

BlueCare

Firm Name: Town of Darien
Firm Number: 002793-300

Anthem 
370 Bassett Road
North Haven, CT 06473

BLUECARE CERTIFICATE

PLEASE READ YOUR CERTIFICATE CAREFULLY

**Town of Darien
Group #002793-300
HBP 001**

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PATIENT PROTECTION AND AFFORDABLE CARE ACT AMENDMENT

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

**BlueCare
BlueCare Plus
BlueCare Point of Service
BlueCare Plus Point of Service
BlueCare Basic
BlueCare Plus Basic
BlueCare Plus Premier
BlueCare Plus Premier Gold
BlueCare Plus NSB
BlueCare Plus Access 10**

including any affected riders, endorsements or other amendments thereto, (hereinafter collectively, "Certificate") 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 Certificate, ("Members"). All of the terms, conditions, and limitations of the Certificate 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 Certificate 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 Certificate:

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.

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 like 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 Certificate 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 Certificate:

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. Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration..

The preventive services referenced above shall be covered in full when received from Participating Providers. The preventive services referenced above are only covered when provided by 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 Certificate that allows us to exclude or otherwise limit coverage for Pre-Existing Conditions until a Member has been continuously covered under the Benefit Program for a stated period is hereby deleted in its entirety with respect to Members 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 Certificate 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 Certificate 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 and the Domestic Partner Dependent Eligibility subsection of the Eligibility Section of the Certificate 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 Certificate 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 Member'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 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 shown in the Certificate.
 8. A Member moves outside of the Local Network Area.
7. **Other Provisions.** All of the terms, conditions, and limitations of the Certificate 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 Certificate 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 Certificate except as shown in this Amendment.

INTRODUCTION

“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 Members 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 Certificate.

BlueCare Benefit Program

This Certificate describes your BlueCare health care coverage. The Certificate explains the benefits; terms; and conditions of Membership; and the guidelines to follow in order for you to get benefits for Covered Services. This Certificate replaces; and supersedes any Certificate; 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 Certificate may occur, as approved by the State of Connecticut Insurance Department. The Effective Date of such changes shall be designated by Anthem BCBS; and notice to the Contractholder will be provided by Anthem BCBS.

BlueCare is one of the Health Maintenance Organization (HMO) Benefit Programs that is fully insured by Anthem BCBS. This Benefit Program provides service throughout the state of Connecticut. The selection of Primary Care Physician (PCP) is required. However, this is a managed care program which requires that you observe all guidelines; and procedures for getting Covered Services.

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

BlueCare has a statewide network of Participating Physicians, Providers and Hospitals that you may get in-network services from. For a listing of these Providers, please see the BlueCare Provider Directory.

Anthem BCBS is not in charge of telling a Physician’s patients when the Provider leaves the Participating Provider network, except that in the case of a Primary Care Physician the following applies: Anthem BCBS will provide written notice to each affected Member at his or her last known address no later than 30 days after sending or receiving notice of the termination or withdrawal of their Primary Care Physician from the Network. Although the BlueCare Physicians Directory is updated often to keep Members informed of a Provider’s status with Anthem BCBS; we suggest that you check with the Provider as to their status prior to getting 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 Certificate. The Covered Services therein are subject to the terms; conditions; and limitations of the Policy and the Certificate.

BlueCard Program

Anthem BCBS, like other Blue Cross and Blue Shield Licensees, participates in a program called “BlueCard”. This program provides Anthem BCBS Members with access to benefits for urgent and emergency care outside of the Local Network Area. When a Member obtains Covered Services outside of the Local Network Area, the claims for those services may be processed through the BlueCard program and presented to Anthem BCBS for payment in conformity with network access rules of the BlueCard policies then in effect. Under BlueCard, when Members receive Covered Services outside of the Local Network Area, in an area served by another Blue Cross and/or Blue Shield Plan that is in the BlueCard program (“Host Plan”), Anthem BCBS will remain responsible to the Members in accordance with this Certificate. However, the other Blue Cross and/or Blue Shield Plan in the BlueCard program will only be responsible, in accordance with applicable BlueCard policies, to provide access to such Covered Services on behalf of Members through contracting arrangements it has with its participating providers. In addition, that Blue Cross and/or Blue Shield plan will handle interactions with its participating providers. If a Blue Cross and/or Blue Shield plan does not participate in the BlueCard program, then Anthem BCBS will not be able to access that plan’s reimbursement arrangements with its participating providers.

Customer Service

Questions?

Member Services is available to explain policies and procedures; and answer questions about available benefits.

For information and help, a Member may call; or write Anthem BCBS. The telephone number for Member Services is printed on the Member's ID Card. The address of Anthem BCBS is:

Anthem Blue Cross and Blue Shield
Member Services
P.O. Box 541
370 Bassett Road
North Haven, Connecticut 06473

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.

Customer Service Telephone

Toll free in and outside of Connecticut – 1 (800) 545-0948
Monday through Friday - 8:00 a.m. to 5:00 p.m.

Home Office Address

You may visit our home office during normal business hours.
370 Bassett Road, North Haven, CT 06473

SCHEDULE OF BENEFITS

BlueCare

SCHEDULE A

This Schedule describes the benefits offered for Covered Services under this Certificate. For a more detailed explanation of benefits provided for in this Certificate, a member should refer to the proper Section. This Schedule is subject to all the terms, conditions and limitations set forth in this Certificate.

SUMMARY

SUMMARY	PARTICIPATING OPTION
TYPE OF SERVICE AND BENEFIT MAXIMUMS	MEMBER COST-SHARE
Office Visit Copayment <i>Primary Care Physician</i> <i>Participating Physician, Participating Provider</i>	 \$15 per visit \$15 per visit
Person Responsible for Prior Authorization	Primary Care Physician Participating Physician Participating Provider
Lifetime Maximum Benefit	Unlimited
Human Organ and Tissue Transplant Lifetime Maximum	Unlimited
PREVENTIVE SERVICES	
Well Child Care: <i>1 exam a month, from birth to 5 months.</i> <i>1 exam every 2 months, from 6 to 12 months old.</i> <i>1 exam every 3 months, from 13 months to 2 years of age.</i> <i>1 exam every 6 months, from 25 months to 3 years of age.</i> <i>1 exam every Calendar Year, from 4 through 21 years of age.</i>	No Cost-Share
Adult Physical Exams: <i>1 exam every Calendar Year 22 years of age and older</i>	No Cost-Share
1 Routine gynecological exam Including pap smear per Calendar Year (no Referral is required)	No Cost-Share

SUMMARY	PARTICIPATING OPTION
TYPE OF SERVICE AND BENEFIT MAXIMUMS	MEMBER COST-SHARE
Mammography One baseline screening for female 35 through 39 years of age or more frequently if recommended by a physician One screening mammogram every Calendar Year for female 40 years of age and older or more frequently if recommended	No Cost-Share
Immunizations and vaccinations	No Cost-Share
1 Vision exam and Refraction Every Calendar Year	No Cost-Share
1 Routine Hearing Screening (When performed as part of an exam)	No Cost-Share
Walk-In Center Services	\$15 per visit
MEDICAL SERVICES	
Medical Office Visits:	
<i>Primary Care Physician</i> (Including surgical procedures done in the Office)	\$15 per visit
<i>Participating Physician (Specialist)</i> (Including surgical procedures done in the Office)	\$15 per visit
Surgical Services Performed by a Surgeon or Physician (Specialist) in any setting other than an Office Visit	No Cost-Share
Non-Surgical Services of a Physician or Surgeon (Other than a medical office visit) These services may include after care or attending medical care	No Cost-Share
Home Visits by Physicians:	
<i>Primary Care Physician</i>	\$15 per visit
<i>Participating Physician</i>	\$15 per visit
Diagnostic X-ray and Imaging:	
<i>In a Radiologists office</i>	No Cost-Share
<i>Standalone Outpatient Hospital</i>	No Cost-Share
<i>High Cost Diagnostic Tests</i> <i>MRI, MRA, CAT, CTA, PET and SPECT scans</i>	No Cost-Share
Radiation Therapy	No Cost-Share
Laboratory Services	No Cost-Share

SUMMARY	PARTICIPATING OPTION
TYPE OF SERVICE AND BENEFIT MAXIMUMS	MEMBER COST-SHARE
Allergy Office Visit/Testing <i>Primary Care Physician</i> <i>Participating Physician</i>	\$15 per visit \$15 per visit
Allergy Injection Immunotherapy or other therapy treatments	No Cost-Share
Infertility Services Please see Maternity/Family Planning Section of the document	
<i>Office Visit</i>	\$15 Office Visit Copay
<i>Outpatient Hospital</i>	Same as Hospital Outpatient Cost-Share
<i>Inpatient Hospital</i>	Same as Hospital Inpatient Cost Share
Note: Infertility Drugs (with infertility diagnosis) The maximum supply of a drug for which benefits will be provided when dispensed under any one prescription is 30 day supply or 100 unit dose, whichever is greater 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.	
Maternity	\$15 Office Visit Copay First visit only
Nutritional Counseling	No Cost-Share
HOSPITAL SERVICES	
All Inpatient Admissions	\$150 per Admission (waived if readmitted within 30 days for the same diagnosis)
Ancillary Services	No Cost-Share
Outpatient Surgery (Including colonoscopy) Note: See Other Medical Services section also, for Outpatient Surgery rendered in an ambulatory surgical center	No Cost-Share
OTHER HEALTH CARE SERVICES	

SUMMARY	PARTICIPATING OPTION
TYPE OF SERVICE AND BENEFIT MAXIMUMS	MEMBER COST-SHARE
<p>Outpatient Surgery In a licensed ambulatory surgical center (not located in a Hospital setting) (including colonoscopy)</p> <p>Note: See the Hospital Services section also for Outpatient Surgery rendered in a Hospital setting.</p>	No Cost-Share
<p>Skilled Nursing Facility Up to 120 days per Calendar Year</p>	Same as Hospital Inpatient Cost-Share
<p>Inpatient Rehabilitation Services</p>	No Cost-Share
<p>Home Health Care (Includes In-Home Hospice Care) Nursing and therapeutic services Home health aide services</p> <p>In the Home Hospice Medical Social Services Under the direction of a Physician up to \$420</p>	No Cost-Share
<p>Infusion Therapy Unlimited</p>	No Cost-Share
<p>Private Duty Nursing</p>	Not Applicable
<p>Outpatient Rehabilitation Services:</p>	
<p>Physical, Occupational and Speech Therapy and Chiropractic Care</p> <p>Note: Any visits limits for physical, occupational and speech therapy will not apply to Autism Spectrum Disorder services.</p>	\$15 per visit
<p>Autism Services:</p> <p>Behavioral Therapy</p> <p>All Autism Services are subject to the following maximums per Member:</p> <ul style="list-style-type: none"> • 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 Cost-Share
<p>Cardiac Rehabilitative Therapy</p>	\$15 per visit

SUMMARY	PARTICIPATING OPTION
TYPE OF SERVICE AND BENEFIT MAXIMUMS	MEMBER COST-SHARE
Durable Medical Equipment Unlimited maximum per Calendar Year	20% Coinsurance
Diabetic equipment, drugs and supplies	
Hearing Aid coverage Available for dependent children age 12 years and under with a maximum of \$1,000 within a two year period	20% Coinsurance
Prosthetic Devices Unlimited maximum per Calendar Year	20% Coinsurance
Surgical Removal of any breast implant Up to \$1,000 per Calendar Year	No Cost-Share
Wig Up to \$350 maximum per Member per Calendar Year.	No Copay
Hospice Care (Inpatient)	No Cost-Share
Home Oxygen	No Cost-Share
Specialized Formula	No Cost-Share
MEDICAL EMERGENCY/URGENT CARE SERVICES	
Emergency Room Treatment Copayment waived if the Member is admitted directly to the Hospital from the emergency room	\$25 per visit
Ambulance Services Cost-Share (waived if admitted) <i>Land & Air:</i> Paid according to the Department of Public Health Ambulance Service Rate Schedule.	No Cost-Share
Physician's Office Medical Emergency Visit: <i>Primary Care Physician</i> <i>Participating Physician</i>	\$15 per visit \$15 per visit
Urgent Care Facility Visits	\$25 per visit
MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES	
OUTPATIENT	\$15 per visit
INPATIENT	Same as Hospital Inpatient Cost-Share

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 employee working 30 or more hours per week (unless a different Waiting Period has been mutually agreed upon by Anthem BCBS and the Contractholder) 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.

ADMISSION: The term Admission means the period from the date the Member 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 Member does not require immediate medical treatment to prevent death, disability or serious impairment of bodily part or function.

AFFILIATION PERIOD: A period of time that must expire before benefits for Covered Services will be provided to a Late Enrollee under this Benefit Program; and during which time no Premium is received by Anthem BCBS.

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

APPLIANCES: The term Appliances means: leg; arm; back; or neck braces; or artificial legs; arms or eyes; and any prosthesis with supports, including: replacement if a Member's physical condition changes.

AUTHORIZE: The term Authorize (Authorized) means that approval has been obtained from Anthem BCBS for the Emergency Admission of a Member to: 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 Member's licensed physician, licensed psychologist, or licensed clinical social worker determines a shorter period is appropriate or changes the results of the Member'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 PROGRAM: The terms Benefit Program means the program of health care benefits that is identified on the cover page of the Certificate 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 terms 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.

CERTIFICATE: The terms Certificate means this document; which describes the: rights; benefits; terms; conditions; and limitations of the coverage available to Covered Persons and eligible Dependents; including: the Schedule of Benefits; the Membership application; rate page; and any Riders and amendments thereto.

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 Member 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 decide its continued Medical necessity; starting from the assignment of the initial Prior Authorization of days and continuing to the Member's discharge.

CONTRACTHOLDER: The term Contractholder means the Employer Group to which the Group Health Care Benefits Contract is issued.

