City of Waterbury

Effective Date: January 2006
Plan Number: 001645

BlueCare Point of Service
Summary Booklet

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PLEASE READ YOUR SUMMARY BOOKLET CAREFULLY

Anthem

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INTRODUCTION

This Summary Booklet describes generally this Benefit Program, which is funded by the **City of Waterbury** and for which Anthem Blue Cross and Blue Shield (Anthem BCBS) performs various administrative services**.** It is a copy of the Description of Benefits that was provided to the Employer.

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

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

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

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

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

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

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery and 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

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

BlueCare Point of Service Benefit Program

This Summary Booklet describes your BlueCare Point of Service health care coverage. The Summary Booklet explains the benefits, exclusions, limitations, terms and conditions of membership and services; and the guidelines which must be adhered to in order for you to obtain benefits for Covered Services. This Summary Booklet replaces; and supersedes any Summary Booklet; contract; policy; or program of the same or similar coverage that Anthem BCBS may have issued to you prior to the issue date of this Benefit. Amendments to this Summary Booklet may occur. The Effective Date of such changes shall be designated by Anthem BCBS; and notice to the Contractholder will be provided by Anthem BCBS.

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

This Benefit Program allows you to decide how you wish to access benefits; and get Covered Services. There are two levels of coverage under this Benefit Program: In-Network and Out-Of Network coverage. When you visit an Anthem BlueCare Provider for Covered Services, you are responsible for the In-Network Copayments; and any Cost-Shares. ***Your benefits are highest when you visit an Anthem BlueCare Provider.***

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

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

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

Anthem BCBS is not responsible for notifying a Physician's patients when the Provider leaves the Participating Provider network. Although the BlueCare Physicians Directory is updated often to keep Covered Persons informed of a Provider's status with Anthem BCBS; we suggest that you check with the Provider as to their status prior to getting services.

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

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

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

BlueCard Program

Anthem BCBS, like other Blue Cross and Blue Shield Licensees, participates in a program called "BlueCard". This program provides Anthem BCBS Covered Persons with access to benefits for urgent and emergency care outside of Connecticut. When a Covered Person obtains urgent or emergency care outside of Connecticut, the claims for those services may be processed through the BlueCard program and presented to Anthem BCBS for payment in conformity with network access rules of the BlueCard policies then in effect. Under BlueCard, when Covered Persons receive urgent or emergency care outside of Connecticut, in an area served by another Blue Cross and/or Blue Shield Plan that is in the BlueCard program ("Host Plan"), Anthem BCBS will remain responsible to the Covered Person in accordance with this Summary Booklet. However, the other Blue Cross and/or Blue Shield plan in the BlueCard program will only be responsible, in accordance with applicable BlueCard policies, to provide access to such urgent or emergency care on behalf of Covered Persons through contracting arrangements it has with its participating providers. In addition, that Blue Cross and/or Blue Shield plan will handle interactions with its participating providers. The Host Plan may administer its managed care guidelines when providing access to such urgent or emergency care on behalf of its Covered Persons. Covered Persons may have access to benefits for some services rendered outside of Connecticut that may not be available under this Summary Booklet due to variations in managed care guidelines among the Blue Cross and/or Blue Shield plans in the BlueCard program. However, if benefits for urgent or emergency care are available under this Summary Booklet, these benefits will be available to a Covered Person whether inside or outside of Connecticut. But in no event will Covered Persons be entitled to benefits for services, wherever rendered, that are specifically excluded or limited from coverage under this Summary Booklet. If a Blue Cross and/or Blue Shield plan does not participate in the BlueCard program, then Anthem BCBS will not be able to access the plan's reimbursement arrangements with its participating providers.

Customer Service

Questions?

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

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

Anthem Blue Cross and Blue Shield
Member Services
P.0. Box 533
370 Bassett Road
North Haven, Connecticut 06473]

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

Customer Service Telephone

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

Home Office Address

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

SCHEDULE OF BENEFITS

BlueCare Point-of-Service

SCHEDULE A

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

SUMMARY

SUMMARY	PARTICIPATING OPTION	SELF-REFERRAL OPTION
Office Visit Copayment Note: Does not include preventive services		
Primary Care Physician	$20 per visit	Not Applicable
Participating Physician, *Other Participating Provider*	$20 per visit	Deductible & Coinsurance
Coinsurance **(Any Covered Service not listed in Schedule A which is obtained through the Self-Referral Option is subject to a Coinsurance.)**	Not Applicable	30% After the Deductible has been met, the Covered Person pays the Coinsurance of the Maximum Allowable Amount established by Anthem BCBS, plus any amount above the Maximum Allowable Amount.
Calendar Year Deductible	Not Applicable	
Covered Person *Family (2 Covered Persons)* *Family*		$400 $800 $1,200
Calendar Year Coinsurance Limit	Not Applicable	
Covered Person *Family (2 Covered Persons)* *Family*		$1,600 $3,200 $4,800
Person Responsible for Prior Authorization	Primary Care Physician Participating Physician Participating Provider	Covered Person

SUMMARY	PARTICIPATING OPTION	SELF-REFERRAL OPTION
Penalty for Failure to Prior Authorize Elective Hospital Admissions or Authorize a Medical Emergency Admission within 48 hours **Please note that the combined penalty amount for Facility Benefit and the Admitting Physician Benefit will be no greater than $500.**	No Penalty	$500
Lifetime Maximum Benefit	Unlimited	
Human Organ and Tissue Transplant	$1,000,000	Not Covered
PREVENTIVE SERVICES		
Well Child Care:		
6 exams from birth to 1 year of age 6 exams 1 through 5 years of age 1 exam every 2 Calendar Years 6 through 10 years of age 1 exam every Calendar Year 11 through 21 years of age	$20 per visit	Not Covered
Adult Physical Exams:		
1 exam every 5 Calendar Years 22 through 29 years of age 1 exam every 3 Calendar Years 30 through 39 years of age 1 exam every 2 Calendar Years 40 through 49 years of age 1 exam per Calendar Year 50 years of age and older	$20 per visit	Not Covered
1 Routine gynecological exam including pap smear per Calendar Year (no Referral is required)	$20 per visit	Deductible & Coinsurance

SUMMARY	PARTICIPATING OPTION	SELF-REFERRAL OPTION
Mammography One baseline screening for female 35 through 39 years of age or more frequently if recommended by a physician One screening mammogram every Calendar Year for female 40 years of age and older or more frequently if recommended	No Cost-Share	Deductible & Coinsurance
Immunizations and vaccinations (includes those needed for travel)	No Cost Share	Not Covered
1 Vision Exam and Refraction every 2 Calendar Years	$20 per visit	Deductible & Coinsurance
1 Routine Hearing Screening (when performed as part of an exam)]	No Cost-Share	Deductible & Coinsurance
Walk-In Center Services	$20 per visit	Deductible & Coinsurance
MEDICAL SERVICES		
Services of a Physician or Surgeon (other than a medical office visit)	No Cost-Share	Deductible & Coinsurance
Medical Office Visits:		
Primary care Physician	$20 per visit	Not Applicable
Other Providers	$20 per visit	Deductible & Coinsurance
Home Visits by Physicians		
Primary care Physician	$20 per visit	Not Applicable
Other	$20 per visit	Deductible & Coinsurance

SUMMARY	PARTICIPATING OPTION	SELF-REFERRAL OPTION
Diagnostic X-ray and Imaging:		
In a Radiologists office	No Cost-Share	Deductible & Coinsurance
Standalone Outpatient Hospital	No Cost Share	Deductible & Coinsurance
Radiation Therapy	No Cost-Share	Deductible & Coinsurance
Laboratory Services	No Cost-Share	Deductible & Coinsurance
Allergy Office Visit/Testing		
Primary care Physician	$20 per visit	Not Applicable
Other	$20 per visit	Deductible & Coinsurance
Allergy Injections Immunotherapy or other therapy treatments up to 60 visits in 2 Calendar Years	No Cost-Share	Deductible & Coinsurance
Infertility Services **up to $5,000 lifetime combined Maximum for Phase I and Phase II/III**		
Phase I (Evaluation)	$20 per visit	Not Covered
Phase II/III (Diagnostic and Treatment)]	50% Coinsurance	Not Covered
Maternity	$20 Copay first visit only	Deductible & Coinsurance
Nutritional Counseling with a Maximum of 3 visits per Calendar Year	No Cost-Share	Deductible & Coinsurance
HOSPITAL SERVICES		
All Inpatient Admissions (waived if re-admitted within 30 days for the same diagnosis)	$200 Copay	Deductible & Coinsurance
Ancillary Services	No Cost-Share	Deductible & Coinsurance

