Over 65 High Option/Plan 81 with Major Medical

Firm Name: City of Waterbury
Firm Number 001645-030

TABLE OF CONTENTS

DEFINITIONS....2

GENERAL PROVISIONS....11

EFFECTIVE DATE, ELIGIBILITY AND TERM OF COVERAGE....12

SCHEDULE OF HIGH OPTION MEDICARE SUPPLEMENTARY BENEFITS....13

HIGH OPTION....14

SCHEDULE OF MEDICAL/SURGICAL SUPPLEMENTARY BENEFITS PL-81....17

PLAN 81....18

SCHEDULE OF MAJOR MEDICAL BENEFITS....19

MAJOR MEDICAL BENEFITS – MM65....20

MEDICARE SUPPLEMENTARY COVERAGE....26

EXCLUSIONS, CONDITIONS AND LIMITATIONS....27

OTHER PROVISIONS....33

COORDINATION OF BENEFITS....34

GENERAL PROVISIONS....37

Subject to the Exclusions, Conditions and Limitations and Schedules of Eligibility and Benefits of this Policy, a Member is entitled to the benefits of this Medicare Supplementary Coverage Section for Covered Services rendered by a Provider in amounts specified in the Schedule of Benefits when prescribed as Medically Necessary Care by a Physician.

DEFINITIONS

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

Approved Expenses: The term Approved Expenses means: a)the amount approved by the Carrier as a basis for making payments for medical services covered under Medicare Part B; or b) the total covered charges approved by the Intermediary as a basis for making payments for services covered under Medicare.

The Company will use Approved Expenses as the basis for paying benefits.

Calendar Year: The term Calendar Year means a year beginning on January 1 and ending on December 31 of the same year. The first Calendar Year will begin on the Policy Effective Date and end on December 31 of the same year.

Carrier: The term Carrier means an agency or organization which has entered into an agreement with the United States Secretary of Health and Human Services to: a) determine covered services and the amount approved as the basis for making payments; and b) make such payments as required by Medicare.

Certified Independent Social Worker: The term Certified Independent Social Worker means a person who is certified under the provisions of Chapter 383b and who has passed the clinical examination of the American Association of State Social Work Boards and has completed at least 2,000 hours of the post-master's social work experience in a non-profit agency qualifying as a tax-exempt organization under Section 501(c) of the Internal Revenue Code of 1986 or any subsequent corresponding Internal Revenue Code of the United States, as from time to time amended, in a municipal, state or federal agency or in an institution licensed by the Department of Health Services under C.G.S. Section 19a-490. Persons who are certified under the provisions of Chapter 383b before October 1, 1990 are exempted from post-certification requirements.

Certified Marriage and Family Therapist: The term Certified Marriage and Family Therapist means a person who is certified under the provisions of Chapter 383(a) and has completed at least two thousand hours of the post masters marriage and family therapy work experience in a nonprofit agency qualifying as a tax-exempt organization under Section 501(c) of the Internal Revenue Code of 1986 or any subsequent corresponding Internal Revenue Code of the United States, as from time to time amended, in a municipal, state or federal agency or in an institution licensed by the Department of Health Services under section 19a-490. Persons who are certified under the provisions of chapter 383(a) prior to October 1, 1992 are exempted from post-certification requirements.

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.

Covered Service(s): The term Covered Service means services, supplies or treatment as described in this Policy. To be a Covered Service, the service, supply or treatment must be:

a. Medically Necessary or otherwise specifically included as a benefit under this Policy.
b. Within the scope of the license of the Provider performing the service.

c. Rendered while coverage under this Policy is in force.
d. Not Experimental or Investigational or otherwise excluded or limited by the Policy.
e. Authorized in advance by Anthem BCBS if such Prior Authorization is required under the Policy.

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.

Dependent: The term Dependent means the Covered Person's spouse who is eligible for benefits under Medicare and who is enrolled under Medicare.

Effective Date: The term Effective Date means the date upon which the Member is eligible to receive benefits under this Policy as provided in the Eligibility Section.

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 evaluated the safety, toxicity or efficacy of 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 demonstrated 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 of 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 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 physician, 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 in the 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.

Explanation of Medicare Benefits: The term Explanation of Medicare Benefits means a statement sent to the Member by the Carrier or Intermediary showing use of Medicare benefits. This statement shows the Member how much of the Member's expenses have been credited to the deductible and the amount of benefits paid by Medicare.

Home Health Agency: The term Home Health Agency means an organization which is federally certified as a Home Health Agency and duly licensed, if such licensing is required by the appropriate licensing authority, to provide nursing and other therapeutic services.

Hospital: The term Hospital means an institution which:

1. is registered as such by the American Hospital Association;

2. is primarily engaged in providing diagnostic and therapeutic facilities for the surgical and medical diagnosis, treatment and care of injured and sick persons on an inpatient basis;

3. provides care under the supervision of a staff of Physicians (M.D.);

4. continuously provides 24 hour a day nursing services by a licensed registered nurse (R.N.); and

5. is not, other than incidentally, a nursing home, a place for rest or for the aged.

   a. 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.

   b. 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.

   c. 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).

Any Hospital located outside of the United States must satisfy the criteria listed in 2. through 5. above.

d. 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.

e. 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.

f. 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.

Intermediary: The term Intermediary means an agency or organization which has entered into an agreement with the United States Secretary of Health and Human Services to make payments for care which has been determined necessary under Public Law 89-97 (Federal Health Insurance for the Aged) as amended.

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

Licensed or Certified Alcohol and Drug Counselor: The term Licensed or Certified Alcohol and Drug Counselor means a person who is either licensed or certified according to the provisions of C.G.S. 20-74s.

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

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

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, an amount negotiated with a Non-Participating Hospital for Covered Services provided to a Member, or in the absence of a negotiated amount, a Non-Participating Hospital's charge reduced by Cost-Shares for the Covered Services. 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 Service.

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

   <u>Non-Participating Out-of-State Provider Cost Share Calculation</u>
   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 (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 and 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.

   <u>Maximum Allowable Amount: Non-Participating Out-of-State Provider</u>
   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 the 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, any other contingent payment arrangements and any other non-claims transactions with all of the Host Plan's health care providers or one or more particular Providers that the Host Plan passes on to Anthem BCBS. Average discounts tend to have a greater range of variability than do estimated prices. Such estimated prices or average discounts may be prospectively adjusted to correct for

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) 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 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

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 the program of health care for the aged and disabled established by Title XVIII of the Social Security Act of 1965, as amended.

Medicare Part B: The term Medicare Part B means the Part B program of health care for the aged and disabled established by Title XVIII of the Social Security Act of 1965, as amended.

Member: The term Member means either the Covered Person or an enrolled Dependent.

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

Physician, Doctor: The term Physician or Doctor 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./Psy.D.) who is licensed to practice in the state in which services are rendered. For the purpose of C.G.S. 38a-526, the term Physician, Doctor will also include:

licensed physician assistant, certified nurse practitioner, certified psychiatric-mental health clinical nurse specialist or certified nurse midwife.