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

COST-SHARE: The term Cost-Share means the amount which the Member 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 Coinsurance amounts which are paid by the Member on a Calendar Year basis. The Cost-Share Maximum does not include: Copayments; Penalties; Cost-Shares applicable to all Inpatient Hospital/Inpatient Facility Admission; Cost-Shares applicable to benefits beyond the limits for Non-Participating infusion therapy benefits; Cost-Shares for human organ and tissue transplants when the facility is not designated and approved by Anthem BCBS; and charges that exceed the Maximum Allowable Amount.

COVERED PERSON: The terms 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 for whom Anthem BCBS has accepted the appropriate Premium and in whose name an ID Card is issued.

COVERED SERVICES: The term Covered Service means services, supplies or treatment as described in this Certificate. To be a Covered Service, the service, supply or treatment must be:

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

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.

CRISIS INTERVENTION: The term Crisis intervention means a therapeutic treatment designed to help alleviate a Mental Health Emergency or Substance Abuse Emergency.

CUSTODIAL CARE: The term Custodial Care means care primarily for the purpose of assisting the Member 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.

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.

DOMESTIC PARTNER(S): The term Domestic Partner(s) means two individuals, of the same or opposite sex that live together in a long-term relationship of indefinite duration with an exclusive mutual commitment in which the Domestic Partner(s) agree to be jointly responsible for each other's common welfare and share financial obligations.

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 worsening of the Member'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.

EMPLOYER GROUP: The terms 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 evidence 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.

GROUP HEALTH CARE BENEFITS CONTRACT: The term Group Health Care Benefits Contract means the administrative agreement solely between Anthem BCBS and the Contractholder.

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 Members under the terms of the Policy.

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 Policy.

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.

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

INPATIENT: The term Inpatient means a Member 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 a diagnosis; care; or treatment on a 24 hours a day to patients such as: a Skilled Nursing Facility; Hospice; Substance Abuse Treatment Facility; Substance 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 chance to enroll for coverage under any health insurance plan sponsored by the Employer Group.

LEARNING DISABILITY: The terms 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.

LOCAL NETWORK AREA: The term Local Network Area means the State of Connecticut and any area outside of the State of Connecticut that Anthem Blue Cross Blue Shield designates as part of the Local Network Area for the member.

MAINTENANCE CARE: The term Maintenance Care means treatment provided for the Member's continued well-being by preventing deterioration of the Member'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.

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 care provided to a Member. When applicable, it is the Member'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 Member or an amount negotiated with a Non-Participating Physician and Non-Participating Provider for Covered Services provided to a Member. 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 Member'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 Member. When applicable, it is the Member'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 provide to a Member or an amount negotiated with a Non-Participating Hospital for Covered Services provided to a Member. 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 Member'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-Local Network Area Provider Cost Share Calculation

When Covered Services are rendered outside of the Local Network Area by Non-Participating Physicians, Non-Participating Providers and/or Non-Participating Hospitals, the Member's Cost Share obligation may be calculated based upon one of the following (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 Member 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 in 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-Local Network Area Provider

When Covered Services are rendered outside of the Local Network Area to a Member 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 the Blue Cross and/or Blue Shield Plan in that area outside of the Local Network Area.

The Maximum Allowable Amount may be:

1. 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 the Local Network Area 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
2. Under BlueCard, the negotiated price, which may be the actual price paid on the claim by the Host Plan to the Provider or may include an estimated price or average discount off of billed charges that factors in settlements, withholds, any other contingent payment arrangements and any other non-claims transactions with all of the Host Plan's health care providers or one or more particular providers that the Host Plan passes on to Anthem BCBS. Average discounts tend to have a greater range of variability than do estimated prices. Such estimated prices or average discounts may be prospectively adjusted to correct for past over- or underestimation of prices or discounts applicable to BlueCard Program claims. There will be no retrospective adjustment or return of funds to, or request additional payment from, the Member because the amount paid by the Member is a final price.

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.*

Under the BlueCard, there may be a small number of states where state law may either specify the basis for the calculation of the Cost-Share obligation for Covered Services that does not reflect the entire savings realized or expected to be realized on a particular claim, or add a surcharge. The Cost-Share obligation will be based on those statutory provisions, as applicable.

*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 enough severity that a Member reasonably believes that emergency medical treatment is needed.

MEDICALLY NECESSARY (MEDICALLY NECESSARY CARE, MEDICAL NECESSITY): The terms Medically Necessary (Medical 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 terms 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.

OUTPATIENT: The term Outpatient means that the Member 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.

PARTICIPATING GROUP: The term Participating Group means a multi-specialty, multi-disciplinary group (including at least one psychiatrist; and may also include: psychologists; certified independent social workers; psychiatric nurse practitioners; and other licensed and/or certified mental health professionals) which has been designated and contracted by Anthem BCBS to be a Participating Provider; and to provide Members with Mental Health Care and Substance Abuse Care.

Participating Group Physician: The term Participating Group Physician means a Physician who has a license to practice medicine in the State of Connecticut; and who has been designated and approved by Anthem BCBS as part of a Participating Group under this Benefit Program.

Participating Group Provider: The term Participating Group Provider means an appropriately licensed and/or certified health care professional or facility, other than a Participating Group Physician; who has been designated and approved by Anthem BCBS as part of a Participating Group.

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 Members.

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

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.

PREMIUM: The term Premium means the amount charged by Anthem BCBS to provide benefits for Covered Services under this Benefit Program.

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

PROOF: The term Proof means any data that may be required by Anthem BCBS in order to satisfactorily decide a Member'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 Members.

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 Members.

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.

REFERRAL SERVICE: The term Referral Service means any Covered Service that cannot be performed by the Member's Primary Care Physician/Provider and for which the Primary Care Physician/Provider has given the Member a Referral to any other Provider. However, a Referral does not guarantee or imply coverage for those services or procedures.

REFERRAL (OR REFERRED): The term Referral (or Referred) means authorization given by the Member's Primary Care Physician/Provider for the Member to see any other Provider. A Referral is required for all non-emergency care; however, a Referral does not guarantee or imply coverage for those services or procedures.

REMITTING AGENT: The term Remitting Agent means any: person; partnership; association; or corporation which as agent for the Contractholder, has agreed to collect; and remit to Anthem BCBS the Premiums payable hereunder. Such Remitting Agent may be the Employer Group; or may represent such Employer Group. In no case, however, shall the Remitting Agent be; or be constructed to be the agent of Anthem BCBS.

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 extra benefit of this Benefit Program; which has been bought by the Employer Group.

ROUTINE PATIENT CARE COSTS: 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 Member 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 Member during the course of treatment in Cancer 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 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 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 noninvestigational 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 insured 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 guidance of a registered nurse; and
- e. is not a place mainly used for the treatment of nervous-mental disorders; pulmonary tuberculosis; a place of rest; Custodial Care; or acute Inpatient level of care.

SPECIALIZED FORMULA: This term 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 dietary management of specific diseases.

SUBACUTE CARE FACILITY: The term Subacute Care Facility means a facility that: generally provides 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.

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 decide if a Member is Totally Disabled under the terms of the Policy. 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 terms 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 Member.

WALK-IN CENTER: The term Walk-In Center means a free-standing center providing episodic health services without appointments for: diagnosis; care; and treatment.

ELIGIBILITY

The enrollment application; and any other forms as requested by Anthem BCBS must be received; and accepted by Anthem BCBS before the person shall be considered for Membership under the Benefit Program. The employee's and Dependent's right to coverage is subject to the condition that all data the employee provides to Anthem BCBS is true; correct; and complete to the best of his or her knowledge and belief. The Contractholder must inform Anthem BCBS of all names; address; or phone number changes.

Eligible Employees

Eligible employees may be: current employees; retirees of the Employer Group who meet the Employer Group's conditions for eligibility into the Benefit Program; or former employees who choose 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:

1. Current employees must be employed full-time and working at least 30 hours a week (unless a different Waiting Period has been mutually agreed upon by Anthem BCBS and the Contractholder) on a regular basis; and be Actively At Work on the date coverage is to go into effect.
2. A newly hired employee must be Actively At Work at least 31 consecutive days.
3. If the employee is not Actively At Work on the date coverage would become effective; the Effective Date of coverage for that employee; and any Dependent Members shall be delayed until the date the employee is Actively At Work.
4. 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 Members 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.
5. If you are a Late Entrant, coverage will be provided after the employee has met the three month Affiliation Period. The Affiliation Period starts upon your enrollment date and runs concurrently with your waiting period.
6. Eligibility for membership under the Benefit Program will not be offered to any employee; if he or she lives; and works outside of the Local Network Area for a period of more than 90 consecutive days.
7. 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.
8. 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.
9. 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.

Eligible Dependents

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

Your employer decides Dependent eligibility and Effective Dates according to the terms of the Group Health Care Benefits Contract. Your Dependent must meet all of your employer's Dependent Member's eligibility requirements prior to their Effective Date of coverage

Eligibility for membership under the Benefit Program will not be offered to any Dependent if he or she lives outside of the Local Network Area for a period of more than 90 consecutive days.

If the Dependent was covered under another fully-insured health Plan; and the Dependent is an Inpatient on the Effective Date of the Benefit Program; the prior carrier will pay for all eligible expenses; until the Dependent is discharged from the Inpatient Facility; or until any contract maximums have been met.

The following are eligible 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 or 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 chosen as the responsible party under a Qualified Medical Child Support Order (QMCSO).

4. 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 may be given to Anthem BCBS within 31 days from the date of birth; and Anthem BCBS eligibility requirements must be met.

5. 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 from birth; but is not eligible for enrollment past this 31 day period under the Benefit Program; 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 include care for injury or sickness; including Medically Necessary Care and treatment of medically diagnosed congenital defects and birth abnormalities; subject to the terms and conditions of this Certificate.

6. Disabled Dependent Child

A disabled Dependent child who cannot sustain employment due to a physical or mental handicap may continue as an enrolled Dependent; or be eligible past the age limit set forth in the Benefit Program; provided:

- a. The unmarried disabled Dependent child is over the age limit in the Benefit Program; and
- b. The child cannot sustain employment due to a 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 like coverage as a Dependent at the time of enrollment.

Proof acceptable to Anthem BCBS of such disability must be received within 31 days of the date the child gets to the limiting age when coverage would have ceased in the absence of such disability. The disability must be certified at the time of enrollment by a Physician; and then no more than once per year thereafter.

7. Qualified Medical Child Support Orders

A Dependent child may become eligible for Covered Services as a result of a domestic relations order issued by a state court to a divorced parent who is a Covered Person. Enrollment may be needed even when the child was not enrolled before in the Benefit Program; and might not otherwise be eligible for coverage. For further details about medical child support orders; and the Employer Group's procedures for putting into action 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.

Domestic Partner Eligibility

Eligibility for Domestic Partners for two people of the same or opposite sex will be available when all of the following requirements have been met:

Domestic Partners must meet all of the following:

- Each party is the sole Domestic Partner of the other;
- Each party is at least eighteen (18) years of age;
- Both parties currently share a common legal residence for at least 12 months prior to their application of Domestic Partner coverage;
- Domestic Partners must be jointly responsible for basic living expenses;
- Both parties are in a relationship of mutual support, caring, and commitment and intend to remain in such a relationship in the indefinite future;
- Neither party is married to another person.
- Neither party is related to the other by adoption or blood to a degree of closeness that would bar marriage in the state in which they reside, except for those states that legally recognizes Domestic Partners as a legal valid marriage.

2. Domestic Partners must have in effect and provide Proof of any one of the following:

- Designation of Domestic Partner as beneficiary for life insurance and retirement contract; or
- Designation of Domestic Partner as primary beneficiary in the (Covered Person's) will; or
- Documentation by one Domestic Partner designating the other partner as his/her agent for:

Personal relationship issues; or

Health care decisions; or
Health care agent.

3. Neither party has filed a Termination of Domestic Partnership with the preceding 12 months.
4. To enroll an eligible Domestic Partner, both the Covered Person and the Domestic Partner must complete; and sign the Anthem BCBS Statement of Domestic Partnership. Signatures must be witnessed; and notarized by a notary public. Anthem BCBS reserves the right to make the final decision in deciding eligibility of the Domestic Partner.

Domestic Partner Dependent Eligibility

Dependent children of the Covered Person and/or Domestic Partner are eligible for benefits for Covered Services if the following are met:

1. The child(ren) is/are primarily dependent upon the Covered Person and/or Domestic Partner for support; and a parent-child relationship exists between the Covered Person and child(ren) based on all of the conditions below:
 - The child(ren) must be unmarried; and live in the same household as the Covered Person and Domestic Partner; with the Covered Person and Domestic Partner's home as the primary place of residence;
 - The child(ren) must be within the age limits as stated in the Policy;
 - The Covered Person and/or Domestic Partner assume full parental control; including any and all debts incurred by the child(ren) (i.e., charges for health care services and supplies); and
 - The Covered Person and/or Domestic Partner must be:
 - i. a biological parent; or
 - ii. have a court appointed legal relationship with the child(ren) (i.e., guardianship; adoption; foster child); or
 - iii. designated as the responsible party under a Qualified Medical Child Support Order (QMCSO).

Note: Dependency is required in accordance with the applicable Internal Revenue Service guidelines.

2. In the case of a newborn child of the Covered Person and/or Domestic Partner or enrolled dependent, such child shall be eligible for Covered Services from birth through the first 31 days of life under the policy of the parent(s), subject to the provisions of this Policy.
3. In the case of a full-time student of the Covered Person and/or Domestic Partner, a full-time student is eligible for coverage when he/she meets the requirements of a full-time student as described in the Eligible Dependents section.
4. In the case of a disabled dependent child of the Covered Person and/or Domestic Partner, the disabled dependent child is eligible for coverage when he/she meets the requirements of a disabled dependent child as shown in the Eligible Dependents section.

Termination of Domestic Partnership

If the Domestic Partnership status changes and the Domestic Partner is no longer eligible for coverage; the Covered Person must complete and file a Termination of Domestic Partnership form within 30 days of the change in the Domestic Partner status.