SUMMARY	PARTICIPATING OPTION	SELF-REFERRAL OPTION
OTHER HEALTH CARE SERVICES		
Skilled Nursing Facility up to 90 days per Calendar Year	$200 Copay	Deductible & Coinsurance
Inpatient Rehabilitation Services up to 60 consecutive days	$200 Copay	Deductible & Coinsurance
Home Health Care **(For the Self Referral Option, after a $50 Deductible has been met, the Covered Person shall pay the applicable Coinsurance, plus amounts above the Maximum Allowable Amount. The Deductible for Home Health Care benefits accrues towards the Covered Persons annual Deductible.)** Unlimited nursing, therapeutic and home health aide services	No Cost-Share	20% Coinsurance
Infusion Therapy	No Cost-Share	Deductible & Coinsurance
Outpatient Rehabilitation Services:		
Physical, Occupational and Speech Therapy and Chiropractic Care Unlimited maximum	$20 per visit	Deductible & Coinsurance
Cardiac Rehabilitative Therapy up to 36 visits per cardiac episode	$20 per visit	Deductible & Coinsurance
Outpatient Surgery In a licensed ambulatory surgical center (including colonoscopy)	$100 Copay	Deductible & Coinsurance
Durable Medical Equipment Unlimited maximum Diabetic equipment and supplies	No Cost-Share	Deductible & Coinsurance

SUMMARY	PARTICIPATING OPTION	SELF-REFERRAL OPTION
Hearing Aid coverage available for dependent children age 12 years and under with a maximum of $1,000 within a two year period	No Cost-Share	Deductible & Coinsurance
Prosthetic Devices Unlimited maximum	No Cost-Share	Deductible & Coinsurance
Surgical Removal of any breast implant up to $1,000 per Calendar Year	No Cost-Share	Deductible & Coinsurance
Wig Up to $350 maximum per Covered Person per Calendar Year.	No Copay	No Cost-Share
Hospice Care		
Inpatient	No Cost-Share	Deductible & Coinsurance
In the Home	No Cost-Share	Deductible & Coinsurance
In the Home Hospice Medical Social Services under the direction of a Physician up to the greater of $420 or 6 visits	No Cost-Share	Deductible & Coinsurance
Home oxygen	No Cost-Share	Deductible & Coinsurance
Specialized Formula	No Cost-Share	Deductible & Coinsurance
MEDICAL EMERGENCY/URGENT CARE SERVICES		
Emergency Room Treatment Copayment waived if the Covered Person is admitted directly to the Hospital from the emergency room	$75 per visit	$75 per visit
Ambulance Services Land & Air: Paid according to the Department of Public Health Ambulance Service Rate Schedule	No Cost-Share	No Cost-Share

SUMMARY	PARTICIPATING OPTION	SELF-REFERRAL OPTION
Physician's Office Medical Emergency Visit	$20 per visit	$20 per visit
Urgent Care Facility Visits	$75 per visit	$75 per visit
MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES		
Outpatient		
Mental Health Office Visits	$20 per visit	Deductible & Coinsurance
Inpatient	$200 Copay	Deductible & Coinsurance

DEFINITIONS

ACTIVELY AT WORK: The term Actively At Work means the employee must work at the Employer Group's place of business or at such place(s) as normal business requires. The employee must perform all duties of the job as required of a full time employee working 20 or more hours per week (unless a different Waiting Period has been mutually agreed upon by Anthem BCBS and the Contractholder) on a regularly scheduled basis. Eligible employees who do not satisfy the criteria, solely due to a health-related reason, are considered Actively At Work for purposes of initial eligibility under the Benefit Program.

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

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

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

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

AFFILIATION PERIOD: A period of time that must expire before benefits for Covered Services will be provided to a Late Enrollee under this Benefit Program.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

COVERED EMPLOYEE: The term Covered Employee means an Employee of the Employer Group who meets the criteria for eligibility as described in this Summary Booklet and who is duly enrolled into the Benefit Program.

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

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

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

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

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

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

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

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

Care can be Custodial whether or not it is recommended or performed by a professional and whether or not it is performed in a facility (e.g. hospital or skilled nursing facility) or at home.

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

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

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

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

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

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

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

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

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

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

EXPERIMENTAL OR INVESTIGATIONAL: The term Experimental or Investigational means any drug; biologic; device; diagnostic; product; equipment; procedure; treatment; service; 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 notbeen granted; or

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

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

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

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

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

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

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

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

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

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

1. Published authoriative, 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 file with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the drug; biologic; device; diagnostic; product; equipment; procedure; treatment; service; or supply; or

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

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

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

7. Medical records; or

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

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

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

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

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

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

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

A non-Hospital based clinic;

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

An institution operated mainly for care of the aged;

A health resort; spa; or sanitarium; or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

   It is the Covered Person's obligation to pay Cost-Shares as a component of this Maximum Allowable Amount.

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

4. Non-Participating Hospital: except as otherwise required by law, an amount negotiated with a Non-Participating Hospital for Covered Services provided to a Covered Person, 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 Covered Person's obligation to pay Cost-Shares and amount in excess of this Maximum Allowable Amount.

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

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

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

When Covered Services are rendered outside of Connecticut by Non-Participating Physicians, Non-Participating Providers and/or Non-Participating Hospitals, the Covered Person's Cost Share obligation may be calculated based upon one of the following: (except that in the case of the BlueCard Program, the Cost-Share calculation shall be based in item 3.):

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

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

When Covered Services are rendered outside of Connecticut to a Covered Person by Non-Participating Physicians, Non-Participating Providers and/or Non-Participating Hospitals, (whether or not such physicians, providers or hospitals are Host Plan participating physicians, providers or hospitals), the Maximum Allowable Amount shall be determined by 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 Covered Person because the amount paid by the Covered Person is a final price.

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

   *Applicable to BlueCard and arrangements other than BlueCard.

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

MEDICALLY NECESSARY (MEDICALLY NECESSARY CARE, MEDICAL NECESSITY): The terms Medically Necessary (Medical Necessary Care, Medical Necessity) means an intervention that is or will be provided for the diagnosis; evaluation; and treatment of a condition; illness; disease; or injury; and this is determined solely by Anthem BCBS to be:

1. Medically appropriate for and consistent with the symptoms and proper diagnosis or treatment of a condition; illness; disease; or injury;

2. Obtained from a Physician and/or duly licensed, certified; or registered Provider;

3. Provided in accordance with applicable medical and/or professional standards;

4. Known to be effective, as proven by scientific evidence, in materially improving health outcomes;

5. The most appropriate supply, setting; or level of service that can safely be provided to the Covered Person and which cannot be omitted consistent with recognized professional standards of care (which, in the case of hospitalization, also means that safe and adequate care could not be obtained as an outpatient);

6. Cost-effective compared to alternative interventions; including no intervention. “Cost-effective” does not mean lowest cost;

7. Not Experimental or Investigational;

8. Not primarily for the convenience of the Covered Person; the Covered Person’s family; or the Provider;

9. Not otherwise subject to an Exclusion under this Summary Booklet.

   The fact that a Physician and/or Provider may prescribe; order; recommend; or approve care; treatment; services or supplies does not, of itself, make such care; treatment; services or supplies Medically Necessary.

   egardless of Medical Necessity, no benefits will be provided for care that is not a Covered Service even if performed by your PCP or authorized as a Referral Service.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

RESIDENTIAL TREATMENT FACILITY: The term Residential Treatment Facility means a treatment center for children; and adolescents which provides residential care and treatment for emotionally disturbed individuals; is

licensed by the Department of Children and Families (DCF); and is accredited by the Council on Accreditation; or The Joint Commission on the Accreditation of Health Care Organizations as a Residential Treatment Facility.

RETENTION: The term Retention means all administrative fees and other fees and charges payable to Anthem BCBS for services rendered or coverages provided in accordance with the Administrative Services Only Agreement.

