where the Covered Person has a right of recovery against third parties for the cost of Covered Services. Acceptance of Covered Services will constitute consent by the Covered Person to Anthem BCBS's right of recovery. The Covered Person agrees to take all further action to execute and deliver such additional instruments and to take such other action as Anthem BCBS shall require to implement this provision. Anthem BCBS will have the right to bring suit against such third party in the name of the Covered Person and in its own name as subrogee. The Covered Person shall do nothing to prejudice the rights given to Anthem BCBS by this provision without its consent.

If a Covered Person received payment from a third party by suit or settlement for the cost of Covered Services, such Covered Person is obligated to reimburse Anthem BCBS less Anthem BCBS's pro rata share of the reasonable attorney's fees and cost the Covered Person sustained in obtaining the recovery.

We have established recovery policies to determine which recoveries are to be pursued, when to incur costs and expenses and settle or compromise recovery amounts. We will not pursue recoveries for overpayments if the cost of collection exceeds the overpayment amount. We may not provide you with notice of overpayments made by Us or you if the recovery method makes providing such notice administratively burdensome.

8. Termination: Your Summary Booklet is amended with the addition of the chapter *Termination.*

TERMINATION

This Section describes how coverage for a Member can be: cancelled; rescinded; suspended; or not renewed.

Termination of the Covered Person

The Covered Person's enrollment in the Benefit Program shall terminate:

12. The date the Group Contractholder's contract with us terminates;

13. The last day of the month that required charges are paid for your coverage if we do not receive payment when due. Your payment of charges to the Group Contractholder does not guarantee coverage unless we receive full payment when due;

14. The last day of the month you enter military service for duty lasting more than 30 days;

15. At the Covered Person's option during an Employer Group's Open Enrollment Period; and shall be effective as of the renewal date of the Benefit Program;

16. The day following the Covered Person's death. When a Covered Person dies, Dependents shall be terminated the first of the month following the Covered Person's death;

17. The first day of the month following the loss of eligibility due to:

    - Loss of employment with the Employer Group; or
    - a reduction in work hours; or
    - He or she no longer meets the eligibility requirements of the Benefit Program as defined in the Eligibility Section of this Summary Booklet;

18. Following the effective date of the Benefit Program, Anthem BCBS may rescind, cancel or limit the Benefit Program; if the Covered Person has submitted false information to Anthem BCBS, or omitted information during the application and enrollment process concerning eligibility, insurability or health status and such information was material to the underwriting of the application at the time submitted and acceptance by Anthem BCBS of that application for coverage.

    Anthem BCBS may also initiate and conduct a review on a post claim basis to obtain information when the information sought is:

    - in relation to a medical condition not disclosed on the application, or;
    - when the information on the claim or the facts and circumstances of the medical treatment for which a claim is submitted clearly indicate the response or responses to the questions on the application, or the information provided on the application, might be suspect in any way.

    The Benefit Program may not be rescinded, cancelled or limited more than 2 years after the effective date of the policy. The date of rescission shall be the Effective Date of the Benefit Program.

19. When a Member ceases to be a Covered Person or Dependent, or the required contribution, if any, is not paid, the Member's coverage will terminate at the end of the last day for which payment was made;

20. Termination of an enrolled Dependent Spouse's Coverage (as defined in the Eligibility section) will occur as follows:

    - On the first day of the month following a divorce or legal separation of the spouse;
    - On the first day of the month following when other enrolled Dependent's criteria are no longer met by the spouse;
    - Enrollment in the Benefit Program shall be terminated on the day after the death of an enrolled Dependent Spouse.

    It is the sole responsibility of the covered employee to notify Anthem BCBS of any changes in the Dependent Spouse's status.

21. Termination of an enrolled Dependent child's coverage (as defined in the Eligibility section) will occur as follows:

    - Coverage shall terminate no earlier than the Benefit Program renewal date when the Dependent child reaches the maximum age of the Benefit Program;
    - Coverage shall terminate no earlier than the Benefit Program renewal date when a Dependent child obtains coverage under a group health plan through the Dependent child's own employment;
    - On the day after the death of an enrolled Dependent child.

    It is the sole responsibility of the covered employee to notify Anthem BCBS of any changes in the Dependent child's status.

22. A Covered Person will cease to be covered under the Benefit Program, on the first day of the month in which he or she attains age 65 and is eligible for Medicare, except as required by law. If a Covered Person is covered by law, he or she will automatically terminate from the Benefit Program on the first day of the month in which such eligibility ceases. The Covered Person who certifies before this termination date that he or she is not enrolled in Part B of Medicare will be reinstated under the Medical/Surgical Section without interruption of membership. Applications are available upon request, but Anthem BCBS is not responsible for notifying the Covered Person of the necessity for applying.