Once a Termination of Domestic Partnership has been submitted, the Covered Person may not cover another partner for at least 12 months from the date of the status change.

Persons Eligible for Medicare

Coverage under the Benefit Program will Terminate on the first day of the month in which a Member Becomes eligible to enroll in Medicare (Part A and Part B). However, a Subscriber or the spouse of a Subscriber who remains Actively At Work after reaching age 65 may continue group health care coverage under the Benefit Program provided they select this Benefit Program as their Primary Plan.

Late Enrollees

A Late Enrollee is an eligible employee or Dependent of an eligible employee who requests coverage more than 31 days after the employee's earliest opportunity to enroll for coverage as determined by the Benefit Program's eligibility rules, or after the Employer Group's Open Enrollment Period, unless otherwise agreed upon by Anthem BCBS and the Employer Group. An eligible employee and/or Dependent shall not be considered a Late Enrollee if a request for membership is made and one of the following conditions is satisfied:

- a. 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 coverage is lost under the plan due to employment termination, an employer no longer offering benefits to a class of individuals such as part time workers, lifetime maximum being met under such insurance, death of a spouse, divorce or due to that plan's involuntary termination or cancellation by its carrier for reasons other than non-payment of Premium, and the employee and/or Dependent enrolls under the Benefit Program within 31 days after loss of membership under the other plan; or
- b. The eligible employee and/or Dependent is employed by an employer which offers multiple health program options, and the employee and/or Dependent elects a different program option during an Open Enrollment Period; or
- c. A court has ordered coverage be provided for a spouse or minor child under the Employer Group's health care benefits plan and a request for enrollment is made within 31 days after issuance of such court order; or
- d. The request for enrollment is made within 31 days after;
 - i. the marriage of the Subscriber, or
 - ii. the birth, or adoption of a child by the Subscriber, or
 - iii. issuance of a court order of legal guardianship or qualified medical child support.

Proof of such marriage, birth, adoption or court order must be provided to Anthem BCBS.

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

- a. The marriage of the Covered Person; or an enrolled Dependent child;
- b. The divorce of the Covered Person;
- c. The birth of a child of a Member;
- d. A Dependent child attains the maximum age limit for coverage under the Benefit Program.
- e. A Covered Person's termination of employment; or reduction in work hours;
- f. Loss of eligibility for other reasons shown in the Certificate.
- g. A Member moves outside of the Local Network Area.

MANAGED BENEFITS – Managed Care Guidelines

Introduction

A member's right to benefit for Covered Services provided under this Certificate 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 Member should contact his/her Physician and/or Anthem BCBS to be sure that Prior Authorization has been obtained.

The Member should consult his/her Physician concerning courses of treatment and care. Notwithstanding any benefit determination, the Member and the Member'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 Member'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.

Guidelines

1. Each Member May Select a Primary Care Physician
 - a. At the time of enrollment under this Benefit Program, each Member may select a Primary Care Physician from the list of internal medicine; family practice; and pediatric participating Physicians. Each Member of a family may select their own Primary Care Physician.
 - b. Each Member shall receive an Anthem BCBS ID Card that lists his or her Primary Care Physician. The Member should carry his or her Anthem BCBS ID Card at all times.
 - c. Each Member may change his or her Primary Care Physician at any time by calling the telephone number on the back of the Member's Identification Card or by referring to Anthem BCBS's website at: www.Anthem.com. The effective date of the change shall be the date the Member notifies Anthem BCBS. At that time, the Member will be issued a replacement Anthem BCBS ID Card.
 - d. While it is not required, the Member should rely on his or her Primary Care Physician to manage his or her medical care.

2. Each Member must receive Covered Services from a Primary Care Physician, Participating Physician, Participating Provider, or Participating Hospital. Anthem BCBS will not provide benefits for Covered Services from a Non-Participating Physician, Non-Participating Providers, or Non-Participating Hospitals; unless they are arranged by a Primary Care Physician, Participating Physician, or Participating Provider; and when Prior Authorization has been obtained from Anthem BCBS.

All diabetic equipment, supplies and drugs will be considered Covered Services rendered by a Participating Provider and adjudicated accordingly.

3. A Member can only get Preventive Covered Services from a Primary Care Physician, or a Participating Physician, as shown in Preventive Services.

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 (“requesting Provider”). 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 Member is responsible for Prior Authorization

The Member is financially responsible for services and/or settings that are not covered under the Certificate 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

Anthem BCBS has a designated In-Network vendor for home delivery of Specialized Formula. If a Member does not use the In-Network vendor but obtains Specialized Formula from any other source or vendor, no benefits will be available. To receive In-Network benefits, the Member, or the Member’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 Member’s Identification Card for information regarding how to contact the vendor.

Case Management

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

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

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 the Member, nor for other Members. All other terms and conditions of this Benefit Program shall be administered by Anthem BCBS. Anthem BCBS has the right to alter; or discontinue Case Management when it is no longer Medically Necessary. The Member or the Member's representative shall be notified in writing.

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 Certificate 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.

Member Appeal Process

If Anthem BCBS denies; reduces; or terminates benefits at any time during the review process; the Member; Member's representative; Hospital; Skilled Nursing Facility; Substance Abuse Treatment Facility; Residential Treatment Facility; Hospice; or other Inpatient Facility or Physician may ask for an Appeal review. Please see the Member Appeal Process Section for more details.

BENEFIT SECTION

This Section lists Covered Services and the benefits we pay. This Benefit Program shall provide benefits for the Covered Services shown in this section when performed by a Participating Physician; Participating Provider; Participating Hospital and subject to the Managed Benefits Section of this Certificate. The Member is responsible for Copayments if the Covered Services are rendered by a Participating Physician; Participating Provider; or Participating Hospital. Not complying with the guidelines shown in the Managed Benefits Section of the Certificate will result in Penalties or denial of benefits. Please see to the Schedule of Benefits for Cost-Shares.

The following conditions apply to the description of Covered Services referenced in the Benefit Section:

- a. All Covered Services and Benefits are subject to the conditions, exclusions, limitations, terms and provisions of this Certificate, including any attachments and riders.
- b. To receive maximum benefits for Covered Services, you must follow the terms of the Certificate, 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. If you do not have an Out-Of-Network benefit, your entire claim will be denied.
- e. Benefits for Covered Services may be payable subject to an approved treatment plan created under the terms of the Certificate.
- f. Anthem BCBS's payment for Covered Services will be limited by any applicable Copayment, Deductible or annual or lifetime payment limit in the Certificate, 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 TRANSPORT SERVICES

This Certificate Covers:

Medically Necessary medical transport services as follows:

1. From the place where the Member is injured by an accident or taken ill to a General Hospital where treatment is to be given; or
2. From a General Hospital where a Member is an inpatient to another General Hospital; or a free-standing facility to receive specialized diagnostic or therapeutic services are not to be had at the first General Hospital; and the return to the first General Hospital; if that payment is only made for one such transport during the period between the day of Admission to the General Hospital; and the day of discharge from the General Hospital; or
3. From a General Hospital to another General Hospital when the discharging General Hospital does not have the proper facilities for treatment; and the receiving General Hospital has the proper treatment facilities; and
4. To provide in the course of such transport, such care as may be reasonably necessary to maintain the life of; or stabilize the condition of such Member.

Coverage for Medically Necessary ambulance services is limited to the maximums found in the Summary.

Covered Services do not include:

Transport for Elective Hospital Admissions.

Transport solely for the ease of the Member.

DIAGNOSTIC SERVICES

This Certificate Covers:

Services of a physician for lab and X-ray services in giving; and interpreting a diagnostic lab or X-ray exam.

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

Laboratory and diagnostic tests; including PSA tests; to screen for prostate cancer.

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.

Covered Services do not include:

An exam made in; or through a Hospital unless:

It is made during Outpatient care; and
No other benefit is paid for it under this Benefit Program.

A dental X-ray; unless it is in connection with:

An injury; or
Any of the oral surgical procedures covered under this Benefit Program.

Any Covered Services in excess of any Diagnostic Services maximum as shown in the Summary.

<p>DURABLE MEDICAL EQUIPMENT, PROSTHETIC DEVICES, SUPPLIES & APPLIANCES</p>
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**Durable Medical Equipment
and
Prosthetic Devices
Rider**

Issued by:

Anthem Health Plans, Inc. d/b/a
Anthem Blue Cross and Blue Shield
370 Bassett Road
P. O. Box 541
North Haven, Connecticut 06473-0541

This Durable Medical Equipment and Prosthetic Devices Rider makes benefits available for the purchase of durable medical equipment and prosthetic devices, subject to the terms and conditions of the Certificate and this rider, when the employer group has selected this rider as part of its benefit program.

This rider is not available to any person who does not have coverage under the benefit program. This rider replaces and supersedes any other rider of similar coverage that may have been issued prior to the effective date of this rider. The Certificate is amended as described herein.

Approved: January 1, 1996
Form: N6502

**Amendatory
Durable Medical Equipment and Prosthetic Devices
Rider**

A member's rights to benefits for durable medical equipment and prosthetic devices as provided in this rider are subject to the terms and conditions of the Managed Care section in the Certificate.

It is agreed that the Certificate is amended as follows:

For purposes of this rider, the Definitions section of the Certificate is amended by adding the following definitions:

Definitions

DURABLE MEDICAL EQUIPMENT - Equipment which:

- a. Is designed for repeated use in the medically necessary care, diagnosis or treatment of an illness or injury;
- b. Improves the functions of a malformed body part or prevents or retards further deterioration of the member's medical condition; and
- c. Is not useful in the absence of injury or illness.

ORTHOTIC APPLIANCE - A rigid or semi-rigid supportive appliance which restricts or eliminates motion of a weak or diseased body member.

Covered Services

For purposes of this rider, the Certificate is amended as follows:

1. Prosthetic devices or orthotic appliances, subject to the terms and conditions of the Managed Care section in the Certificate, when medically necessary and prior authorized by Anthem BCBS. In addition:
 - a. The item must be a prosthetic device or orthotic appliance as defined by Anthem BCBS.
 - b. The items must be obtained from an Anthem BCBS approved supplier.
 - c. Repair, replacement, fitting, and adjustments are covered when made necessary by normal wear and tear or by body growth or change. Repair and replacement made necessary because of loss or damage caused by misuse or mistreatment are not covered. Anthem BCBS must authorize the extent to which replacement prosthetic devices and orthotic appliances are medically necessary.
2. Durable medical equipment, subject to the terms and conditions of Section 4 Managed Care in the Certificate, when medically necessary and prior authorized by Anthem BCBS. Anthem BCBS will consider purchase of such 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. In addition:
 - a. The equipment must be an item of durable medical equipment as defined by Anthem BCBS and must be appropriate for use in the home.

- b. The equipment must be obtained from an Anthem BCBS approved supplier.
- c. The equipment, whether purchased or rented, remains the property of Anthem BCBS or its agent and must be returned when no longer medically necessary.

Diabetic drugs, equipment and supplies.

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 Certificate.

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.

Hearing aid coverage available for children 12 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.

Exclusions

For purposes of this rider, the Exclusions and Limitations section of the Certificate is amended to include the following:

1. Expenses for durable medical equipment, except as provided in the Certificate.

Examples of non-covered items include, but are not limited to:

- a. Deluxe equipment such as motor-driven wheelchairs and beds, unless medically necessary, for the treatment of the member's condition and required in order for the member to operate the equipment him/herself;
- b. Items not medical in nature;
- c. Comfort and convenience items such as bed boards, bathtub lifts, over bed tables, adjust-a-beds, telephone arms, and air conditioners;
- d. Physician's equipment such as sphygmomanometers and stethoscopes;
- e. Disposable supplies such as disposable sheets and elastic stockings;
- f. Exercise and hygienic equipment such as exercycles, Moore wheels, bidet toilet seats, and bathtub seats;
- g. Self-help devices not primarily medical in nature such as sauna baths, elevators and ramps, special telephone or communications devices, corrective shoes and arch supports; and

- h. Experimental or investigational research equipment.
2. Prosthetic devices and orthotic appliances, except as provided in the Certificate. Examples of non-covered items include, but are not limited to:
 - a. Dental devices except for maxillo-facial prostheses used to replace anatomic structures lost during treatment of tumors;
 - b. Non-rigid appliances and supplies such as elastic stockings, garter belts, corsets, wigs, or hair pieces;
 - c. Orthotics (except for medically necessary foot orthotics, abduction and rotation bars. One set/pair per member per calendar year), arch supports and corrective shoes;
 - d. Experimental or investigational research devices, appliances, or prostheses;
 - e. Eyeglasses or contact lenses.
 3. This rider provides no benefits for any service that is or has been covered under any other Section of the Certificate.

Schedule of Benefits

For purposes of this rider, the Schedule of Benefits Section of the Certificate is amended as follows:

Other Health Care Services:

Prosthetic devices and Orthotic devices when prior authorized by Anthem BCBS;

Durable medical equipment when prior authorized by Anthem BCBS.

HOME HEALTH CARE

This Certificate Covers:

Home health care when at least one of the following is received:

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 on hand.

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

- a. Occupational; speech; and respiratory therapy;
- b. Medical; and surgical supplies; and prescribed Durable Medical Equipment;
- c. Prescription Drugs dispensed from a retail Pharmacy;
- d. Oxygen; and its administration;
- e. Home health aide services that consist of: patient care of a medical; or therapeutic nature;
- f. Laboratory services;
- g. Services in regards to diet;
- h. Transport to and from a Hospital for treatment; re-Admission; or discharge by the most safe and cost-effective means available.

Benefit Period:

A benefit period for Home Health Care begins:

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

In lieu of an Admission: upon receipt of Prior Authorization.

For a Terminal Illness: upon diagnosis by a Physician.

Notes:

The Member must be confined at home; and home health care services must be rendered to treat the same illness; or injury for which the Member was hospitalized.

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

All Covered Services coordinated by a Non-Participating Provider home health agency must be Prior Authorized directly by Anthem BCBS.