RIDER: The term Rider means an extra benefit of this Benefit Program; which has been bought by the Employer Group.

ROUTINE PATIENT CARE COSTS: The term Routine Patient Care Costs means: Costs for Medically Necessary health care services that are incurred as a result of treatment rendered to a Covered Person for purposes of a Cancer Clinical Trial that would otherwise be covered if such services were not rendered in conjunction with a Cancer Clinical Trial. Such services shall include those rendered by a Physician, diagnostic or laboratory tests, hospitalization or other services provided to the Covered Person during the course of treatment in Cancer Clinical Trial and Coverage for Routine Patient Care Costs incurred for off-label drug prescriptions.

Routine Patient Care Costs shall not include:

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

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

1. Accepts; and charges for patients on an Inpatient basis;
2. is primarily engaged in providing skilled nursing care, rehabilitative; and related services to patients requiring medical; and skilled nursing care;
3. is under the supervision of a licensed Physician;
4. provides 24 hour a day nursing service under the guidance of a registered nurse; and
5. is not a place mainly used for the treatment of nervous-mental disorders; pulmonary tuberculosis; a place of rest; Custodial Care; or acute Inpatient level of care.]

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

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

SUBSCONTRACTOR: The term Subcontractor means an entity with whom Anthem BCBS may subcontract particular services to such as organizations or entities that have specialized expertise in certain areas. This may include but is not limited to prescription drugs and mental health/behavioral health and substance abuse services.

Such subcontracted organizations or entities may make benefit determinations and/or perform administrative, claims paying, or customer service duties on Anthem BCBS's behalf.

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

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

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

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

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

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

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

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

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

ELIGIBILITY

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

Eligible Employees

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

The following eligibility rules apply to employees:

1. Current employees must be employed full-time and working at least 20 hours a week (unless a different Waiting Period has been mutually agreed upon by Anthem BCBS and the Contractholder) on a regular basis; and be Actively At Work on the date coverage is to go into effect.

2. A newly hired employee must be Actively At Work and will be effective the first of the month following the date of hire.

3. If the employee is not Actively At Work on the date coverage would become effective; the Effective Date of coverage for that employee; and any Dependent Covered Persons shall be delayed until the date the employee is Actively At Work.

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

5. If the employee is a Late Enrollee; coverage will be provided after the employee has met the three month Affiliation Period.

6. Eligibility for membership under the Benefit Program will not be offered to any employee; if he or she lives; and works outside of the Service Area for a period of more than 90 consecutive days.

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

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

Eligible Dependents

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

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

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

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

The following are eligible as Dependents under the Benefit Program:

1. Spouse

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

2. Unmarried Dependent Child Under Age 25

   The Dependent child under age 25 of the Covered Person or spouse including: a step-child or a child legally placed for adoption; a legally adopted child; a child for whom the Covered Person has been appointed a legal guardian; the Dependent child under age 25 of the Covered Person or spouse for whom the Covered Person has been chosen as the responsible party under a Qualified Medical Child Support Order (QMCSO).

3. Newborn Dependent Child

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

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

4. A Newborn of Enrolled Dependent Child

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

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

5. Disabled Dependent Child

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

   a. The unmarried disabled Dependent child is over the age limit in the Benefit Program***;*** and

   b. The child cannot sustain employment due to a physical or mental handicap as certified by a Physician; and for whom the Covered Person or his or her spouse is chiefly responsible for support and maintenance; and

   c. The child became disabled prior to the limiting age for a Dependent child; and he or she had like coverage as a Dependent at the time of enrollment.

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

6. Qualified Medical Child Support Orders

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

Effective Date of Coverage

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

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

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

Applications for new Covered Persons received and accepted by Anthem BCBS will be effective immediately upon completing the eligibility waiting period.

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

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

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

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

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

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

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

Persons Eligible for Medicare

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

Late Enrollees

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

1. Coverage was not elected when the employee and or Dependent was first eligible under the Benefit Program solely because another group health insurance plan provided coverage for the eligible employee and/or Dependent and coverage is lost under the plan due to employment termination, an employer no longer offering benefits to a class of individuals such as part time workers, lifetime maximum being met under such insurance, death of a spouse, divorce or due to that plan's involuntary termination or cancellation by its carrier for reasons other than non-payment of Premium, and the employee and/or Dependent enrolls under the Benefit Program within 31 days after loss of membership under the other plan,; or
2. The eligible employee and/or Dependent is employed by an employer which offers multiple health program options, and the employee and/or Dependent elects a different program option during an Open Enrollment Period; or
3. A court has ordered coverage be provided for a spouse or minor child under the Employer Group's health care benefits plan and a request for enrollment is made within 31 days after issuance of such court order; or
4. The request for enrollment is made within 31 days after;

    a. the marriage of the Subscriber, or
    b. the birth, or adoption of a child by the Subscriber, or
    c. issuance of a court order of legal guardianship or qualified medical child support.

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

Changes Affecting Eligibility

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

1. The marriage of the Covered Person; or an enrolled Dependent child;
2. The divorce of the Covered Person;
3. The birth of a child of a Covered Person;
4. A Dependent child attains the maximum age limit for coverage under the Benefit Program.
5. A Covered Person's termination of employment; or reduction in work hours;
6. Loss of eligibility for other reasons shown in the Summary Booklet.
7. A Covered Person moves outside of the service area.

MANAGED BENEFITS – Managed Care Guidelines

Introduction

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

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

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

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

Anthem Medical Policy

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

The level of benefits for Covered Services which are specified in the Benefit Section will depend upon which of two options the Covered Person chooses: either the participating option; or the Self-Referral option. Please see Schedule A for the Cost-Shares and Penalties of both options. If the managed care guidelines are not followed for either option, it will result in either Penalties; or denial of benefits.

Choosing A Primary Care Physician

The Covered Person must choose a Primary Care Physician at the time of enrollment; whether he or she chooses to use the participating option; or the Self-Referral option to get Covered Services.

1. Each Covered Person Must Choose a Primary Care Physician

    a. At the time of enrollment under this Benefit Program, each Covered Person must choose a Primary Care Physician from the list of internal medicine; family practice; and pediatric Participating Physicians. Each Covered Person of a family may choose their own Primary Care Physician.

    b. Each Covered Person shall receive an Anthem BCBS ID Card listing his or her Primary Care Physician. The Covered Person should carry his or her ID Card at all times.

c. Each Covered Person may change his or her Primary Care Physician at any time by calling; or writing his or her Member Services/Customer Business Unit. The Effective Date of the change shall be the date the Covered Person notifies Anthem BCBS. At that time, the Covered Person will be issued another ID Card.

Participating Option

1. When a Covered Person chooses the participating option, the Covered Person can reduce Cost-Shares and avoid Penalties as shown in Schedule A. Covered Services can be obtained from a Covered Person's Primary Care Physician; a Participating Physician; a Participating Hospital; or a Participating Provider. If the Covered Person gets services from a Non-Participating Physician or Non-Participating Provider benefits for Covered Services shall be administered as shown in the Self-Referral option guidelines.

2. A Covered Person can only get preventive Covered Services from a Primary Care Physician or a Participating Physician; unless otherwise shown in the Preventive Services Section.

3. A Covered Person can only get benefits for the following Covered Services under the participating option:

   Treatment of infertility;
   Human organ and tissue transplants.

Covered Services Requiring Prior Authorization

Whenever a Covered Person gets any of the following services; Prior Authorization must be obtained from Anthem BCBS by the Primary Care Physician; Participating Physician; or Participating Provider.

Under the Self-Referral option some services will be covered; but only if the Covered Person gets Prior Authorization from Anthem BCBS.

a. Outpatient surgery/same day surgery (other than in a physician's office);
b. Human organ; and tissue transplants (Includes a Referral for evaluation);
c. Skilled nursing care;
d. Outpatient Hospice care;
e. Transfer of care;
f. Newborn care;
g. Psychological testing where conducted to diagnose a mental illness; or when rendered in the treatment of such mental illness; or
h. Mental Health Care or Substance Abuse Care.
i. Specialized Formula. Anthem BCBS has a designated In-Network vendor for home delivery of Specialized Formula. If a Specialized Formula is not obtained from the In-Network vendor but from any other source or vendor, it would be considered Out-of-Network.