1. 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 under the terms of the Policy.

2. Non-Participating Physician: The term Non-Participating Physician means any appropriately licensed Physician who is not a Participating Physician under the terms of the Policy.

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; or employee benefit organization plan.

Policy: The term Policy means this document, which describes the rights, benefits, terms, conditions and limitations of the coverage available to the Member and eligible Dependents, including schedules, the membership application, health statement, rate page, and riders and any amendments thereto.

Prescription Drugs: The term Prescription Drugs means insulin and those drugs and drug compounds which are included in the United States Pharmacopeia National Formulary and which are required to be dispensed pursuant to a Prescription and which, by law, are required to bear the legend: “Caution – Federal Law prohibits dispensing without Prescription” or which are approved by Anthem BCBS.

Residential Treatment Facility: The term Residential Treatment Facility means a treatment center for children and adolescents under the age of 19 which provides residential care and treatment for emotionally disturbed individuals and is licensed by the Department of Children and Youth Services and is accredited as a residential treatment center by the Council on Accreditation or the Joint Commission on Accreditation of Health Organizations.

Skilled Nursing Facility: The term Skilled Nursing Facility means any institution which accepts and charges for patients on an inpatient basis. This institution must be primarily engaged in providing skilled nursing care, rehabilitative and related services to patients requiring medical and skilled nursing care. It must be under the supervision of a registered nurse. It must not be a place primarily for the nursing service under the supervision of a registered nurse. It must not be a place primarily for the treatment of nervous-mental disorders, a place of rest, custodial care or acute inpatient level of care.

Spell of Illness: The term Spell of Illness means any Hospital or Skilled Nursing Facility stay, or any combination of these, which is not separated by 60 days between discharge and readmission. Any readmission to a Hospital or Skilled Nursing Facility within 60 days of discharge is considered the same Spell of Illness.

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 Health Services.
- If out-of-state, a facility must have equivalent licensure and have appropriate accreditation from the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO).

Treatment Plan: The term Treatment Plan means a written report showing the problems or diagnosis and recommended therapeutic treatment needed for a specific illness or injury. Appropriate Physician or Provider authorization is required on the Treatment Plan. The need, type and anticipated length of treatment must be approved by Anthem BCBS. A Treatment Plan for pre-determination of benefits(s) must be submitted by the Member at the onset of treatment.

GENERAL PROVISIONS

1. Any institution a Member is admitted to must have an agreement with the Secretary of Health and Human Services of the United States to provide benefits under Medicare.

2. Anthem BCBS's payments will be based on Approved Expenses as determined by a Carrier or Intermediary.

3. A claim under this Section must be made in a form satisfactory to Anthem BCBS. If the information is not available from the Carrier or Intermediary, the Member must provide Anthem BCBS a copy of the Explanation of Medicare Benefits and any itemized bills requested by Anthem BCBS. This claim must be made by or on behalf of the Member no later than three years after the Covered Services are incurred.

4. If in any Calendar Year the Member incurs Approved Expenses in excess of the Medicare Part B deductible amount, Anthem BCBS will make payment toward those Approved Expenses. The Member must submit a copy of the Explanation of Medicare Benefits provided by the Carrier or Intermediary. If expenses are incurred outside the United States which would be considered Approved Expenses if received in the United States the Member must submit copies of paid itemized bills to Anthem BCBS. These claims must be submitted to Anthem BCBS within 90 days after the end of the Calendar Year.

5. No legal proceeding may be brought under this Section of the Policy after a three year period from the date Covered Services are incurred.

6. Anthem BCBS will not pay for care which has been determined to be unnecessary under Medicare or under this Policy. Anthem BCBS will not pay for charges deemed unreasonable under existing Medicare regulations or under this Policy.

EFFECTIVE DATE, ELIGIBILITY AND TERM OF COVERAGE

1. The entire Policy between the Policyholder and Anthem BCBS consists of this document, with Group Application, Acceptance page and individual membership applications, endorsements, attached papers, and amendments, if any. Anthem BCBS may not use any statement the Policyholder makes in the Group Application or a Member makes in his/her individual membership application in any legal proceeding under this Policy unless the application or a copy of it is attached to this Policy.

2. The effective date of this Policy is established in accordance with Anthem BCBS's underwriting requirements.

3. In order for a person to have coverage under this Policy:

   a. The Policy must be in effect (unless otherwise provided for in this Policy);

   b. He/she must meet the eligibility criteria established by the Policyholder and Anthem BCBS;

   c. He/she must be actively enrolled in Medicare Part A and Part B;

   d. He/she must have completed an individual membership application on the form provided for that purpose;

   e. The individual membership application must have been made effective by Anthem BCBS; and

   f. Premiums must have been paid by the Policyholder on a current basis.

SCHEDULE OF HIGH OPTION MEDICARE SUPPLEMENTARY BENEFITS

Subject to the Exclusions, Conditions and Limitations of the Policy, a Member is entitled to benefits for Covered Services described in the Medicare Supplementary Coverage High Option Benefits Section in the amounts as specified in this Schedule of Benefits when prescribed or ordered as Medically Necessary Care by a Physician and rendered by a Participating Provider.

DEDUCTIBLE	Covered in full
COPAYMENT 61ST THROUGH 90TH DAY	Covered in full
OPTIONAL 60 DAYS MEDICARE LIFETIME RESERVE DAYS	Covered in full
WORLD WIDE COVERAGE	30 Days
SKILLED NURSING FACIITY COPAYMENT PER DAY	Covered in full

OTHER BENEFITS ARE DESCRIBED IN THE POLICY

NON-PARTICIPATING PROVIDER

The allowance for Covered Services when prescribed or ordered as Medically Necessary Care by a Physician and rendered by a Non-Participating Provider is as follows:

In Connecticut

Benefits will be the same as extended to a Participating Provider, except for 365 additional days after exhaustion of Medicare Lifetime Reserve days which are paid as follows:

a. 80% of charges for total inpatient Covered Services
b. 80% of charges for outpatient Covered Services

Outside of Connecticut

If the Hospital is a Participating Hospital of an approved Blue Cross Plan, full coverage is extended as provided by this Policy; otherwise coverage is as follows:

a. 80% of charges for total inpatient Covered Services
b. 80% of charges for outpatient Covered Services

Outside of the United States

100% of charges for Covered Services based on rate of exchange at time when incurred.

HIGH OPTION

BENEFITS PROVIDED

1. If a Member is admitted as a bed patient, Anthem BCBS will pay the amount indicated on the Schedule of Benefits as payable toward the Initial Deductible.

2. If a Member continues to be Hospitalized, Anthem BCBS will pay the amount indicated on the Schedule of Benefits as payable toward the daily Copayment for the 61st through the 90th day.

3. If a Member has an extended hospitalization and must use any or all of the 60 Medicare Lifetime Reserve Days, Anthem BCBS will pay the amount indicated on the Schedule of Benefits as payable toward the Medicare Lifetime Reserve Days.