Covered Services do not include:

Meals; personal comfort items; and house keeping services.

Nursing services rendered in the home by a relative; even if that person is a registered nurse; or a licensed practical nurse.

HOSPICE SERVICES

This Certificate Covers:

Inpatient Hospice services in a Hospice; Hospice unit in a Hospital; or Skilled Nursing Facility.

Part-time 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 occupational therapy.

Medical supplies; and drugs prescribed by a Physician.

Medical social services under the guidance 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 services of a home health aide for patient care up to 8 hours per day.

Notes:

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

Prior Authorization is required. Please see the Managed Benefits Section of this Certificate on how to get Prior Authorization.

Covered Services do not include:

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

HOSPITAL SERVICES

This Certificate Covers:

Inpatient Hospital Services including the following:

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 decides 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 both the Member; and Physician agree to a shorter stay.

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 sound improvement of a Member's condition;

Radiation therapy;

Electroshock therapy;

Chemotherapy for treatment of cancer;

Laboratory tests;

X-ray; or imaging studies

Outpatient surgery

Pre-Admission testing

Tests and studies that are required with a scheduled Admission for surgery.

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

Services connected 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.

If a Member is admitted as an Inpatient as result of Outpatient surgery; the Member must tell Anthem BCBS within two business days of the Admission. Please see the Managed Benefits Section of this Certificate for how to tell us of your Admission.

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

Inpatient and Outpatient 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 per the Prior Authorization requirements; and:

1. the patient has been determined by a licensed dentist along with a licensed Primary Care Physician to have a dental condition complex enough 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.

HUMAN ORGAN AND TISSUE TRANSPLANT SERVICES

This Certificate Covers:

When Prior Authorized, the Policy shall provide the benefits shown in this Section for services of the following:

- Heart;
- Lung;
- Heart-lung;
- Pancreas;
- Liver (adult or child);
- Kidney;
- Bone marrow;
- Peripheral Stem Cell procedures when performed along with the administration of high dose chemotherapy

In addition; this Benefit Program shall provide benefits without Prior Authorization for the following services when used with human organ and tissue transplant services:

- Blood transfusion;
- Cornea transplant;
- Bone and cartilage grafting;
- Skin grafting

Hospital Covered Services with Prior Authorization from Anthem BCBS.

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

Services; and supplies furnished by the Hospital.

Care given in a special care unit that has all the: facilities; equipment; and supportive services needed to provide an intensive level of care for critically ill patients.

Use of operating and treatment rooms.

Diagnostic services; which include a referral for evaluation.

Rehabilitative; and restorative physical therapy services.

Hospital supplies:

- Prescribed drugs;
- Whole blood; administration of blood; and blood processing;
- Anesthesia; anesthesia supplies; and services;
- Medical and surgical dressings; and supplies.

Surgical Covered Services when used with covered human organ and tissue transplants with Prior Authorization from Anthem BCBS.

Surgery; including diagnostic services related to a surgery (separate payment will not be made for pre-operative and post-operative services; or for more than one surgery done during one operative session).

Services of a physician who actively assists the operating surgeon;

Meting out of anesthesia ordered by the attending Physician; and rendered by a Physician or other Provider other than the surgeon or assistant at surgery.

Medical Covered Services related to covered human organ and tissue transplants with Prior Authorization from Anthem BCBS.

Inpatient medical care visits.

Intensive medical care rendered to a Member whose condition needs: a Physician's constant attendance; and treatment for a prolonged length of time.

Medical care given at the same time with surgery during the Hospital stay by a Physician; other than the operating surgeon for treatment of a medical condition; and separate from the condition for which the surgery was performed.

Medical care by two or more Physicians given at the same time during the Hospital stay when the nature; or severity of the Member's condition requires the skills of separate Physicians.

Consultation services given by another Physician at the request of the attending Physician; other than staff consultations; which are needed per Hospital rules and regulations.

Home; office; and other Outpatient medical care visits for exam; and treatment of the Member.

Diagnostic services; which includes: a referral for evaluation.

Rehabilitative and restorative therapy services;

Services provided in a Skilled Nursing Facility; with Prior Authorization from Anthem BCBS; which are neither custodial; nor for the ease of the Member or the Physician; and only until the Member has reached the maximum level of recovery possible for the given condition; and no longer needs skilled nursing care; or definitive treatment other than routine supportive care.

Home health care Covered Services to a homebound Member when prescribed by the Member's attending Physician in lieu of hospitalization; and arranged prior to discharge from the Hospital.

Medically Necessary immunosuppressant drugs prescribed with covered human organ and tissue transplants; and which, under Federal law, may only be dispensed by prescription; and which are approved for general use by the Food and Drug Administration.

Benefits for transport and lodging for the transplant receiver and companion(s) limited to: \$10,000 a maximum per transplant; except as otherwise stated in the Exclusions Subsection of this Section.

Transport costs spent for travel to and from the site of surgery for Covered Services for a transplant receiver; and one other person traveling with the patient; or if the transplant receiver is a minor child; transport costs for two other persons traveling with the patient.

1. Lodging; not to exceed \$150 total per day (\$200 total; if two persons are traveling with a minor child), will be paid for the person traveling with the patient.
2. Lodging for the Member while receiving Medically Necessary post-operative Outpatient care at the Hospital.

Benefits for the following services when provided with covered human organ and tissue transplants:

1. Transport of the surgical harvesting team; and donor organ; or tissue; and
2. Evaluation; and surgical removal of the donor organ; or tissue; and related supplies.

If a human organ or tissue transplant is provided from a donor to a transplant receiver; the following apply:

When both the receiver; and the donor are Members; each is entitled to the Covered Services shown in this Section.

When only the receiver is a Member; both the donor and the receiver are entitled to the Covered Services as shown in this Section:

1. 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; grants; foundations; government programs; etc;
2. Benefits provided to the donor will be charged against the receiver Member's coverage under the Policy.

When the receiver is uninsured; and the donor is a Member; this Benefit Program will only provide benefits related to the procurement of the organ up to the maximum stated in this Subsection.

No benefits will be provided for procurement of a donor organ; or organ tissue which is not used in a covered transplant procedure; unless the transplant is cancelled due to the Member'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 organ tissue which has been sold rather than donated.

These Covered Services including: Hospital; surgical; medical; storage; and transport costs; will be subject to a maximum of \$15,000 per transplant.

Notes:

This Benefit Program shall provide benefits for human organ and tissue transplant services only with Prior Authorization from Anthem BCBS. The Hospital must be designated; and approved by Anthem BCBS to perform the Covered Services provided under this Section. It should be noted that not every designated Hospital performs each of the Covered Services. In addition, the Member must follow all provisions in this Benefit Program.

Prior Authorization is required for all Covered Services provided in this Section. Please see the Managed Care Section of this Certificate for details on getting Prior Authorization.

The term "donor" means a person who provides organ tissue for transplant in a histo-compatible receiver.

The benefits for all Covered Services shown in this Section are limited to a \$1,000,000 lifetime maximum per Member as shown in the Schedule of Benefits enrolled under this Benefit Program; and any other health care product offered by Anthem BCBS; or its affiliates. Only those organ and tissue transplants; and related procedures shown in this Section are Covered Services under this Benefit Program.

Benefits will only be given for Covered Services; and supplies furnished to the transplant receiver during the time starting five days before the day on which a transplant procedure which is a Covered Service is performed; and ends 365 days after the operation.

When a Member gets human organ and tissue transplant; Covered Services from a Hospital; or facility that is not designated; and approved by Anthem BCBS; he or she pay any Cost-Shares; as well as amounts that exceed the Maximum Allowable Amount. These costs will not be used to meet the Cost-Share Maximum.

Covered Services do not include:

Benefits for services if the Member is not a suitable candidate; as decided by the Hospital designated; and approved by Anthem BCBS to provide such services.

Benefits for services for donor searches; or tissue matching; or personal living expenses related to donor searches; or tissue matching, for the receiver or donor; or their respective family or friends.

Any human organ and tissue transplant service that is determined to be Experimental or Investigational is not a Covered Service.

Benefits for transport and lodging for the transplant receiver and companion(s); when the human organ or tissue transplant is provided in a Hospital or other facility not designated; and approved by Anthem BCBS.

MATERNITY/FAMILY PLANNING SERVICES

This Certificate 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, shown in Section: Hospital Services of this Certificate.

Abortions and Miscarriages.

Infertility services

Infertility drugs (with 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.

In accordance with Ct. General Statute 38a-530c Inpatient care for a female Member and newborn will be provided for no less than 48 hours following a vaginal delivery; and for a minimum of 96 hours following a cesarean delivery; unless a shorter stay is agreed upon by the Member 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 Member 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 see the Exclusions and Limitations Section of this Certificate for other services not covered under this Benefit Program.

MEDICAL EMERGENCY

This Certificate Covers:

Ambulance services when the Member'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:

This Benefit Program shall only provide benefits for Medical Emergency services; if the care is found to be for a Medical Emergency. All Admissions due to a Medical Emergency must be approved by Anthem BCBS within two business days of the diagnosis; care; or treatment of the Medical Emergency.

If the emergency calls for the Member be taken to the nearest Hospital; this Benefit Program shall provide benefits for Covered Services for the Medical Emergency; whether or not the nearest Hospital is a Participating Hospital or Non-Participating Hospital.

If the emergency requires that the Member 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; whether or not the Physician or Provider is a Participating Physician or Provider; or Non-Participating Physician; or Provider.

If the Medical Emergency needs a Member's Admission to a Non-Participating Hospital; this Benefit Program shall provide benefits for Covered Services as if the services were given at a Participating Hospital only through the day when the Member can be transferred to a Participating Hospital; as decided by Anthem BCBS.

Claims for services rendered to the Member shall be reviewed by Anthem BCBS. Based on Anthem BCBS's review; the Member may be liable for Cost-Shares; or the full cost of all services rendered; if Anthem BCBS decides that the services provided were not for a Medical Emergency. Medical Emergency Covered Services are limited to the treatment rendered during the first 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 benefits as shown in the Schedule of Benefits and Benefit section.

Covered Services do not include:

Coverage for ambulance services in excess of the maximum per trip for land ambulance services; and in excess of the maximum per trip for air ambulance services.

MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

This Certificate 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:

Prior Authorization is required. Please see the Managed Benefits Section on how to get 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 direction 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:

- a. the insured has a Medically Necessary, serious mental or nervous condition that substantially impairs the insured's thoughts, perception of reality, emotional process or judgment or grossly impairs the behavior of the insured, and, upon an assessment of the insured 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
- b. A treatment plan must be prescribed by a Physician with goals; and objectives suitable to both the patient and the proposed treatment plan.

Covered Services do not include:

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

ORAL SURGERY

This Certificate Covers:

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.

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 Certificate for other services not covered under this Benefit Program.

OTHER PROVISIONS

This Certificate Covers:

Birth to Three Program: Services from birth to age three for early intervention Covered Services for a Member 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.

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 which are not replaced; or will not be replaced by blood donors; or a blood bank.

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 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.

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.

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 this Certificate 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 license. Benefits are provided for: 10 hours of initial training; 4 hours of extra training because of changes in the person's condition; and 4 hours of training required by new developments in the treatment of diabetes.

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. More treatment is covered if recommended by a board-certified rheumatologist; infectious disease specialist; or neurologist.

Covered Services do not include:

Please see the Exclusions and Limitations Section of this Certificate for other services not covered under this Benefit Program.

PHYSICIAN MEDICAL/SURGICAL SERVICES
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This Certificate Covers:

Medical services for the treatment of an illness or injury.

Medical office visits; specialist consultations; injections; and home visits by a Physician.

Chiropractic services; including: office visits with tests; and measurements for treatment planning.

Allergy testing.

Inpatient Hospital/Inpatient Facility visits during a covered Admission.

Acute Psychiatric Care while an Inpatient at a Hospital or Inpatient Facility.

Inpatient consultations by other than the attending Physician.

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 up to the per Member per Calendar Year amount as shown in the Schedule of Benefits.

In accordance with C.G.S. 38A-516C, 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 assistant services.

Notes:

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.

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

Reconstructive surgeries, procedures and services: 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 Certificate; 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 surgeries, procedures and 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 Certificate, 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.

If more than one surgical procedure is performed during the same operation, we will calculate the allowable charge for all of 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.

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.

PREVENTIVE SERVICES

This Certificate Covers:

Coverage for hearing examinations includes screening to determine the Medical Necessity for hearing correction when performed by a 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 for other services not covered under this Benefit Program.

Exams in any way related to employment.

PRIVATE DUTY NURSING SERVICES

This Certificate Covers:

Private Duty Nursing Services.

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 Member or while the Member 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 Certificate for other services not covered under this Benefit Program.

SKILLED NURSING FACILITIES

This Certificate Covers:

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

Notes:

Prior Authorization is required. Please see the Managed Benefits Section of this Certificate for how to get Prior Authorization.

Not more than the maximums shown in the Schedule of Benefits will be covered.

Covered Services do not include:

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

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

THERAPY SERVICES

This Certificate 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.); and Anthem BCBS's Utilization Management Department;

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. pain management;
4. Covered Services will include: supplies; solutions; and pharmaceuticals.

Notes:

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

Any Cost-Shares or Maximum visits listed in the Schedule of Benefits for Outpatient Physical, Occupational, and Speech Therapy services apply regardless of place of service.

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 count towards the Cost-Share Maximum.

Covered Services do not include:

Please see the Exclusions and Limitations Section of this Certificate for other services not covered under this Benefit Program.

URGENT CARE SERVICES

This Certificate Covers:

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

In the Local Network Area:

When Urgent Care services are needed; the Member must first try to tell their Primary Care Physician or Participating Physician prior to getting such care; or the Member will have to pay for any services received. The physician will instruct the Member to do one of the following:

Go to the physician's office;

Go to the: emergency room; free-standing emergency facility; or Urgent Care Facility; or

Go to another Participating Provider's office.