In-Network

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

Out-of-Network

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

When a Covered Person is scheduled for an Admission to a Hospital; Skilled Nursing Facility; Substance Abuse Treatment Facility; Hospice; Residential Treatment Facility; or other Inpatient Facility, the Primary Care Physician or admitting Participating Physician must get Prior Authorization from Anthem BCBS; unless the Admission is due to a Medical Emergency. Anthem BCBS must be told of all Admissions due to a Medical Emergency within two business days of the diagnosis; care; or treatment of the Medical Emergency. If Anthem BCBS decides that the services provided were not for a Medical Emerg ency, benefits for such services will be denied or reduced.

Inpatient benefits for Covered Services will be provided for a minimum of 48 hours following a mastectomy or lymph node dissection; unless an agreement by the Covered Person and the Participating Physician has been reached.

The Self-Referral Option

The Self-Referral option allows the Covered Person to get Covered Services from any Non-Participating Physician; Non-Participating Hospital; or Non-Participating Provider. If the Covered Person chooses to use the Self-Referral option; the Covered Person must get Prior Authorization from Anthem BCBS. If the necessary Prior Authorization is not obtained, benefits for Covered Services will be reduced subject to a Penalty. Please see the Schedule A for any Cost-Shares and Penalties.

Self-Referral Option Limitations

The following services are not available when obtained through the Self-Referral option; and cannot be rendered by a Non-Participating Physician or Non-Participating Provider:

Treatment of infertility;
Preventive health services (unless otherwise specified in the Preventive Services Section);
Human organ and tissue transplants.

Case Management

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

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

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

Covered Person Appeal Process

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

BENEFIT SECTION

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

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

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

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

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

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

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

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

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

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

AMBULANCE/MEDICALLY NECESSARY TRANSPORT SERVICES

This Summary Booklet Covers:

Medically Necessary medical transport services as follows:

1. From the place where the Covered Person is injured by an accident or taken ill to a General Hospital where treatment is to be given; or

2. From a General Hospital where a Covered Person is an inpatient to another General Hospital; or a free-standing facility to receive specialized diagnostic or therapeutic services not available at the first General Hospital; and the return to the first General Hospital; if that payment is only made for one such transport during the period between the day of Admission to the General Hospital; and the day of discharge from the General Hospital; or

3. From a General Hospital to another General Hospital when the discharging General Hospital does not have the proper facilities for treatment; and the receiving General Hospital has the proper treatment facilities; and

4. To provide in the course of such transport, such care as may be reasonably necessary to maintain the life of; or stabilize the condition of such Covered Person.

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

Covered Services do not include:

Transport for Elective Hospital Admissions.

Transport solely for the ease of the Covered Person.

DIAGNOSTIC SERVICES

This Summary Booklet Covers:

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

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

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

Colorectal cancer screening, including, but not limited to:

An annual fecal occult blood test; and

Colonoscopy, flexible sigmoidoscopy or radiologic imaging.*

Notes:

*Out patient Surgical Cost-Shares apply.

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

Covered Services do not include:

An exam made in; or through a Hospital unless:
It is made during Outpatient care; and
No other benefit is paid for it under this Benefit Program.

A dental X-ray; unless it is in connection with:
An injury; or
Any of the oral surgical procedures covered under this Benefit Program.

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

DURABLE MEDICAL EQUIPMENT, PROSTHETIC DEVICES, SUPPLIES & APPLIANCES

A Covered Person's rights to benefits for durable medical equipment and prosthetic devices as provided in this rider are subject to the terms and conditions of the Managed Care Section in the Summary Booklet.

It is agreed that the Summary Booklet is amended as follows.

For purposes of this rider, the Definitions Section of the Summary Booklet is amended by adding the following definitions:

Definitions

DURABLE MEDICAL EQUIPMENT - Equipment which:

a. Is designed for repeated use in the Medically Necessary care, diagnosis or treatment of an illness or injury;

b. Improves the functions of a malformed body part or prevents or retards further deterioration of the Covered Person's medical condition; and

c. Is not useful in the absence of injury or illness.

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

Covered Services

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

1. Prosthetic devices or orthotic appliances, subject to the terms and conditions of the Managed Care Section in the Summary Booklet, when Medically Necessary and Prior Authorized by Anthem BCBS. In addition:

a. The item must be a prosthetic device or orthotic appliance as defined by Anthem BCBS.
b. The items must be obtained from a Anthem BCBS approved supplier.
c. Repair, replacement, fitting, and adjustments are covered when made necessary by normal wear and tear or by body growth or change. Repair and replacement made necessary because of loss or damage caused by misuse or mistreatment are not covered. Anthem BCBS must authorize the extent to which replacement prosthetic devices and orthotic appliances are Medically Necessary.

2. Durable medical equipment, subject to the terms and conditions of the Managed Care Section in the Summary Booklet, when Medically Necessary and Prior Authorized by Anthem BCBS. Anthem BCBS will consider purchase of such equipment if the cost would be less than rental. In either case, the total benefit will not exceed the cost of the least expensive equipment necessary to meet the medical condition. In addition:

   a. The equipment must be an item of durable medical equipment as defined by Anthem BCBS and must be appropriate for use in the home.
   b. The equipment must be obtained from a Anthem BCBS approved supplier.
   c. The equipment, whether purchased or rented, remains the property of Anthem BCBS or its agent and must be returned when no longer Medically Necessary.

Diabetic equipment and supplies.

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

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.

Hearing aid coverage available for children 12 years of age or younger. Subject to the maximums stated in the Schedule of Benefits.

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

Exclusions

For purposes of this rider, the Exclusions Section of the Summary Booklet is amended to include the following:

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

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

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

2. Prosthetic devices and orthotic appliances, except as provided in the Summary Booklet. Examples of non-covered items include, but are not limited to:

    a. Dental devices except for maxillo-facial prostheses used to replace anatomic structures lost during treatment of tumors;
    b. Non-rigid appliances and supplies such as elastic stockings, garter belts, corsets, wigs, or hair pieces;
    c. Orthotics (except for Medically Necessary foot orthotics, abduction and rotation bars. One set/pair per Covered Person per calendar year), arch supports and corrective shoes;
    d. Experimental or investigational research devices, appliances, or prostheses;
    e. Eyeglasses or contact lenses.

3. This rider provides no benefits for any service that is or has been covered under any other Section of the Summary Booklet.

HOME HEALTH CARE

This Summary Booklet Covers:

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

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

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

c. Occupational; speech; and respiratory therapy;

d. Medical; and surgical supplies; and prescribed Durable Medical Equipment;

e. Prescription Drugs dispensed from a retail Pharmacy;

f. Oxygen; and its administration;

g. Home health aide services that consist of: patient care of a medical; or therapeutic nature;

h. Laboratory services;

i. Services in regards to diet;

j. Transport to and from a Hospital for treatment; re-Admission; or discharge by the most safe and cost-effective means available.

Benefit Period:

A benefit period for Home Health Care begins:

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

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

c. For a Terminal Illness: upon diagnosis by a Physician.

Notes:

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

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

Covered Services do not include:

Meals; personal comfort items; and house keeping services.

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

HOSPICE SERVICES

This Summary Booklet Covers:

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

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

Psychological; and dietary counseling.

Consultation; or Case Management services by a Physician.

Physical; and occupational therapy.

Medical supplies; and drugs prescribed by a Physician.

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

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

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

Notes:

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

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

Covered Services do not include:

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

HOSPITAL SERVICES

This Summary Booklet Covers:

Inpatient Hospital Services including the following:

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

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

At least 48 hours after a mastectomy; or lymph node dissection; unless both the Covered Person; and Physician agree to a shorter stay.

Inpatient and Outpatient Hospital services and supplies:

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

Prescribed drugs;

Administration of blood; and blood processing;

Anesthesia; Anesthesia supplies; and services;

Medical; and surgical dressing; supplies; casts; and splints;

Diagnostic services;

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

Radiation therapy;

Electroshock therapy;

Chemotherapy for treatment of cancer;

Laboratory tests;

X-ray; or imaging studies.

Outpatient surgery in a licensed ambulatory surgical center.

Pre-Admission testing.

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

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

Services connected with: accidental consumption; or ingestion of a controlled drug; or other substance.

Notes:

Outpatient Surgical Cost-Shares apply to colonoscopies performed on an Outpatient basis. Please refer to the Schedule of Benefits for the appropriate Cost-Shares.