4. Upon exhaustion of all Medicare Hospital inpatient coverage including Medicare Lifetime Reserve Days, Anthem BCBS will provide full coverage for a semi-private room, meals and general nursing care plus full coverage for special services toward the 365 Lifetime Additional Days after exhaustion of Medicare Lifetime Reserve Days. If a private room is used, Anthem BCBS will pay the weighted average charge for a semi-private room. The Member will pay the difference. These benefits are not available for nervous-mental conditions.

5. If a Member is treated for outpatient care, Anthem BCBS will pay the amount not covered by Medicare if the Member is enrolled in Part A and Medicare Part B. If the Member is not enrolled in Medicare Part B, Anthem BCBS will pay only 20% of Hospital outpatient charges.

6. If a Member is admitted to a Specialty Hospital, Anthem BCBS will pay appropriate amounts stated in the Schedule of Benefits. Anthem BCBS will not provide any benefits in excess of the Medicare maximum of a 190 day lifetime benefit for nervous-mental disorders.

7. If a Member is hospitalized outside the United States, Anthem BCBS will provide coverage toward the Hospital's published charges for a semi-private room, meals and general nursing care for a maximum period as shown on the Schedule of Benefits. Full coverage of special services also will be provided. If a private room is used, Anthem BCBS will pay the weighted average charge for a semi-private room and the Member will pay the difference. Benefits also will be provided for outpatient care required in a Hospital located outside the United States.

8. If a Member is admitted to a Skilled Nursing Facility, Anthem BCBS will pay the amount indicated on the Schedule of Benefits as payable toward Skilled Nursing Facility Copayment Per Day. The benefit period is 80 days per Spell of Illness starting on the 21st day of the Member's confinement. In order to qualify for these benefits, the Member must be eligible for Medicare Benefits.

9. Anthem BCBS will pay for Post Hospital Prescription Drugs as follows:

   Anthem BCBS will pay for Prescription Drugs purchased at a licensed retail pharmacy up to a maximum of $500 for a period of 150 days following date of initial admission to the Hospital or 120 days following date of discharge, whichever is greater. Anthem BCBS will pay for Prescription Drugs purchased at a licensed retail pharmacy up to the maximum of $500 mentioned above for a period of 150 days following an outpatient

surgical procedure performed in a licensed Hospital. If the Member is readmitted or receives an outpatient surgical procedure performed in a licensed Hospital, the benefits available from the prior admission will cease and a new $500 maximum will begin with the day of readmission.

If the Prescriptions are filled by a Participating Provider, Anthem BCBS will provide full coverage. If the Prescriptions are filled by a Non-Participating Provider, Anthem BCBS will pay an amount equal to the amount payable to a Participating Provider.

Special Exclusions and Limitations

The maximum supply of a drug for which benefits will be provided when dispensed under any one prescription is a 34-day supply or 100-unit dose, whichever is greater.

Benefits are not provided for:

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

Prescription Drugs used in connection with drug addiction;

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

Antibacterial soaps, detergents, shampoos, toothpastes/gels, and mouthwashes/rinses;

Contraceptives and oral contraceptives regardless of intended use;

Any charge for other items which are not Prescription Drugs such as contraceptive devices, therapeutic devices, artificial appliances, hypodermic needles, syringes or similar devices;

Vaccines and allergenic extracts;

Parenteral nutritional products;

Any drug whose status is Experimental or Investigational or rendered solely for research purposes; or

Prescription Drugs covered in whole or in part by public or private grants.

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

10. If a Member receives home health aid services, we will pay up to $500 per Member per Calendar Year under the following conditions:

    a. the services must be provided by a certified home health aide employed by a home health agency licensed pursuant to C.G.S. Sections 19a-490 to 19a-503 inclusive;

    b. the Member's Physician has certified, in writing, that such services are Medically Necessary; and

    c. the services are not paid for by Medicare.

If two or more Medicare Supplement policies are issued by the same insurer to the same individual, such coverage for home health aide services shall be payable under only one such policy, i.e., limited to $500 per Member per Calendar Year.

11. Anthem BCBS will provide benefits to any woman covered under this Policy for a mammographic (screening) examination every year, or more frequently if recommended by the woman's physician, when such examinations are not paid for by Medicare.

12. Coverage under Medicare Part A for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations or already paid for under Part B.

SCHEDULE OF MEDICAL/SURGICAL SUPPLEMENTARY BENEFITS PL-81

MEDICARE PART B DEDUCTIBLE *	Covered in full
20% COPAYMENT OF APPROVED EXPENSES*	Covered in full
MEDICAL SERVICES RENDERED OUTSIDE THE UNITED STATES *	As described in Policy

NON-PARTICIPATING PROVIDER

Same as Participating Provider.

PLAN 81

MEDICAL/SURGICAL

1. Anthem BCBS will pay the Medicare Part B deductible amount as shown in the Schedule of Benefits, incurred by a Member for Approved Expenses under Medicare Part B, in any Calendar Year.

2. Anthem BCBS will pay 20% of all Approved Expenses as shown in the Schedule of Benefits, incurred by a Member in excess of the Medicare Part B deductible amount paid in any Calendar Year.

3. Anthem BCBS will pay for medical services rendered to a Member outside of the United States if those services would result in Approved Expenses under Medicare Part B if they were performed in the United States. Payments will not exceed the maximum amount payable for equivalent services under the Comprehensive Schedule of Professional Services for medical/surgical benefits in effect at the time when the services were incurred.

4. If a Member receives home health aide services, Anthem BCBS will pay up to $500.00 per Member per Calendar Year under the following conditions:

   a. the services must be provided by a certified home health aide employed by a home health agency licensed pursuant to C.G.S. Sections 19a-490 to 19a-503, inclusive;

   b. the Member's physician has certified, in writing, that such services are Medically Necessary; and

   c. the services are not paid for by Medicare.

   If two or more Medicare Supplement policies are issued by the same insurer to the same individual, such coverage for home health aide services shall be payable under only one such policy, i.e., limited to $500.00 per Member per Calendar Year.

5. Anthem BCBS will provide benefits to any woman covered under this Policy for a mammographic (screening) examination every year, or more frequently if recommended by the woman's Physician, when such examinations are not paid for by Medicare.

6. Effective January 1, 1990, coverage under Medicare Part B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations), unless replaced in accordance with federal regulations or already paid for under Part A, subject to the Medicare deductible amount.

SCHEDULE OF MAJOR MEDICAL BENEFITS

BENEFIT PERIOD	Calendar Year
DEDUCTIBLE	
Individual	$50
Family	$100
COINSURANCE	20% per Member per Calendar Year up to the Lifetime Maximum
NERVOUS/MENTAL CARE	
Inpatient Lifetime Maximum	$5,000 per Member
Outpatient	50% up to $2,000 per Member per Calendar Year
LIFETIME MAXIMUM	$50,000 per Member

COVERED SERVICES

Major Medical Services

Physician Services	
Hospital Services	
Prescription Drugs	
Private Duty Nursing Care	In and Out of Hospital Only
Durable Medical Equipment	
Ostomy Related Services	
Prosthetic Appliances	
Skilled Nursing Facility Services	
Home Health Care Services	

MAJOR MEDICAL BENEFITS – MM65

Subject to the Exclusions, Conditions and Limitations, and Schedules of Eligibility and Benefits of this Policy, a Member is entitled to benefits for Covered Services as described in this Major Medical Benefits Section for Medically Necessary Care when prescribed or ordered by a Physician.

