Anthem BlueCross BlueShield
108 Leigus Road, Wallingford, CT 06492

Group Retiree Plan

State of Connecticut Teachers' Retirement Board
Effective Date: January 1, 2020

GROUP CERTIFICATE

Issued By:

Anthem Blue Cross and Blue Shield

108 Leigus Road
Wallingford, Connecticut 06492

This is a Group Certificate. It is an agreement between the State of Connecticut Teachers' Retirement Board ("Contractholder") and Anthem BCBS. THIS CERTIFICATE IS NOT A MEDICARE SUPPLEMENTAL CONTRACT. If a Member is eligible for Medicare, review the Medicare Guide to Health Insurance for People with Medicare available from Anthem BCBS.

Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente.

If you need Spanish-language assistance to understand this document, you may request it at no additional cost by calling Customer Service at the number on the back of your Identification Card.

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SECTION 1 INTRODUCTION

This plan is designed to coordinate with Medicare and provide secondary coverage for services approved by Medicare. This plan also covers Additional Covered Services as described within the "Additional Covered Services Not Covered Under Medicare Part A or Part B" section. Coverage for Additional Covered Services are underwritten and administered by Anthem BCBS and subject to the exclusions and limitations as described herein.

SECTION 2 DEFINITIONS

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, representatives, contractors, subcontractors or affiliates.

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

Anthem BCBS will use Approved Expenses as the basis for paying benefits coordinated with Medicare.

Anthem BCBS will use Authorized Expenses, defined herein, as the basis for paying for Additional Covered Services defined in the "Additional Covered Services Not Covered Under Medicare Part A or Medicare Part B" section of this Certificate.

Authorized Expenses: The term Authorized Expenses means the maximum payment that Anthem BCBS will allow for Additional Covered Services defined in the "Additional Covered Services Not Covered Under Medicare Part A or Medicare Part B" section of this Certificate. For more information, see the "Reimbursement for Additional Covered Services" section in the "Additional Covered Services Not Covered Under Medicare Part A or Medicare Part B" section of this Certificate.

Anthem BCBS will use Approved Expenses as the basis for paying benefits coordinated with Medicare.

Benefit Period: A Medicare Part A Benefit Period starts when a Member enters a Hospital. When a Member has been out of a Hospital or Skilled Nursing Facility for 60 consecutive days (including the day of discharge), the Benefit Period ends. A new Benefit Period starts the next time a Member is admitted to a Hospital.

A Medicare Part B Benefit Period starts on January 1 and ends December 31 of each year. But a Member's first Benefit Period starts on his/her effective date of coverage, and ends December 31 of the same year. Your first Benefit Period starts on your effective date of coverage, and ends December 31 of the same year.

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

Anthem is not a Carrier in terms of this obligation to this Contract.

Certificate: The term Certificate means this document, with Group Application, and member enrollment form, endorsements, Plan Specification Page, attached papers, and amendments, if any.

Contractholder: The term Contractholder means the group in whose name the Certificate is issued and who is responsible for paying the premiums as stated in the Certificate.

Covered Person: The term Covered Person means an Eligible Person as defined in the "Effective Date, Eligibility and Term of Coverage" section of this Certificate , who has been accepted for membership under this health plan and in whose name a membership identification card is issued.

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

General Hospital: The term General Hospital means a Hospital which provides acute, short-term care, is licensed by the State of Connecticut and has appropriate accreditation from the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and participates with Medicare.

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

Hospital: The term Hospital means a General or Specialty Hospital which participates with Medicare.

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

Lifetime Reserve Days: Lifetime Reserve Days are available to the Member when the Member has been in the Hospital 90 days in a single Medicare Part A Benefit Period. There are 60 Medicare Lifetime Reserve Days that can be used only once.

Medicare: The term Medicare means The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as then constituted or later amended.

Medicare Eligible Expenses: Medicare Eligible Expenses are expenses of the kinds covered by Medicare "Parts A and B", to the extent recognized as reasonable and medically necessary by Medicare.

Medicare Coinsurance and Copayment: Medicare Coinsurance and Copayment is that portion of the health care charges that a Member is required to pay for under Medicare after the applicable Medicare Deductible is met.

Medicare Part A or Part B Deductible: Medicare Part A or Part B Deductible means the amount of health care charges Medicare requires the Member to pay before Medicare Part A or Part B benefits are paid.

Medicare Part B: The term Medicare Part B means the Part B program of The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as then constituted or later amended.