If the Member is unable to contact their Primary Care Physician or Participating Physician; the Member should call Anthem BCBS before seeking Urgent Care services.

Out-of-the Local Network Area:

As part of the BlueCard Access® Program, you have access to in-network benefits for Urgent Care when you are out-of-the Local Network Area. This program links all Blue Cross and Blue Shield plans across the country. When Urgent Care services are needed; the Member should call 1-800-810-BLUE to locate a Participating Physician, Participating Provider, or Participating Hospital. BlueCard Access is available 24 hours a day, 7 days a week, and 365 days a year. Please have your Member Identification Card handy when calling. The Member should also contact Anthem BCBS within 48 hours or two business days of an urgent visit in order for any claims to be processed according to the Plan's in-network benefits.

Out-of-country:

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).

Notes:

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

Use of an emergency room; freestanding emergency facility; or Urgent Care center for care that is not urgent will not be covered.

Urgent Care Facilities are available when a Participating Provider is not available to treat the Member.

Urgent Care services will be covered only if the Member'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 see the Exclusions and Limitations Section of this Certificate for other services not covered under this Benefit Program.

WALK-IN CENTER SERVICES

This Certificate Covers:

Services at a Participating Walk-In Center and provided by a Participating Physician.

Covered Services include: services that are deemed not to be Emergency Medical Services.

Notes:

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

The Member does not need to contact their Primary Care Physician to get a referral to a Walk-In Center.

Services rendered in a Walk-In Center will be covered only if the Member's signs; and symptoms at the time of treatment are determined to be Medically Necessary.

Covered Services do not include:

Adult routine physicals; and well child care exams.

Please refer to the Exclusions and Limitations Section 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 Certificate, no benefits will be provided for expenses related to the services, supplies, conditions or situations described in this section. These items and services are not covered even if you receive them from your Provider or according to your Provider's Referral.

Please remember, this plan does not cover any service or supply not specifically listed as a covered service in this certificate. The following list of exclusions is not a complete list of all services, supplies, conditions or situations that are not covered services. If a service is not covered, then all services performed in conjunction with that service are not covered. Anthem 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 Certificate.

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:

Described in the Certificate;
Rendered or ordered by a Physician;
Within the scope of the Physician's, Provider's or Hospital's licensure, and
Medically Necessary Care for the proper diagnosis and treatment of the Member

2. Benefits may be reduced; or denied if subject to the Managed Benefits – Managed Care Guidelines. Any reduced or denied benefits paid by the Member do not count towards any applicable 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 like those stated on the Managed Benefits – Managed Care Guidelines, are not paid as a Covered Service.
4. Benefits for services rendered before the Member'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 getting services after his or her Benefit Program is: rescinded; suspended; cancelled; interrupted; or terminated for any reason will be liable for payment of such services.
6. Care for conditions that 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 required by law.
8. Services covered in whole; or in part by public; or private grants.
9. Studies related to pregnancy; except for major medical reasons.
10. Simplified or self-administered tests; and multiphasic screening.
11. Prenatal medical conferences with a pediatrician regarding an unborn child; unless the visit is the result of a medical referral.

12. Charges for the Member's room and board when the Member has a leave of absence from: the Hospital; Substance Abuse Treatment Facility; or other Inpatient Facility.
13. Evaluation; treatment; procedures; and Prescription Drugs related to and performance of sex-change operations including: follow-up treatment; care; and counseling.
14. Vaccines (other than routine immunizations; or those needed for travel).
15. Services; medical supplies; or supplies not 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.
16. 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.
17. 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.
18. 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 close family Member or relation; even if a Participating Physician or Participating Provider.
19. Services which the Member or Anthem BCBS is not legally required to pay.
20. Wigs; and other cranial prosthesis; except as noted in the Covered Services Section.
21. Inpatient services which can be properly rendered as Outpatient services.
22. Disease contracted; or injuries resulting from war.
23. Charges after the Provider's or Hospital's regular discharge hour on the day indicated for the Member's discharge by his/her Physician.
24. Eyeglasses; contact lenses.
25. Travel; whether or not recommended by a Physician.
26. Certain pulmonary function tests which; in the opinion of Anthem BCBS; do not meet the definition of a covered diagnostic laboratory test.
27. Services or procedures rendered without regard for specific clinical indications; routinely for groups or persons; or which are performed solely for research purposes.
28. Services or procedures which have become obsolete; or are no longer medically justified as determined by appropriate medical fields.
29. Radiation therapy as a treatment for acne vulgaris.
30. Services required by third parties for: employment; membership; enrollment; or insurance, such as: school or employment physicals; physicals for summer camp; enrollment in health, athletic, or similar clubs; premarital blood work or physicals; or physicals required by insurance companies or court ordered alcohol or drug abuse courses.

31. Durable Medical Equipment and other items for home or personal use; except as provided in the Benefit section.
32. Prosthetic Devices; except as provided in the Benefit section. Examples of non-covered items include; but are not limited to:
 - Bite plates/dental prosthetics; except for maxillo-facial Prosthetic Devices used to replace anatomic structures lost during treatment of tumors;
 - Optical; or visual aids; including: eyeglasses or contact lenses; except for the treatment of: congenital aphakia; or for aphakia following cataract surgery when an intraocular lens is not medically possible;
 - Penile implants;
 - Xomed audiant bone conductors;
 - Orthotics (except for Medically Necessary: molded foot orthotics; abduction; and rotation bars. One set/pair per Member per Calendar Year); arch supports; and corrective shoes;
 - Experimental; or research prostheses.
33. Treatment of pattern baldness;
34. Items generally used for personal comfort and/or useful to the Member's household; including but not limited to:
 - Air conditioners; humidifiers; air cleaners; filtration units; and related apparatus;
 - Whirlpools; saunas; and related apparatus;
 - Vans; and van lifts;
 - Stair; and chair lifts;
 - Exercise bicycles; and other types of exercise equipment.
35. Physical therapy; chiropractic care; occupational therapy; speech therapy; and cardiac rehabilitative therapy; except as provided in the Benefit section.
36. Testing for or treatment of a Learning Disability; except as provided in the Benefit section.
37. Testing; training; or rehabilitation for educational; or developmental purposes; except as provided in the Benefit section.
38. 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 as set forth in this Certificate.
39. Dental diagnosis; care; treatment or diagnostic imaging studies; except as provided in the Benefit section. Examples of non-Covered Services include; but are not limited to: the extraction of impacted wisdom teeth; correction of malposition of the teeth and jaw; treatment of dental caries; periodontics; endodontics; orthodontics; replacement of teeth; bonding; gold foil restorations; application of sealants; bitewing x-rays; crown or tooth preparations; fillings; crowns; bridges; dentures; inlays and onlays; and services with respect to congenital malformations. Anesthesia; x-ray; laboratory; or facility fees for dental non-Covered Services shall also not be covered. Prosthetic Devices are not a Covered Service; except as provided in the Benefit section.
40. Oral surgery; except as provided in the Benefit section. An example of a non-Covered Service is; but is not limited to: the correction of malposition of the teeth or jaw; or the teeth and jaw.
41. Surgical and non-surgical exam; 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. Examples of non-Covered Services include; but are not limited to: physiotherapy, such as therapeutic muscle exercises; galvanic or transcutaneous nerve stimulation; vapocoolant sprays, ultrasound or

diathermy; behavior modification such as: biofeedback psychotherapy; Appliance therapy such as: occlusal Appliances (splints); or other oral Prosthetic Devices; and their adjustments; orthodontic therapy such as: braces; prosthodontic therapy such as: crowns; bridgework; and occlusal adjustments.

42. Routine foot care rendered:

- a. In the exam, treatment or removal of all or part of: corns; callosities; hypertrophy; or hyperplasia of the skin; or subcutaneous tissues of the foot; or
- b. In the cutting; trimming; or other non-operative partial removal of toenails; except when Medically Necessary in the treatment of neuro-circulatory conditions.

43. Emergency room services that are not related to a Medical Emergency.

44. Custodial Care when:

- a. Primarily to provide room and board (with or without nursing care); and
- b. Needed to help to support the essentials of daily living; and
- c. Supervisory care by a Physician for a Member who is mentally or physically disabled; and who is not under active and specific medical; surgical; and/or psychiatric treatment which would be expected to reduce the disability to the extent needed for the Member to function outside a: protected; monitored; and/or controlled environment; or when despite such treatment there is no reasonable likelihood that the disability shall be so reduced.

Care shall be considered custodial even if:

- a. The Member is under the care of the Primary Care Physician; or a Participating Physician;
- b. The Primary Care Physician or the Participating Physician prescribes services to: support; and maintain the Member's condition; or
- c. The services and supplies are being provided by a registered nurse; or licensed practical nurse.

45. Ambulance services, including but not limited to:

- a. Transport for elective Hospital Admissions; and
- b. Transport solely for the convenience of: the Member; family; or physician or Provider; except when Medically Necessary; or in the case of a Medical Emergency.

46. Private room accommodations; except as noted in the Benefit section.

47. Drugs or medications; legend and over-the-counter; prescribed for use as an Outpatient; except as otherwise stated herein.

48. Whole blood; blood plasma; and other blood derivatives; and donor services that are provided by the American Red Cross.

49. Contraceptive devices.

50. Reversal of voluntary sterilization.

51. Sperm collection and preservation, all services related to surrogate parenting arrangements and preparatory treatment.

52. Marriage counseling other than for the treatment of: a diagnosed mental illness; stress management; parent-child management; and pain control.

53. Psychiatric and other treatment for sexual dysfunction; including: sex therapy; unless documented to be caused by a medical condition and Prior Authorized by Anthem BCBS.
54. Care; treatment; procedures; services; or supplies that are primarily for dietary control including; but not limited to: any exercise or weight reduction programs; whether formal or informal; and whether or not recommended by a physician or Provider.
55. Special nutritional formulas for the treatment of Crohn's disease.
56. Hypnosis.
57. Human organ and tissue transplants; or associated donor costs; except as stated in the Benefit section.
58. Care; treatment; service; or supplies to the extent that the Member has obtained benefits under any applicable law; government program; or public or private grant; except for: Medicare; Medicaid; or any similar state program.
59. Any illness or injury for which benefits are paid; payable; or eligible for coverage under any Worker's Compensation Law; Automobile; or no-fault law to the extent permissible by law, or other similar law.
60. Anthem BCBS does not have to pay for expenses of services; which the Member or Anthem BCBS is not legally required to pay.
61. Routine eye exams; or refractions; except as provided in the Benefit Description.
62. Radial keratotomy.
63. Eye exercises and visual therapy.
64. Human growth hormone therapy; except when Medically Necessary for cases of hypopituitarism; and with Prior Authorization from Anthem BCBS.
65. Hospital Outpatient clinic services.
66. Penalties imposed on a Member by the primary payer.
67. Inpatient private duty nursing.
68. Any medication or drug; which has a biotechnical application; is a genetically engineered biological product; or is listed in the formulary as such.
69. Hypodermic needles or syringes prescribed by a physician; except for the purpose of administering medicine for medical conditions; provided such medicines are Covered Services.
70. No benefits will be available for Maintenance Care which is:
 - a) Treatment provided for the Member's continued well-being by preventing deterioration of a chronic clinical condition; and
 - b) Maintenance of an achieved stationary status; which is a point where little; or no improvement in musculo-skeletal function can be made despite therapy.

This includes without limitation, Methadone and Suboxone maintenance or any other similar maintenance therapy program and its related testing, supplies, visits and treatment.

71. All other services and items of care not listed in this Certificate; except as provided by Riders to this Benefit Program and agreed upon by both parties.
72. Benefits for services caused by or resulting from the Member's participation in a riot or civil disorder; act of or attempt to commit an assault or felony.
73. Services for Chronic Care.
74. The following is a list of procedures which are not covered:
- a. 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:
 1. When at least five out of six histocompatibility complex antigens match between the patient; and the donor.
 2. The mixed leukocyte culture is non-reactive.
 3. 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.

- b. 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:
 1. Non-Hodgkin's lymphoma; high grade; first or subsequent remission. No morphological evidence of bone marrow involvement should be evident.
 2. Hodgkin's disease as defined above with an absence of bone marrow involvement.

3. Acute nonlymphocytic leukemia in second remission; in which no HLA matched donor exists; or an allogeneic transplant is inappropriate.
4. Acute lymphocytic leukemia in second remission; in which no HLA matched donor exists; or an allogeneic transplant is inappropriate.
5. Retinoblastoma; adjuvant setting after successful induction (consolidation).
6. 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.

75. Any exclusion above will not apply to the extent that:

- Coverage is specifically provided by name in this Plan; or
- Coverage of the charges is required under any law that applies to the coverage.

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 Member has a right of recovery against third parties for the cost of Covered Services. Acceptance of Covered Services will make up consent by the Member to Anthem BCBS's right of recovery. The Member agrees to take all further action to execute and deliver such extra instruments and to take such other action as Anthem BCBS shall need to put into practice this provision. Anthem BCBS will have the right to bring suit against such third party in the name of the Member and in its own name as subrogee. The Member shall do nothing to prejudice the rights given to Anthem BCBS by this provision without its consent. If a Member received payment from a third party by suit or settlement for the cost of Covered Services, such Member must pay Anthem BCBS less Anthem BCBS's pro rata share of the reasonable attorney's fees and cost the Member incurred in getting the recovery.

WORKERS' COMPENSATION

To the extent allowed 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 Member.

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 Member is entitled.
2. To charge the Member for such dollar value; to the extent that the Member has been paid for the Covered Services.
3. To reduce any sum owing to the Member by the amount that the Member has received payment.
4. To place a lien on any sum owing to the Member for the amount Anthem BCBS has paid for Covered Services rendered to the Member; in the event that there is a disputed claim between the Member's Employer Group; and the designated Workers' Compensation insurer as to whether or not the Member 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 financial settlement to the full extent of such settlement.
6. If a Member is entitled to benefits under Worker's Compensation, employer's liability or occupational disease law, it must follow all of the guidelines in the Managed Benefits Section in order to continue providing benefits for Covered Services when the Workers' Compensation benefits are used up.