A. DEFINITIONS

In addition to the defined terms listed in the Definitions Section of this Policy, the following also apply to this Major Medical Benefits Section:

1. Deductible: The term Deductible means: That portion of the Covered Services incurred in a Calendar Year which is the Member's responsibility to pay.

   a. The individual and family Deductible amounts as shown on the Schedule of Benefits.

   b. A family Deductible amount will be satisfied when one Member meets an individual Deductible and the other family Members collectively meet the difference between the individual Deductible and family Deductible amounts, unless otherwise stated in the Schedule of Benefits. If the family Deductible is more than two times the individual Deductible, in no event will any one Member be required to meet more than the individual Deductible amount.

   c. Any Covered Services incurred during the last three months of a Calendar Year and applied toward the Deductible for that year will be applied also to the Deductible for the succeeding Calendar Year.

2. Maximum Allowable Amount: For the purpose of describing Major Medical benefits, the term Maximum Allowable Amount means for each of the following:

   a. Physician and 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 discretion, which is assigned as reimbursement for Covered Services provided to a Member or an amount negotiated with a Physician or 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 and amounts in excess of the Maximum Allowable Amount.

   b. Hospital: Except as otherwise required by law, an amount negotiated with a Hospital for Covered Services provided to a Member, or in the absence of a negotiated amount, a Hospital's charge reduced by Cost-Shares for the Covered Services. It is the Member's obligation to pay Cost-Shares and amounts in excess of this Maximum Allowable Amount.

      Please note that the Maximum Allowable Amount may be greater or less than the Physician's, Provider's or 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.

c. When Covered Services are rendered outside of Connecticut by Physicians, Providers and/or Hospitals, the Member's Cost-Share obligation may be calculated based upon one of the following (except that in the case of the BlueCard Program, the Cost-Share calculation shall be based on Item C):

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

When Covered Services are rendered outside of Connecticut to a Member by a Physician, Provider or Hospital participating in the BlueCard Program, the Maximum Allowable Amount shall be determined by the Blue Cross and/or Blue Shield Plan in that area outside of Connecticut.

The Maximum Allowable Amount may be:

1. The applicable rate for such services, before deduction of any applicable risk withholds, negotiated with the provider (physician, hospital, other provider) by 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. The negotiated price, which can include an estimated price or average discount off of billed charges that factors in settlements or other non-claims transactions for all providers (physicians, hospitals, other providers) or for a specific group of providers (physicians, hospitals, other providers) that the Blue Cross and/or Blue Shield Plan passes on to Anthem BCBS. Such estimated prices or average discounts may be prospectively adjusted to correct for over or underestimation of prices or discounts applicable to BlueCard Program claims. There will be no retrospective adjustment or return of funds to the Member.

   In addition, that Blue Cross and/or Blue Shield Plan will be calculating the Cost-Share obligation (i.e. Coinsurance) amount for those Covered Services.

   There may be a small number of states where state law may 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. The Cost-Share obligation will be based on those statutory provisions, as applicable.

3. Private Duty Nursing Care: The term Private Duty Nursing Care means the Medically Necessary Care rendered by a licensed registered nurse (R.N.) in the course of patient care. The level of care must be of such complexity that it requires the skills of a R.N. The R.N. must be licensed in the state in which care is given. Such care must include the assessment and evaluation of the patient's health care needs, collaboration in and implementation of Physician (M.D.) directed treatment, and teaching to facilitate the patient's ability to performed skilled functions in the absence of a nurse.

4. Skilled Nursing Facility: The term Skilled Nursing Facility means an institution which accepts and charges for patients on an inpatient basis. This institution must be primarily engaged in providing skilled

nursing care, rehabilitative and related services to patients requiring medical and skilled nursing care. It must be under the supervision of a licensed Physician and provide 24-hour a day nursing service under the supervision of a registered nurse. It must not be a place primarily for the treatment of nervous-mental disorders, a place of rest, custodial care, or acute inpatient level of care.

B. OTHER MAJOR MEDICAL PROVISIONS

1. The provisions of this Major Medical Section will be provided to Members who are eligible for and enrolled in Medicare Parts A and B, Anthem Blue Cross 65 and Anthem Blue Shield 65. In addition, Members may also be enrolled in Medicare Part D.

2. Major Medical benefits will only be available to supplement the benefits of Medicare Parts A and B, and/or D, Anthem blue Cross 65 and Anthem Blue Shield 65 and will not be available to duplicate these benefits.

3. In the absence of any portion of an acceptable basic program, Major Medical benefits will not be available to cover any services for which benefits would have been provided under the acceptable basic program.

4. In order to be eligible for reinstatement of the lifetime maximum benefits under this Major Medical Benefits Section, proof of insurability, acceptable to Anthem BCBS, must be furnished by the Member.

5. Benefits paid for outpatient Nervous/Mental Care are considered a part of and are applied to the lifetime maximum as shown in the Schedule of Major Medical Benefits. Provided, however, Anthem BCBS will provide outpatient Nervous/Mental Care benefits up to the amount as shown in the Schedule of Major Medical Benefits.

6. The Member's coinsurance amount for Covered Services for outpatient Nervous/Mental Care is not considered a part of and is not applied to the coinsurance maximum, if any, as shown on the Schedule of Major Medical Benefits.

7. No benefits will be available under this Major Medical Benefits Section for services related to procurement of an organ used in a covered organ transplant procedure.

C. COVERED SERVICES

Subject to any Deductible, Coinsurance or Benefit Program maximums, as shown in the Schedule of Benefits, the following services are payable at the Maximum Allowable Amount:

1. Services of a Physician; subject to the terms and conditions of this Policy.

2. Services of a Physician surgical assistant, subject to Hospital rules regarding participation in surgery and where a Physician in an approved physician-in-training program is not available. Anthem BCBS will provide benefits for one surgical assistant whose services are regularly separately billed for. Anthem BCBS will not pay for services rendered outside of a Hospital or for the services of a physician-in-training.

3. Hospital charges to the extent not already provided for in basic coverages.

4. Blood and blood plasma.

5. Administration of chemotherapeutic agents, including the cost of the agents required for the treatment of malignant disease.

6. Prescription Drugs or insulin dispensed by a Pharmacy.

7. Anesthesia when provided for a procedure(s) which is considered a covered service under the basic programs under which the Member is enrolled.

8. X-ray and radiation therapy, including radioactive isotopes; inhalation therapy; oxygen and other gases and their administration.