Member: The term Member means either the Covered Person or his or her lawful spouse under a legally valid existing marriage as defined by the Contractholder, age 65 or older, who is enrolled in Medicare Parts A and B.

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

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

Physician: Includes the following when licensed by law and provide services within the scope of their licenses:

- Doctor of Medicine (M.D.) legally entitled to practice medicine and perform surgery,
- Doctor of Osteopathy (D.O.) legally licensed to perform the duties of a D.O.,
- Doctor of Chiropractic (D.C.), legally licensed to perform the duties of a chiropractor;
- Doctor of Podiatric Medicine (D.P.M.) legally entitled to practice podiatry, and
- Doctor of Dental Medicine (D.D.M.), Doctor of Dental Surgery (D.D.S.), legally entitled to provide dental services.
- Naturopathic Physician (N.D.) legally entitled to engage in the practice of naturopathy.

Optometrists, Clinical Phycologists (PhD), and surgical chiropodists are also Physicians when legally licensed and providing member care within the scope of their licenses.

Provider: A Provider is a licensed Physician, Hospital, Skilled Nursing Facility, or other Provider authorized by the Medicare program, or Anthem BCBS, to provide services or supplies under this plan, including midwife, physician assistant, certified nurse practitioners, certified psychiatric-mental health clinical nurse specialists providing member care in the scope of their license.

Skilled Nursing Facility: The term Skilled Nursing Facility means any institution which accepts and charges for patients on an inpatient basis. This institution must be primarily engaged in providing skilled nursing care, rehabilitative, and related services to patients requiring medical and skilled nursing care. It must be under the supervision of a licensed Physician and provide 24-hour a day nursing service under the supervision of a registered nurse. It must not be a place primarily for the treatment of nervous-mental disorders, a place of rest, or custodial care.

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) and participates with Medicare.

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

Special Services: The term Special Services means hospital services and supplies including, but not restricted to use of operating, delivery, and treatment rooms and equipment; prescribed drugs; administration of blood and blood processing; anesthesia; anesthesia supplies and services; medical and surgical dressings, supplies, casts and splints; diagnostic services; occupational and physical therapy; radiation and chemotherapy; and laboratory and x-ray.

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

SECTION 3 GENERAL PROVISIONS

(1) Anthem BCBS will provide benefits for the specific services and supplies specified in this Certificate.

(2) Anthem BCBS will not pay for any charges not approved by Medicare, except for the benefits specified in the "Additional Covered Services Not Covered Under Medicare Part A or Part B" section of this Certificate.

(3) Before a person can be considered eligible for benefits under this health plan, a person must first be enrolled in Medicare Part A and Part B and care must be determined necessary under Federal regulations. Anthem BCBS will not provide any benefits which duplicate Medicare, Medicaid and Medicare Supplemental certificate benefits.

(4) Anthem BCBS will only provide benefits for a Member in a Hospital or Skilled Nursing Facility when medically necessary care as approved by Medicare, or are covered as an Additional Benefit under this plan, and has been prescribed by a licensed Physician or licensed dentist. Also, the institution a Member is admitted to must have an agreement with the Secretary of Health and Human Services of the United States to provide benefits under Medicare, except as otherwise provided for in this Certificate.

(5) In determining benefits for the number of days of care in a Hospital or Skilled Nursing Facility, the calendar day of admission or the calendar day of discharge will be included, but not both.

(6) When Anthem BCBS determines the availability of benefits under this health plan, Anthem BCBS does not make medical judgments, but Anthem BCBS does determine what services are covered by this health plan.

(7) All notices required by this health plan will be provided to the Contractholder.

(8) If a Member transfers from another health plan to coverage as provided under this health plan, no benefits will be paid under this health plan to the extent that benefits are payable under the prior health plan for any hospitalization that began prior to the effective date of the new health plan.

(9) TIME LIMIT ON CERTAIN DEFENSES: This Certificate shall be incontestable, except for non-payment of premiums, after it has been in force for two years from its date of issue.

(10) If an otherwise eligible person is hospitalized on the date upon which coverage would have become effective, the effective date of coverage for that person will be delayed until the day following his/her discharge.

(11) The Contractholder agrees that retroactive credits, addition, deletions or refunds must be approved by Anthem BCBS.

(12) When both the eligible person and spouse were employed by the same employer and by reason of employment both are enrolled in the plan, Anthem shall furnish each of the eligible person and spouse their own Certificate and the benefits described in this Certificate will therefore be available to the eligible person and spouse independently, consistent with the requirements set forth in C.S.G., Section 10-183t (or successor provision, to the extent applicable) of the Contractholder's enabling legislation. There is no dependent coverage available under this policy, and thus no two party coverage. In no event shall benefits provided under this health plan exceed 100% of charges for covered expenses or services.

