

Century Preferred

Firm Name: Town of Darien

Firm Number: 002793-310 – Public Works



370 Bassett Road
North Haven, CT 06473

CENTURY PREFERRED CERTIFICATE

PLEASE READ YOUR CERTIFICATE CAREFULLY

**Town of Darien
Firm #002793-310
HBP #002**

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PATIENT PROTECTION AND AFFORDABLE CARE ACT
AMENDMENT

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

Century Preferred
Century Preferred Comprehensive
Century Preferred Comprehensive HSA

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 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.
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” refers to the Covered Person or the Dependent of the Covered Person who is named on the Identification (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.

Century Preferred Health Care Benefit Program

This Certificate describes your Century Preferred health care coverage. The Certificate explains the benefits, exclusions, limitations, terms and conditions of Membership and services and the guidelines which must be adhered to in order for you to obtain benefits for Covered Services. This 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 notification to the Contractholder will be provided by Anthem BCBS.

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

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

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

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

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

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

Anthem BCBS is not responsible for notifying 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 Century Preferred Provider Directory is updated regularly to keep Members informed of a Provider’s participating/non-participating status; we recommend that you verify with the Provider their participating status prior to incurring services.

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

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

The Member is entitled to the Covered Services described in the Benefits Section of the Certificate. The Covered Services therein are subject to the terms; conditions; and limitations of the Policy and the Certificate.

BlueCard PPO 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 Covered Services outside of Connecticut. When a Member obtains Covered Services outside of Connecticut, 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 Connecticut, 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 Member 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. To locate participating Providers throughout the United States please call 1 (800) 810-BLUE.

Customer Service

Member Services is available to explain policies and procedures and answer questions regarding the availability of benefits.

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

Anthem Blue Cross and Blue Shield
Member Services/Customer Action Team
P.O. Box 533
370 Bassett Road
North Haven, Connecticut 06473

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 at:
370 Bassett Road, North Haven, CT 06473

SCHEDULE OF BENEFITS

CENTURY PREFERRED

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

COVERED SERVICE	IN-NETWORK SERVICES	OUT-OF-NETWORK SERVICES
Member Annual Deductible	Not Applicable	\$250 individual \$500 two person \$750 family
Member Coinsurance	Not Applicable	20%
Member Cost-Share Maximum	Not Applicable	\$1,000 individual \$2,000 two person \$3,000 family
Lifetime Maximum	Unlimited	
PREVENTIVE SERVICES		
Well Child Care: 1 exam a month, from birth to 5 months. 1 exam every 2 months, from 6 to 12 months old. 1 exam every 3 months, from 13 months to 2 years of age. 1 exam every 6 months, from 25 months to 3 years of age. 1 exam every Calendar Year, from 4 through 21 years of age.	No Copay	Deductible & Coinsurance
Adult Physical Examinations: 1 exam every Calendar Year 22 years of age and older	No Copay	Deductible & Coinsurance
Routine Gynecological Visit 1 visit per Calendar Year including pap smear	No Copay	Deductible & Coinsurance
Mammography One baseline screening for female 35 through 39 years of age One screening mammogram every Calendar Year for female 40 and older Note: or more frequently if recommended	No Copay	Deductible & Coinsurance

Immunizations and Vaccinations Includes those needed for travel	No Copay	Deductible & Coinsurance
Vision Exams 1 vision exam and refraction every Calendar Year	\$15 Copay	Deductible & Coinsurance
Hearing Exams 1 hearing exam every 2 Calendar Years	\$15 Copay	Deductible & Coinsurance
HOSPITAL SERVICES		
All Inpatient Admissions	\$150 Copay per Admission	Deductible & Coinsurance
Specialty Hospital	Same as Hospital Inpatient Cost-Share	Deductible & Coinsurance
Outpatient Surgery (Including colonoscopy) Note: See Other Medical Services section also, for Outpatient Surgery rendered in an ambulatory surgical center.	No Outpatient Hospital Copay	Deductible & Coinsurance
DIAGNOSTIC SERVICES		
Diagnostic, Laboratory and X-Ray Services	No Copay	Deductible & Coinsurance
High Cost Diagnostic Tests MRI, MRA, CAT, CTA, PET, and SPECT scans	No Cost-Share	Deductible & Coinsurance

THERAPY SERVICES		
<p>Outpatient Rehabilitation Outpatient rehabilitative and restorative physical, occupational, speech and chiropractic therapy for up to 50 combined visits per Calendar Year</p> <p>Additional visits available, subject to Out of Network Cost-Shares.</p> <p>Note: Any visits limits for physical, occupational and speech therapy will not apply to Autism Spectrum Disorder services.</p>	\$15 Copay	Deductible & Coinsurance
<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 Copay	Deductible & Coinsurance
<p>Other Therapy Services: Outpatient cardiac rehabilitation therapy Radiation therapy: Chemotherapy for the treatment of cancer Electroshock Therapy Kidney Dialysis in a Hospital or free-standing dialysis center</p>	No Copay	Deductible & Coinsurance
<p>Allergy Office Visit/Testing</p>	\$15 Copay	Deductible & Coinsurance
<p>Allergy Injections Immunotherapy, or other therapy treatments</p>	No Copay	Deductible & Coinsurance
MEDICAL EMERGENCY / URGENT CARE SERVICES		
<p>Emergency Room Treatment Emergency Room Copayment waived if the Member is admitted directly to the Hospital from the emergency room</p>	\$25 Copay	Paid as an In-Network Service
<p>Urgent Care Services</p>	\$25 Copay	Paid as an In-Network Emergency Room Service

Ambulance Land & Air: Paid according to the Department of Public Health Ambulance Service Rate Schedule	No Copay	Paid as an In-Network Service
PHYSICIAN MEDICAL/ SURGICAL SERVICES		
Medical Office Visit Primary Care Services (Including surgical procedures done in the Office) Specialist Services (Including surgical procedures done in the Office)	\$15 Copay \$15 Copay	Deductible & Coinsurance Deductible & Coinsurance
Surgical Services Performed by a Surgeon or Physician (Specialist) in any setting other than an Office Visit	No Copay	Deductible & Coinsurance
Non-Surgical Services of a Physician or Surgeon (Other than a medical office visit) These services may include after care <i>or</i> attending medical care	No Copay	Deductible & Coinsurance
MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES		
Outpatient Treatment for Mental Health Care and Substance Abuse Care	\$15 Copay	Deductible & Coinsurance
Inpatient Hospital Services In a Hospital or Residential Treatment Center for Mental Health Care Per Admission	Same as Hospital Inpatient Cost Share	Deductible & Coinsurance
Inpatient Rehabilitation Treatment for Substance Abuse Care In a Hospital or Substance Abuse Treatment Facility Per Admission	Same as Hospital Inpatient Cost Share	Deductible & Coinsurance
OTHER MEDICAL SERVICES		
Outpatient Surgery In a licensed ambulatory surgical center (Not located in a Hospital setting) (Including colonoscopy) Note: See the Hospital Services section also for Outpatient Surgery rendered in a Hospital setting.	No Copay	Deductible & Coinsurance
Skilled Nursing Facility Up to 120 days per Calendar Year	Same as Hospital Inpatient Cost Share	Deductible & Coinsurance

<p>Infertility Services Please see Maternity/Family Planning Section of this document</p> <p>Office Visit</p> <p>Outpatient Hospital</p> <p>Inpatient Hospital</p> <p>Infertility Drugs 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</p> <p>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.</p>	<p>\$15 Copay</p> <p>Same as Hospital Outpatient Cost-Share</p> <p>Same as Hospital Inpatient Cost-Share</p> <p>Paid as Out-of-Network</p>	<p>Deductible & Coinsurance</p> <p>Deductible & Coinsurance</p> <p>Deductible & Coinsurance</p> <p>Deductible & Coinsurance</p>
<p>Maternity</p>	<p>\$15 Copay first visit only</p>	<p>Deductible & Coinsurance</p>
<p>Hospice Care (inpatient)</p>	<p>No Copay</p>	<p>Deductible & Coinsurance</p>
<p>Wig Up to \$350 maximum per Member per Calendar Year.</p>	<p>No Copay</p>	<p>No Cost-Share</p>
<p>Specialized Formula</p>	<p>No Copay</p>	<p>Deductible & Coinsurance</p>
OTHER		
<p>Penalty for Failure to Prior Authorize Covered Services</p> <p>Please note that the combined penalty amount for the Facility Benefit and the Admitting Physician Benefit will be the lesser of \$500 or 50%.</p>	<p>\$250 Hospital and \$250 Physician (of Maximum Allowable Amount (MAA))</p>	<p>\$250 Hospital and \$250 Physician (of Maximum Allowable Amount (MAA))</p>

Pre-Existing Condition Limitation Exclusion – For Late Enrollees, this Certificate does not cover charges for Pre-Existing Conditions diagnosed or treated during the 6 months immediately preceding the original Effective Date of continuous coverage during the Pre-Existing Condition Limitation Period. The Pre-Existing Condition Limitation Period may last up to 12 months from your Enrollment Date. Credit from prior Creditable Coverage will be applied if applicable to reduce your specific Pre-Existing Condition Limitation Period. You will be notified in writing by Anthem BCBS exactly how many months you will be subject to this exclusion.

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

DEFINITIONS

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

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

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.

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

APPLIANCE(S): The term Appliance(s) means leg, arm, back or neck braces, or artificial legs, arms or eyes, and any prosthesis with supports, including replacement if a 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 a Hospital, Skilled Nursing Facility, Substance Abuse Treatment Facility, Residential Treatment Facility or Hospice, when required under the terms of this Benefit Program.

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

AUTISM SPECTRUM DISORDERS: "Autism spectrum disorders" means the pervasive developmental disorders set forth in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders," including, but not limited to, Autistic Disorder, Rett's Disorder, Childhood Disintegrative Disorder, Asperger's Disorder and Pervasive Developmental Disorder Not Otherwise Specified. The results of an autism spectrum diagnosis shall be valid for a period of twelve months unless the 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 EXCLUSION PERIOD: The term Benefit Exclusion Period means a period of time during which no benefits will be provided for a Pre-Existing Condition.