AUTOMOBILE INSURANCE

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

Anthem BCBS shall be entitled:

To charge the insurer required under such law for the dollar value of those benefits to which a Member is entitled;

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

To reduce any sum owing to the Member by the amount that the Member 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; for Covered Services a Member receives under an automobile insurance policy which provides benefits without regard to fault.

A Member who fails to secure no-fault insurance required by 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 benefits or other benefits provided for injury if such a no-fault policy had been obtained.

If a Member is entitled to benefits under a no-fault or other automobile insurance policy; benefits for Covered Services will only be provided when a Member follows all of the guidelines stated in the Managed Benefits Section. 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 used up.

COORDINATION OF BENEFITS

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

Applicability

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

1. If the Member 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 Member by the primary carrier are not subject to COB;
 - d. The Member 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 Member 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 Member, the reasonable cash value of the Covered Services provided by this Benefit Program.

Order Of Benefit Determination Rules

1. General Rule

When a Member 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 Certificate; 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 Member 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 Member 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, B and D of Medicare.

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 Member allows the release of data needed to apply the COB rules. Any Member 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 Member shall be limited to the Allowable Expense that the Member has received from another Plan. Acceptance of Covered Services will make up consent by the Member to Anthem BCBS’s right of recovery. The Member 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 Member

The Member'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 Member'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 reduced work hours; or
 - He or she no longer meets the eligibility requirements of the Benefit Program; as defined in the Eligibility Section of this Certificate;

However the Employer Group, upon a Covered Person's voluntary termination or termination of the Covered Person by the Employer Group, may elect to receive a credit for the portion of the premium paid for your coverage. As such, an earlier date of termination may apply if the Employer Group notifies Anthem BCBS within 72 hours of the date the Employer Group has terminated a Covered Person due to voluntary termination or termination by the Employer Group; in which case the date of termination shall be 72 hours following the date termination is issued by the Employer Group.

In the event that the Employer Group contacts Anthem BCBS after 72 hours from the date the Employer Group has terminated a Covered Person or due to the Covered Person's voluntary termination the standard termination date will apply without exception as described above.

Receipt of a credit for the portion of the premium paid for the Covered Person's coverage may trigger the need to return the portion of said premium contributed by the Covered Person whose coverage is being terminated. Accordingly, upon the Employer Group's election to receive a credit for the portion of the premium paid for the Covered Person's coverage, it is the Employer Group's responsibility to notify the Covered Person of the termination of the Covered Person's insurance coverage within 72 hours of the date the employment of the Covered Person has terminated due to voluntary termination or termination by the Employer Group.

7. Following the effective date of the policy, Anthem BCBS may rescind, cancel or limit the Benefit Program; if the Member has submitted false information to Anthem BCBS, or omitted information, during the application and enrollment process about 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;

In the event that Anthem BCBS failed to complete underwriting with respect to health status prior to the acceptance of the application for coverage by Anthem BCBS, Anthem BCBS must obtain prior approval from the Insurance Department to rescind, cancel or limit the policy.

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 cease at the end of the last day for which payment was made;
9. Termination of an enrolled Dependent's Coverage will occur on the first day of the month following the:
 - Divorce; or legal separation of the spouse.
 - Other enrolled Dependent's criteria are no longer met by: the spouse; or enrolled Dependents as defined in the Eligibility Section.
 - Enrollment in the Benefit Program shall be terminated on the day after the death of an enrolled Dependent.

In the event of the termination of the Covered Person based on Anthem BCBS standard termination rules or the Employer Group's election of early termination in order to receive a credit against premium payment, coverage under the Benefit Program will also terminate for any and all Dependents enrolled under the Benefit Program.

Termination of the Employer Group

1. The Benefit Program may be terminated in accordance with valid 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 go into effect on the first of the month following the end of the 15 day notice period;
 - By Anthem BCBS; in the event the Employer Group fails to pay all; or any part of the Premium due Anthem BCBS. Termination will go into effect on the last to occur of the date to which such Premium have been paid by the Employer Group; or the 30th day following the date when such Premium are due;
 - By Anthem BCBS; in the event the Employer Group receives 30 days prior written notice from Anthem BCBS that 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 Group Health Care Benefits Contract and as described below:

Contribution requirements do not apply to continuation of coverage under Connecticut Continuation Rights, C.G.S.38a-538 and 38a-554, or the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) P.L.99-272.: esl.

PARTICIPATION REQUIREMENTS:

A. 1-50 Eligible Employees

The Employer Group agrees to contribute at least 25% of the class I (single person) premium rate for all eligible employees, excluding Members covered under the provisions of COBRA or other applicable law.

If the Employer Group offers employees a choice of health plans, the Employer Group agrees to make equitable contributions on behalf of all eligible employees. Equitable contributions are defined as contributions that do not financially discriminate against eligible employees who select Anthem BCBS. Acceptable policies are: equal dollar or percentage contributions, reasonable amounts for salary or projected utilization differentials, designated amounts up to the maximums contributed by the Employer Group to the base plan, or reasonable maximums if Anthem BCBS would be offered at little or no cost, or any other formula that is mutually accepted by the Employer Group and Anthem BCBS.

Participation Requirement:

2-9 Eligible Employees – 100%*
10+ Eligible Employees – 75%*

*exclusive of employees waiving coverage due to spousal coverage

B. 51+ Eligible Employees

The Employer Group agrees to contribute at least 50% of the class I (single person) premium rate for all eligible employees, excluding Members covered under the provisions of COBRA or other applicable law.

Contribution levels below 50% (not less than 25%) will require proof that participation minimums are met and may require additional underwriting consideration and/or approval. Anthem BCBS will not accept contribution levels less than 25%.

Participation Requirement:

75% of net eligible lives less valid credits (waivers) and 50% of total eligible employees. Eligible lives is the total eligible employees prior to credits (waivers) given for each eligible employee that has coverage elsewhere as determined by Anthem BCBS.

2. During the first two years following the effective date of the policy, 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 Group Health Care Benefits Contract by the Contractholder; or Anthem BCBS will instantly result in the termination of each Covered Person's or Dependent's right to coverage; and benefits under this Benefit Program.

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 the event. The Member hereby acknowledges that the: termination; expiration; non-renewal; or cancellation of the contract will 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.

Member Notification

Pursuant to Connecticut General Statutes; 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 Member; and his or her covered Dependents who terminate from this Benefit Program. The data in 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 data regarding prior coverage to help it 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 Certificates of Creditable Coverage by contacting Member Services.

Confinement at the Time of Termination

If the Member is Inpatient in a Hospital; and is entitled to receive benefits for Covered Services subject to: the terms; conditions; limitations; and exclusions in this Certificate on the date upon which coverage otherwise would terminate; the Member shall be entitled to receive benefits for Covered Services through the day of discharge from that Hospital.

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 group contract terminates; or required charges are not paid when due.

Qualifying Event	Who May Continue	Maximum Continuation Period
Employment ends; retirement; leave of absence; in the event of a layoff, or reduction in hours (except gross misconduct dismissal)	Group Member and Dependent Members	Earliest of: 30 months; or Enrollment Date in other group coverage or Medicare; or Date Coverage would otherwise end.
Divorce or Legal Separation	Former spouse and child Dependent Members.	Earliest of: 36 months; or Enrollment Date in other group coverage or Medicare; or Date Coverage would otherwise end.
Death of Group Member	Surviving spouse and child Dependent Members.	Earliest of: 36 months; or Enrollment Date in other group coverage or Medicare; or Date Coverage would otherwise end.
Child Dependent Member loses eligibility	Child Dependent Member.	Earliest of: 36 months; or Enrollment Date in other group coverage or Medicare; or Date Coverage would otherwise end.
Total Disability of Group Member	Group Member and Dependent Members	Earliest of: 29 months after the Group Member leaves employment, or Date total disability ends, or 3. Enrollment Date in other Group coverage or Medicare, or Date Coverage would otherwise end.
Employment ends, retirement, leave of absence, or reduction in hours (except gross misconduct dismissal) as a result of a Member's eligibility to receive Social Security income	Group Member and Dependent Members	Until midnight of the day preceding such Member'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 Members	Lifetime Continuation
Surviving Dependent Members of a retiree on lifetime continuation due to: bankruptcy of Group Contractholder	Surviving spouse and child Dependent Members.	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: persons who had coverage under the Benefit Program 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.

Choosing Continuation

Upon notice of the qualifying event; the Group Contractholder must tell the Group Member of the option to continue coverage within 10 days.

You must choose to continue coverage by telling the Group Contractholder in writing. You have 60 days to choose to continue coverage; starting with the date of the notice of continuation; or the date coverage is terminated; whichever is later. If you fail to choose continuation within the required time period; it will make you ineligible to choose continuation at a later date.

Coverage

You have 45 days from the date of choosing to continue to pay the first continuation charges. After this first grace period; you must pay charges monthly in advance to the Employer Group to keep coverage in force. If you fail to remit continuation charges within 30 days of the due date; it will result in termination of coverage. Charges for continuation are the group rate; plus a 2% administrative fee. If the Group Member's total disability was the qualifying event for continuation; the cost to continue coverage could be the group rate; plus a 2% administrative fee.

Social Security Determination for Total Disability

If the Covered Person; or the Dependent Member is Totally Disabled at the time the Group Member leaves employment; or becomes disabled with the first 60 days of continuation of coverage; an additional 11 months shall be available to the Group Member and enrolled Dependents. In order to qualify for this extension; the person must 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; or becomes disabled at any time during the first 60 days of continued coverage. The Covered Person or enrolled Dependent must provide notice of the disability to Anthem BCBS not later than 60 days after the date of the Social Security Administration's determination; and before the end of the initial 18 months of continuation coverage.

If it is determined that the Member 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.

Special Rule for Pre-Existing Conditions

If you get other group coverage that excludes benefits for Pre-Existing Conditions; you may choose to remain on the continuation under this Benefit Program until: the date the continuation would otherwise end; or until the Pre-Existing Condition exclusion period under the new Plan is met; whichever occurs first.

Special Continuation Rights for Totally Disabled Members When Group Contract Terminates

Upon termination of the Benefit Program by the Employer Group or Anthem BCBS; benefits for Covered Services for a Member who was Totally Disabled on the date of termination shall be continued for up to 12 months without Premium payment. The claim must be submitted within 12 months of the termination of the Benefit Program.

Continuation Options

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

1. Connecticut Continuation Rights, C.G.S. Section 38a-538 and 38a-554
 - a. As provided by Connecticut law, (Connecticut Continuation Rights, C.G.S. Section 38a-538 and 38a-554) the Policyholder shall allow a Member and his or her Dependents who become ineligible for continued participation under this Policy to elect to continue coverage as described below.
 - (i) Upon termination of the Member's employment, other than as a result of death or the gross misconduct of the Member, the Member and his or her Dependent may continue coverage until the end of 30 months following the day on which he or she ceased to be eligible for coverage under this Policy;
 - (ii) Upon the Member's death, his or her Dependent may continue coverage until the end of 36 months following the day on which they ceased to be eligible for coverage under this Policy;
 - (iii) Upon dissolution of the Member's marriage, his or her Dependent may continue coverage until the end of 36 months following the day on which they ceased to be eligible for coverage under this Policy;
 - (iv) Upon termination of employment, reduction of hours, or leave of absence that results from a Member's eligibility to receive Social Security income, the Member and the Member's Dependents may continue coverage until midnight of the day preceding the Member's eligibility for benefits under Title XVIII of the Social Security Act.
 - b. Upon the Member's absence from employment due to illness or injury, a Member and his or her Dependents may continue during the course of such illness or injury or for up to 12 months from the beginning of such absence.
 - c. Upon termination of the Policy by the Policyholder or Anthem BCBS, benefits for Covered Services for a Member who was Totally Disabled on the date of termination shall be continued without premium payment during the continuance of such disability for a period of 12 months following the month in which the Policy was terminated, provided the claim is submitted within one year of termination of the Policy.
 - d. An additional 11 months shall be available to a Member 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 Connecticut Continuation Rights, or becomes disabled at any time during the first 60 days of Connecticut Continuation Rights coverage. The Member or enrolled Dependent must provide notice of the disability determination to Anthem BCBS not later than 60 days after the date of the Social Security Administration's determination, and before the end of the initial 18 months of Connecticut Continuation Rights coverage.
 - e. A Member is required to provide timely notice to the Policyholder of his or her election to continue coverage. Except as provided in (c) above, a Member who continues coverage may be required to remit the applicable premium payment to the Policyholder. Payment of such premiums need not be made on behalf of the Member by the Policyholder if they are not received by the Policyholder on a timely basis. Failure of the Member to remit such premium may result in termination.
2. Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) P.L. 99-272
 - a. Members in groups subject to the Consolidated Omnibus Budget Reconciliation Act of 1985, P.L. 99-272 (COBRA) may continue membership in the Policy to the extent permitted by law. The Policyholder is responsible for notifying the Member regarding whether the Policyholder or Anthem BCBS will be

administering the program. Coverage shall also be available to a child born to or placed for adoption with the Member while the Member is continuing coverage pursuant to COBRA.

(i) Continuation of coverage for up to 36 months shall be available for an enrolled Dependent following:

- a. The death of the Member;
- b. The legal separation or divorce from the Member;
- c. The Member's entitlement for Medicare;
- d. The attainment of the limiting age for an enrolled Dependent child or student.

(ii) Continuation of coverage for up to 18 months shall be available to a Member and his or her enrolled Dependents following:

- a. The Member's reduction in work hours;
- b. The Member's voluntary resignation;
- c. Lay-off or termination of the Member for any reason (other than gross misconduct).

- b. An additional 11 months shall be available to a Member 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 Member or enrolled Dependent must provide notice of the disability determination to Anthem BCBS not 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 Member 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.