9. Private Duty Nursing Care outside a Hospital.

   Benefits for Private Duty Nursing Care will not be provided for the convenience of the patient or while an in-patient at an acute care Hospital or other Skilled Nursing Facility.

10. Rental of durable medical equipment which:

    a. is designed for repeated use in the diagnosis or treatment of an illness or injury;

    b. to improve the functions of a malformed body member; or

    c. to prevent or retard further deterioration of the Member's medical condition; and

    d. which is not useful in the absence of injury or illness. Anthem BCBS will consider purchase of such equipment if the cost would be less than rental. In either case, the total benefit will not exceed the cost of the least expensive equipment necessary to meet the medical condition.

11. Services of a Licensed Occupational Therapist under the following condition:

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

    b. the services prescribed in the plan of care are certified by the Physician (M.D.) to be available only from a Licensed Occupational Therapist; and

    c. the plan of care is reviewed and recertified by the Physician (M.D.) at least every 2 months.

12. Prosthetic appliances which replace a missing part of the body, including an external breast prosthesis following mastectomy for malignancy or other disease of breast tissue.

    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.

13. Nervous-mental care as an outpatient or outside a Hospital.

    a. Anthem BCBS will provide benefits for the following services.

1. Services provided by a Physician (M.D.) practicing as a psychiatrist, licensed psychologist, Certified Independent Social Worker, Certified Marriage and Family Therapist, Licensed or Certified Alcohol and Drug Counselor, or an appropriately licensed professional counselor.

2. Services of a person with a master's degree in social work when such person renders service in a child guidance clinic or Residential Treatment Facility under the supervision of a Physician (M.D.) or Physician (M.D.) practicing as a psychiatrist or licensed psychologist, Certified Independent Social Worker, Certified Marriage and Family Therapist, Licensed or Certified Alcohol and Drug Counselor, or an appropriately licensed professional counselor.

3. Services in a non-profit, community mental health center as defined by the State of Connecticut, Department of Mental Health, or in 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 (M.D.) practicing as a psychiatrist or licensed psychologist or Certified Independent Social Worker, Certified Marriage and Family Therapist or Licensed or Certified Alcohol and Drug Counselor, or an appropriately licensed professional counselor practicing within the scope of the license issued to the center or clinic by the Department of Health Services or to the Residential Treatment Facility by the Department of Children and Youth Services.

4. Polysomnography for the diagnosis of sleep apnea or narcolepsy, when provided in a facility accredited by the Association of Sleep Disorders Center – Clinical Sleep Society. Polysomnograms are payable once per Member per Calendary year when ordered by a Physician as Medically Necessary Care. Examples of diagnosis that are not considered for coverage include: sexual dysfunction disorders, psychogenic sleep disorders, non-organic sleep disorders, epilepsy, myoclonus, respiratory disorders and other disorders of sleep.

5. Services offered in conjunction with Polysomnography as specified in sub-paragraph 4.

14. Inpatient Skilled Nursing Facility Care: Benefits will be provided for Covered Services incurred for 120 days per Calendar Year.

15. Dental Services: 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.

    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.

    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.

16. Non-Dental prostheses and maxillo-facial prostheses used to replace an anatomic structure lost during treatment for head or neck tumors or additional appliances essential for the support of such prostheses.

17. Diagnostic Services

    a. Diagnostic x-rays, diagnostic radioisotope studies, ultrasound, electrocardiograms, electroencephalograms.

    b. Laboratory tests including clinical pathology, examinations of body tissue, blood or body fluid recommended by a Physician and performed solely for the diagnosis of disease or injury.

    c. Benefits for diagnostic imaging procedures such as computerized axial tomography.

18. After benefits have been exhausted under the Home Health Care Benefits Section of this Benefit Program, home health care benefits will be provided in accordance with C.G.S. Section 38a-520.

19. Mammographic examinations as follows:

    a. A baseline, screening mammogram for any female Member who is 35 to 39 years of age, inclusive;

    b. A screening mammogram every year for any female Member who is 40 years of age or older, or more frequently if recommended by the woman's Physician (M.D.).

D. <u>RELATED EXCLUSIONS, CONDITIONS AND LIMITATIONS</u>

Benefits are not provided for Prescription Drugs which are used in connection with male or female sexual dysfunctions or inadequacies, or erectile dysfunctions or inadequacies, regardless of origin or cause.

MEDICARE SUPPLEMENTARY COVERAGE

Subject to the Exclusions, Conditions and Limitations and Schedules of Eligibility and Benefits of this Policy a Member is entitled to benefits for Covered Services as described in this Medicare Supplementary Coverage Section for Medically Necessary Care when prescribed or ordered by a Physician.

EXCLUSIONS, CONDITIONS AND LIMITATIONS

In addition to the other limitations, conditions and exclusions set forth elsewhere in this Policy, no benefits will be provided for the 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 Policy. 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 Policy.

A. Anthem BCBS will provide benefits only for services: (1) specifically described in this Policy; (2) rendered or ordered by a Physician; (3) within the scope of the Physician's, Provider's or Hospital's licensure; and (4) which constitute Medically Necessary Care for the proper diagnosis and treatment of the Member.

B. Except as specifically provided in this Policy, no benefits will be provided for the following:

   1. Duplicate Coverage and Other Third Party Liability

      a. Workers' Compensation or Coverage Provided by Law: No benefits will be provided for services paid, payable or required to be provided under any Workers' Compensation Law or which, by law, were rendered without expense to the Member. Anthem BCBS will not enter into any agreement or obligation under which coverage under this Policy is made or is construed to be primary to or in place of any other benefits covered or obtained under a Workers' Compensation Law.

      b. No-Fault: To the extent permissible by law, no benefits will be provided for services paid, payable or required to be provided as Basic Reparations Benefits under C.G.S. Section 38a-365 (a) or similar benefits under any other No-Fault Automobile Insurance Law.

      c. An uninsured motorist will be considered to be self-insured. Anthem BCBS will not be required to extend benefits which are required to be provided under any No-Fault Automobile Insurance Laws to the extent permissible by law.

      d. Duplicate Coverage: If the Member is enrolled in another Plan, benefits will be subject to the Coordination of Benefits provisions of this Policy.

C. Services Specifically Excluded: Anthem BCBS will provide only the benefits which are described in this Policy. Benefits which are not provided include:

   1. Inpatient services which can be properly rendered as an outpatient service.

   2. Tests for premarital or pre-employment examination, studies relating to pregnancy except for significant medical reasons, simplified or self-administered tests and multiphasic screening.

3. Certain pulmonary function tests which in the opinion of Anthem BCBS do not meet the definition of a covered diagnostic laboratory test.