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

CANCER CLINICAL TRIAL: The term Cancer Clinical Trial means an organized, systematic, scientific study of therapies, tests or other clinical interventions for purposes of treatment or palliation or therapeutic intervention for the prevention of cancer in human beings 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 term 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 determine 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 the 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 plus Coinsurance amounts which are paid by the Member on a Calendar Year basis.

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

COVERED SERVICE(S): The term Covered Service means services, supplies or treatment as described in this 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 preauthorization 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.

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.

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

1. The individual and family Deductible amounts are shown in the Schedule of Benefits
2. The family Deductible amount (2 Member) is met when each Member meets the individual Deductible amount as specified in the Schedule of Benefits.

3. The family Deductible amount (3 or more Members) is met when one Member meets and the other family Members collectively meet the difference between the individual Deductible and family Deductible amounts, as specified in the Schedule of Benefits.

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

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

1. is designated for repeated use in the Medically Necessary Care, diagnosis or treatment of an illness or injury;
2. improves the function of a malformed body part or prevents or retards further deterioration of the 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 term Employer Group means a business entity which meets the underwriting requirements established by Anthem BCBS, and is accepted by Anthem BCBS.

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

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

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

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

1. Cannot be legally marketed in the United States without the final approval of the Food and Drug Administration ("FDA") or any other state or federal regulatory agency and such final approval has not been granted; or
2. Has been determined by the FDA to be contraindicated for the specific use; or
3. Is provided as part of a clinical research protocol or clinical trial or is provided in any other manner that is intended to evaluate the safety, toxicity or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply; or
4. Is subject to review and approval of an Institutional Review Board ("IRB") or other body serving a similar function; or
5. Is provided pursuant to informed consent documents that describe the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply as Experimental or Investigational or otherwise indicate that the safety, toxicity or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply is under evaluation.

- B. Any service not deemed Experimental or Investigational based on the criteria in subsection A. may still be deemed to be Experimental or Investigational by Anthem BCBS. In determining whether a service is

Experimental or Investigational, Anthem BCBS will consider the information described in subsection C. and assess the following:

1. Whether the scientific evidence is conclusory concerning the effects of the service or health outcomes;
 2. Whether the evidence demonstrates the service improves the net health outcomes of the total population for whom the service might be proposed by producing beneficial effects that outweigh any harmful effects;
 3. Whether the evidence demonstrates the service has been shown to be as beneficial for the total population for whom the service might be proposed as any established alternatives;
 4. Whether the evidences demonstrates the service has been shown to improve the net health outcomes of the total population of whom the service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.
- C. The information considered or evaluated by Anthem BCBS to determine whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental or Investigational under subsections A. and B. may include one or more items from the following list which is not all inclusive:
1. Published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or
 2. Evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or
 3. Documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the drug; biologic; device; diagnostic; product; equipment; procedure; treatment; service; or supply; or
 4. Documents of an IRB or other similar body performing substantially the same function; or
 5. Consent document(s) used by the treating physicians, other medical professionals, or facilities or by other treating physicians, other medical professionals or facilities studying substantially the same drug; biologic; device; diagnostic; product; equipment; procedure; treatment; service; or supply; or
 6. The written protocol(s) used by the treating physicians, other medical professionals, or facilities or by other treating physicians, other medical professionals or facilities studying substantially the same drug; biologic; device; diagnostic; product; equipment; procedure; treatment; service; or supply; or
 7. Medical records; or
 8. The opinions of consulting providers and other experts in the field.
- D. Anthem BCBS has the sole authority and discretion to identify and weigh all information and determine all questions pertaining to whether a drug; biologic; device; diagnostic; product; equipment; procedure; treatment; service; or supply is Experimental or Investigational.

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

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

FREE STANDING MAGNETIC RESONANCE IMAGING FACILITY: The term Free Standing Magnetic Resonance Imaging Facility means a facility which has received certificate of need approval for its magnetic resonance equipment and its services from the State of Connecticut Commission on Hospitals and Health Care. Also, the facility must be accredited either as an Ambulatory Health Care facility by the Joint Commission on

Accreditation of Healthcare Organization (JCAHO) or a Magnetic Resonance Imaging Facility by the American College of Radiology (ACR). The term Free-Standing Magnetic Resonance Imaging Facility does not include physician's offices where the primary care is medical services.

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.

IDENTIFICATION 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.

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

INPATIENT: The term Inpatient means a 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 diagnosis, care or treatment on a 24 hour basis to patients such as a Skilled Nursing Facility, Hospice, Substance Abuse Treatment Facility, Sub-acute Care Facility and Residential Treatment Facility.

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

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

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.

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

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

1. Participating Physician and Participating Provider: except as otherwise required by law, an amount agreed upon by Anthem BCBS and a Participating Physician and Participating Provider as full compensation for Covered Services provided to a 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 provided 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-State Provider Cost Share Calculation

When Covered Services are rendered outside of Connecticut by Non-Participating Physicians, Non-Participating Providers and/or Non-Participating Hospitals, the Member's Cost Share obligation may be calculated based upon one of the following items (note that in the case of items a. and b. the method of Cost-Share calculation must be mandated by the law of the state in which the 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 on item c.):

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

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

When Covered Services are rendered outside of Connecticut to a 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 that Blue Cross and/or Blue Shield Plan in that area outside of Connecticut.

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 Connecticut which that Blue Cross and/or Blue Shield Plan passes on to Anthem BCBS (which may include fee for service rates, per diem rates, scheduled charges, capitated charges, or other pricing mechanisms in that Blue Cross and/or Blue Shield Plan's discretion); or
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, another 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 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 sufficient severity that a Member reasonably believes that emergency medical treatment is needed.

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

1. In accordance with generally accepted standards of medical practice;
2. clinically appropriate, in terms of type, frequency, extent, site and duration and considered effective for the patient's illness, injury or disease; and
3. not primarily for the convenience of the patient, physician or other health care provider and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

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

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

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

MENTAL HEALTH CARE: The term Mental Health Care means services provided to treat a mental disorder as defined in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders". Mental Health Care does not include (1) mental retardation, (2) learning disorders, (3) motor skills disorder, (4) communication disorders, (5) caffeine-related disorders, (6) relational problems, and (7) additional conditions that may be a focus of clinical attention, that are not otherwise defined as mental disorders in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders".

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

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

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.

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

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

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

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

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

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

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

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

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

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

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

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

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

PROOF: The term Proof means any information that may be required by Anthem BCBS in order to satisfactorily determine a 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.

REMITTING AGENT: The term Remitting Agent means any individual, 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 additional benefit of this Benefit Program, which has been purchased 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 supervision of a registered nurse; and
- e. is not a place primarily for the treatment of nervous-mental disorders, pulmonary tuberculosis, a place of rest, Custodial Care or acute Inpatient level of care.

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

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

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

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

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

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

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

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

Anthem BCBS will determine if a 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 term Urgent Care Facility means a Participating Provider from whom Urgent Care services may be obtained after 5 p.m. and before 9 a.m. weekdays, or on weekends or on holidays when a Participating Physician or covering Physician is not available to treat the Member.

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

ELIGIBILITY

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

Eligible Employees

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

The following eligibility rules apply to employees and their Dependents:

1. Current employees must be employed full-time, or part-time and working at least 30 hours a week on a regularly scheduled basis and be Actively At Work on the date coverage is to be effective.
2. A newly hired employee must be Actively At Work at least 30 consecutive days (unless a different waiting period has been mutually agreed upon by Anthem BCBS and the Contractholder).
3. If the employee is not Actively At Work on the date upon which coverage would otherwise be effective, the Effective Date of coverage for that employee and any Dependent 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.
4. Retirees who are under age 65 who are former employees of the Employer Group must be entitled to group health coverage under a trust agreement or comparable agreement.
5. If you return from full-time active service following a call to active military duty, no waiting period applies. You and eligible family members can reenroll in the Plan, provided you apply for reemployment within the time period permitted by the Uniformed Services Employment and Reemployment Act. The time period allowed for reemployment depends on the length of your active military duty. To reenroll in the Plan, your application must be received within 31 days of your reemployment date. Coverage will be effective on the effective date of your reemployment.

Eligible Dependents

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

Your employer determines Dependent eligibility and Effective Dates in accordance with the terms of the 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.

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

1. Spouse

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

2. Unmarried Dependent Child Under Age 26

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

3. Newborn Dependent Child

Benefits for Covered Services under the Benefit Program shall be provided for a newborn of the Covered Person from the moment of birth up to and including 31 days immediately following birth.

With respect to coverage after 31 days following birth, a newborn of a Covered Person may become an enrolled Dependent under the Benefit Program when a completed application is submitted by the Covered Person and accepted by Anthem BCBS. The application must be submitted to Anthem BCBS within 31 days following the date of birth and Anthem BCBS eligibility requirements must be met as specified in this Section.

4. A Newborn of Enrolled Dependent Child

A newborn of an enrolled Dependent child is eligible for benefits for Covered Services only from the moment of birth up to and including 31 days immediately following birth, but is not eligible for enrollment beyond this 31 day period under the Benefit Program until and unless the Covered Person is appointed by a court as legal guardian and can offer Proof of such legal guardianship.

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

5. Disabled Dependent Child

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

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

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

6. Qualified Medical Child Support Orders

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

Effective Date of Coverage

Your employer determines employee eligibility and Effective Dates in accordance with the terms of the Group Health Care Benefits Contract. You must meet all your employer's eligibility requirements prior to your Effective Date of coverage.

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

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

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

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

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.

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

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

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

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

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

Late Enrollee and Special Enrollment Periods

A Late Enrollee is an eligible employee or Dependent of an eligible employee who requests coverage more than 31 days after the earliest opportunity to enroll for coverage as determined by the Benefit Program's eligibility rules, or after the Employer Group's Open Enrollment Period. Late Enrollees will be subject to a 12 month Pre-Existing

Condition limitation period with credit given for prior continuous qualifying coverage. An eligible employee and/or Dependent shall not be considered a Late Enrollee if a request for Membership is made and each of the following conditions is satisfied:

1. Coverage was not elected when the employee and/or Dependent was first eligible under the Benefit Program solely because another group health insurance Plan provided coverage for the eligible employee and/or Dependent; and
2. He or she completed any required written waiver of coverage and stated in writing that, at such time, other health insurance coverage was the reason for declining enrollment; and
3. Coverage is lost under other group health insurance due to his or her COBRA or state continuation coverage being exhausted, employment termination, reduction in hours, death of a spouse, or divorce, employer contribution toward the coverage being terminated, an employer no longer offering benefits to a class of individuals such as part time workers, lifetime maximum being met under such insurance, or due to that Plan's involuntary termination or cancellation by its carrier; and
4. The Employee and/or Dependent enrolls under the Benefit Program within 31 days after loss of Membership under the other Plan.