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

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

Inpatient and Outpatient Dental Services – Anesthesia; nursing; and related Hospital charges for Inpatient dental services; outpatient hospital dental services; or one day dental services are covered if deemed Medically Necessary by the treating dentist; or oral surgeon; and the patient's Primary Care Physician per the Prior Authorization requirements; and:

1. the patient has been determined by a licensed dentist along with a licensed Primary Care Physician to have a dental condition complex enough that it requires Inpatient services; outpatient hospital dental services; or one day dental services or

2. the patient has a developmental disability; as determined by a licensed Primary Care Physician; that places him or her at serious risk.

Covered Services do not include:

Private duty nursing services during an Inpatient Hospital Admission.

HUMAN ORGAN AND TISSUE TRANSPLANT SERVICES

This Summary Booklet Covers:

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

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

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

Blood transfusion;
Cornea transplant;
Bone and cartilage grafting;

Skin grafting

Hospital Covered Services with Prior Authorization from Anthem BCBS:

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

Services and supplies furnished by the Hospital.

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

Use of operating and treatment rooms.

Diagnostic services; which include a Referral for evaluation.

Rehabilitative; and restorative physical therapy services.

Hospital supplies:

Prescribed drugs;

Whole blood; administration of blood; and blood processing;

Anesthesia; anesthesia supplies; and services;

Medical and surgical dressings; and supplies.

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

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

Services of a physician who actively assists the operating surgeon;

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

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

Inpatient medical care visits.

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

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

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

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

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

Diagnostic services; which includes: a Referral for evaluation.

Rehabilitative and restorative therapy services:

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

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

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

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

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

1. Lodging; and meal expenses, not to exceed $150 total per day ($200 total; if two persons are traveling with a minor child), will be paid for the person traveling with the patient.

2. Lodging for the Covered Person while receiving Medically Necessary post-operative Outpatient care at the Hospital.

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

1. Transport of the surgical harvesting team; and donor organ; or tissue; and

2. Evaluation; and surgical removal of the donor organ; or tissue; and related supplies.

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

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

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

1. The donor benefits are limited to only those not provided; or available to the donor from any other source. This includes; but is not limited to: other insurance coverage; grants; foundations; government programs; etc.;

2. Benefits provided to the donor will be charged against the receiver Covered Person's coverage under the Policy.

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

No benefits will be provided for procurement of a donor organ; or organ tissue which is not used in a covered transplant procedure; unless the transplant is cancelled due to the Covered Person's medical condition or death; and the organ cannot be transplanted to another person. No benefits will be provided for procurement of a donor organ; or organ tissue which has been sold rather than donated.

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

Notes:

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

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

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

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

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

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

Covered Services do not include:

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

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

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

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

MATERNITY/FAMILY PLANNING SERVICES

This Summary Booklet Covers:

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

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

Abortions and Miscarriages.

Notes:

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

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

Inpatient care for a female Covered Person and newborn will be provided for no less than 48 hours following a vaginal delivery; and for a minimum of 96 hours following a cesarean delivery; unless a shorter stay is agreed upon by the Covered Person and the Physician. If the Covered Person and the Physician agree to an earlier discharge time, benefits for Covered Services shall be provided for a follow-up home visit within 48 hours of discharge; and an extra follow-up visit within 7 days. The time period shall commence at the time of delivery.

Covered Services do not include:

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

MEDICAL EMERGENCY

This Summary Booklet Covers:

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

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

Medical Emergency services provided by a Physician.

Notes:

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

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

If the emergency requires that the Covered Person receive diagnosis; care; or treatment from the first available Physician or Provider, this Benefit Program shall provide benefits for Covered Services for the Medical Emergency; whether or not the Physician or Provider is a Participating Physician or Provider; or Non-Participating Physician; or Provider.

If the Medical Emergency needs a Covered Person's Admission to a Non-Participating Hospital; this Benefit Program shall provide benefits for Covered Services as if the services were given at a Participating Hospital only through the day when the Covered Person can be transferred to a Participating Hospital; as decided by Anthem BCBS. If the Covered Person chooses to remain in the Non-Participating Hospital; the Covered Person must pay for Non-Participating Hospital Cost-Shares as shown in the Schedule of Benefits.

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

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

Covered Services do not include:

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

MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

This Summary Booklet Covers:

Outpatient treatment for Mental Health Care; and Substance Abuse Care.

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

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

Partial Hospitalization sessions; and Day/Night Visits.

Notes:

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

The Hospital Inpatient/Inpatient Facility Coinsurance amounts are not subject to Cost-Share Maximums.

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

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

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

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

1. The Covered Person has a serious mental illness which substantially impairs the Covered Person's thought, perception of reality, emotional process, or judgement or grossly impairs behavior as manifested by recent disturbed behavior;

2. The Covered Person has been confined in a Hospital for such illness for a period of at least three days immediately preceding such confinement in a Residential Treatment Facility; and
3. Such illness would otherwise necessitate continued confinement in a Hospital if such care and treatment were not available through a Residential Treatment Facility; and an individual treatment plan must be prescribed by a Physician with certain specific attainable goals and objectives appropriate to both the patient and the treatment modality of the program.

ORAL SURGERY

This Summary Booklet Covers:

Oral Surgery Services

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

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

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

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

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

Notes:

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

Covered Services do not include:

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

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

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

OTHER PROVISIONS

This Summary Booklet Covers:

Services from birth to age three for early intervention Covered Services for a Covered Person; and his/her family Covered Persons provided as part of a personal family service plan.

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

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

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

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

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

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

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

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

Notes:

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

Payment for birth to age three services shall not be applied against maximum lifetime; or annual limits shown in this Summary Booklet.

Outpatient diabetes self-management training is covered if: prescribed by a licensed health care professional; and performed by: a certified; licensed; or registered health care professional trained in diabetes care; and operating within the scope of their license. Benefits are provided for: 10 hours of initial training; 4 hours of extra training because of changes in the person's condition; and 4 hours of training required by new developments in the treatment of diabetes.

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

Covered Services do not include:

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

PHYSICIAN MEDICAL/SURGICAL SERVICES

This Summary Booklet Covers:

Medical services for the treatment of an illness or injury.

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

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

Allergy testing.

Inpatient Hospital/Inpatient Facility visits during a covered Admission.

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

Inpatient consultations by other than the attending Physician.

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

When multiple or bilateral surgical procedures are performed at the same operative session; benefits for Covered Services are provided at 100% of the Maximum Allowable Amount; less any Cost-Shares for the procedure with the highest reimbursement; and 50% of the Maximum Allowable Amount; less any Cost-Shares, for the procedure with the next highest reimbursement.

For breast implants which were surgically implanted as a result of a mastectomy; benefits for Covered Services for the Medically Necessary removal of such implants due to a medical complication of a mastectomy will be covered the same as any other illness or injury. As to all other breast implants; benefits for Covered Services for the Medically Necessary removal of any breast implant without regard to the reason for implantation up to the per Covered Person per Calendar Year as shown in the Schedule of Benefits.

Surgical assistant services.

In accordance with the Women's Health and Cancer Rights Act services are covered for reconstructive surgery after a mastectomy including; but not limited to: augmentation mammoplasty; reduction mammoplasty; and mastopexy:

- On each breast on which a mastectomy has been performed;
- On a non-diseased breast to produce a symmetrical appearance.
- On one or both breasts for the treatment of physical complications at all stages of a mastectomy, including lymphedemas.

Notes:

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

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

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

Covered Services do not include:

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

Separate charges for pre and post-operative care.

PREVENTIVE SERVICES

This Summary Booklet Covers:

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

Notes:

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

Covered Services do not include:

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

Exams in any way related to employment.

SKILLED NURSING FACILITIES

This Summary Booklet Covers:

Skilled nursing care;

Rehabilitative; and related services; and

Semiprivate room and board.