4. Custodial Care which means care designed essentially to assist an individual to meet his/her activities of daily living such as: (a) help in walking and getting in and out of bed; (b) assisting in bathing, dressing, feeding, using the toilet; (c) care which does not require admission to a Hospital or other institution, or locality, for the treatment of an illness, injury, or for the performance of surgery; (d) care primarily to provide room and board (with or without routine nursing care, training in personal hygiene and other forms of self-care); (e) supervisory care by a Physician for a person who is mentally or physically disabled and who is not under specific medical, surgical or psychiatric treatment to reduce the disability to the extent necessary to enable the patient to live outside an institution providing medical care or when despite such treatment, there is no reasonable likelihood that the disability will be so reduced.

5. Services covered in whole or in part by public or private grants.

6. Care in a Veterans' Hospital or any Federal Hospital except as otherwise required by law.

7. Charges after the Provider's or Hospital's regular discharge hour on the day indicated for the Member's discharge by his/her Physician.

8. Disease contracted or injuries resulting from war.

9. 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 the teeth, unless otherwise provided for in this Policy.

10. Eyeglasses, contact lenses and hearing aids or examinations for prescriptions or fittings unless otherwise provided for in this Policy.

11. Travel, whether or not recommended by a Physician.

12. Services or supplies not specifically listed as Covered Services, such as speech therapy, educational therapy, marital counseling, sex therapy, weight control programs, nutritional programs, exercise programs and medical supplies, unless otherwise provided for in this Policy.

13. Services or supplies which in the opinion of Anthem BCBS are not required for the diagnosis or treatment of injury or illness such as: (a) whirlpool baths for cleansing; (b) hygienic care or foot comfort; (c) trimming of toe nails; and (d) removal of corns or calluses.

14. Charges in excess of the Maximum Allowable Amount.

15. Physical examinations unless otherwise provided for in this Policy.

16. Contraceptive or contraceptive devices, regardless of the reason for their use.

17. Private Duty Nursing Care unless otherwise provided for in this Policy.

18. 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; as well as 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.

19. Blood and blood plasma.

20. Treatment of acne valgaris except as otherwise provided in this Policy.

21. Wigs, under any circumstances.

22. Evaluation, treatment, procedures, and Prescription Drugs related to and performance of sex-change operations.

23. Services for Chronic Care.

24. Vaccines (other than routine immunizations or those needed for travel).

D. Medicare: Except for the Dental Benefits Section of this Policy, if applicable, Anthem BCBS will not provide benefits for services rendered to a Member after the last day of the month preceding the month in which he or she reaches age 65, if at the time such services were rendered the Member was eligible to be a beneficiary of Medicare, unless otherwise required by law.

E. Services Utilizing Equipment or Facilities Subject to Prior Approval Programs: Anthem BCBS will not provide benefits for services involving the use of equipment, procedures or facilities if they must have government approval for their use or acquisition and such approval has not been obtained. When there is no such approval program, then benefits are provided only if the service was performed utilizing equipment or a facility approved for this purpose by Anthem BCBS.

F. Except as otherwise provided for in this Policy, Anthem BCBS will not provide benefits for any charges for services or procedures performed or ordered by a Physician, Provider or Hospital; (1) without regard for specific clinical indications (2) routinely for groups or individuals; or (3) which are performed solely for research purposes.

G. Anthem BCBS will not provide benefits for any charges for services rendered by a Physician or other Provider to himself or herself or for services rendered to his or her immediate family including parents, spouse and children.

H. Anthem BCBS will not provide benefits for expenses related to cosmetic surgery or procedures performed solely to improve appearance and not designed to restore body function or to correct deformity resulting from the treatment of malignancy or physical trauma unless otherwise determined by Anthem BCBS to be medically necessary.

I. Anthem BCBS will not provide benefits for services and supplies which are Experimental or Investigational. Such services or supplies shall include but not be limited to any diagnosis, treatment, procedure, facility, equipment, drugs, drug usage, devices or supplies which are determined in the sole discretion of consultant(s) designated by Anthem BCBS to be Experimental or Investigational.

J. Anthem BCBS will not provide benefits for services and supplies (meaning any treatment, procedure, facility, equipment, drugs, drug usage, devices, or supplies) requiring federal or other governmental agency approval not granted at the time services were rendered.

K. Anthem BCBS will not provide benefits for services or procedures which have become obsolete or are no longer medically justified as determined by appropriate medical specialties.

L. No benefits will be provided for inpatient admissions occurring or Covered Services rendered before the Member's Effective Date under this Policy.

M. Some benefits, as specifically noted in this Policy or any other Policy issued by Anthem BCBS, will be reduced if the Member fails to obtain or comply with the following programs (if applicable):

1. Mandatory Pre-Certification Review for certain elective admissions to General Hospitals.

2. Mandatory Pre-Certification of Inpatient Admissions for certain elective surgical procedures which can be performed in an ambulatory (outpatient) setting.

Any such reduced benefit amounts are not reimbursable as a Covered Service under any provision or section of this Policy.

N. If a Member is enrolled in another Plan and reductions similar to those stated in Paragraph L. above, however termed or characterized, are imposed, any such reduced benefit amounts are not reimbursable as a Covered Service under any provision or section of this Policy.

O. No benefits will be provided for charges for any leave of absence day(s) where the Member's room and bed are being held for the Member while the Member has an authorized leave of absence and will return to the Hospital, Substance Abuse Treatment Facility, Residential Treatment Facility or other inpatient facility.

P. No benefits will be available for maintenance care which is (1) treatment provided for the Member's continued well-being by preventing deterioration of the Member's chronic clinical condition; and (2) maintenance of an achieved stationary status which is a point where little or no measurable objective improvement in musculo-skeletal function is effectuated despite therapy.

Q. 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 major 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's disease
- Mucopolysaccharidoses and lipidoses to include Hurler's syndrome, Sanfilippo's syndrome,Maroteaux-Lamy syndrome, Morquio's syndrome, Hunter's syndrome, and metachromatic leukodystrophy

All other uses of Allogeneic or Syngeneic Bone Marrow Transplant 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. Non-Hodgkin's lymphoma, low grade with conversion to high grade. No morphological evidence of bone marrow involvement should be evident.

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

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

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

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

   g. 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.

R. Reimbursement of benefits for procedures billed under unspecified Physician's Current Procedural Terminology (CPT) codes will be denied.

OTHER PROVISIONS

A. Right of Recovery: To the extent permissible by law, Anthem BCBS shall have a right of reimbursement for benefits provided under the terms of this Policy where the Member exercises rights of recovery against third parties. The Member shall execute and deliver such instruments and take such other action as Anthem BCBS shall require to implement this provision. The Member shall do nothing to prejudice the rights given to Anthem BCBS by this provision without its consent.

B. Medicare: If a Member is eligible for Medicare, and still covered under this Policy, Anthem BCBS will provide the benefits of this Policy, 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 Policy or Parts A, B and/or D of Medicare.

C. Anthem BCBS is not obligated for reimbursement of expenses for Covered Services which the Member is not legally required to pay.

COORDINATION OF BENEFITS

All benefits provided under this Policy are subject to this provision.

A. DEFINITIONS

The following definitions apply to this Section:

1. The term Plan will be applied separately with respect to each arrangement for benefits or services and separately with respect to that portion of any arrangement which reserves the right to take the benefits or services of other Plans into consideration in determining its benefits and that portion which does not.