Special Enrollment Periods

Individuals that meet the above criteria will be eligible to enroll in the Plan at anytime through out 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 Member and the Group Member's spouse who have not been covered under other group coverage following marriage, a birth or adoption. Dependent children other than the newly born or newly acquired Dependent are eligible for the special enrollment period as a result of the acquisition of new family Members.

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

1. The employee's or Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
2. The employee or Dependent becomes eligible for a subsidy (state premium assistance program under Medicaid or CHIP).

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

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

Changes Affecting Eligibility

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

1. The marriage of the Covered Person or an enrolled Dependent child;
2. The divorce of the Covered Person;
3. The birth of a child of a Member;

4. A Dependent child attains the maximum age limit for coverage under the Benefit Program.
5. A Covered Person's termination of employment or reduction in work hours;
6. Loss of eligibility for other reasons specified in the Certificate.

PRE-EXISTING CONDITION EXCLUSION PROVISION

Pre-Existing Condition Exclusion

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

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

Exceptions to the Pre-Existing Condition exclusion:

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

Certificate of Creditable Coverage

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

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

If you have questions about the preexisting condition exclusion and creditable coverage, please contact Customer Service at (203) 234-1800 or (800) 331-0150.

MANAGED BENEFITS – Managed Care Guidelines

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

Introduction

A Member's right to benefits 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.

Your Responsibilities When Obtaining Health Care – Prior Authorization

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

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

With Prior Authorization, we guarantee payment for services that we approve in advance if the services are otherwise covered under the Certificate, the Pre-Existing Condition limitation provision is satisfied, the Coinsurance/Copayment/Deductible requirements are satisfied, and you are covered on the date you receive care. Benefits for Covered Services are subject to the terms, conditions and limitations of the Certificate. The Prior

Authorization will indicate a period for approval. Any service not performed in the specified time frame will need to be re-authorized.

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

Requesting Prior Authorization

Most Network Providers know which services require Prior Authorization and will obtain any required Prior Authorization or request a predetermination if they feel it is necessary. Your primary care physician and other Participating Providers have been provided detailed information regarding managed care guideline procedures and are responsible for assuring that the requirements of managed care guidelines are met. The ordering (or “requesting”) Provider, facility or attending Physician will contact Us to request a Prior Authorization or predetermination review (“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

In-Network

Anthem BCBS has a designated In-Network vendor for home delivery of Specialized Formula. To receive In-Network benefits, the Member, 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.

Out-of-Network

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

Prior Authorization for Admissions

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

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

Elective Admissions

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

- a. Once Anthem BCBS has been notified of the Admission, Anthem BCBS will contact the Member's Physician to obtain medical information relating to the Admission.
- b. During this process for Elective Admissions, the Admission day of the week will be checked. Friday or Saturday Admissions, or a Sunday Admission when Monday is a holiday will not be Authorized by Anthem BCBS unless the weekend Admission is determined to be Medically Necessary.
- c. For an Elective Admission, Anthem BCBS will either: Prior Authorize a number of Inpatient days or advise that Inpatient days cannot be Prior Authorized. The Member, Physician and Hospital will be notified in writing.

Medical Emergency Admissions

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

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

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

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

Concurrent Review

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

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

If continued Hospitalization can no longer be authorized beyond a specific date, Anthem BCBS will assist the Member, 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.

Penalties For Not Obtaining Prior Authorization

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

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

Case Management

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

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

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 request an Appeal review. Please refer to the Member Appeal Process Section for further information regarding this process.

COVERED SERVICES

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

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

- a. All Covered Services and Benefits are subject to the conditions, exclusions, limitations, terms and provisions of this 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 TRANSPORTATION SERVICES

This Certificate Covers:

Medically Necessary Medical transportation services:

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

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

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

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

Notes:

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

Covered Services do not include:

Transportation for Elective Hospital Admissions.

Transportation solely for the convenience of the Member.

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

DIAGNOSTIC SERVICES

This Certificate Covers:

Diagnostic x-ray or imaging studies

Magnetic Resonance Imaging (MRI)

Laboratory and pathology tests

Electronic diagnostic medical procedures

Outpatient polysomnography

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

CAT Scan

Colorectal cancer screening, including, but not limited to:

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

Notes:

*Outpatient Surgical Cost-Shares apply.

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

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

Covered Services do not include:

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

<p align="center">DURABLE MEDICAL EQUIPMENT, PROSTHETIC DEVICES, SUPPLIES & APPLIANCES</p>

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

This Certificate Covers:

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

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

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

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

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

Diabetic equipment and supplies

Diabetic drugs

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

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

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

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

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

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

Notes:

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

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

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

Covered Services do not include:

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

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

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

HOME HEALTH CARE

This Certificate Covers:

Benefit Period:

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

In lieu of an Admission

Terminal Illness – upon diagnosis by a Physician

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

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

Other Covered Services

Occupational, speech and respiratory therapy;

Medical and surgical supplies and prescribed Durable Medical Equipment;

Prescription Drugs dispensed from a retail Pharmacy;

Oxygen and its administration;

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

Laboratory services;

Dietary services;

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

Notes:

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

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

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

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

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

Covered Services do not include:

Meals, personal comfort items and housekeeping services.

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

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

HOSPICE SERVICES

This Certificate Covers:

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

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

Psychological and dietary counseling.

Consultation or Case Management services by a Physician.

Physical and/or occupational therapy.

Medical supplies, drugs and medicines prescribed by a Physician.

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

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

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

Psychological and dietary counseling.

Notes:

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

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

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

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

Covered Services do not include:

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

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

HOSPITAL SERVICES

This Certificate Covers:

Inpatient Hospital Services:

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

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

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

Inpatient and Outpatient Hospital services and supplies:

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

Prescribed drugs;

Administration of blood and blood processing;

Anesthesia, anesthesia supplies and services;

Medical and surgical dressing, supplies, casts and splints;

Diagnostic services;

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

Radiation therapy;

Chemotherapy for treatment of cancer;

Laboratory tests;

X-ray or imaging studies;

Outpatient surgery;

Pre-admission testing;

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

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

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

Notes:

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

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

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

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

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

The Specialty Hospital benefit period is Unlimited per Member per Calendar Year.

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

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

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

If a Member is admitted as an Inpatient a result of Outpatient surgery, the Member must notify Anthem BCBS within 2 business days of the Admission. Please refer to the Managed Benefits Section of this Certificate for information on how to notify 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 Hospital Dental Services - Anesthesia, nursing and related hospital charges for Inpatient dental services; outpatient hospital dental services; or one day dental services are covered if deemed Medically Necessary by the treating dentist or oral surgeon and the patient's primary care physician is accordance with Prior Authorization requirements and (1) the patient has been determined by a licensed dentist in conjunction with a licensed primary care physician to have a dental condition of sufficient complexity that it requires Inpatient services; outpatient hospital dental services; or one day dental services, or (2) the patient has a developmental disability, as determined by a licensed primary care physician, that places him or her at serious risk.

Covered Services do not include:

Private duty nursing services during an Inpatient Hospital Admission.

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

HUMAN ORGAN AND TISSUE TRANSPLANT SERVICES

This Certificate Covers:

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

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

In addition, this Benefit Program shall provide the benefits specified in this Section without Prior Authorization for the following services provided in connection 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 determines that a private room is Medically Necessary.

Services and supplies furnished by the Hospital.

Care provided in a special care unit which concentrates all facilities, equipment, and supportive services necessary to provide an intensive level of care for critically ill patients.

Use of operating and treatment rooms.

Diagnostic services, which includes 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 in connection with covered human organ and tissue transplants with Prior Authorization from Anthem BCBS.

Surgery, including diagnostic services directly associated with a surgery (separate payment will not be made for pre-operative and post-operative services, or for more than one surgical procedure performed at one operative session);

Services of a physician who actively assists the operating surgeon in the performance of such surgery;

Administration 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 in connection with 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 requires a Physician's constant attendance and treatment for a prolonged period of time.

Medical care rendered concurrently with surgery during the Hospital stay by a Physician other than the operating surgeon for treatment of a medical condition separate from the condition for which the surgery was performed.

Medical care by two or more Physicians rendered concurrently during the Hospital stay when the nature or severity of the Member's condition requires the skills of separate Physicians.

Consultation services rendered by another Physician at the request of the attending Physician, other than staff consultations which are required by Hospital rules and regulations.

Home, office and other Outpatient medical care visits for examination 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 in nature nor for the convenience of the Member or the Physician, and only until the Member has reached the maximum level of recovery possible for the particular condition and no longer requires 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 in connection with covered human organ and tissue transplants and which, under Federal law, may only be dispensed by written prescription and which are approved for general use by the Food and Drug Administration.

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

Transportation costs incurred for travel to and from the site of surgery for Covered Services for a transplant recipient and one other individual accompanying the patient, or if the transplant recipient is a minor child, transportation costs for two other individuals accompanying the patient.

1. Reasonable and necessary lodging, not to exceed \$150 total per day (\$200 total if two companions are accompanying a minor child), are payable for the individual accompanying 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 in connection with covered human organ and tissue transplants:

1. Transportation 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 recipient, the following apply:

When both the recipient and the donor are Members, each is entitled to the Covered Services specified in this Section.

When only the recipient is a Member, both the donor and the recipient are entitled to the Covered Services specified 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 recipient Member's coverage under the Policy.

When the recipient 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 transplant procedure which is a Covered Service, 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 transportation 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 authorization from Anthem BCBS. The Hospital must be designated and approved by Anthem BCBS to perform specific Covered Services provided under this Section. It should be noted that not every designated Hospital performs each of the specified Covered Services. In addition, the Member must follow all provisions in this Benefit Program.