(13) The Contractholder hereby expressly acknowledges understanding that this Certificate constitutes a contract solely between the Contractholder and Anthem BCBS, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans (the "Association") permitting Anthem BCBS to use the Blue Cross and Blue Shield servicemarks in the State of Connecticut, and that Anthem BCBS is not contracting as an agent of the Association. The Contractholder further acknowledges and agrees that the Contractholder has not entered into this Certificate based upon representations by any person other than Anthem BCBS and that no person, entity or organization other than Anthem BCBS shall be held accountable or liable to the Contractholder for any of Anthem BCBS's obligations to the Contractholder created under this. This paragraph shall not create any additional obligations whatsoever on the part of Anthem BCBS other than those obligations created under other provisions of this Certificate.

SECTION 4 EFFECTIVE DATE, ELIGIBILITY AND TERM OF COVERAGE

(1) The entire Certificate between the Contractholder and Anthem BCBS consists of this document, with Group Application, member enrollment forms, endorsements, attached papers, and amendments, if any. Anthem BCBS may not use any statement the Contractholder makes in the Group Application or a Member makes in his/her member enrollment form in any legal proceeding under this Certificate unless the application or a copy of it is attached to this Certificate.

(2) The effective date of this Certificate is established in accordance with Anthem BCBS's agreement with the Contractholder.

(3) In order for a person to have coverage under this Certificate:

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

b) The person meet the eligibility criteria established by Anthem BCBS and the Contractholder as set forth in this section;

c) The person must be actively enrolled in Medicare Part A and Part B;

d) The person must have completed an member enrollment form in the format provided for that purpose;

e) The member enrollment form must have been made effective by Anthem BCBS; and

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

SECTION 5 SUBMISSION OF CLAIMS AND REIMBURSEMENT

(1) A claim under this Certificate must be made in a form satisfactory to Anthem BCBS.

For claims covered first by Medicare, if the information is not available from the Carrier or Intermediary a Member must provide a copy of the Explanation of Medicare Benefits and any itemized bills that Anthem BCBS requests.

The Explanation of Medicare Benefits is not required for claims submitted for services listed in the "Additional Covered Services Not Covered Under Medicare Part A and Part B" section of this Certificate.

Claim forms will usually be available from most Providers. If forms are not available, either send a written request for a claims form to us, or contact Member Services and ask for a claims form to be sent to you. If you do not receive the claims form, written notice of services rendered may be submitted to us without the claim form. The same information that would be given on the claim form must be included in the written notice of claim. This includes:

- Name of patient.
- Identification number.
- Date, type of service, and place of service.
- Your signature and the Provider's signature.

Claims must be made by a Member or on his/her behalf no later than three years after the covered expenses are incurred.

(2) As partial consideration for the payment of benefits, a Member agrees to furnish, and authorize any Hospital, Skilled Nursing Facility, pharmacy, Physician or other Provider to furnish to Anthem BCBS, such information as Anthem BCBS may require. This data will relate to the history and diagnosis of any illness, disease, condition or symptom for which benefits have been sought. Anthem BCBS will treat this information as confidential.

(3) Anthem BCBS does not practice medicine or provide health services. Anthem BCBS's sole obligation is to provide the benefits described in this Certificate. No action at law based upon or arising out of the physician-patient relationship will be maintained against Anthem BCBS.

(4) No lawsuit or legal action of any kind related to a benefit decision may be filed by you in a court of law or in any other forum, unless it is commenced no earlier than 60 days after we receive the claim or other request for benefits and within three years of our final decision on the claim or other request for benefits. If we decide an appeal is untimely, our latest decision on the merits of the underlying claim or benefit request is the final decision date. You must exhaust our internal appeals process before filing a lawsuit or other legal action of any kind against us.

(5) Payments for Medicare Eligible Expenses will be based on the Approved Expenses as determined by a Carrier or Intermediary, except as otherwise stated in this Certificate.

(6) If a Member receives services covered under this health plan from a Provider who accepts Medicare assignment, benefit payments will be sent directly to the Provider.

(7) Benefit payments for services covered under this health plan from Providers who do not accept Medicare assignment will be given to a Member, except as otherwise noted in the Certificate. Benefit payments paid to the member under this plan will be no greater than the amount accepted by Providers accepting Medicare assignment.