2. Covered Services means any Medically Necessary, reasonable and customary item of expense for services covered in whole or in part under any Plan in which a Member is enrolled.

   When benefits are provided in the form of services, the reasonable cash value of each service will be deemed the benefit.

3. Claim Determination Period means a Calendar Year. The Claim Determination Period will not begin before or extend after the period a Member was covered by this Policy.

4. Dependent means an Eligible Dependent as stated in the Schedule of Eligibility.

B. EFFECT ON BENEFITS

1. If the benefit payable under this Policy and under any other Plan for Covered Services received during any Claim Determination Period would exceed the charges of the Covered Services, then Anthem BCBS will reduce its benefit payment by the amount of such excess. Benefits payable under other Plans include benefits that would have been payable if a claim had been made.

2. However, if another Plan contains a provision coordinating its benefits with those of this Policy and its rules require the benefits of this Policy to be determined first, and the provisions of paragraph 3 of this Section require the benefits of this Policy to be determined first, then Anthem BCBS will pay benefits without regard to the benefits of the other Plan.

3. Anthem BCBS will apply the following rules for the purpose of determining benefits payable:

   a. the benefits of a Plan which covers the person as other than a Dependent will be determined first;

   b. the benefits of a Plan which covers a child as a Dependent of a person whose date of birth month and day, excluding year of birth, occurs earlier in the Calendar Year, will be determined first. If both parents have the same birthday, the benefits of the Plan which covered the parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.

If the person for whom claim is made is the dependent child of divorced or separated parents, the following rules will be applied for determining benefits payable:

1. if there is a court decree which makes one person financially responsible for the medical, dental or other health care expenses of the Dependent, the benefits of the Plan covering the child as a Dependent of the financially responsible parent will be determined first;

2. if there is no court decree:

   a. if the parent with custody of the child has not remarried, the benefits of the Plan covering the child as a Dependent of such parent will be determined first.

   b. if the parent with custody of the child has remarried, the benefits of the Plan covering the child as a Dependent of such parent will be determined before the benefits of a Plan covering the child as a Dependent of a stepparent. The benefits of the Plan covering the child as a Dependent of a stepparent will be determined before the benefits of the Plan covering the child as the Dependent of a parent without custody;

   c. when rules (a) and (b) do not apply, the benefits of the Plan which has covered the person on whose expense claim is based for the longer period of time will be determined first; except:

      1. the benefits of a Plan covering a person who is laid-off or retired will be determined after the benefits of a Plan covering such person other than as a laid-off or retired employee or Dependent of such person; and

      2. if either Plan does not have a provision regarding laid off or retired employees and as a result each Plan determines its benefits after the other, then (c) (1) above will not apply.

4. If another Plan has no provision relating to the order of benefit determination, the benefits under that Plan will be determined before the benefits under this Policy. If another Plan does contain rules relating to the order of benefit determination, but such rules do not establish the same order of benefit determination rules as this Policy, then the benefits under that Plan will be determined before the benefits under this Policy, unless under the benefit determination rules of both this Policy and that Plan, this Policy's benefits are determined first. If another Plan provides that is benefits are "excess" or "always secondary" and if this Policy is determined to be secondary under this Policy's coordination of benefit provisions, the amount of benefits payable under this Policy shall be determined on the basis of this Policy being secondary.

5. 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 benefit 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.

6. Except when federal law requires the Plan to be the primary payor, the benefits under this Policy for Members age 65 and older, or Members otherwise eligible for Medicare, do not duplicate any benefits for which Members are entitled under Medicare, including Parts A, B and/or D.

C. RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

For the purpose of determining the applicability and implementing coordination of benefits provisions of this Policy or another Plan, Anthem BCBS may without notice to the Member and without the Member's consent, release or obtain information from another Plan, organization or person which Anthem BCBS feels is necessary. Any Member claiming benefits under this Policy will furnish to Anthem BCBS information which Anthem BCBS determines is necessary for coordinating benefits.

D. FACILITY OF PAYMENT

Whenever payments should have been made under this Policy in accordance with this provision, but the payments have been made under another Plan, Anthem BCBS has the right to pay to those organizations making the other payments any amounts Anthem BCBS determines to be warranted to satisfy the intent of this provision. Amounts paid will be deemed to be benefits paid under this Policy and, to the extent of the payment for Covered Services, Anthem BCBS will have fully discharged its obligations under this Policy.

E. RIGHT OF RECOVERY

1. Whenever Anthem BCBS has made payments for Covered Services in excess of the Maximum Allowable Amount of payment necessary at that time to satisfy the intent of this provision, irrespective of to whom paid, Anthem BCBS has the right to recover the excess payment from one or more of the following: any persons to or for whom such payments were made, any insurance companies or any other organizations.

2. The Member personally and on behalf of his or her Dependents will, upon receipt, 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 Member's failure to comply may result in a withdrawal of benefits already provided or a denial of benefits requested.

GENERAL PROVISIONS

A. ENTIRE POLICY – CHANGES OR AMENDMENTS

1. This Policy with the Group Application, the individual applications (if any) of the Members, and any endorsements or amendments is the entire Policy between the Policyholder and Anthem BCBS. No change in this Policy will be effective until approved by an authorized Anthem BCBS officer. This approval must be noted on or attached to this Policy. No agent or representative of Anthem BCBS other than an Anthem BCBS officer may otherwise change this Policy or waive any of its provisions. All statements made by the Policyholder or by any Member in a group or individual application shall, in the absence of fraud as determined by a court of competent jurisdiction, be deemed representations and not warranties, and no such statement shall be used in defense to a claim under this Policy, unless the application or a copy of it is attached to the Policy.

2. Anthem BCBS reserves the right to amend this Policy upon written notice to the Policyholder.

B. BENEFITS TO WHICH MEMBERS ARE ENTITLED

1. Anthem BCBS's sole obligation is to provide the benefits specified in this Policy.

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

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

C. RECORDS OF MEMBER ELIGIBILITY AND CHANGES IN MEMBER ELIGIBILITY

1. The Policyholder must furnish Anthem BCBS with any data required by Anthem BCBS for coverage of Members under this Policy. In addition, the Policyholder must provide prompt notification to Anthem BCBS of the effective date of any changes in a Member's coverage status under this Policy.

2. All notification by the Policyholder to Anthem BCBS must be furnished on all forms approved by Anthem BCBS. The notification must include all information reasonably required by Anthem BCBS to effect changes.

3. Clerical errors or reasonable delays in recording or reporting dates will not invalidate coverage which would otherwise be in force or continue coverage which would otherwise terminate. Upon discovery of errors or delays, an equitable adjustment of charges and benefits will be made; provided, however, excess premiums will not be refunded for a period of more than one year. Anthem BCBS will not routinely issue a premium refund of less than $1.00 except upon a written request.

4. The Policyholder is liable for the cost of all Policy benefits which are provided for services rendered to a terminated Member because of the Policyholder's failure to notify Anthem BCBS of such Member's termination on or before the termination date.