Termination of the Employer Group

4. The Benefit Program may be terminated in accordance with applicable law as follows:

    - At the option of the Employer Group; without cause upon delivery of 15 days prior written notice to the other party, to be effective the first of the month following the end of the 15 day notice period;

    - By Anthem BCBS, at its option; in the event the Employer Group receives 30 days prior written notice from Anthem BCBS of the Employer Group's failure to satisfy any other condition in the Benefit Program or any underwriting requirement adopted by Anthem BCBS. Such termination will go into effect on the first day of the month following such 30 day notice period;

- Anthem BCBS may not renew the entire contract in the event the Contractholder fails to meet the participation or contributory requirements stated in the Administrative Services Only Agreement.

5. During the first two years following the effective date of the Benefit Program, Anthem BCBS may rescind, cancel, or limit the Benefit Program if Anthem BCBS determines after completing underwriting, there was false, misleading or fraudulent information submitted by or information omitted, during the initial application and enrollment process, and such information was material to the acceptance of the application at the time submitted to Anthem BCBS. Such information may include, but is not limited to, information regarding the eligibility of the Employer Group or any Members to receive coverage under the Benefit Program. The date of rescission shall be the Effective Date of the Benefit Program.

6. The termination, expiration, non-renewals, or cancellation of the Administrative Services Only Agreement by the Contractholder or Anthem BCBS will automatically result in the termination of each Covered Person's or Dependent's right to coverage and benefits under this Administrative Services Agreement.

Consent

No event of termination, expiration, non-renewal, or cancellation of the Benefit Program shall affect the rights and obligations of the parties arising out of any transactions occurring prior to the Effective Date of any such event. The Member hereby acknowledges that the termination, expiration, non-renewal, or cancellation of the contract will automatically result in the termination of the Benefit Program.

Rescission of the Benefit Program by Anthem BCBS will cause the Benefit Program and any other contracts or agreements between Anthem BCBS and the Employer Group to be null and void.

Covered Person Notification

If the Covered Person's Employer Group or Anthem BCBS cancels or discontinues this Benefit Program with respect to the entire group or a class of employees; the Employer Group must send the Covered Person written notice of cancellation or discontinuation of this Benefit Program at least 15 days before the Effective Date of cancellation or discontinuation. Coverage will be terminated regardless of whether the notice was given. Failure to furnish such notice results in the Employer Group's liability for benefits to the same extent to which Anthem BCBS would have been liable if coverage had not been canceled or discontinued.

Certificates of Creditable Coverage

Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA); a Certificate of Coverage must be issued to a Covered Person and his or her covered Dependents who terminate from this Benefit Program. The information included on the Certificate of Creditable Coverage will include: the names of any Members terminating; the date coverage under this Benefit Program ended; and the type of coverage provided under this Benefit Program. This Certificate of Creditable Coverage will provide a subsequent insurer or group Plan with information regarding prior coverage to help in determining any Pre-Existing Condition exclusion period or Affiliation Period. This Certificate of Creditable Coverage should be presented by the Member to his or her next Employer Group; and/or

when applying for subsequent group health insurance. A Certificate of Creditable Coverage will be issued to terminating Members 14 days after the date Anthem BCBS is notified of his or her termination. In addition, a terminated Member may request an additional copy of the Certificate of Creditable Coverage by contacting Member Services.

9. General Provisions:

A. **General Provisions – Termination:** Your Summary Booklet has been amended as follows: the subsections of *Termination of Covered Person's Coverage Under the Benefit Program* and *Termination of the Employer Group* have been removed from the *General Provisions* section and added as their own chapter called *Termination*.

B. **General Provisions – Claims Provisions:** Your Summary Booklet has been amended as follows: the subsections of *Claims Procedures*, *Payment of Benefit*, and *Claim Denials* have been removed from the *General Provisions* section and added as their own chapter called *Claims Provisions.*

10. Claims Provisions: Your Summary Booklet is amended with the addition of the chapter *Claims Provisions.*

CLAIMS PROVISIONS

Anthem BCBS reserves the right to review any submitted claims for services; and has complete discretion to interpret; and apply the terms of the Benefit Program; and to decide which services are eligible for payment.