Notes:

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

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

Covered Services do not include:

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

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

THERAPY SERVICES

This Summary Booklet Covers:

Outpatient Rehabilitation

Outpatient physical, occupational, speech and chiropractic therapy;

Outpatient cardiac rehabilitation therapy;

Other Therapy Services

Radiation therapy;

Chemotherapy for the treatment of cancer;

Electroshock Therapy;

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

Infusion Therapy: Benefit will be provided for Outpatient Hospital; or home Infusion Therapy regimens under the following conditions:

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

2. The plan of care is reviewed; and recertified by the Physician (M.D.); and Anthem BCBS's Utilization Management Department;

3. Infusion Therapy is limited to:

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

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

Notes:

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

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

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

Coinsurance amounts for Out-Of-Network Providers for infusion therapy do not count towards the Cost-Share Maximum.

Covered Services do not include:

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

URGENT CARE SERVICES

This Summary Booklet Covers:

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

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

Go to the Physician's office;
Go to the: emergency room; free-standing emergency facility; or Urgent Care Facility; or
Go to another Participating Provider's office.

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

Out-of-state:
As part of the *BlueCard Access*® program, you have access to In-Network benefits for Urgent Care when you are out-of-state. This program links all Blue Cross and Blue Shield plans across the country. When Urgent Care services are needed; the Covered Person should call 1-800-810-BLUE to locate a Participating Physician. The Covered Person should contact Anthem BCBS within 48 hours or two business days of an urgent visit in order for any claims to be processed according to the plan's In-Network benefits.

Out-of-country:
BlueCard Worldwide® allows access to providers and hospitals internationally. When Urgent Care services are needed out-of-country; the Covered Person should call 1-800-810-BLUE to locate a Participating Physician. The *BlueCard Worldwide*® provider should be paid in full at the time of the service and the Covered Person will be reimbursed by Anthem BCBS upon receipt of the claim (minus any applicable Cost-Shares).

Notes:

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

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

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

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

Covered Services do not include:

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

WALK-IN CENTER SERVICES

This Summary Booklet Covers:

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

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

Notes:

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

The Covered Person does not need to contact their Primary Care Physician to get a Referral to a Walk-In Center.

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

Covered Services do not include:

Adult routine physicals; and well child care exams.

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

EXCLUSIONS AND LIMITATIONS

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

Please remember, this plan does not cover any services or supply not specifically listed as a covered service in this Summary Booklet. The following list of exclusions is not a complete list of all services, supplies, conditions or situations that are not covered services. If a service is not covered, then all services performed in conjunction with that service are not covered. Anthem BCBS is the final authority for determining if services or supplies are Medically Necessary.

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

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

1. Benefits for services which are not:

    a. Described in the Summary Booklet;
    b. Rendered or ordered by a Physician;
    c. Within the scope of the Physician's, Provider's or Hospital's licensure, and
    d. Medically Necessary Care for the proper diagnosis and treatment of the Covered Person]

2. Benefits may be reduced; or denied if subject to the Managed Benefits – Managed Care Guidelines. Any reduced or denied benefits paid by the Covered Person do not count towards any applicable Cost Share Maximums shown in the Schedule of Benefits.

3. Any reduction in benefits; including but not limited to: Penalties, imposed by another Plan; which are like those stated on the Managed Benefits – Managed Care Guidelines, are not paid as a Covered Service.

4. Benefits for services rendered before the Covered Person's Effective Date under this Benefit Program.

5. Benefits for services rendered after the person's Benefit Program has been: rescinded; suspended; cancelled; interrupted; or terminated. Any person getting services after his or her Benefit Program is: rescinded; suspended; cancelled; interrupted; or terminated for any reason will be liable for payment of such services.

6. Care for conditions that are required by State or Local law to be treated in a public facility.

7. Services and care in a Veteran's Hospital; or any Federal Hospital; except as may be required by law.

8. Services covered in whole; or in part by public; or private grants.

9. Studies related to pregnancy; except for major medical reasons.

10. Simplified or self-administered tests; and multiphasic screening.

11. Prenatal medical conferences with a pediatrician regarding an unborn child; unless the visit is the result of a medical Referral.

12. Charges for the Covered Person's room and board when the Covered Person has a leave of absence from: the Hospital; Substance Abuse Treatment Facility; or other Inpatient Facility.

13. Evaluation; treatment; procedures; and Prescription Drugs related to and performance of sex-change operations including: follow-up treatment; care; and counseling.

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

15. Services; medical supplies; or supplies not listed as Covered Services. These include; but are not limited to: educational therapy; marital counseling; sex therapy; weight control programs; nutritional programs; and exercise programs.

16. Experimental or Investigational treatment; procedure; facility; equipment; drugs; devices; or supplies. Any services associated with; or as follow-up to any of the above is not a Covered Service.

17. Any treatment; procedure; facility; equipment; drug; device; or supply which requires Federal or other governmental agency approval not granted at the time services are rendered. Any service associated with; or as follow-up to; any of the above is not a Covered Service.

18. Any services by a Physician or Provider to himself or herself; or for services rendered to his or her: parent; spouse; children; grandchildren; or any other close family member or relation; even if a Participating Physician or Participating Provider.

19. Services which the Covered Person or Anthem BCBS is not legally required to pay.

20. Wigs; and other cranial prosthesis except as noted in the Covered Services section.

21. Inpatient services which can be properly rendered as Outpatient services.

22. Disease contracted; or injuries resulting from war.

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

24. Eyeglasses; contact lenses.

25. Travel; whether or not recommended by a Physician.

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

27. Services or procedures rendered without regard for specific clinical indications; routinely for groups or persons; or which are performed solely for research purposes.

28. Services or procedures which have become obsolete; or are no longer medically justified as determined by appropriate medical fields.

29. Radiation therapy as a treatment for acne vulgaris.

30. Services required by third parties for: employment; membership; enrollment; or insurance, such as: school or employment physicals; physicals for summer camp; enrollment in health, athletic, or similar clubs; premarital blood work or physicals; or physicals required by insurance companies or court ordered alcohol or drug abuse courses.

31. Durable Medical Equipment and other items for home or personal use; except as provided in the Benefit Section.

32. Prosthetic Devices; except as provided in the Benefit Section. Examples of non-covered items include; but are not limited to:

    - Bite plates/dental prosthetics; except for maxillo-facial Prosthetic Devices used to replace anatomic structures lost during treatment of tumors;
    - Optical; or visual aids; including: eyeglasses or contact lenses; except for the treatment of: congenital aphakia; or for aphakia following cataract surgery when an intraocular lens is not medically possible;
    - Penile implants;
    - Xomed audiant bone conductors;
    - Orthotics (except for Medically necessary: molded foot orthotics; abduction; and rotation bars. One set/pair per Covered Person per Calendar Year); arch supports; and corrective shoes;
    - Experimental; or research prostheses.

33. Treatment of pattern baldness;

34. Items generally used for personal comfort and/or useful to the Covered Person's household; including but not limited to:

    - Air conditioners; humidifiers; air cleaners; filtration units; and related apparatus;
    - Whirlpools; saunas; and related apparatus;
    - Vans; and van lifts;
    - Stair; and chair lifts;
    - Exercise bicycles; and other types of exercise equipment]

35. Physical therapy; chiropractic care; occupational therapy; speech therapy; and cardiac rehabilitative therapy; except as provided in the Benefit Section.

36. Testing for or treatment of a Learning Disability; except as provided in the Benefit Section.

37. Testing; training; or rehabilitation for educational; or developmental purposes; except as provided in the Benefit Section.

38. Cosmetic surgery; or services 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.

39. Dental diagnosis; care; treatment or diagnostic imaging studies; except as provided in the Benefit Section. Examples of non-Covered Services include; but are not limited to: the extraction of impacted wisdom teeth; correction of malposition of the teeth and jaw; treatment of dental caries; periodontics; endodontics; orthodontics; replacement of teeth; bonding; gold foil restorations; application of sealants; bitewing x-rays; crown or tooth preparations; fillings; crowns; bridges; dentures; inlays and onlays; and services with respect to congenital malformations. Anesthesia; x-ray; laboratory; or facility fees for dental non-Covered Services shall also not be covered. Prosthetic Devices are not a Covered Service; except as provided in the Benefit Section.

40. Oral surgery; except as provided in the Benefit Section. An example of a non-Covered Service is; but is not limited to: the correction of malposition of the teeth or jaw; or the teeth and jaw.