D. TERMINATION OF THE POLICY

1. This Policy may be terminated in accordance with applicable law at the option of the Policyholder 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.

2. This Policy will be terminated at Anthem BCBS's option for the Policyholder's non-payment of premium. Termination will go into effect on the last to occur of the date to which such premiums have been paid by the Policyholder or the 30th day following the date when such premiums are due.

3. This Policy will be terminated at Anthem BCBS's option, in the event the Policyholder receives 30 days prior written notice from Anthem BCBS of the Policyholder's failure to perform any obligation required by this Policy. Such termination shall occur the first day of the month following such 30 day notice period.

4. Anthem BCBS may now renew this Policy in the event the Policyholder fails to meet the participation or contributory requirements stated below during the policy period for more than 60 continuous days.

   Anthem BCBS may not renew this Policy in the event the Policyholder fails to meet the participation or contributory requirements at the time of renewal.

   a. Contributory Requirements

      When a Policyholder contributes toward the cost of a Member's premium payment, Anthem BCBS will require a minimum of 25% of the Member's premium amount to be contributed by the Policyholder. In a multiple carrier situation, in addition to the 25%
      Policyholder contribution, the contribution must be proportionate among all carriers by either a percentage or dollar amount. If the plan is non-contributory and the Policyholder pays 100% of the premium, Anthem BCBS will require all eligible employees to enroll.

      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.

b. Participation Requirements

	Eligible Employees	Minimum Contract/%
All Anthem BCBS products, sole carrier only	1 – 9 10 – 99	100% 75%
Anthem BCBS as sole carrier; one Anthem BCBS product, or multiple Anthem BCBS products offered	100 +	75%
Anthem BCBS co-existing with other carriers, multiple Anthem BCBS products offered	100+	75%
Anthem BCBS co-existing with other carriers, one Anthem BCBS product offered	200+	25%
Dental (Stand Alone)	50+	75% (minimum 50 enrolled)
Prescription Drugs (Stand Alone)	Not available	Not available

5. The termination, expiration, non-renewal or cancellation of the Policy by the Policyholder or Anthem BCBS will automatically result in the termination of each Member's or Dependent's right to coverage and benefits under this Policy.

E. GRACE PERIOD

1. In the event of the Policyholder's failure to pay premiums when due, at Anthem BCBS's option, a grace period of one calendar month will be offered to the Policyholder to make such payment.

2. If the Policyholder does not make premium payment during the grace period, the Policy will be cancelled on the last day of the grace period. The Policyholder will be liable to Anthem BCBS for the payment due, including premiums for the grace period, whether or not replacement coverage has been obtained by the Policyholder.

F. TERMINATION OF MEMBER'S COVERAGE UNDER THE POLICY

1. When a Member ceases to be a Member 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.

2. A Dependent child will cease to be covered under this Policy the first of the month following the month in which he or she:

   a. marries, or

   b. is no longer dependent on the Member for support; or

   c. reaches the limiting age allowed under the Policy unless the child is physically or mentally handicapped; or

d. reaches the limiting age allowed for full-time student at a recognized college, university or trade school, whichever event occurs first.

   It is the sole responsibility of the Member to notify Anthem BCBS of any change in the Dependent status.

3. A Dependent spouse will cease to be covered under this Policy upon the first day of the month following a divorce, or annulment, except as provided in the Conversion Section.

4. The Policyholder must give the Members 15 days prior notice in the event this Policy is cancelled or discontinued. However, coverage will be terminated regardless of whether the notice was given.

5. During the first 2 years following the effective date of the policy Anthem BCBS may rescind the Benefit Program; if the Member has provided Anthem BCBS with false; or misleading data about eligibility; insurability; or health status; and Anthem BCBS decides material falsification exists.

G. <u>CONTINUATION OPTIONS</u>

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 18 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 Disable 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 this 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 become 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.

H. NOTICE OF CLAIM

1. Anthem BCBS will not be liable under this 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 musts include that data necessary for Anthem BCBS to determine benefits. An expense will be considered incurred on the date the service or supply was received.

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

I. PLAN INFORMATION PRACTICES NOTICES

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.

J. LIMITATION OF ACTIONS

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

K. PAYMENT OF BENEFITS

1. Anthem BCBS is authorized to make payments directly to Physicians, Providers or Hospitals furnishing Covered Services for which benefits are provided under this Policy. However, except as otherwise provided for in any participating agreement, Anthem BCBS reserves the right to make payments directly to either the Member or the Covered Person in Anthem BCBS's discretion. In the absence of a participating agreement, and one parent or custodian who has custody of a minor Dependent child, Anthem BCBS will make payments to that custodial parent or custodian in accordance with C.G.S. Section 46b-84(c).

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

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

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

5. 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 Policy, 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 Member 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.

L. MEMBER/PHYSICIAN/PROVIDER/HOSPITAL RELATIONSHIP

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

2. Anthem BCBS does not furnish Covered Services but only provides benefits 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 or a Physician's, Provider's or Hospital's failure or refusal to render Covered Services to a Member.

3. The use or non-use of an adjective such a "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.

4. Anthem BCBS does not make medical judgments but only decides what benefits will be available under this Policy.

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

M. AGENCY RELATIONSHIPS

The Policyholder is the agent of the Member, not Anthem BCBS.

N. POLICY

Anthem BCBS will provide a Policy that describes the Plan's benefits and claim filing instructions, to the Policyholder for delivery to Members.Policy

O. IDENTIFICATION CARDS

Anthem BCBS will provide the Policyholder with identification cards for delivery to Members.

P. APPLICABLE LAW

This Policy is entered into in and is subject to the laws of the State of Connecticut.

Q. MEMBER RIGHTS

A Member shall have no rights or privileges except as specifically provided in this Policy.

R. NOTICE

Any Notice required under this Policy must be in writing. Notice given to the Policyholder will be sent to the Policyholder's address stated in the Group Application. Notice given to Anthem BCBS will 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 Policyholder. The Policyholder, Anthem BCBS, or a Member, may, by written notice, indicate a new address for giving notice. Notice to the Policyholder may also be published in the daily newspapers in the State of Connecticut.

S. 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 an adverse 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.

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.

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.

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 and 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.

T. 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 judgement 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.

U. DISCLOSURE

The Policyholder on behalf of itself and its Members hereby expressly acknowledges its understanding that the Policy constitutes a contract solely between the Policyholder and Anthem BCBS, 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 Policyholder further acknowledges and agrees that it has not entered into the Policy 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 Policyholder for any of Anthem BCBS obligations to the Policyholder created under the Policy. 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 Policy.

V. CERTIFICATES OF CREDITABLE COVERAGE

Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), a certificate of creditable coverage must be issued to a Member and his or her covered Dependents who terminate from this Policy. The information included on the certificate of creditable coverage will include the names of any Members terminating, the date coverage under this Policy ended, and the type of coverage provided under this Policy. 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.

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