Prior Authorization is required for all Covered Services provided under this Section. Please refer to the Managed Care Section of this Certificate for information on how to obtain Prior Authorization.

The term “donor” means a person who furnishes organ tissue for transplantation in a histo-compatible recipient.

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

Benefits will only be provided for Covered Services and supplies furnished to the transplant recipient during the period beginning five days before the day on which a transplant procedure which is a Covered Service is performed, and ends 365 days post operatively.

When a Member obtains human organ and tissue transplant Covered Services from a Hospital or facility that is not designated and approved by Anthem BCBS, he or she shall be responsible for all applicable Cost-Shares as well as amounts that exceed the Maximum Allowable Amount. These expenditures will not accumulate toward the Cost-Share Maximum.

Covered Services do not include:

Benefits for services if the Member is not a suitable candidate as determined 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 recipient 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 transportation and lodging for the transplant recipient 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, specified in this Section: Hospital Services of this Certificate.

Abortions and Miscarriages.

Infertility services

Infertility drugs (with an Infertility diagnosis)

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

Notes:

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

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

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 refer to 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:

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

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

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

If the emergency requires that the 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 regardless of whether the Physician or Provider is a Participating Physician or Provider or Non-Participating Physician or Provider.

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

Claims for services rendered to the Member shall be subject to review 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 determines that the services provided were not for a Medical Emergency. Medical Emergency Covered Services are limited to the treatment rendered during the initial visit only.

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

Covered Services do not include:

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

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:

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

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

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

Outpatient care for mental illness includes services by a person with a master's degree in social work when such person renders service in a child guidance clinic or in a Residential Treatment Facility under the supervision of a Physician practicing as a psychiatrist, licensed psychologist, certified Independent Social Worker, certified Marriage and Family Therapist or a Licensed or certified Alcohol and Drug Counselor or appropriately licensed professional counselor.

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

1. the 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
2. An individual Treatment Plan must be prescribed by a Physician with certain specific attainable goals and objectives appropriate to both the patient and the treatment modality of the program.

Covered Services do not include:

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

ORAL SURGERY

This Certificate Covers:

For office based services see Physician Medical/ Surgical Section

For Hospital based services see Hospital Service Section

Oral Surgery Services

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

1. An initial visit for the prompt immediate repair of trauma, due to an accident or injury, to the jaw, natural teeth, cheeks, lips, tongue and/or the roof of the mouth. Benefits available for services provided during the initial visit, include but are not limited to the following:
 - Evaluation;
 - Radiology to evaluate extent of injury;
 - Treatment of the wound; tooth fracture or evulsion.

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

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

Notes:

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

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

Covered Services do not include:

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

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

Please refer to the Exclusions and Limitations Section of this 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

Blood derivatives when purchased through a blood derivative supplier.

Blood lead screenings and clinically indicated risk assessments.

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

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

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

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

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

Routine Patient Care Costs in connection with Cancer Clinical Trial. A Cancer Clinical Trial must be conducted under the auspices of an independent peer-reviewed protocol that has been reviewed and approved by:

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

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

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

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

Covered Services do not include:

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

PHYSICIAN MEDICAL/SURGICAL SERVICES

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, evaluation and treatment:

Allergy testing.

Inpatient Hospital/Inpatient Facility visits during a covered Admission.

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

1 session per Inpatient day

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

Surgical Procedures:

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.

In accordance with CGS 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.

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

Surgical assistant services.

Notes:

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

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

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

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 a 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 orthognatic 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.

Covered Services do not include:

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

Separate charges for pre and post-operative care.

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

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 or Non-Participating Physician certified as an otolaryngologist or a legally qualified audiologist holding a Certificate of Clinical Competence in Audiology from the American Speech and Hearing Association in the absence of any applicable licensing requirements.

Notes:

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

Covered Services do not include:

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

PRIVATE DUTY NURSING

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:

Coverage includes:

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

Notes:

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

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

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

Covered Services do not include:

Please refer to the Exclusions and Limitations Section of this 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 shall be excluded.

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.);
3. Infusion Therapy is limited to:
 - a. Chemotherapy (including gamma globulin);
 - b. intravenous antibiotic therapy;
 - c. total parenteral nutrition;
 - d. enteral therapy when nutrients are only available by a Physician's prescription;
 - e. intravenous pain management;
4. Covered Services will include supplies, solutions, and pharmaceuticals and nursing.

Notes:

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

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 Outpatient Hospital program or a combined Outpatient Hospital and home program covered under this Policy, the benefits will not exceed the amount as shown on the Schedule of Benefits.

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

Covered Services do not include:

Please refer to the Exclusions and Limitations Section of this 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.

Notes:

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

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

Urgent Care Facilities are only available after 5 p.m. and before 9 a.m. weekdays, or on weekends and holidays 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 refer to the Exclusions and Limitations Section of this Certificate 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:
 - a. specifically described in the Certificate
 - b. rendered or ordered by a Physician
 - c. within the scope of the Physician's, Provider's or Hospital's licensure; and
 - d. Medically Necessary Care for the proper diagnosis and treatment of the Member.
2. Benefits may be reduced or denied if subject to the Managed Benefits – Managed Care Guidelines. Any reduced or denied benefits paid by the Member do not apply toward the Cost Share Maximums shown in the Schedule of Benefits.
3. Any reduction in benefits, including but not limited to Penalties, imposed by another Plan, which are similar to those stated on the Managed Benefits – Managed Care Guidelines, are not reimbursable 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 obtaining services after his or her Benefit Program is rescinded, suspended, cancelled, interrupted or terminated for any reason will be solely responsible for payment of such services.
6. Care for conditions which are required by State or Local law to be treated in a public facility.
7. Services and care in a Veteran's Hospital or any Federal Hospital, except as may be otherwise required by law.
8. Services covered in whole or in part by public or private grants.
9. Services required by third parties, including but not limited to: school, employment, summer camp and premarital physicals and related tests.
10. Studies related to pregnancy except for significant medical reasons.
11. Simplified or self-administered tests and multiphasic screening.
12. Cosmetic surgeries, procedures and services performed primarily to improve appearance and not otherwise determined by Anthem BCBS to meet the coverage criteria for reconstructive surgeries, procedures and services as set forth in this Certificate.
13. Dental diagnosis, care, treatment, x-rays, or Appliances, for any of the diseases or lesions of the oral cavity, its contents or contiguous structures, the extraction of teeth, the correction of malpositions of the teeth and jaw, or

for pain, deformity, deficiency, injury or physical condition of teeth, unless otherwise provided for in this Policy.

14. Sperm collection and preservation, all services related to surrogate parenting arrangements and preparatory treatment.
15. Surgical and non-surgical examination, diagnosis, including invasive (internal) and non-invasive (external) procedures and tests, and all services related to diagnosis and treatment, both medical and surgical, of temporomandibular joint dysfunction or syndrome also called myofascial pain dysfunction or craniomandibular pain syndrome. This exclusion includes but is not limited to the following: contrast and non-contrast imaging, arthroscopic and open surgical procedures, physical therapy, and appliance therapy such as occlusal Appliances (splints) or adjustments. Anthem BCBS will not provide benefits unless otherwise provided for by an Amendatory Rider to this Policy.
16. Routine foot care in the absence of systemic or vascular disease affecting the foot, including hygienic care, treatment of corns or calluses, services performed in conjunction with fitting of supportive or comfort devices for the foot or other foot care.
17. Services for Custodial Care, Chronic Care and/or Maintenance Care. Including without limitation, Methadone and Suboxone maintenance or any other similar maintenance therapy program and its related testing, supplies, visits and treatment.
18. Prenatal medical conferences with a pediatrician regarding an unborn child unless the visit is the result of a medical referral.
19. Charges for the Member's room and board when the Member has a leave of absence from the Hospital, Substance Abuse Treatment Facility or other Inpatient Facility.
20. Evaluation, treatment, procedures and Prescription Drugs related to and performance of sex-change operations including follow-up treatment, care and counseling.
21. Vaccines other than routine immunizations or those needed for travel.
22. Services, medical supplies or supplies not specifically listed as Covered Services. These include but are not limited to educational therapy, marital counseling, sex therapy, weight control programs, nutritional programs and exercise programs.
23. Experimental or Investigational treatment, procedure, facility, equipment, drugs, devices or supplies. Any services associated with or as follow-up to any of the above is not a Covered Service.
24. Any treatment, procedure, facility, equipment, drug, device or supply which requires Federal or other governmental agency approval not granted at the time services are rendered. Any service associated with, or as follow-up to, any of the above is not a Covered Service.
25. Any services by a Physician or Provider to himself or herself or for services rendered to his or her parent, spouse, children, grandchildren or any other immediate family Member or relation, even if a Participating Physician or Participating Provider.
26. Services which the Member or Anthem BCBS is not legally required to pay.
27. Wigs, except as noted in the Covered Services Section.
28. Inpatient services which can be properly rendered as Outpatient services.
29. Disease contracted or injuries resulting from war.
30. Charges after the Provider's or Hospital's regular discharge hour on the day indicated for the Member's discharge by his/her Physician.
31. Charges in excess of the Maximum Allowable Amount.
32. Eyeglasses and contact lenses.
33. Supervisory care by a Physician for a Member who is mentally or physically disabled and who is not under specific medical, surgical or psychiatric treatment to reduce the disability to the extent necessary to enable the

patient to live outside an institution providing medical care; or when despite such treatment, there is no reasonable likelihood that the disability will be so reduced.