41. Surgical and non-surgical exam; diagnosis; including: invasive (internal) and non-invasive (external) procedures and tests; and all services related to diagnosis and treatment; both medical and surgical; of temporomandibular joint dysfunction or syndrome also called myofascial pain dysfunction or craniomandibular pain syndrome. Examples of non-Covered Services include; but are not limited to: physiotherapy, such as

therapeutic muscle exercises; galvanic or transcutaneous nerve stimulation; vapocoolant sprays, ultrasound or diathermy; behavior modification such as: biofeedback psychotherapy; Appliance therapy such as: occlusal Appliances (splints); or other oral Prosthetic Devices; and their adjustments; orthodontic therapy such as: braces; prosthodontic therapy such as: crowns; bridgework; and occlusal adjustments.

42. Routine foot care rendered:

    a. In the exam, treatment or removal of all or part of: corns; callosities; hypertrophy; or hyperplasia of the skin; or subcutaneous tissues of the foot; or

    b. In the cutting; trimming; or other non-operative partial removal of toenails; except when Medically Necessary in the treatment of neuro-circulatory conditions.]

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

44. Custodial Care when:

    a. Primarily to provide room and board (with or without nursing care); and

    b. Needed to help to support the essentials of daily living; and

    c. Supervisory care by a Physician for a Covered Person who is mentally or physically disabled; and who is not under active and specific medical; surgical; and/or psychiatric treatment which would be expected to reduce the disability to the extent needed for the Covered Person to function outside a: protected; monitored; and/or controlled environment; or when despite such treatment there is no reasonable likelihood that the disability shall be so reduced.

    Care shall be considered custodial even if:

    a. The Covered Person is under the care of the Primary Care Physician; or a Participating Physician;

    b. The Primary Care Physician or the Participating Physician prescribes services to: support; and maintain the Covered Person's condition; or

    c. The services and supplies are being provided by a registered nurse; or licensed practical nurse.]

45. Ambulance services, including but not limited to:

    a. Transport for elective Hospital Admissions; and

    b. Transport solely for the convenience of: the Covered Person; family; or physician or Provider; except when Medically Necessary; or in the case of a Medical Emergency.

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

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

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

49. Contraceptive devices.

50. Reversal of voluntary sterilization.

51. Sperm collection and preservation, all services related to surrogate parenting arrangements and preparatory treatment.
52. Marriage counseling other than for the treatment of: a diagnosed mental illness; stress management; parent-child management; and pain control.

53. Psychiatric and other treatment for sexual dysfunction; including: sex therapy; unless documented to be caused by a medical condition and Prior Authorized by Anthem BCBS.

54. Surgical treatment or hospitalization for the treatment of morbid obesity; except where determined to be Medically Necessary.

55. Care; treatment; procedures; services; or supplies which are primarily for dietary control including; but not limited to: any exercise or weight reduction programs; whether formal or informal; and whether or not recommended by a physician or Provider.

56. Special nutritional formulas for the treatment of Crohn's disease.

57. Hypnosis.

58. Human organ and tissue transplants; or associated donor costs; except as stated in the Benefit Section.

59. Care; treatment; service; or supplies to the extent that the Covered Person has obtained benefits under any applicable law; government program; or public or private grant; except for: Medicare; Medicaid; or any similar state program.

60. Any illness or injury for which benefits are paid; payable; or eligible for coverage under any Worker's Compensation Law; Automobile; or no-fault law to the extent permissible by law, or other similar law.

61. Anthem BCBS does not have to pay for expenses of services; which the Covered Person or Anthem BCBS is not legally required to pay.

62. Routine eye exams; or refractions; except as provided in the Benefit Description.

63. Radial keratotomy.

64. Eye exercises and visual therapy.

65. Human growth hormone therapy; except when Medically Necessary for cases of hypopituitarism; and with Prior Authorization from Anthem BCBS.

66. Hospital Outpatient clinic services.

67. Penalties imposed on a Covered Person by the primary payer.

68. Inpatient private duty nursing.

69. Any medication or drug; which has a biotechnical application; is a genetically engineered biological product; or is listed in the formulary as such.

70. Hypodermic needles or syringes prescribed by a physician; except for the purpose of administering medicine for medical conditions; provided such medicines are Covered Services.

71. No benefits will be available for Maintenance Care which is:

    a. Treatment provided for the Covered Person's continued well-being by preventing deterioration of a chronic clinical condition; and

    b. Maintenance of an achieved stationary status; which is a point where little; or no improvement in musculo-skeletal function can be made despite therapy.]

72. All other services and items of care not listed in this Summary Booklet; except as provided by Riders to this Benefit Program and agreed upon by both parties.

73. Benefits for services caused by or resulting from the Covered Person's participation in a: riot or civil disorder; act of or attempt to commit an assault or felony.

74. Services for Chronic Care.

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

    1. Allogeneic; or Syngeneic Bone Marrow Transplant; or other forms of stem cell rescue; and stem cell infusion (with or without high dose chemotherapy and/or radiation) are those with a donor other than the patient. They are not covered; except in the following cases:

        a. When at least five out of six histocompatibility complex antigens match between the patient; and the donor.
        b. The mixed leukocyte culture is non-reactive.
        c. One of the following conditions is being treated:

        *Severe aplastic anemia;
        *Acute nonlymphocytic leukemia in first or subsequent remission or early first relapse;
        *Myelodysplastic syndrome;
        *Secondary acute nonlymphocytic leukemia as initial therapy;
        *Acute lymphocytic leukemia in second or subsequent remission;
        *Acute lymphocytic leukemia in first remission;
        *Chronic myelogenous leukemia in chronic and accelerate phase;
        *Non-Hodgkin's lymphoma, high grade, in first or subsequent remission;
        *Hodgkin's lymphoma low grade, which has undergone conversion to high grade;
        *Neuroblastoma, stage 3 or relapsed stage 4;
        *Ewing's sarcoma;
        *Severe combined immunodeficiency syndrome;
        *Wiskott-Aldrich syndrome;
        *Osteopetrosis, infantile malignant;
        *Chediak-Higashi syndrome;
        *Congenital life-threatening neutrophil disorders to include Kostmann's syndrome, chronic granulomatous disease, and cartilage hair hypoplasia;
        *Diamond Blackfan syndrome;
        *Thalassemia;
        *Sickle cell anemia;
        *Primary thrombocytopathy including: Glanzmann's syndrome;
        *Gaucher disease;
        *Mucopolysaccharidoses; and lipidoses to include: Hurler's syndrome; Sanfilippo's syndrome; Maroteaux-Lamy syndrome; Morquio's syndrome; Hunter's syndrome; and metachromatic leukodystrophy.

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

2. Autologous Bone Marrow Transplantation; or other forms of stem cell rescue; and stem cell infusion (in which the patient is the donor) with high dose chemotherapy or radiation are not covered except for the following:

   a. Non-Hodgkin's lymphoma; high grade; first or subsequent remission. No morphological evidence of bone marrow involvement should be evident.

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

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

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

   e. Retinoblastoma; adjuvant setting after successful induction (consolidation).

   f. Neuroblastoma; adjuvant setting after successful induction (consolidation).

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

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

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

RIGHT OF RECOVERY

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

WORKERS' COMPENSATION

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

Anthem BCBS shall be entitled to the following:

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

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

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

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

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

6. If a Covered Person is entitled to benefits under Worker's Compensation, employer's liability or occupational disease law, it must follow all of the guidelines in the Managed Benefits Section in order to continue providing benefits for Covered Services when the Workers' Compensation benefits are used up.

AUTOMOBILE INSURANCE

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

Anthem BCBS shall be entitled:

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

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

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

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

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

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

COORDINATION OF BENEFITS

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

Applicability

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

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

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

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

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

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

Definitions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Order Of Benefit Determination Rules

1. General Rule

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

   a. The other Plan has rules coordinating its benefits with those described in the Summary Booklet; and

b. Both the other Plan's rules; and this Benefit Program's coordination rules; as described below, require that this Benefit Program's benefits be determined before those of the other Plan.