The continuation of coverage must be equal to the benefits available to currently employed Members. A Member who is eligible for continuation of coverage must be provided with at least 60 days in which to elect such coverage. A Member's eligibility for such continuation of coverage ends earlier than the above periods if:

1. The Member 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 Member; or
2. The premium for continuation of coverage is not paid on time; or
3. The Member becomes entitled to Medicare benefits; or
4. The Policyholder 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 Certificate 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 Certificate 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 Certificate 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 Certificate.

The Health Reinsurance Association of Connecticut (HRA)

Connecticut residents who are no longer eligible for Employer Group coverage under this Benefit Program may apply for conversion of coverage from the HRA. The benefits; Premium rates; and eligibility criteria for the plans offered by the HRA are determined by the HRA.

Connecticut residents must make application to the HRA within 31 days of their termination date from the Employer Group benefit plan; in order to continue without a break in coverage; and for the period of coverage under the Employer Group benefit plan to be counted towards any Pre-Existing Benefit Exclusion Period of the HRA plans.

For those Members in groups subject to the Health Insurance Portability and Accountability Act of 1996; Members who have used up other coverage; and are no longer eligible for continuation coverage will be eligible for coverage through the HRA. These are persons who:

1. have not previously been terminated by Anthem BCBS for fraud; or non-payment;
2. previously had 18 months of continuous coverage with the most recent coverage under a group health Plan;
3. are ineligible for other group coverage;
4. have used up the COBRA continuation coverage period; or like state continuation coverage period.

Inquiries as to the HRA plans should be made to:

The Health Reinsurance Association of Connecticut
100 Great Meadow Road
Suite 112
Wethersfield, CT 06109
1-800-842-0004

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, Provider or Hospital.

If further review of a claim is requested, the Member should first contact Member Services. If resolution is not met, the Member should follow the guidelines set forth in the Member Appeal/Grievance Process Section of this Certificate.

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 Member when a Member receives Covered Services from a Non-Participating Physician, Provider or Hospital. The Member 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 accordance with the Payment of Covered Services Section of the Certificate.

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 Member should first contact Member Services. If resolution is not met, the Member should follow the guidelines set forth in Member Appeal/Grievance Process Section of the Certificate.

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 Member 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 Member.

In order to be considered for payment, claims submitted by a Member for payment for Covered Services provided by Non-Participating Physicians, Non-Participating Providers and Non-Participating Hospitals must be received by Anthem BCBS within 180 days from the date the Covered Services were performed. Claims for Covered Services

more than 180 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
370 Bassett Road
North Haven, CT 06473

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

Claims for benefits for Covered Services provided to a Member 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 Member written notice of the reason(s) for the delay.

If the time to process a health claim is extended because the Member 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 Member until the date Anthem BCBS receives the Member's response. Anthem BCBS will make a claim decision within fifteen (15) days after receipt of the requested information. Members 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 Member of Provider overpayments not made to or held by such Member 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 Member a written notice within the established time periods described in the section Payment for Covered Services. The Member or the Member's duly authorized representative may appeal the denial as described in the Member 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 Member'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 Member 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 Member upon request and at no charge.

MEMBER APPEAL PROCESS

Questions may be posed about the Member's health benefit plan. Since questions often can be handled informally, these questions may be addressed by contacting Member Service/Customer Service, utilizing the telephone number provided on the back of the Member's Identification Card. In addition, information about the following Appeal process may be obtained by contacting Member Service/Customer Service.

The Appeal process is available to the Member, the Member's duly authorized representative, the Provider of record, or the Provider of record's duly authorized representative.

This Appeal process applies to any adverse utilization review determination (which is considered an adverse pre-service claim determination) or any adverse non-utilization review determination (which is considered a post-service claim determination) under this Policy. Utilization review determinations, such as Prior Authorization or concurrent review, are determinations where receipt of the benefit, in whole or part, is conditioned upon approval of the benefit in advance. Non-utilization review determinations concern issues relating to the Member's Policy, such as eligibility for benefits, coverage of claims or claims processing.

An external appeal process administered by the State of Connecticut Insurance Department is available to Members of a fully insured health plan or self-insured governmental plan. A Member may utilize the external appeal process directly, and would not need to exhaust all internal appeals in order to file for an external appeal if it is determined that the time frame for completion of an expedited internal appeal may cause or exacerbate an emergency or life threatening situation. Please see the Other Member's Rights section for addition information regarding the external appeals process.

Please see the Claims Procedures section for additional claims processing and timeframe information.

Appeal Process for Adverse Utilization Review Determinations

FIRST LEVEL APPEAL

If a utilization review determination is not satisfactory, this is considered an adverse determination and a First Level Appeal review of the adverse determination may be requested. The First Level Appeal review request can be initiated orally, electronically or in writing within one hundred eighty (180) days from the date the initial adverse determination is received. Written First Level Appeal review requests should be mailed to:

Anthem Blue Cross and Blue Shield
First Level Appeal Review
370 Bassett Road
P.O. Box 1038
North Haven, Connecticut 06473-4201

A First Level Appeal review request should include copies of any additional documentation supporting the First Level Appeal.

A First Level Appeal determination will be issued in writing within fifteen (15) days from the date the First Level Appeal request is received. The written determination will be issued within five (5) business days from the date the Appeal decision is made. The written Appeal determination shall state the decision; the specific reason(s) for the decision with a citation to provisions of the Policy on which the decision was based, if applicable; and general information about the next step in the Appeal process.

In the event of an emergency or a life-threatening situation, or when a claim involves urgent care, or when a Member is denied benefits for an otherwise Covered Service on the grounds that it is Experimental and the Member

has been diagnosed with a condition that creates a life expectancy of less than two years, an expedited First Level Appeal review may be requested. A determination will be issued within one (1) business day or 72 hours, whichever is earlier, from the date the expedited appeal request is received.

If the First Level Appeal determination is not satisfactory, a Member of a fully insured health plan who has been diagnosed with a condition that creates a life expectancy of less than two years and the denial is based on the grounds that the proposed service is Experimental, may seek information (including the application) regarding an external appeal process administered by the Insurance Department without completing the Second Level Appeal review request through Anthem Blue Cross and Blue Shield.

SECOND LEVEL APPEAL

If the First Level Appeal determination is not satisfactory, a Second Level Appeal review may be requested. The Second Level Appeal review request can be initiated orally, electronically or in writing to the Second Level Appeal Panel within sixty (60) days from the date the First Level Appeal determination is received. At this time, an in-person presentation, telephonic conference, or conference via other form of acceptable technology may be requested and should be noted in the written Second Level Appeal request, if desired. Written Second Level Appeal requests should be mailed to:

Anthem Blue Cross and Blue Shield
Second Level Appeal Panel
370 Bassett Road
P.O. Box 1038
North Haven, Connecticut 06473-4201

A Second Level Appeal review request should include copies of any additional documentation supporting the Second Level Appeal.

A Second Level Appeal determination will be issued in writing within fifteen (15) days from the date the Second Level Appeal request is received. The written determination will be issued within five (5) business days from the date the Appeal decision is made. The written Appeal determination shall state the decision; the specific reason(s) for the decision with a citation to provisions of the Policy on which the decision was based, if applicable; and general information about the next step in the Appeal process.

In the event of an emergency or a life-threatening situation, or when a claim involves urgent care, or when a Member is denied benefits for an otherwise Covered Service on the grounds that it is Experimental and the Member has been diagnosed with a condition that creates a life expectancy of less than two years, an expedited Second Level Appeal review may be requested. A determination will be issued within one (1) business day or 72 hours, whichever is earlier, from the date the expedited appeal request is received.

After the completion of both the First and Second Level Appeal for a utilization review determination, a Member, the provider of record or provider, or the duly authorized representative of a Member of a fully insured health plan may seek information (including the application) regarding an external appeal process administered by the Insurance Department by contacting:

State of Connecticut Insurance Department
P.O. Box 816
Hartford, CT 06142-0816

Telephone: (860) 297-3910

Any request for an external appeal regarding an adverse utilization review determination must be received by the Insurance Department within sixty (60) days from the date of the receipt of the final Appeal determination, unless the Member is eligible for an expedited external appeal. Please see Other Member Rights for additional information regarding the external appeal process.

Appeal Process for Adverse Non-Utilization Review Determinations

FIRST LEVEL APPEAL

If a non-utilization review determination is not satisfactory, this is considered an adverse determination and a First Level Appeal review of the adverse determination may be requested. The First Level Appeal review request can be initiated orally, electronically or in writing within one hundred eighty (180) days from the date the initial adverse determination is received. Written First Level Appeal review requests should be mailed to:

Anthem Blue Cross and Blue Shield
First Level Appeal Review
370 Bassett Road
P.O. Box 1038
North Haven, CT 06473-4201

A First Level Appeal review request should include copies of any additional documentation supporting the First Level Appeal.

A First Level Appeal determination will be issued in writing within thirty (30) days of receipt of the First Level Appeal. The written determination will be issued within five (5) business days from the date the Appeal decision is made. The written Appeal determination shall state the decision; the specific reason(s) for the decision with a citation to provisions of the Policy on which the decision was based, if applicable; and general information about the next step in the Appeal process.

SECOND LEVEL APPEAL

If the First Level Appeal determination is not satisfactory, a Second Level Appeal review may be requested. At this time, an in-person presentation, telephonic conference, or conference via other form of acceptable technology may be requested and should be noted with the Second Level Appeal request, if desired.

The Second Level Appeal review request can be initiated orally, electronically or in writing to the Second Level Appeal Panel. The Second Level Appeal review request must be received within ten (10) days from the date the First Level Appeal determination is received. If the Second Level Appeal request is received more than ten (10) days from the date that the First Level Appeal determination is received, the time period in excess of that ten days will be considered a request for an extension by the Member. Such extension shall be granted for a period of up to sixty (60) days from the date that the First Level Appeal determination is received. Written Second Level Appeal requests should be mailed to:

Anthem Blue Cross and Blue Shield
Second Level Appeal Review
370 Bassett Road
P.O. Box 1038
North Haven, CT 06473-4201

A Second Level Appeal review request should include copies of any additional documentation supporting the Second Level Appeal. Please see Other Member Rights for additional information regarding the external appeal process.

A Second Level Appeal determination will be issued in writing within twenty (20) days from the date the Second Level Appeal request is received. The written Appeal determination will be issued within five (5) business days from the date the Appeal decision is made. The written Appeal determination will state the decision; the specific reason(s) for the decision with reference to the Policy provisions on which the decision is based, if applicable; and general information about the next step in the Appeal process.

The First and Second Levels of Appeal for an adverse non-utilization review determination will not take longer than sixty (60) days from Anthem Blue Cross and Blue Shield's receipt of the First Level Appeal review request as prescribed by state law, unless an extension as described above has been granted.

After the completion of the previous steps for an adverse non-utilization review determination based on Medical Necessity, a Member, the provider of record or provider, or duly authorized representative of the Member may seek information (including the application) regarding an external appeal process administered by the Insurance Department by contacting:

State of Connecticut Insurance Department
Consumer Affairs
P.O. Box 816
Hartford, Connecticut 06142-0816

Any request for an external appeal regarding an adverse non-utilization review determination based on Medical Necessity must be received by the Insurance Department within sixty (60) days from the date of the receipt of the final Appeal determination.

Other Member Rights

- The Member is entitled to receive upon request and free of charge, reasonable access to, and copies of, any documents, records and other information relevant to the Member's claim for benefits.
- If an internal rule, guideline, protocol or other similar criterion is relied upon in making the adverse benefit determination, the specific rule, guideline protocol or other similar criterion will be provided to the Member free of charge upon request.
- If the adverse benefit determination is based on a Medical Necessity, or Experimental treatment, or other similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination applying the terms of the health benefit plan to the Member's medical circumstances will be provided free of charge upon request.
- If a consultant's advice was obtained in connection with a Member's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination, the consultant will be identified upon request.
- The Member, the Provider or the duly authorized representative of the Member or Provider may, at any time, seek further review of an adverse determination by writing to the Insurance Commissioner.
- To be eligible for an external appeal, the Member must first exhaust all of the utilization review company's internal appeal mechanisms unless it is determined that the time frame for completion of an expedited internal appeal may cause or exacerbate an emergency or life threatening situation. In an emergency or life threatening situation, the enrollee, or provider acting on behalf of the enrollee with the enrollee's consent, would not need to exhaust all internal appeals in this situation in order to file for an external appeal. The expedited appeal application must be filed with the Insurance Department immediately following receipt of the utilization review company's initial adverse determination or at any level of adverse appeal determination. If the expedited appeal is not accepted on an expedited basis, and the enrollee has not previously exhausted all internal appeals, the enrollee may resume the internal appeal process until all internal appeals are exhausted and then may file for a standard external appeal within 60 days following receipt of the final denial letter. If all internal appeals were previously exhausted, the enrollee's rejected expedited external appeal will automatically be eligible for consideration for standard external appeal. The enrollee is not required to submit a new application.

- The external appeals process is not available to enrollees who are covered under a non-governmental self-insured plan or to denials regarding workers compensation.

PLAN INFORMATION PRACTICES NOTICE

The purpose of this information practices notice is to provide a notice to Members regarding the Plan's standards for the collection, use, and disclosure of information gathered in connection with the Plan's business activities.

- The plan may collect personal information about a Member from persons or entities other than the Member.
- The Plan may disclose Member information to persons or entities outside of the Plan without Member authorization in certain circumstances.
- A member has a right of access and correction with respect to all personal information collected by the Plan.
- A more detailed notice will be furnished to you upon request.

NOTICE

Any notice required under the Group Health Care Benefits Contract must be in writing. Notice given to the Contractholder will be sent to the Contractholder's address stated in the Group Application. Notice given to Anthem BCBS must be sent to Anthem BCBS's address stated in the Group Application. Notice given to a Member will be sent to the Member's address as shown on the records of Anthem BCBS; or in care of the Contractholder. The Contractholder; Anthem BCBS; or a Member, may by written notice; show a new address for giving notice. Notice to the Contractholder may also be published in the daily newspaper in the State of Connecticut.