(8) Benefits for emergency medical care rendered outside of the United States are payable only to a Member in United States currency in an amount based on the bank transfer exchange rate in effect on the day services are rendered.

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

(10) The benefits provided under this health plan are for the personal benefit of the member and cannot be transferred or assigned. Any attempt to assign this contract will automatically terminate all rights under this contract.

SECTION 6 SUMMARY OF BENEFITS

Limitations apply to most benefits. Please refer to the Benefits subsection for a detailed description of available benefits.

Benefits

This Section provides benefits for persons who are enrolled in Medicare Parts A and B and covered under the terms and conditions of this Certificate. Hospital and Physician services must be Medicare Eligible Expenses under the Medicare program and Medicare benefits must be payable for the following services to receive the benefits provided by this Section of the Certificate. Benefits are subject to all of the terms, conditions and limitations in Medicare and in this Certificate, including but not limited to "General Provisions" and "Exclusions, Conditions, and Limitations".

Inpatient Hospital Benefits

Medicare Eligible Expenses incurred on or after the effective date of this coverage for the Member under this health plan will pay:

a) Part A Medicare Eligible Expenses up to the Medicare Part A Coinsurance amount, other than up to $250 per inpatient admission, for inpatient Hospital days 61-90; and then

b) Part A Medicare Eligible Expenses up to the Medicare Part A Coinsurance amount when a Member is using his/her 60 Medicare Lifetime Reserve Days; and then

c) Unlimited Medically Necessary Inpatient Hospital days following the 60 Medicare Lifetime Reserve Days. See the “Additional Covered Services Not Covered Under Medicare Part A or Part B Section for additional information.

Blood Deductible

The health plan will pay the Medicare Parts A and B blood Deductible for the first 3 pints.

Medical Care Benefits

After the Member pays the Medicare Part B Deductible, the health plan will pay:

20% of all Part B Medicare Eligible Expenses, after:

- up to a $10 copayment per office visit;
- up to a $100 copayment for ambulance services;
- up to a $100 copayment per emergency room visit;
- up to a $100 copayment for outpatient facility services.

The emergency room copayment of up to $100 is waived if admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.

Please note Provider charges above the Medicare Approved Expense for Providers not accepting Medicare assignment are not reimbursable under this plan.

Medicare Part A Deductible

If a Member is admitted to a Hospital, the health plan will pay the Medicare Part A Deductible, per Benefit Period.

Skilled Nursing Facility Care

(1) If a Member is admitted to a Skilled Nursing Facility, the health plan will pay charges up to the daily Medicare Part A Coinsurance amount, other than up to a $250 copayment per inpatient admission, for the 21st through 100th day of Skilled Nursing Facility care in a Medicare Benefit Period. A Skilled Nursing Facility is a facility that provides skilled nursing care that is approved for payment by Medicare.

(2) All services must be covered by Medicare and the Skilled Nursing Facility must participate in the Medicare program. There are no benefits after 100 days of Skilled Nursing Facility care in a Medicare Benefit Period.

Annual Copayment Maximum

As stated above, copayments apply to Medicare Eligible Expenses for: office visits, emergency room visits, ambulance services, inpatient admissions, including admissions to Skilled Nursing Facilities, and outpatient hospital services, up to a combined copayment maximum of $2,000 per calendar year. Once the Annual Copayment Maximum is met, benefits for Medicare Eligible Expenses will be covered at 100%. The Annual Copayment Maximum does not include: member payments to satisfy the Medicare Part B Deductible; or Provider charges above the Medicare Approved Expense for Providers not accepting Medicare assignment; or the amount above Anthem BCBS's Authorized Expense for Additional Covered Services defined the "Additional Covered Services Not Covered Under Medicare Part A or Medicare Part B" section.

SECTION 7 EXCLUSIONS, CONDITIONS AND LIMITATIONS

Anthem BCBS will not pay for diagnosis, treatment, or care, charges or services which are either excluded or fail to meet the conditions and limitations described in this Certificate. In the event that any of the exclusions, conditions and limitations in this Section are more restrictive than those permissible under Medicare, they will be construed in accordance with Medicare law and regulations. In addition, Anthem BCBS will not pay for diagnosis, treatment or care, charges or services which duplicate coverage under any other certificate or other health benefits certificate that provides the same coverage as described in the certificate, unless otherwise provided for in this Certificate.

(1) Medicare Part B Deductible.