2. Coordination Rules:

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

a. Other than a Dependent

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

b. Dependent Child/Parents Not Separated or Divorced:

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

c. Dependent Child/Separated or Divorced Parents:

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

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

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

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

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

d. Active/Inactive Employee

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

e. Longer/Shorter Length of Coverage

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

f. Medicare

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

Effect Of This Benefit Program On The Benefits

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

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

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

Right To Receive And Release Needed Information

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

Facility Of Payment

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

Right Of Recovery

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

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

TERMINATION

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

Termination of the Covered Person

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

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

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

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

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

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

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

    - Loss of employment with the Employer Group; or reduced work hours; or

    - He or she no longer meets the eligibility requirements of the Benefit Program; as defined in the Eligibility Section of this Summary Booklet;

7. During the first 2 years following the Effective Date of the Benefit Program Anthem BCBS may rescind the Benefit Program; if the Covered Person has provided Anthem BCBS with false; or misleading data about eligibility; insurability; or health status; and Anthem BCBS decides material falsification exists;

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

9. Termination of an enrolled Dependent's Coverage will occur on the first day of the month following the:

    - Divorce; or legal separation of the spouse.
    - Other enrolled Dependent's criteria are no longer met by: the spouse; or enrolled Dependents as defined in the Eligibility Section.
    - Enrollment in the Benefit Program shall be terminated on the day after the death of an enrolled Dependent.

Termination of the Employer Group

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

    - At the option of the Employer Group; without cause upon delivery of 15 days prior written notice to the other party; to go into effect on the first of the month following the end of the 15 day notice period;

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

    - Anthem BCBS may not renew the entire contract in the event the Contractholder fails to meet the participation; or contributory requirements.

2. During the first two years following the Effective Date of the policy, Anthem BCBS may rescind the Benefit Program if Anthem BCBS decides there was material falsification on behalf of the Employer Group by virtue of the provision to Anthem BCBS of: false; misleading; or fraudulent data; during the initial application; and enrollment process; regarding the eligibility of the Employer Group or any Covered Persons to receive coverage under the Benefit Program. The date of rescission shall be the Effective Date.

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

Consent

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

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

Covered Person Notification

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

Certificates of Creditable Coverage

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

Confinement at the Time of Termination

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

CONTINUATION OF COVERAGE

Continuation Options

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

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

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

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

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

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

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

   b. An additional 11 months shall be available to a Covered Person and an enrolled Dependent who is; determined to be disabled under Title II or Title XVI of the Social Security Act at the time he or she becomes eligible for extended continuation of coverage under COBRA, or becomes disabled at any time during the first 60 days of COBRA continuation coverage. The Covered Person or enrolled Dependent must provide notice of the disability determination to Anthem BCBS not later than 60 days after the date of the Social Security Administration's determination, and before the end of the initial 18 months of COBRA continuation coverage.

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

      Upon termination of employment reduction of hours, or leave of absence that results from a Covered Person's eligibility to receive Social Security income, the Covered Person and Covered Person's Dependents may continue coverage until midnight of the day preceding the Covered Person's eligibility for benefits under Title XVIII of the Social Security Act.

   When a Covered Person leaves for duty in the military service the Covered Person's and Covered Person's Dependents may continue coverage 24 months beginning on the first date of the Covered Persons absence from work or the day after the date on which the Covered Person fails to apply for or return to a position of employment.

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

1. The Covered Person becomes eligible for benefits under another group health plan as a result of employment, re-employment, or marriage, except when the new plan contains any exclusion or limitation relating to any pre-existing condition of the Covered Person; or
2. The premium for continuation of coverage is not paid on time; or

3 The Covered Person becomes entitled to Medicare benefits; or

4 The Policyholder no longer provides group health coverage for any of its employees.

Continuation of Coverage Due To Military Service

In the event you are no longer Actively At Work due to military service in the Armed Forces of the United States, you may elect to continue health coverage for yourself and your Dependents (if any) under this Certificate in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.

”Military service” means performance of duty on a voluntary or involuntary basis, and includes active duty, active duty for training, initial active duty for training, inactive duty training, and full-time National Guard duty.

You may elect to continue to cover yourself and your eligible Dependents (if any) under this Certificate and upon payment of any required contribution for health coverage. This may include the amount the employer normally pays on your behalf. If your military service is for a period of time less than 31 days, you may not be required to pay more than the active employee contribution, if any, for continuation of health coverage. If continuation is elected under this provision, the maximum period of health coverage under this Certificate shall be the lesser of:

- The 24 months beginning on the first date of your absence from work; or

- The day after the date on which you fail to apply for or return to a position of employment.

Regardless whether you continue your health coverage, if you return to your position of employment your health coverage and that of your eligible Dependents (if any) will be reinstated under this Certificate.

CLAIMS PROVISIONS

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

Claim Procedures

Participating Physician, Providers and Hospitals

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

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

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

Non-Participating Physicians, Providers and Hospitals

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

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

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

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

Payment For Covered Services

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

In order to be considered for payment, claims submitted by a Covered Person for payment for Covered Services provided by Non-Participating Physicians, Non-Participating Providers and Non-Participating Hospitals must be received by Anthem BCBS within 120 days from the date the Covered Services were performed. Claims for Covered Services more than 120 days after the date the services were performed shall not be covered or paid. Claims for Covered Services must be submitted to:

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

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

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

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

Claim Overpayments

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

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

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

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

Claim Denials

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

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

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

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

COVERED PERSON APPEAL PROCESS

Questions may be posed about the Covered Person'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 Covered Person'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 Covered Person, the Covered Person'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 Covered Person'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 Benefit Program 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 Covered Person is denied benefits for an otherwise Covered Service on the grounds that it is Experimental and the Covered Person 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 from the date the expedited appeal request is received.

If the First Level Appeal determination is not satisfactory, a Covered Person of a fully insured health plan or a self insure governmental health plan which is not subject to ERISA, 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 Benefit Program 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 Covered Person is denied benefits for an otherwise Covered Service on the grounds that it is Experimental and the Covered Person 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 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 Covered Person, the provider of record or provider, or the duly authorized representative of a Covered Person of a fully insured health plan or a self-insured governmental health plan which is not subject to ERISA, 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 thirty (30) 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 Benefit Program 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 Covered Person. 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 Benefit Program 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, unless an extension as described above has been granted.

Other Covered Person Rights

- The Covered Person 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 Covered Person'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 Covered Person free of charge upon request.

- If the adverse benefit determination is based on a Medica 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 Covered Person's medical circumstances will be provided free of charge upon request.

- If a consultant's advice was obtained in connection with a Covered Person'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.

Plan Information Practices Notice

The purpose of this information practices notice is to provide a notice to Covered Persons 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 Covered Person from persons or entities other than the Covered Person.

- The Plan may disclose Covered Person information to persons or entities outside of the Plan without Covered Person authorization in certain circumstances.

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

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

NOTICE

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

MISCELLANEOUS PROVISIONS

Entire Contract

This Summary Booklet; and the Administrative Services Only Agreement issued to: the Contractholder and the Covered Person application make up the entire contract of coverage. You may ask to see the Administrative Services Only Agreement at the Employer Group's office. The Contractholder is the plan administrator for your health plan. We have authority to decide your eligibility for benefits; and to construe the provisions of the Administrative Services Only Agreement and this Summary Booklet.

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

Anthem BCBS as the Insurance Carrier

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

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

The use or non-use of an adjective such as: "participating" or "non-participating" in modifying the term "Physician;" "Provider;" or "Hospital" is not a statement as to the ability of the Physician; Provider; or Hospital.

Disclosure

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

Authority for Discretionary Decisions

Anthem BCBS, or anyone acting on its behalf, shall determine the administration of benefits and eligibility for participation in such a manner that has a rational relationship to the terms set forth herein. However, Anthem BCBS, or anyone acting on its behalf, has complete discretion to determine the administration of the Covered Person's benefits. Anthem BCBS's determination shall be final and conclusive and may include, without

limitations, determination of whether the services, care, treatment, or supplies are Medically Necessary, Investigational/Experimental-Investigative, whether surgery is cosmetic, and whether charges are consistent with its Maximum Allowable Amount. However, a Covered Person may utilize all applicable Covered Person Appeals procedures.

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

Release of Records

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

Clerical Errors

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

Assigning Coverage

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

Filing a Claim

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

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

Limitation of Actions

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

Changes to the Contract

This Benefit Program shall remain in effect unless: amended; terminated; rescinded; suspended; or cancelled as described herein. Anthem BCBS may amend the Summary Booklet and the Administrative Services Only Agreement with approval from the State of Connecticut Department of Insurance. The Effective Date of such changes shall be designated by Anthem BCBS.

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

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

Time Periods

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