34. Travel, whether or not recommended by a Physician.
35. Certain pulmonary function tests which in the opinion of Anthem BCBS do not meet the definition of a covered diagnostic laboratory test.
36. Services or procedures rendered without regard for specific clinical indications, routinely for groups or individuals or which are performed solely for research purposes.
37. Services or procedures which have become obsolete or are no longer medically justified as determined by appropriate medical specialties.
38. Radiation therapy as a treatment for acne vulgaris.
39. Services rendered by a Physician in the employ of a Home (e.g. Skilled Nursing Facility) do not qualify as Home & Office Care.
40. Drugs or medications, legend and over-the-counter, prescribed for use as an Outpatient except as otherwise stated herein.
41. The following is a list of procedures which are not covered:
 1. Allogeneic or Syngeneic Bone Marrow Transplant or other forms of stem cell rescue and stem cell infusion (with or without high dose chemotherapy and/or radiation) are those with a donor other than the patient. They are not covered except in the following cases:
 - a. When at least five out of six histocompatibility complex antigens match between the patient and the donor.
 - b. The mixed leukocyte culture is non-reactive.
 - c. One of the following conditions is being treated:
 - * Severe aplastic anemia
 - * Acute nonlymphocytic leukemia in first or subsequent remission or early first relapse
 - * Myelodysplastic syndrome
 - * Secondary acute nonlymphocytic leukemia as initial therapy
 - * Acute lymphocytic leukemia in second or subsequent remission
 - * Acute lymphocytic leukemia in first remission
 - * Chronic myelogenous leukemia in chronic and accelerate phase
 - * Non-Hodgkin's lymphoma, high grade, in first or subsequent remission
 - * Hodgkin's lymphoma low grade, which has undergone conversion to high grade
 - * Neuroblastoma, stage 3 or relapsed stage 4
 - * Ewing's sarcoma
 - * Severe combined immunodeficiency syndrome
 - * Wiskott-Aldrich syndrome
 - * Osteopetrosis, infantile malignant
 - * Chediak-Higashi syndrome
 - * Congenital life-threatening neutrophil disorders to include Kostmann's syndrome, chronic granulomatous disease, and cartilage hair hypoplasia
 - * Diamond Blackfan syndrome
 - * Thalassemia
 - * Sickle cell anemia
 - * Primary thrombocytopathy including Glanzmann's syndrome
 - * Gaucher disease
 - * Mucopolysaccharidoses and lipidoses to include Hurler's syndrome, Sanfilippo's syndrome, Maroteaux-Lamy syndrome, Morquio's syndrome, Hunter's syndrome, and metachromatic leukodystrophy

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

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

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

RIGHT OF RECOVERY

To the extent permissible by law, Anthem BCBS shall have a right of recovery against third parties for benefits for Covered Services provided under the terms of this Benefit Program, where the Member has a right of recovery against third parties for the cost of Covered Services. Acceptance of Covered Services will constitute consent by the Member to Anthem BCBS's right of recovery. The Member agrees to take all further action to execute and deliver such additional instruments and to take such other action as Anthem BCBS shall require to implement this provision. Anthem BCBS will have the right to bring suit against such third party in the name of the 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 is obligated to reimburse Anthem BCBS less Anthem BCBS's pro rata share of the reasonable attorney's fees and cost the Member sustained in obtaining the recovery.

WORKERS' COMPENSATION

To the extent permissible by law no benefits shall be provided for Covered Services paid, payable or eligible for coverage under any Workers' Compensation Law, employer's liability or occupational disease law, denied under a managed Workers' Compensation program as Out-of-Network services or which, by law, were rendered without expense to the 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 and/or controverted 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 monetary settlement to the full extent of such settlement.
6. If a Member is entitled to benefits under Workers' Compensation, employer's liability or occupational disease law, it is necessary to follow all of the guidelines in the Managed Benefits Section in order for this Benefit Program to continue to provide benefits for Covered Services when the Workers' Compensation benefits are exhausted.

AUTOMOBILE INSURANCE

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

Anthem BCBS shall be entitled:

- To charge the insurer obligated under such law for the dollar value of those benefits to which a 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 of this Certificate, 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 applicable law shall be deemed to be his or her own insurer and Anthem BCBS shall reduce his or her benefits for Covered Services by the amount of basic reparations benefits or other benefits provided for injury if such a no-fault policy had been obtained.
- If a 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 of the Certificate. It is necessary to follow all the guidelines in the Managed Benefits Section in order for Anthem BCBS to continue to provide benefits for Covered Services when the no-fault or other automobile insurance policy benefits are exhausted.

COORDINATION OF BENEFITS

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

Applicability

1. The Coordination of Benefits (COB) provision applies to this Benefit Program when a Member has health care coverage under more than one Plan as defined below.
2. If the Member is covered by this Benefit Program and another Plan, the Order of Benefit Determination Rules in this Section shall determine 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 provided under this Benefit Program 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 similar 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 in excess of 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 stated in this Section and under those rules the Plan determines 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 his or her benefits are determined in relation to each other. The benefits of the Secondary Plan may take into consideration 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 specified 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 determines 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 stepparent; 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 specific 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 determines 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 required 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 exceed the actual charges for services covered in whole or in part by either this Benefit Program or Parts A, B and D of Medicare.

(Note: Certain services may not require Prior Authorization when it is determined that Anthem BCBS is the Secondary Plan. Contact Customer Service before any services are rendered to determine if such services require Prior Authorization. In the event that a later determination finds that Anthem BCBS is the Primary

Plan, any services that were obtained without Prior Authorization while Anthem BCBS was administering benefits as a Secondary Plan will not require Prior Authorization as would be required under a Primary Plan.)

Effect Of This Benefit Program On The Benefits

1. This Subsection applies when, in accordance with the Order of Benefit Determination Rules, this Benefit Program is a Secondary Plan as to one or more other Plans. In that event, the benefits of this Benefit Program may be reduced under this Subsection. Such other Plan or Plans are referred to as “the other Plans.”
2. Reduction in this Benefit Program’s benefits. When the Benefit Program is the Secondary Plan, Anthem BCBS will provide benefits under the Benefit Program so that the sum of the reasonable cash value of any Covered Service provided by the Benefit Program and the benefits payable under the other Plans shall not total more than the Allowable Expense. Benefits will be provided by the Secondary Plan at the lesser of: the amount that would have been paid had it been the Primary Plan or the balance of the bill. Anthem BCBS shall never pay more than it would have paid as the Primary Plan.

If another Plan provides that its benefits are “excess” or “always secondary” and if this Benefit Program is determined to be secondary under this Benefit Program’s COB provisions, the amount of benefits payable under this Benefit Program shall be determined on the basis of this Benefit Program being secondary.

Right To Receive And Release Needed Information

Certain information is needed to apply these COB rules. Anthem BCBS has the right to decide which information it needs. By enrolling in the Benefit Program the Member consents to the release of information necessary to apply the COB rules. Any Member claiming benefits under this Benefit Program must furnish information to Anthem BCBS which Anthem BCBS determines 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 organization 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, as applicable, from one or more of the persons it has paid or for whom it has paid, insurance companies, or other organizations.

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 constitute 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 required and do whatever else is necessary to secure Anthem BCBS’s rights to recover excess payments. The Covered Person’s failure to comply 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 a reduction in work hours; or
 - He or she no longer meets the eligibility requirements of the Benefit Program as defined in the Eligibility Section of this 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 concerning eligibility, insurability or health status and such information was material to the underwriting of the application at the time submitted and acceptance by Anthem BCBS of that application for coverage.

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

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

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 terminate 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 occurrence of
 - 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 applicable law as follows:
 - At the option of the Employer Group without cause upon delivery of 15 days prior written notice to the other party, to be effective the first of the month following the expiration of the 15 day notice period;
 - By Anthem BCBS, at its option, in the event the Employer Group fails to pay all or any portion of the Premium due Anthem BCBS. Such termination shall be effective on the last to occur of the date to which such Premium has been paid by the Employer Group or the 30th day following the date when such Premium is due;
 - By Anthem BCBS, at its option, in the event the Employer Group receives 30 days prior written notice from Anthem BCBS of the Employer Group's failure to satisfy any other covenant or obligation contained in the Benefit Program, or any underwriting requirement adopted by Anthem BCBS. Such termination shall occur 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 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 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 automatically 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 any such event. The Member hereby acknowledges that the termination, expiration, non-renewal, or cancellation of the contract will automatically result in the termination of the Benefit Program.

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

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 notification 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 information included on the Certificate of Creditable Coverage will include the names of any Members terminating, the date coverage under this Benefit Program ended, and the type of coverage provided under this Benefit Program. This Certificate of Creditable Coverage will provide a subsequent insurer or group Plan with information regarding previous coverage to assist it in determining any Pre-Existing Condition exclusion period or Affiliation Period. This Certificate of Creditable Coverage should be presented by the Member to his or her next Employer Group and/or when applying for subsequent group health insurance. A Certificate of Creditable Coverage will be issued to terminating Members 14 days after the date Anthem BCBS is notified of his or her termination. In addition, a terminated Member may request an additional copy of the Certificate of Creditable Coverage by contacting Member Services.

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: 1. 30 months, or 2. Enrollment Date in other group coverage or Medicare, or 3. Date Coverage would otherwise end.
Divorce or Legal Separation	Former spouse and child Dependent Members.	Earliest of: 1. 36 months, or 2. Enrollment Date in other group coverage or Medicare, or 3. Date Coverage would otherwise end.
Death of Group Member	Surviving spouse and child Dependent Members.	Earliest of: 1. 36 months, or 2. Enrollment Date in other group coverage or Medicare, or 3. Date Coverage would otherwise end.
Child Dependent Member loses eligibility	Child Dependent Member.	Earliest of: 1. 36 months, or 2. Enrollment Date in other group coverage or Medicare, or 3. Date Coverage would otherwise end.
Total Disability of Group Member	Group Member and Dependent Members	Earliest of: 1. 29 months after the Group Member leaves employment, or 2. Date total disability ends, or 3. Enrollment Date in other Group coverage or Medicare, or 4. Date Coverage would otherwise end.
Employment ends, retirement, leave of absence, or reduction in hours (except gross misconduct dismissal) as a result of a Member's eligibility to receive Social Security income	Group Member and Dependents 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 individuals who had coverage under the Benefit Program immediately prior to the qualifying event and are either covered employees, spouses or Dependent Children of covered employees. A qualified beneficiary also includes a child born to or placed for adoption with the covered employee during the continuation period.

Choosing Continuation

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

You must choose to continue coverage by notifying the Group Contractholder in writing. You have 60 days to elect to continue coverage, starting with the date of the notice of continuation or the date coverage is terminated, whichever is later. Your failure to choose continuation within the required time period will make you ineligible to choose continuation at a later date.