(2) Third Party Liability

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

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

(3) Benefits Specifically Excluded: Without limiting the general exclusion of benefits not specifically described herein, no benefits will be paid for the following:

a) Services covered in whole or in part by public or private grants.

b) Services, any portion of which, by law, were rendered, or but for the benefits herein provided would have been rendered, without expense to the Member.

c) Charges after the Hospital's or Skilled Nursing Facility's regular discharge hour on the day indicated for the Member's discharge by his/her Physician.

d) Services required as a result of war or an act of war.

e) Personal comfort items.

f) Routine physical check-ups and immunizations required for travel, enrollment in any insurance program, as a condition of employment, for licensing, sports programs, or for other purposes, which are not required by law under the "Preventive Care" benefit.

g) Eyeglasses, eye exams for the purpose of prescribing or fitting or changing eyeglasses.

h) Care, treatment, filling, removal, or replacement of teeth or structures supporting the teeth.

i) Custodial care, unless otherwise provided for in this Certificate.

j) Care rendered by immediate relatives of the Member or members of his or her household.

k) Treatment of an injury or illness that results from a crime you committed, or tried to commit. This Exclusion does not apply if: during the time of the crime or attempted crime you had an elevated blood alcohol content or were under the influence of an intoxicating liquor or any drug or both; or your involvement in the crime was solely the result of a medical or mental condition, or where you were the victim of a crime, including domestic violence.

(4) Anthem BCBS will not pay for expenses related to cosmetic surgery or procedures performed solely to improve appearance and not designed to restore body function, except due to accidental injury or for improvement of the functioning of a malformed body member.

(5) Benefits will be provided only for covered services rendered on or after the Member's effective date under this Certificate.

(6) Anthem BCBS will not pay for services and supplies which are experimental or investigational, except as required by law. Such services or supplies shall include but not be limited to any diagnosis, treatment, procedure, facility, equipment, drugs, drug usage, devices or supplies which are determined by Medicare to be experimental or investigational.

(7) Anthem BCBS will not pay for services and supplies (meaning any treatment, procedure, facility, equipment, drugs, drug usage, devices, or supplies) requiring federal or other governmental agency approval not granted at the time services were rendered, except as required by law.

(8) Anthem BCBS will not pay for prescription drugs, devices or products received from a retail or mail order (home delivery) pharmacy, or over the counter medications, even if prescribed by a doctor. This Exclusion does not apply to prescription drugs, devices or products we must cover by law.

(9) Anthem BCBS will not pay for any expenses for items or services which are paid for directly or indirectly by a governmental entity.

(10) Anthem BCBS will not pay for expenses for benefits which are otherwise mandated under Connecticut or other state law, unless the expenses either: 1) constitute a Medicare

Eligible Expense, or 2) are a covered expense described in the "Additional Covered Services Not Covered Under Medicare Part A or Part B" section.

SECTION 8 OTHER PROVISIONS

Right of Recovery:

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

Grace Period:

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

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

SECTION 9 AMENDMENT AND TERMINATION OF CERTIFICATE

(1) This Certificate will be terminated:

a) By either the Contractholder or Anthem BCBS effective as of the first day of any calendar month provided the canceling party has given at least 30 days prior written notice to the other party;

b) At Anthem BCBS's option for the Contractholder's non-payment of premiums when due;

c) At Anthem BCBS's option for the Contractholder's failure to perform any obligation required by this Certificate.

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

(3) A Covered Person’s spouse will cease to be covered under this Policy upon the first day of the month following a divorce, or annulment, except as otherwise provided.

(4) Termination of this Certificate for any reason terminates all of the Member's coverage. Anthem BCBS will have no responsibility to pay benefits for services rendered after such termination.

(5) In the event a Member becomes no longer eligible for coverage under Title XVIII of the Social Security Act, as amended, benefits for that Member under this Certificate will cease. However, membership can be continued under the Direct Pay Plan currently available in accordance with Anthem BCBS underwriting requirements.

(6) The Contractholder must give Members 15 days prior notice in the event the Certificate is canceled or discontinued. If other coverage is substituted for this Certificate, the Contractholder must notify the Covered Person.

(7) This Certificate will be changed automatically to coincide with any changes with respect to exclusions, conditions and limitations in Medicare with regard to Medicare Approved Expenses. The Contractholder will be notified no later than 30 days before the effective date of any changes in the applicable Medicare deductible amount and copayment percentage factors, or of any premium adjustments due to changes in Medicare. The terms of this section do not apply to covered services listed in the “Additional Covered Services Not Covered by Medicare Part A or Part B” section.