MISCELLANEOUS PROVISIONS

Entire Contract

This Certificate; and the Group Health Care Coverage Contract issued to: the Contractholder and the Member application make up the entire contract of coverage. You may ask to see the Group Health Care Coverage Contract at the Employer Group's office. The Contractholder is the plan administrator for your health plan. We have authority to decide your eligibility for benefits; and to construe the provisions of the Group Health Care Coverage Contract and this Certificate.

A Member shall complete and submit to Anthem BCBS such applications; or other forms; or statements as Anthem BCBS may reasonably request. A Member warrants that all data contained therein shall be: true; correct; and complete to the best of the Member's knowledge; and belief; and the Member accepts that all right to benefits under this Benefit Program are conditional upon said warranties. No statement by the Member in his or her application shall void this contract; or be used in any legal proceeding; unless such application or an exact copy thereof is included in or attached to the Certificate.

Anthem BCBS as the Insurance Carrier

Anthem BCBS does not furnish Covered Services. Anthem BCBS makes payment of the Maximum Allowable Amount for Covered Services received by Members. Anthem BCBS is not liable for any: act; or omission of any Physician; Provider; or Hospital. Anthem BCBS has no responsibility for a Physician's; Provider's; or Hospital's failure or refusal to render Covered Services to a Member.

Anthem BCBS's sole obligation is to provide the benefits described in the Certificate. No action at law based upon; or arising out of the Physician-patient; Provider-patient; or Hospital-patient relationship may be maintained against Anthem BCBS.

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.

Disclosure

The Member hereby expressly acknowledges its understanding that the Certificate constitutes a contract solely between the Member 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 Member further acknowledges and agrees that he or she has not entered in this Certificate based upon representations by any person other than Anthem BCBS and that no person, entity or organization other than Anthem BCBS shall be held accountable or liable to the Member for any of Anthem BCBS's obligations to the Member created under the Certificate. This paragraph shall not create any additional obligations whatsoever on the part of Anthem BCBS other than those obligations created under other provisions of the Certificate.

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 Member's benefits. Anthem BCBS's determination shall be final and conclusive and may include, without limitation, 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 Member 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 Certificate. This includes, without limitation, the power to construe the Contract, to determine all questions arising under the Certificate and to make, establish and amend the rules, regulations and procedures with regard to the interpretation and administration of the provisions of this Certificate. However, these powers shall be exercised in such a manner that has reasonable relationship to the provisions of the Certificate, Provider agreements, and applicable state or federal laws. A specific limitation or exclusion will override more general benefit language.

Release of Records

By your application, you have agreed to allow all Providers to give us needed data about the care they provide to you to the extent permitted by law.

Clerical Errors

Clerical errors made in connection with the Benefit Program; whether by Anthem BCBS; the Member or an Employer Group will not terminate coverage that would otherwise have been effective; or continue coverage that would otherwise have ceased; or should not have been in effect.

Assigning Coverage

A Member may not assign this Benefit Program; or any of the Member's rights; benefits; or obligations under this Benefit Program to any other person or entity except with the prior written consent of Anthem BCBS; which consent may be conditioned by or withheld by Anthem BCBS in its sole discretion. Any attempted assignment by a Member in violation of this provision shall not impose any obligation upon Anthem BCBS to honor; or give effect to such assignment and shall be grounds for cancellation of this Benefit Program, effective as of the date to which Premiums have been paid.

Notwithstanding the terms of any provision regarding the payment of benefits payable for a Covered Service, a Member may assign the benefits to a dentist or oral surgeon, who performs such services, in accordance with the Connecticut Law concerning Assignment of Benefits to a Dentist or Oral Surgeon.

Filing a Claim

Anthem BCBS will not be liable under the Policy; unless proper notice is sent to Anthem BCBS that Covered Services have been rendered to a Member. Written notice must be given within 60 days from the date the Covered Services were rendered. The notice must include the data needed for Anthem BCBS to decide benefits. An expense will be considered incurred on the date the service or supply was received.

Failure to give notice to Anthem BCBS within the time shown will not reduce any benefit if it is shown to our approval 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.

Limitation of Actions

No legal action may be taken to recover benefits within 60 days after notice of claim has been given as shown above, nor may any action be brought after two years from the date Covered Services are received.

ID Cards

Anthem BCBS will provide the Contractholder with ID Cards for delivery to Covered Persons.

Changes to the Contract

This Benefit Program shall remain in effect unless: amended; terminated; rescinded; suspended; or cancelled as described herein. Anthem BCBS may amend the Certificate and the Group Health Care Coverage Contract with approval from the State of Connecticut Department of Insurance. The Effective Date of such changes shall be designated by Anthem BCBS.

No agent or representative of Anthem BCBS; other than an officer of Anthem BCBS; is allowed to change this Benefit Program; or to waive any of its provisions. Any such changes or waivers must be in writing.

Anthem BCBS has the right to: develop medical and managed care policies and procedures; and to amend such policies and procedures from time to time. The Effective Date of such changes shall be designated by 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 p.m. eastern standard time.

PLAN DESCRIPTION INFORMATION

Participating Provider Reimbursement

Reimbursement methodologies include but are not limited to the following:

- Participating Providers are paid according to a fee-schedule for services rendered, which is an amount these Providers accept as compensation in full for Covered Services. Individual Providers can contract through a corporate entity in an assumed risk-sharing position with the Plan for services rendered by professional Providers whom the entity represents.
- Global Case Rate: This is an amount for pre-procedure, procedure and post-procedure covered benefits which are all related to the same Covered Service.
- Global Capitation: This involves setting health care budget for each Member of a health care delivery system. The delivery system tries to perform at or under the amount. If successful, the delivery system shares in the success. If it fails, the delivery system is accountable for amounts over budget on an annual basis.

Participating Institutional Providers

Institutional Providers include, but are not limited to: general Hospitals, rehabilitation Hospitals, ambulatory surgery centers, and behavioral health facilities.

Reimbursement methodologies include but are not limited to the following:

billed charges;
discounts off billed charges;
per day payments;
per episode-of-care payments; and
fixed payment per Member per month.

Member Satisfaction Information

HMO Satisfaction:

Overall, **91.1%** of Anthem BCBS members have positive rating regarding their health plan. To reach Anthem BCBS during normal business hours (8:00 a.m.-5:00 p.m.) please call the telephone number indicated on the back of your identification card. After normal business hours: *members* may call the same telephone number, and receive information via an automated telephone system. A *member* may also receive information via Anthem Blue Cross Blue Shield web site at www.Anthem.com. This web site is available twenty- four hours every day, seven days a week.

Medical Loss Ratio

The medical loss ratio is defined as the ratio of incurred claims to earned premium for the prior calendar year for managed care plans issued in Connecticut and shall other wise be calculated in accordance with the requirements of

Connecticut state law. The medical loss ratio for Anthem Blue Cross and Blue Shield in Connecticut for calendar year **2009** is **87.9%**.

NCQA Status

On January 6, 2006, BlueCare was awarded three-year, full accreditation from the National Committee for Quality Assurance (NCQA). This is the highest performance level possible. The NCQA monitors health plans for their quality care delivery. To earn this “seal of approval,” Anthem BCBS met 50 specific quality criteria in six major categories.

Utilization Review Determinations

During **2009**, Anthem BCBS’s utilization review department determined the following, based on its review of each case relative to medical necessity, and covered service parameters (for Connecticut enrollees only):

Requests for pre-admission review and admission review	73,477
Number of pre-admission and admission review denials	3,261
Number of appeals of denials	682
Number of denials reversed or negotiated upon appeal	497

To reach Anthem BCBS’s utilization review department, call (in-state) 1-800-238-2227 or (out-of-state) 1-800-248-2227. The telephone system is capable of accepting and recording calls received after hours, on weekends, and holidays. Callers are provided with instructions and may leave a recorded message with detailed information. Calls are returned during normal business hours no later than one (1) business day from the date on which the call was received or the details necessary to respond are received from the caller.

Member Notification

When a primary care physician leaves the BlueCare provider network, Anthem Blue Cross and Blue Shield is responsible for informing the member in writing within 30 days of the date of the primary care physician’s departure.

EMPLOYER INFORMATION

**Town of Darien
2 Renshaw Road
Darien, CT 06820**

Note: See your Employer for additional Information such as: Employer Identification Number (EIN), Plan Number, Plan Administrator, Telephone Number of Plan Administrator, Agent for Legal Process and Funding.

3-TIER PRESCRIPTION DRUG RIDER

SCHEDULE OF PRESCRIPTION DRUG BENEFITS

Participating Pharmacy

COPAYMENT – Retail Pharmacy

- \$7 per prescription – Generic Prescription Drugs
- \$15 per prescription - Brand Name Prescription Drugs
- \$25 per prescription - Non-Listed Brand Name Prescription Drugs

COPAYMENT – Mail Order (Maintenance Drugs)

- \$14 per prescription – Generic Prescription Drugs
- \$30 per prescription - Brand Name Prescription Drugs
- \$50 per prescription - Non-Listed Brand Name Prescription Drugs

NOTE: The Member will be responsible for the applicable Copayment shown on this schedule for a 31 to 90 day supply of any Prescription Drug purchased through the designated mail order vendor.

Prescription Drug Rider

MAXIMUM

Unlimited per Member per Calendar Year

RENEWAL INTERVAL

Calendar Year

COVERED SERVICES

- Prescription Drugs
- Maintenance Prescription Drugs

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 in full and shall make no charge to the Member 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

If, due to a medical emergency, a Member purchases a Prescription Drug or a Maintenance Prescription Drug at a Non-Participating Pharmacy, the Member shall be reimbursed based on the charge for the Covered Drug, less any applicable Tier 1, tier 2, or Tier 3 Copayment, or amounts exceeding the maximum benefits payable by Anthem BCBS, after review and approval of the claim. Claims must be filed with Anthem BCBS within 120 days after the Covered Drug has been filled. The receipt and explanation must accompany the claim. Members 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.

PRESCRIPTION DRUG BENEFITS

Definitions

In addition to the defined terms listed in the Definitions Section of the Policy, the following definitions also apply:

COVERED DRUG: The term Covered Drug means a Medically Necessary Prescription Drug or Maintenance Prescription Drug.

A Covered Drug includes any of the following:

- a. Any legend Prescription Drug or Maintenance Prescription Drug which is not excluded under 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 this Rider. This includes refills of Covered Drugs.

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 Prescription Drug was prescribed, or any drug that is approved by the Food and Drug Administration (FDA) 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 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.

NON-PARTICIPATING PHARMACY: The term Non-Participating Pharmacy means any appropriately licensed Pharmacy that is not a Participating Pharmacy under the terms and conditions 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.

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 Members under the terms and conditions of this Rider.

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

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.

RIDER: The term Rider means an additional benefit, which has been purchased by the Policyholder.

Other Prescription Drug Benefits Provisions

The amounts payable for Prescription Drugs and Maintenance Prescription Drugs are on file at Anthem BCBS's Home Office.

The Member 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.

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.

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 Member the Federally approved generic equivalent medication.

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 Member, even though a Federally approved generic equivalent medication is available, the Member 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.

A Physician may decide that a brand name Prescription Drug or Maintenance Prescription Drug is Medically Necessary to identify or treat a Member's specific injury or illness. If the Physician writes "No Substitution", for a particular Prescription Drug for the Member, the Member 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.

In the event that there is no generic equivalent for the dispensing of a brand name Prescription Drug, the Member 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.

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.

Covered Drugs and Medically Necessary equipment and supplies for the treatment of diabetes:

- Blood/urine diabetic testing tabs/strips;
- Needles and syringes;
- Lancets; and
- Insulin.

From time to time we may initiate various programs to encourage Members 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 Members to pay a reduced Copayment on selected "once daily dosage" medications. The Half-Tablet Program allows a Member 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 Member'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.

Covered Services

Medically Necessary Prescription Drugs or Maintenance Prescription Drugs dispensed by a Pharmacy.

The maximum supply of a Prescription Drug, except for Maintenance Prescription Drugs, for which benefits shall be provided when dispensed under any one prescription by a retail establishment, is a 30-day supply. Benefits shall be provided for Maintenance Prescription Drugs, when dispensed by the designated mail order vendor, under any one prescription, up to a 90 day supply.

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.

National Pharmacy Network

Members 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 BCBS's Members.

Members may locate an out-of-state Participating Pharmacy by calling the toll-free number listed on their Identification Card.

To obtain benefits, Members 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

Members may order a 1-90 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. Members should refer to the mail order program brochure included with their Member materials for more information on this program, or call their Anthem BCBS Member Services/Customer Service Department.

Special Exclusions and Limitations

Anthem BCBS has the right to deny benefits 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:

- Dispensed before the Member's Effective Date or after the termination date.

- Refills which exceed the number the prescription order calls for; or refills after one year from the date of such order.
- A Pharmacy charge that is less than the applicable Copayment amount as shown on the Schedule of Prescription Drug Benefits.
- Used solely to improve appearance or for cosmetic purposes.
- Covered by Workers' Compensation law or similar laws, or covered by Workers' Compensation coverage, even if the Member chooses not to claim such benefits.
- Furnished by the U.S. Veterans' Administration, unless a charge is made.
- Covered in whole or in part by public or private grants.
- Dispensed or prescribed in a manner contrary to accepted medical and professional standards of practice.
- 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.
- An over-the-counter drug or non-legend drug, even if written as a prescription.
- Provided in connection with a Hospital, clinic, Skilled Nursing Facility, nursing home or other institution.
- Used prior to or after sex transformation surgery.
- Used in connection with weight control.
- A contraceptive or contraceptive device, that: has not been approved by the FDA, and is not prescribed by a licensed Physician.
- An antibacterial soap/detergent, shampoo, toothpaste/gel, or mouthwash/rinse.
- An appliance or device.
- 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.
- An allergenic extract or vaccine.
- All other services and items of care not listed in this Rider.