Paying for Continuation Coverage

You have 45 days from the date of electing continuation to pay the first continuation charges. After this initial grace period, you must pay charges monthly in advance to the Employer Group to maintain coverage in force. Failure to remit continuation charges within 30 days of the due date 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 within 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 individual must be 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 continuation, or becomes disabled at any time during the first 60 days of continuation coverage. The Covered Person 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 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 obtain 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's Dependents may continue coverage until midnight of the day preceding their 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:

- i. 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
- ii. The premium for continuation of coverage is not paid on time; or
- iii. The Member becomes entitled to Medicare benefits; or
- iv. 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 credited 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 exhausted other coverage and are no longer eligible for continuation coverage will be eligible for coverage through the HRA. These are individuals 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 exhausted COBRA continuation coverage period or similar state continuation coverage period.

Inquiries regarding 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 determine which services are eligible for reimbursement.

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 directly 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 Process Section of this Certificate.

Benefits for Covered Services will be reimbursed 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 obtain 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 identification number should be submitted in accordance with the Payment of Covered Services Section of the Certificate.

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

Benefits for Covered Services will be reimbursed 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 the Member Appeal Process Section of the Certificate.

Payment for Covered Services

Payment by Anthem BCBS for Covered Services shall be made directly 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 directly 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 2 years from the date the Covered Services were performed. Claims for Covered Services more than 2 years 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 726
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 or 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 judgement 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.

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 are 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.

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 it appears on the records of Anthem BCBS or in care of the Contractholder. The Contractholder, Anthem BCBS, or a Member, may by written notice, indicate a new address for giving notice. Notice to the Contractholder may also be published in the daily newspaper in the State of Connecticut.

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.

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 discretionary authority to determine 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 information 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 Appeal 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 information 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 constitute 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 furnished to Anthem BCBS that Covered Services have been rendered to a Member. Written notice must be given within 60 days after completion of the Covered Services. The notice must include the data necessary for Anthem BCBS to determine benefits. An expense will be considered incurred on the date the service or supply was received.

Failure to give notice to Anthem BCBS within the time specified will not reduce any benefit if it is shown to our satisfaction 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 specified above, nor may any action be brought after two years from the date Covered Services are received.

Identification Cards

Anthem BCBS will provide the Contractholder with Identification 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, and notification to Contractholders will be provided by Anthem BCBS.

No agent or representative of Anthem BCBS, other than an officer of Anthem BCBS, is authorized 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.

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 Service of Legal Process and Funding.

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.

Non-Participating Provider Reimbursement

Anthem BCBS reimburses Non-Participating Providers based on a Maximum Allowable Amount, except as otherwise required by law. The Maximum Allowable Amount for Non-Participating Providers is a reasonable amount as determined by Anthem BCBS after consideration of industry cost, reimbursement, utilization data and other factors as Anthem BCBS deems appropriate. It is the Members obligation to pay Cost-Shares as a component of the Maximum Allowable Amount, and amounts in excess of the Maximum Allowable Amount.

Out-of-State Non-Participating Providers

When Covered Services are rendered outside Connecticut by Non-Participating Providers, the Member's Cost-Share obligations may be calculated based on:

The Maximum Allowable Amount;
Billed Charges; or
Whichever of these two amounts is lower.

When a Member receives Covered Services outside of Connecticut by licensed affiliated Blue Cross Blue Shield Plans, the Maximum Allowable Amount is determined by the Blue Cross and/or Blue Shield plan in that area. In that case, the Maximum Allowable Amount may be either of the following:

The applicable rate for such services that the local plan negotiated with the Provider and passes on to Anthem BCBS; or

The negotiated price, estimated or average discount off the billed charges that factor in settlements or other non-claim transactions for all Providers or a specific group of Providers, which the local Plan passes on to Anthem BCBS.

Also, the local Plan will calculate the Member's Cost-Share obligations for the Covered Service.

Member Satisfaction Information

In a survey of our Members participating in the Managed Care Plans (non-HMO):

Overall, **92.4%** of Anthem BCBS Members have a positive rating regarding their health plan.

Members may contact Anthem BCBS during normal business hours (8:00a.m. – 5:00 p.m.) by calling the telephone number indicated on the back of their Identification Card. After 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 BCBS's web site at www.Anthem.com. This web site is available twenty-four hours a 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 otherwise 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 **2008** is **85.0%**.

Utilization Review Determinations

During **2008**, Anthem BCBS's utilization review department determined the following, based on its review of each case relative to Medical Necessity and Covered Services parameters (for Connecticut enrollees only):

Requests for certification:	104,833
Number of certification denials:	5,878
Number of appeals of denials:	1,122
Number of denials reversed or negotiated upon appeal:	581

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.

3-TIER MANAGED PRESCRIPTION DRUG 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 3 Tier Managed Prescription Drug Rider makes benefits available for the purchase of Prescription Drugs and Maintenance Prescription Drugs, subject to the terms and conditions of the Policy and this Rider, when the Policyholder has selected this Rider as part of its Policy.

This is an open Formulary Prescription Drug Rider. This 3 Tier Managed Prescription Drug Rider ensures appropriate medications and quantities of the Prescription Drug are dispensed within a time limit. In addition to Prior Authorization, Anthem BCBS conducts drug utilization review when the prescription is presented to be filled at a Pharmacy or through the designated mail order vendor and by audit of submitted claims. The Copayments applicable to Covered Drugs under this Rider are separated into 3 tiers. Tier 1 has the lowest Covered Drug Copayment for Generic Prescription Drugs and Generic Maintenance Prescription Drugs. Tier 2 has the next highest Covered Drug Copayment for Listed Brand Name Prescription Drugs and Listed Brand Name Maintenance Prescription Drugs. Tier 3 has the highest Covered Drug Copayment for Non-Listed Brand Name Prescription Drugs and Non-listed Brand Name Maintenance Prescription Drugs.

This Rider is not available to any person who does not have coverage under the Policy. 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 Policy is amended as described herein.

Pharmacy Benefits Management

The Pharmacy benefits available to you under this Rider are managed by Anthem BCBS's affiliate. The Pharmacy benefits manager is a Pharmacy benefits management company with which Anthem BCBS contracts to manage Pharmacy benefits. The Pharmacy benefits manager has a nationwide network of retail Pharmacies, a mail service Pharmacy, and clinical services that include formulary management.

The management and other services the Pharmacy benefits manager provides include, among others: making recommendations to and updating the Formulary, managing a network of retail Pharmacies and operating a mail service Pharmacy. The Pharmacy benefits manager, in consultation with Anthem BCBS, also provides services to promote and assist Members in the appropriate use of Pharmacy benefits, such as review for possible excessive use, proper dosage, drug interactions or drug/pregnancy concerns.

From time to time we may initiate various programs to encourage 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.

You may contact the Pharmacy benefits manager through Member Services at the number located on the back of your Identification Card or online at the Anthem BCBS website: www.Anthem.com.

The Member may also request a copy of the Formulary by calling a customer service representative at the telephone number on the back of the ID card. The Formulary is subject to periodic review and amendment. Inclusion of a drug or related item on the Formulary is not a guarantee of coverage. Refer to the Prescription Drug benefit section in this Rider for information on coverage, limitations and exclusions.

SECTION 1: DEFINITIONS

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

BRAND NAME MAINTENANCE PRESCRIPTION DRUG: The term Brand Name Maintenance Prescription Drug means a Prescription Drug which has a proprietary or trade name selected by the manufacturer used to describe and identify it and which appears on its container, label or wrapping at the time of packaging. It is used on a continuing basis for the treatment of a chronic illness, such as heart disease, high blood pressure, arthritis and/or diabetes. Brand Name Maintenance Prescription Drugs will be designated by Anthem BCBS in its sole discretion as follows:

1. Listed Brand Name Maintenance Prescription Drug means a Brand Name Maintenance Prescription Drug identified on the Formulary by Anthem BCBS as a Prescription Drug with a Tier 2 Copayment as shown on the Schedule of Prescription Drug Benefits; or
2. Non-Listed Brand Name Maintenance Prescription Drug means a Brand Name Maintenance Prescription Drug which is not identified on the Formulary by Anthem BCBS. It has a Tier 3 Copayment as shown on the Schedule of Prescription Drug Benefits.

BRAND NAME PRESCRIPTION DRUG: The term Brand Name Prescription Drug means a Prescription Drug which has a proprietary or trade name selected by the manufacturer used to describe and identify it and which appears on its container, label or wrapping at the time of packaging. Brand Name Prescription Drugs will be designated by Anthem BCBS in its sole discretion as follows:

1. Listed Brand Name Prescription Drug means a Brand Name Prescription Drug identified on the Formulary by Anthem BCBS as a Prescription Drug with a Tier 2 Copayment as shown on the Schedule of Prescription Drug Benefits; or
2. Non-Listed Brand Name Prescription Drug means a Brand Name Prescription Drug which is not identified on the Formulary by Anthem BCBS. It has a Tier 3 Copayment as shown on the Schedule of Prescription Drug Benefits.

COINSURANCE: The term Coinsurance means the fixed percentage of the Maximum Allowable Amount for Covered Drugs which the Member is required to pay as shown in the Schedule of Prescription Drug Benefits.

COPAYMENT: For purposes of describing the benefits contained in this Rider, the term Copayment is amended to mean the fixed fee, as shown on the Schedule of Prescription Drug Benefits, paid by a Member for each separate Prescription Drug order, Maintenance Prescription Drug order or refill of a Covered Drug.

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 Prescription 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.

FORMULARY: The term Formulary means a listing of Prescription Drugs that are determined by Anthem BCBS in its sole discretion to be designated as Covered Drugs under Tier 2 & Tier 3. The list of approved Prescription Drugs, developed by Anthem BCBS in consultation with Physicians and Pharmacists has been reviewed for their quality and cost effectiveness. This list is subject to periodic review and modification by Anthem BCBS.

GENERIC PRESCRIPTION DRUG: The term Generic Prescription Drug means a Prescription Drug that is considered non-proprietary and is not protected by a trademark. It is required to meet the same bioequivalency test as the original brand name drug. The Member should refer to the Tier 1 Copayment specified in the Schedule of Prescription Drug Benefits.