(8) This Certificate continues until terminated or changed in accordance with its terms.

SECTION 10 ADDITIONAL COVERED SERVICES NOT COVERED UNDER MEDICARE PART A OR PART B

In addition to the Approved Expenses covered by Medicare, the Additional Covered Services listed in this section are also covered, subject to the Utilization Review, exclusions and limitations described herein. For purposes of this Certificate, "Additional Covered Services" are benefits covered by this plan, when Medicare benefits have been exhausted, or are not eligible for coverage by Medicare.

A. Additional Covered Services Schedule of Benefits

Medically Necessary emergency care outside of the U.S. - Inpatient Hospital Facility Charge (30 day limit) - Physician charges related to inpatient stay - Outpatient services - All other medical treatments	 Paid at 80% after up to $250 copayment Paid at 80% Paid at 80% Paid at 80%
Hearing Care Benefits - Routine Hearing Exam (one every 12 months) - Hearing aid (one hearing aid per ear every 24 months)	 Paid at 100% Paid at 100%
Medically Necessary Inpatient Hospital Days (Unlimited, after Medicare Lifetime Reserve Days)	Paid at 100%
All other Additional Covered Services included herein, subject to the following cost shares: - Office Visit - Ambulance Services - Emergency Room Visit - Outpatient Facility - Inpatient Admission - All other services	 $10 copayment $100 copayment $100 copayment $100 copayment $250 copayment Paid at 100%

B. Additional Covered Services include coverage for the following services:

1. Medically Necessary emergency care outside of the United States:

    a) Inpatient Hospital Facility Charge – 30 day limit. Billed charges are paid at 80% after up to a $250 copayment.

b) Physician charges related to inpatient stay are paid at 80%.

c) Outpatient charges are paid at 80%.

d) All other medical treatments are paid at 80%.

e) Prescriptions and lab services are not covered.

If a Member is hospitalized outside the United States, Anthem BCBS will provide coverage toward the Hospital's published charges for a semi-private room, meals and general nursing care for 30 days. If a private room is used, Anthem BCBS will pay the weighted average charge for a semi-private room and the Member will pay the difference. Benefits also will be provided for outpatient care required in a Hospital located outside the United States.

In order for services to be covered outside the United States by this health plan, the service must be a covered benefit by Medicare Part A or Medicare Part B.

2. Hearing Care Benefits:

Routine Hearing Exam: covered at 100% up to the Maximum Allowed Amount, one every 12 months.

Hearing Aids, including attenuators, fittings and adjustments: one (1) hearing aid per person every 24 months.

Hearing Aid benefits apply when charges are incurred by a Covered Person for the purchase of a hearing aid and any related fittings and adjustments.

Hearing care charges are the Usual and Reasonable Charges for the hearing care services shown above. Benefits for these charges are payable up to the maximum amounts shown above for each hearing care service or supply.

Exclusions. No benefits will be payable for the following:

a) Treatment or supplies for which a charge was incurred before a person was covered under this Plan.
b) Charges excluded or limited by the Plan design as stated in this document.
c) Any charges that are covered under a health plan that reimburses a greater amount than this Plan.
d) Charges for hearing aid batteries are not eligible under this plan.

3. Prescription Wigs after chemotherapy: one every year.

4. Unlimited Medically Necessary Inpatient Hospital days.

After the Medicare Lifetime Reserve Days have been used, Anthem will cover 100% of Hospital charges as established by an agreement between the Hospital and Anthem BCBS (or in the absence of such an agreement, the average charge of comparable Hospitals for similar services, as determined by Anthem BCBS) for Part A Medicare

Eligible Expenses for unlimited inpatient Hospital days when care is Medical Necessary.

After the Medicare Lifetime Reserve Days have been used, Anthem has final authority to decide the Medical Necessity of the service, as defined herein. If services are denied you have the right to file a Grievance as outlined in the "Grievance and External Review Procedures" section below.

Covered Services include:

- acute care in a Hospital setting.

- room, board, and nursing services, including:
  - A room with two or more beds.
  - A private room. The most the Plan will cover for private rooms is the Hospital's average semi-private room rate unless it is Medically Necessary that you use a private room for isolation and no isolation facilities are available.
  - A room in a special care unit approved by us. The unit must have facilities, equipment, and supportive services for intensive care or critically ill patients.
  - Routine nursery care for newborns during the mother's normal Hospital stay.
  - Meals, special diets.
  - General nursing services.