Claim Procedures

Participating Physician, Providers and Hospitals

When you receive Covered Services from a Participating Physician; Provider; or Hospital the Physician; or Provider shall file the claim with Anthem BCBS. Any payment due under this Benefit Program shall be made to the Participating Physician; Provide; or Hospital.

If further review of a claim is requested; the Covered Person should first contact Member Services. If resolution is not met; the Covered Person should follow the guidelines set forth in the Covered Person Appeal Process Section of this Summary Booklet.

Benefits for Covered Services will be paid based on the Maximum Allowable Amount for Participating Physicians; Providers; or Hospitals.

Non-Participating Physicians, Providers and Hospitals

Claims must be submitted by the Covered Person when a Covered Person receives Covered Services from a Non-Participating Physician, Provider or Hospital. The Covered Person should get a complete itemized bill for services (charge card receipts; and "balance due" statement are not acceptable) from the Physician; Provider; or Hospital. The itemized bill; along with your name; and ID number should be submitted in as explained in the Payment of Covered Services Section of the Summary Booklet.

In some instances: the Non-Participating Hospital may file the claim to Anthem BCBS; and any payment due under the Benefit Program shall be made to the Non-Participating Hospital.

Benefits for Covered Services will be paid based on the Maximum Allowable Amount for Non-Participating Physicians; Providers; or Hospitals. Hospitals outside the United States are eligible to receive the Maximum Allowable Amount based on the rate of exchange.

If further review of a claim is requested; the Covered Person should first contact the Member Services. If resolution is not met; the Covered Person should follow the guidelines set forth in Covered Person Appeal Process Section of the Summary Booklet.

Payment For Covered Services

Payment by Anthem BCBS for Covered Services shall be made to the Participating Physician, Participating Provider or Participating Hospital. Payment by Anthem BCBS for Covered Services provided by a Non-Participating Physician or Non-Participating Provider shall be made to the Covered Person who shall be responsible for payment to the Provider. In certain situations where a Dependent child receives Covered Services from a Non-Participating Physician or Non-Participating Provider, Anthem BCBS will send payment directly to the custodial parent when Anthem BCBS is notified in writing, even if that parent is not a Covered Person.

In order to be considered for payment, claims submitted by a Covered Person for payment for Covered Services provided by Non-Participating Physicians, Non-Participating Providers and Non-Participating Hospitals must be received by Anthem BCBS within 120 days from the date the Covered Services were performed. Claims for Covered Services more than 120 days after the date the services were performed shall not be covered or paid. Claims for Covered Services must be submitted to:

Anthem Blue Cross and Blue Shield
P.O. Box 533
North Haven, CT 06473

Anthem BCBS will not routinely issue a benefit payment of less than $1.00 except upon written request from the Covered Person.

Claims for benefits for Covered Services provided to a Covered Person will be processed within thirty (30) days of the date the claim is received by Anthem BCBS. If a claim decision cannot be made within the 30-day period, an extension of up to fifteen (15) days may be requested. Before the end of the initial thirty (30)-day period, Anthem BCBS will send the Covered Person written notice of the reason(s) for the delay.

If the time to process a health claim is extended because the Covered Person has not submitted requested information, the time period requirements for claim processing will be tolled from the date the notice of requested information is sent to the Covered Person until the date Anthem BCBS receives the Covered Person's response. Anthem BCBS will make a claim decision within fifteen (15) days after receipt of the requested information. Covered Persons should submit the requested information within forty-five (45) days of receipt of the request.

Claim Overpayments

When Anthem BCBS has made payments for Covered Services either in error or in excess of the maximum amount of payment necessary to satisfy the provisions of this Benefit Program, Anthem BCBS has the right to recover these payments from one or more of the following as may be appropriate. Anthem BCBS will not attempt to recover from any Covered Person or Provider overpayments not made to or held by such Covered Person or Provider. Overpayments may be recovered from:

- Any person to or for whom such payments were made;
- Any insurance companies; or
- Any other organizations.

Anthem BCBS's right to recover may include subtracting from future benefits payments the amount Anthem BCBS has paid in error or in excess. The Covered Person personally and on behalf of his or her Dependents will, upon request, execute and deliver such documents as may be required and do whatever is necessary to secure Anthem BCBS's right to recover any erroneous or excess payments.

Under BlueCard, recoveries made from a Blue Cross and/or Blue Shield plan in the BlueCard program or from participating providers of a Blue Cross and/or Blue Shield plan in the BlueCard program can arise in several ways, including, but not limited to, anti-fraud and abuse audits, provider/hospital audits, credit balance audits, utilization review refunds, and unsolicited refunds. In some cases, the Blue Cross and/or Blue Shield plan will engage third parties to assist in discovery or collection of recovery amounts. The fees of such a third party are netted against the recovery. Recovery amounts, net of fees, if any, will be applied in accordance with applicable BlueCard policies, which generally require correction on a claim-by-claim or prospective basis.