GENERIC MAINTENANCE PRESCRIPTION DRUG: The term Generic Maintenance Prescription Drug means a Prescription Drug that is considered non-proprietary and is not protected by a trademark. It is used on a continuing basis for the treatment of a chronic illness, such as heart disease, high blood pressure, arthritis and/or diabetes. The Member should refer to the Tier 1 Copayment specified in the Schedule of Prescription Drug Benefits.

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.

MEMBER: For the purposes of describing the benefits contained in this Rider, the term Member is amended to mean either a Covered Person or his or her Dependent enrolled in and eligible for benefits for Covered Drugs under this Rider.

NEW FDA APPROVED DRUG PRODUCT OR TECHNOLOGY: The term New FDA Approved Drug Product or Technology means the first release of the brand name product or technology upon the initial FDA New Drug Approval or other applicable FDA approval for its biochemical composition and initial availability in the marketplace for the indicated treatment and use.

New FDA Approved Drug Product or Technology does not include:

1. New formulations: A new dosage form or new formulation of an active ingredient already on the market;
2. Already marketed drug product but new manufacturer: A product that duplicates another firm's already marketed drug product, same active ingredient, formulation, or combination;
3. Already marketed drug product, but a new use: A new use for a drug product already marketed by the same or different firm; or
4. Newly introduced generic medications (generic medications contain the same active ingredient as their counterpart brand-name medications).

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

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.

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

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

SECTION 2: SCHEDULE OF PRESCRIPTION DRUG BENEFITS

This is an open Formulary Prescription Drug Rider. The Copayments applicable to Covered Drugs under this Rider vary depending on whether the Covered Drug is a Generic Prescription Drug, Listed Brand Name Prescription Drug, Non-Listed Brand Name Prescription Drug, Generic Maintenance Prescription Drug, Listed Brand Name Maintenance Prescription Drug or a Non-Listed Brand Name Maintenance Prescription Drug.

A Member's rights to benefits for Covered Drugs as provided in this Rider are subject to the terms and conditions of this Rider.

Participating Pharmacy

Copayments – Retail Pharmacy

Tier 1 - Generic Prescription Drugs:

\$7 per Covered Drug purchased at a Participating Pharmacy

Tier 2 - Brand Name Prescription Drugs:

\$15 per Covered Drug purchased at a Participating Pharmacy

Tier 3 - Non-Listed Brand Name Prescription Drugs:

\$25 per Covered Drug purchased at a Participating Pharmacy

Copayments – Mail Order Pharmacy

Tier 1 - Generic Prescription Drugs:

\$14 per Covered Drug purchased through the designated mail order vendor

Tier 2 - Brand Name Prescription Drugs:

\$30 per Covered Drug purchased through the designated mail order vendor

Tier 3 - Non-Listed Brand Name Prescription Drugs:

\$50 per Covered Drug purchased through the designated mail order vendor

NOTES:

The Covered Person will be responsible for the applicable Tier 1, Tier 2, or Tier 3 copayment shown on this schedule for a 100 day supply of any prescription drug purchased through the designated mail order vendor.

The Member's Prescription Drug Copayment will be the lesser of the Copayment amount or the amount charged for the Prescription Drug by the Pharmacy or the Pharmacy benefits manager.

Non-Participating Pharmacy

Coinsurance*

20% per prescription

*The accumulated Coinsurance for Non-Participating Pharmacy benefits shall not apply to a Member's Cost-Share Maximum. Any amount paid by a Member as a Coinsurance for a Non-Participating Pharmacy benefit shall not be applied to satisfy a Member's Cost-Share Maximum of this Policy. This means that accumulated Coinsurance paid by a Member is not accumulated in satisfaction of the Member's Cost Share Maximum as set forth in the Schedule of Benefits of this Policy.

Prescription Drug Rider Maximum

Unlimited per Member per Calendar Year

Covered Benefits

Prescription Drugs
Maintenance Prescription Drugs

ADDITIONAL NOTE: Your Copayment(s) and/or Coinsurance will not be reduced by any discounts, rebates or other funds received by Anthem BCBS's designated Pharmacy benefits manager from drug manufacturers, wholesalers, distributors, similar vendors and/or funds received by Anthem BCBS from the Pharmacy benefits manager.

SECTION 3: PRESCRIPTION DRUG BENEFITS

Following payment of the amounts shown on the Schedule of Prescription Drug Benefits for each Covered Drug, Anthem BCBS will pay an amount as specified in the subsection entitled Participating Pharmacy Benefits of this section. The Member should refer to the Schedule of Prescription Drug Benefits for the applicable Tier 1, Tier 2 or Tier 3 Copayment(s) and benefit maximum(s). A Member's rights to Covered Drugs as provided in this Rider are subject to the terms and conditions of this Rider.

Benefits are limited to no more than a 100 day supply of each Covered Drug.*

In its sole discretion Anthem BCBS may approve the dispensing of a 100 day supply of a Covered Drug that is a Maintenance Prescription Drug. The dispensing of said 100 day supply is subject to the benefit maximum as shown on the Schedule of Prescription Drug Benefits and it is only available through the designated mail order vendor.

*Certain Covered Drugs have specific quantity limits as determined by Anthem BCBS in its sole discretion to which the general guidelines described above are not applicable. These quantity limits may include limitations imposed by State and Federal Statutes, FDA approved labeling for use and/or drug utilization review. Drug utilization review may include but is not limited to: drug-to-drug interaction screening, dosage-range screening, drug-of-preference screening, therapy protocol screening, gender and age-benefit screening, duration of use and monitoring of refills. The Member should contact the Member Services/Customer Service Department at the number located on his or her identification card to determine the applicable specific quantity limits for a Covered Drug.

In addition to benefits for Covered Drugs for the treatment of diabetes, benefits are also available for Medically Necessary equipment and supplies for the treatment of diabetes.

Therapeutic Substitution of Drugs

Your Pharmacy benefit includes a therapeutic drug substitution program approved by Anthem BCBS and managed by the Pharmacy benefits manager. This voluntary program designed to inform Members and Physicians about formulary or generic alternatives to non-formulary and formulary Brand Name Prescription Drugs. The Pharmacy benefits manager may contact the Member, the Member's representative, or the prescribing Physician to make the Member aware of formulary or Generic Drug substitution options. Therapeutic substitution may also be initiated at the time the Prescription Drug is dispensed. Only the Member and the Member's Physician can determine whether the therapeutic substitution is appropriate.

For a list of therapeutic drug substitutions that have been identified, contact a customer service representative by calling the telephone number on the back of the ID Card. The Member may also review the list of therapeutic drug substitutions on the Pharmacy benefits manager's website at www.Anthem.com. The therapeutic drug substitution list is subject to periodic review and amendment.

Participating Pharmacy Benefits

When a Covered Drug is dispensed by a Participating Pharmacy, the following provisions apply:

1. Anthem BCBS requires that the Participating Pharmacy or mail order vendor dispense to the Member the federally approved Generic Prescription Drug or Generic Maintenance Prescription Drug when a Prescription Drug order or Maintenance Prescription Drug order does not specify "No Substitution". When the Covered Drug is dispensed by a Participating Pharmacy, the Participating Pharmacy will accept the Maximum Allowable Amount and will make no charge to the Member, except for any applicable Tier 1, Tier 2 or Tier 3 Copayment or amounts exceeding the maximum benefits payable by Anthem BCBS.
2. 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, and any amounts exceeding the maximum benefits payable by Anthem BCBS.
3. Where no Generic Prescription Drug or Generic Maintenance Prescription Drug is available the Member is responsible for the applicable Brand Name Prescription Drug or Brand Name Maintenance Prescription Drug Copayment, as shown on the Schedule of Prescription Drug Benefits and any amounts exceeding the maximum benefits payable by Anthem BCBS.
4. 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.
5. Certain Covered Drugs require Prior Authorization. When Prior Authorization is obtained and the Covered Drug is dispensed by a Participating Pharmacy, the Participating Pharmacy will accept the Maximum Allowable Amount and will make no charge to the Member, except for any applicable Tier 1, Tier 2 or Tier 3 Copayment or amounts exceeding the maximum benefits payable by Anthem BCBS.

Payment for Covered Drugs will be made directly to the Participating Pharmacy. The Member may refer to the directory of Participating Pharmacies or contact his or her Member Services/Customer Service Department at the number located on his or her identification card to obtain a listing of Participating Pharmacies.

Non-Participating Pharmacy Benefits

When a Covered Drug is dispensed by a Non-Participating Pharmacy, the following provisions apply:

1. Anthem BCBS requires that the Member obtain the federally approved Generic Prescription Drug or Generic Maintenance Prescription Drug from the Non-Participating Pharmacy or mail order vendor when a Prescription Drug order or Maintenance Prescription Drug order does not specify "No Substitution".
2. When a Prescription Drug order or Maintenance Prescription Drug order does not specify "No Substitution," and the order is filled with a Covered Drug which is either a Brand Name Prescription Drug or a Brand Name Maintenance Prescription Drug at the request of the Member even though a federally approved Generic Prescription Drug or Generic Maintenance Prescription Drug is available, the Member will be responsible for the applicable Coinsurance amount as shown on the Schedule of

Prescription Drug Benefits; and the difference in cost between the federally approved Generic Prescription Drug and the Listed Brand Name Prescription Drug, or the Non-Listed Brand Name Prescription Drug; or the difference in cost between the federally approved Generic Maintenance Prescription Drug and the Listed Brand Name Maintenance Prescription Drug or the Non-Listed Brand Name Maintenance Prescription Drug. In addition, the Member will be responsible for any amounts exceeding the maximum benefits payable by Anthem BCBS under this Rider.

3. In the event that no Generic Prescription Drug or Generic Maintenance Prescription Drug is available for the dispensing of a Prescription Drug or Maintenance Prescription Drug, when the Covered Drug is dispensed a Member is required to pay applicable Coinsurance amount as shown on the Schedule of Prescription Drug Benefits and any amounts exceeding the maximum benefits payable by Anthem BCBS.
4. 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.
5. Certain Covered Drugs require Prior Authorization. When Prior Authorization is obtained and the Covered Drug is dispensed by a Non-Participating Pharmacy, the Member is required to pay the applicable Coinsurance amount shown on the Schedule of Prescription Drug Benefits and any amounts exceeding the maximum benefits payable by Anthem BCBS.