- ancillary services, including:
  - Operating, childbirth, and treatment rooms and equipment.
  - Prescribed Drugs.
  - Anesthesia, anesthesia supplies and services given by the Hospital or other Provider.
  - Medical and surgical dressings and supplies, casts, and splints.
  - Diagnostic services.
  - Therapy services.
  - Treatment for ingestion and accidental consumption of a controlled drug or other substance.

5. Mental Health and Substance Abuse Services include the following:

   - **Inpatient Services** in a Hospital or any Facility that we must cover per state law. Inpatient benefits include psychotherapy, psychological testing, electroconvulsive therapy, detoxification, and stabilization services.

   - **Residential Treatment** in a licensed Residential Treatment Center that offers individualized and intensive treatment, such as detoxification and stabilization services, and includes:

     - Observation and assessment by a physician weekly or more often,
     - Rehabilitation, therapy, and education.

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

- the insured has a Medically Necessary, serious mental or nervous condition that substantially impairs the insured's thoughts, perception of reality, emotional process or judgment or grossly impairs the behavior of the insured, and, upon an assessment of the insured by a physician, psychiatrist, psychologist or clinical social worker, cannot appropriately, safely or effectively be treated in an acute care, partial hospitalization, intensive outpatient or outpatient setting; and
- 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.

- **Outpatient Services** including office visits, therapy, treatment, evidence-based maternal, infant and early childhood home visitation services, detoxification and stabilization services, chemical maintenance treatment, Partial Hospitalization/Day Treatment Programs, Intensive Outpatient Programs, Intensive In-Home Behavioral Health Services, Home-based therapeutic interventions for children, extended day treatments, and Observation beds in an acute hospital setting.

  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, licensed clinical Social Worker, licensed Marriage and Family Therapist or a l-Licensed or certified Alcohol and Drug Counselor; or appropriately licensed professional counselor or licensed Advanced Practice Registered nurse.

  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, licensed clinical Social Worker, licensed Marriage and Family Therapist or a licensed or certified Alcohol and Drug Counselor or appropriately licensed professional counselor or licensed Advanced Practice Registered nurse.

Examples of Providers from whom you can receive Covered Services include:

- Psychiatrist,
- Psychologist,
- Neuropsychologist,
- Licensed clinical social worker (L.C.S.W.),
- Licensed marriage and family therapist (L.M.F.T.),
- Licensed or Certified Alcohol and Drug Counselor,

- Licensed professional counselor (L.P.C),
- Licensed Advanced Practice Registered nurse (A.P.R.N.), or
- Any agency licensed by the state to give these services, when we have to cover them by law.

The Facility must be licensed, registered and approved by the Joint Commission on Accreditation of Hospitals and meet specific rules set by Anthem BCBS.

Mental health Care does not include:

- intellectual disabilities,
- specific learning disorders,
- motor disorders,
- communication disorders,
- caffeine-related disorders,
- relational problems, and
- other 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".

6. Autism Services

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

Covered Services include:

- Behavior Therapy for children up until their 21st birthday, when rendered by an Autism Behavioral Therapy Provider and ordered by a licensed physician, psychologist or clinical social worker in accordance with a treatment plan developed by a licensed Physician, psychologist or licensed clinical social worker;
- Prescription drugs prescribed by a licensed Physician, advanced practiced registered nurse, or licensed physician assistant for the treatment of symptoms and co-morbidities of autism spectrum disorders;
- Direct psychiatric or consultative services provided by a licensed psychiatrist or psychologist;
- Occupational, Physical, and Speech therapy provided by a licensed therapist.

For purposes of this section, "Autism Behavioral Therapy Provider" means Behavioral Therapy provided or under the supervision of a behavior analyst certified by the Behavior Analyst Certification Board; a licensed physician, or a licensed psychologist. "Supervision" means at least 1 hour of face-to-face supervision of the

Autism Services Provider for each ten hours of Behavioral Therapy provided by the supervised certified assistant behavior analyst or behavior therapist.

For purposes of this section, “Autism spectrum disorders” means the "Autism spectrum disorders" as set forth in the most recent edition of the American Psychiatric Association’s “Diagnostic and Statistical Manual of Mental Disorders”. The results of an autism spectrum diagnosis shall be valid for a period of twelve months unless the Member’s licensed physician, licensed psychologist, or licensed clinical social worker determines a shorter period is appropriate or changes the results of the Member’s diagnosis.

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

7. Oral Surgery

   Important Note: Although this Plan covers certain oral surgeries, many oral surgeries (e.g. removal of wisdom teeth) are not covered.