Claim Denials

If benefits are denied, in whole or in part, Anthem BCBS will send the Covered Person a written notice within the established time periods described in the Section Payment for Covered Services. The Covered Person or the Covered Person's duly authorized representative may appeal the denial as described in the Covered Person Appeal Process Section below. The adverse determination notice will include the reason(s) for the denial, reference to the Plan provisions(s) on which the denial is based, whether additional information is needed to process the claim and why the information is needed, the claim appeal procedures and time limits, and if applicable, the Covered Person's right to bring civil action under ERISA section 502(a).

If the denial involves a utilization review determination, the notice will also specify:

- whether an internal rule, guideline, protocol or other criterion was relied upon in making the claim decision and that this information is available to the Covered Person upon request and at no charge;

- that an explanation of the scientific or clinical judgment for a decision based on Medical Necessity, Experimental or Investigational treatment or a similar limitation is available to the Covered Person upon request and at no charge.

11. Inter-Plan Programs: Your Summary Booklet is amended with the addition of the chapter *Inter-Plan Programs.*

INTER-PLAN PROGRAMS

Out-of-Area Services

Anthem BCBS has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever you obtain healthcare services outside of Anthem BCBS service area, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard Program and may include negotiated National Account arrangements available between Anthem BCBS and other Blue Cross and Blue Shield Licensees.

Typically, when accessing care outside Anthem BCBS service area, you will obtain care from healthcare providers that have a contractual agreement (i.e., are "participating providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, you may obtain care from nonparticipating healthcare providers. Anthem BCBS payment practices in both instances are described below.

BlueCard® Program

Under the BlueCard® Program, when you access covered healthcare services within the geographic area served by a Host Blue, Anthem BCBS will remain responsible for fulfilling Anthem BCBS contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare providers.

Whenever you access covered healthcare services outside Anthem BCBS service area and the claim is processed through the BlueCard Program, the amount you pay for covered healthcare services is calculated based on the lower of:

- The billed covered charges for your covered services; or
- The negotiated price that the Host Blue makes available to Anthem BCBS.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price Anthem BCBS uses for your claim because they will not be applied retroactively to claims already paid.

Laws in a small number of states may require the Host Blue to add a surcharge to your calculation. If any state laws mandate other liability calculation methods, including a

surcharge, we would then calculate your liability for any covered healthcare services according to applicable law.

Under certain circumstances, if we pay the healthcare provider amounts that are your responsibility, such as deductibles, co-payments or co-insurance, we may collect such amounts directly from you. You agree that we have the right to collect such amounts from you.

Non-Participating Healthcare Providers Outside Anthem BCBS Service Area

Your Liability Calculation

When covered healthcare services are provided outside of our service area by non-participating healthcare providers, the amount you pay for such services will generally be based on either the Host Blue's nonparticipating healthcare provider local payment or the pricing arrangements required by applicable state law. In these situations, you may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment we will make for the covered services as set forth in this paragraph.

Exceptions

In certain situations, we may use other payment bases, such as billed covered charges, the payment we would make if the healthcare services had been obtained within our service area, or a special negotiated payment, as permitted under Inter-Plan Programs Policies, to determine the amount we will pay for services rendered by nonparticipating healthcare providers. In these situations, you may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment we will make for the covered services as set forth in this paragraph.

BlueCard Worldwide

BlueCard Worldwide® allows access to providers and hospitals internationally. When Urgent Care services are needed out-of-country; the Member should call 1-800-810-BLUE or collect at 804-673-1177 to locate a Provider. If you are hospitalized, please call 1-800-810-BLUE or collect 804-673-1177 to arrange for cashless access at a Participating Hospital. You will be responsible for any applicable Cost-Shares at the time of discharge. The Participating Hospital will submit your claim to the BlueCard Worldwide Service Center.

The BlueCard Worldwide® Physician should be paid in full at the time of the service and the Member will be reimbursed by Anthem BCBS upon receipt of the claim (minus any applicable Cost-Shares).

12. **Covered Person Appeal Process:** This Summary Booklet where applicable is hereby amended with the deletion of the *Covered Person Appeal Process* section and all chapter references for Covered Person Appeal Process and is replaced with the chapter reference Grievance and External Review Process.