When a Medically Necessary Prescription Drug is dispensed by a Non-Participating Pharmacy, the Member shall be responsible for his or her Coinsurance. Anthem BCBS shall pay the Maximum Allowable Amount that is payable to a Non-Participating Provider. The Member shall be responsible for any difference between the Maximum Allowable Amount and the amount charged by the Non-Participating Pharmacy.

Claims must be filed with Anthem BCBS within two years after the Prescription Drug or Maintenance Prescription Drug has been filled. Claims must include the Member's name, Identification Card number, an original itemized bill and explanation including the name and quantity of the Prescription Drug or Maintenance Prescription Drug. 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.

Anthem BCBS shall reimburse to the Member the Maximum Allowable Amount for Non-Participating Providers for Covered Drugs after review and approval of the claim.

NOTE: Pre-existing conditions, if applicable, shall not apply to Prescription Drug and Maintenance Prescription Drug benefits.

National Pharmacy Network

A Member covered under this Rider may obtain Covered Drugs out-of-state at any Pharmacy participating in the National Pharmacy Network servicing Anthem BCBS Members.

A Member may locate a participating out-of-state Pharmacy by calling the toll-free number listed on his or her identification card.

To obtain benefits, a Member should show the participating out-of-state pharmacist his or her identification card. All Covered Drugs are subject to the applicable Tier 1, Tier 2 or Tier 3 Copayment amounts as shown on the Schedule of Prescription Drug Benefits.

Voluntary Mail Order Program

A Member may order a 100 day supply of any Covered Drug that is a Maintenance Prescription Drug from the designated mail order vendor subject to the applicable Tier 1, Tier 2 or Tier 3 Copayments and benefit maximum amount as shown on the Schedule of Prescription Drug Benefits. A Member should refer to the mail order program brochure included with his or her Policy materials for more information on this program, or call their Member Services/Customer Service Department at the number located on his or her identification card.

Other Provisions

1. Anthem BCBS may require a Member to furnish Anthem BCBS with any information about the diagnosis of any injury or illness and about the nature, quality, and quantity of the Prescription Drug or Maintenance Prescription Drug prescribed.
2. 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.

SECTION 4: EXCLUSIONS AND LIMITATIONS

For purposes of this Rider, the Exclusions section of the Policy is amended to include the following.

1. Prescription Drugs requiring Prior Authorization which are obtained by the Member but are not Prior Authorized by Anthem BCBS will not be considered Covered Drugs eligible for reimbursement under this Rider, unless otherwise specified in this Rider. The Member should contact their Member Services/Customer Service Department at the number located on his or her identification card to obtain a listing of Covered Drugs requiring Prior Authorization.
2. Prescription Drugs which are dispensed to the Member in quantities which exceed the applicable limits established by Anthem BCBS, in its sole discretion are not covered.
3. This Rider provides no benefits for any Prescription Drug or Maintenance Prescription Drug that is:
 - Dispensed before the Member's Effective Date or after his or her termination date.
 - Refilled in excess of the number the Prescription Drug order or Maintenance Prescription Drug order calls for or refilled after one year from the date of such order.
 - A Pharmacy charge that is less than the applicable Tier 1, Tier 2 or Tier 3 Copayment amount as shown on the Schedule of Prescription Drug Benefits.
 - 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.
 - Dispensed or prescribed in a manner contrary to accepted medical and professional standards of practice.
 - Considered Experimental or Investigational by Anthem BCBS in its sole discretion. 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.
 - A drug that requires federal or other governmental agency approval not granted at the time the drug was prescribed, or a drug that is approved by the Food and Drug Administration for controlled studies only.
 - An over-the-counter drug or non-legend drug, even if written as a prescription.
 - Provided in connection with any Hospital or Inpatient Facility.
 - Related to sex transformation surgery.
 - Used in connection with weight control.
 - Used in connection with male or female sexual dysfunctions or inadequacies, or erectile dysfunctions or inadequacies, regardless of origin or cause.

- 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.
- A hypodermic needle, syringe, or similar device, except when used for the administration of Covered Drugs.
- An allergenic extract or vaccine.
- Used solely to improve appearance or for cosmetic purposes.
- Any other services or items of care not listed in this Rider.
- Covered under any other section of the Policy.

DOMESTIC PARTNER COVERAGE RIDER

I. DEFINITION:

The definition of Domestic Partnership for this rider shall be 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 Partners (“Partners (s)”) agree to be jointly responsible for each other’s common welfare and share financial obligations.

II. ELIGIBLE GROUPS

1. All employer groups that meet the eligibility requirements for group coverage of Anthem Blue Cross and Blue Shield (Anthem BCBS) may request Domestic Partner coverage.
2. The employer group’s contribution schedule must remain neutral with respect to Domestic Partner coverage.

III. DOMESTIC PARTNER ELIGIBILITY CRITERIA

1. Domestic Partner eligibility between two persons of the same or opposite sex exist when all the requirements identified in A, B, C and D below are satisfied:

A.) Domestic Partners must meet all of the criteria below:

- i. Each party is the sole Domestic Partner of the other.
- ii. Each party is at least eighteen (18) years of age.
- iii. Both parties currently share a common legal residence and have shared said residence for at least 12 months prior to application for Domestic Partner coverage.
- iv. Domestic Partners must be jointly responsible for basic living expenses.
- v. Both parties are in a relationship of mutual support, caring, and commitment and intend to remain in such a relationship in the indefinite future.
- vi. Neither party is married to another person.
- vii. 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.

B.) Domestic Partners must have in effect and provide proof of any one of the following:

- i. Designation of Domestic Partner as beneficiary for life insurance and retirement contract;
or
- ii. Designation of Domestic Partner as primary beneficiary in the (Member’s) will; or,
- iii. Documentation by one Partner designating the other partner as his/her agent for:

Personal relationship issues, or
Health care decisions, or
Health Care agent.

C.) Neither party has filed a Termination of Domestic Partnership within the preceding 12 months.

- D). To enroll an eligible Domestic Partner, both the Member 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 ultimate decision in determining eligibility of the Domestic Partner.

IV. DEPENDENT ELIGIBILITY

Dependent children of the Member and/or Partner are eligible for benefits for covered services if the following requirements are satisfied:

1. The child(ren) is/are primarily dependent upon the Member and/or Partner for support and a parent-child relationship exists between the Member and child(ren) based on all of the conditions as set forth in a, b, c and d below being met:

- a) the child(ren) must be unmarried and reside in the same household as the Member and Partner, with the Member and Partners home as the primary place of residence.
- b) the children must be within the age limits as stated in the Policy.
- c) the Member and/or Partner must assume full parental responsibility and control, including any and all debts incurred by the child(ren) (i.e., charges for health care services and supplies)
- d) The Member and/or Partner must be (1) a biological parent, or (ii) have a court appointed legal relationship with the child(ren) i.e. guardianship, adoption, foster child), or (iii) have been designated as the responsible party under a Qualified Medical Child Support Order (QMCSO).

*Dependency is determined in accordance with the applicable Internal Revenue Service guidelines.

1. In the case of a newborn infant of the Member and/or Partner or enrolled dependent, such child shall be eligible for benefits for covered services from birth through age 31 days under the policy of their parents(s), subject to any applicable managed care or managed benefits provisions of this Policy. An infant age 32 days or over who meets the criteria IV, (1), (a) through (d) is eligible for benefits for covered services as a dependent child.
2. In the case of a full time student if the Member and/or Partner, a full time student is eligible for coverage when he/she meets the criteria in IV, (1), (a) through (d) above; and is between the age limits as stated in the Policy and, is a full-time student at a recognized college, university, or trade school, is accredited by its corresponding trade or professional organization, or is approved by the State Department of Education or Public Health equivalent licensing department in other states.
3. In the case of an unmarried disabled dependent child of the Member and/or Partner, where “disabled” means that the child is incapable of sustaining employment by reason of physical or mental handicap, the disabled child may continue as dependent beyond the age limit set forth in this Policy provided:
 - a) proof of disability is submitted and accepted by Anthem BCBS. Note: Anthem BCBS may require proof of disability annually.
 - b) the child became disabled prior to the age limit for a dependent child set forth in the Policy under which the child was eligible for benefits for Covered Services, and
 - c) the child had comparable coverage as a dependent at the time of application for eligibility for benefits for Covered Services under this Policy.

V. EFFECTIVE DATE OF COVERAGE

Coverage for Domestic Partners and eligible dependents of the Domestic Partner will be as follows:

1. Upon the firm's initial enrollment, provided all Domestic Partnership eligibility requirements are satisfied and approved by Anthem BCBS.
2. A newly hired Member may enroll a Partner provided all Domestic Partnership eligibility requirements are satisfied and approved by Anthem BCBS. The Effective Date of coverage will be in accordance with any applicable waiting period in place by the PolicyHolder and/or Anthem BCBS.
3. In the case where the PolicyHolder has an open enrollment period, an existing Member may enroll the Domestic Partner provided all Domestic Partnership eligibility requirements are satisfied and approved by Anthem BCBS. Eligibility for enrollment other than during the open enrollment period will be in compliance with Anthem BCBS Late Enrollee policy.
4. In the case where the PolicyHolder has no Open Enrollment Period, eligibility will be in compliance with Anthem BCBS Late Enrollee policy.

VI. TERMINATION

If the Domestic Partnership status changes such that the Partner is no longer eligible for coverage, the Member must complete and file a Termination of Domestic Partnership form within 30 days of the change of such status.

Once a Termination of Domestic Partnership has been submitted, the Member may not cover another partner for at least 12 months.

VII. CONTINUATION OF GROUP COVERAGE

Domestic Partners may each continue coverage under applicable State or Federal extension of coverage laws. The termination of the Domestic Partner status shall be considered for the purpose of this rider as a qualifying event to allow for the application of such continuation of benefits.

VIII. CONVERSION TO INDIVIDUAL COVERAGE

Upon termination of a Domestic Partnership, where the partner loses group health coverage, the Partner may apply for coverage through the Health Reinsurance Association (HRA).