   Benefits are limited to certain oral surgeries including:

   - Treatment of medically diagnosed cleft lip, cleft palate, ectodermal dysplasia, or other complex craniofacial disorder;
   - Orthognathic surgery for a physical abnormality that prevents normal function of the upper and/or lower jaw and is Medically Necessary to attain functional capacity of the affected part.
   - Treatment of non-dental lesions, such as removal of tumors and biopsies.
   - Incision and drainage of infection of soft tissue not including odontogenic cysts or abscesses.

8. Medically Necessary Hospital Dental Services

   Your Plan also includes Medically Necessary coverage for anesthesia, nursing, and other related hospital services for inpatient or outpatient hospital dental services, or one day dental services when the treating dentist, oral surgeon and your Primary Care Provider determine the dental services to be Medically Necessary and:

   - You have a dental condition complex enough that it requires Inpatient services, Outpatient hospital dental services, or one day dental services; or
   - You have a developmental disability that places you at serious risk.

9. Medical and Surgical Supplies

Your Plan includes coverage for medical and surgical supplies that serve only a medical purpose, are used once, and are purchased (not rented). Covered supplies include syringes, needles, surgical dressings, splints, and other similar items that serve only a medical purpose.

Benefits include wound-care supplies that are Medically Necessary for the treatment of epidermolysis bullosa and are administered under the direction of a Physician.

Covered Services do not include items often stocked in the home for general use (e.g. Band-Aids, thermometers, and petroleum jelly) and multi-purpose items that could be used for non-medical reasons (e.g. Tape, surgical gloves, batteries, battery chargers, and cleansing agents).

10. Specialized Formula and Modified Foods

    Specialized Formula is a nutritional formula for children up to age twelve that is exempt from the general requirements for nutritional labeling under the statutory and regulatory guidelines of the Federal Food and Drug Administration.

    Coverage for Specialized Formula is intended for use of dietary management of specific disease when under the medical direction and supervision of a Physician, when such specialized formulas are medically necessary for the treatment of that disease or condition.

    Benefits also include Amino acid modified preparations; and low protein modified food products for the treatment of inherited metabolic diseases and cystic fibrosis.

11. Diabetes Equipment, Education, and Supplies

    Your Plan includes coverage for diabetic drugs, supplies and equipment.

    Outpatient self-management training for the treatment of diabetes 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.

12. Intravenous and oral antibiotic therapy for the treatment of Lyme Disease, Pain Management, and chemotherapy. May include injections (intra-muscular, subcutaneous, continuous subcutaneous).

13. Donor Searches

    Your Plan includes one Human Leukocyte Antigen (HLA) testing per lifetime, also referred to as histocompatibility locus antigen testing, for A, B and DR antigens, for use in bone marrow transplantation. The testing must be done at an accredited facility and at the time of testing you must sign a consent form authorizing the results of the testing to be used in the national Marrow Donor Program.

Unrelated donor searches from an authorized, licensed registry for bone marrow / stem cell / cord blood transplants for a Covered Transplant Procedure are covered by when approved through Precertification as described above. Donor search charges are limited to the 10 best matched donors, identified by an authorized registry.

14. Prosthetics

Your Plan also includes benefits for prosthetics, which are artificial substitutes for body parts for functional or therapeutic purposes, when they are Medically Necessary for activities of daily living.

Benefits include the purchase, fitting, adjustments, repairs and replacements. Covered Services may include, but are not limited to:

- Breast prosthesis (whether internal or external) after a mastectomy, as required by the Women's Health and Cancer Rights Act.
- Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
- Restoration prosthesis (composite facial prosthesis).

15. Home Care Services

Benefits are available for Medically Necessary Covered Services performed by a Home Health Care Agency or other Providers in your home. "Home Health Care Agency" means a Facility, licensed in the state in which it is located, that gives skilled nursing and other services on a visiting basis in your home; and supervises the delivery of services under a plan prescribed and approved in writing by the attending Physician.

To be eligible for benefits, you must essentially be confined to the home, as an alternative to a Hospital stay, and be physically unable to get needed medical services on an outpatient basis. Services must be prescribed by a Physician or an Advanced Practice Registered Nurse (APRN) and the services must be so inherently complex that they can be safely and effectively performed only by qualified, technical, or professional health staff.

Covered Services by a licensed health care professional include but are not limited to:

- Intermittent skilled nursing services by an R.N. or L.P.N.
- Medical / social services
- Nutritional guidance
- Training of the patient and/or family/caregiver
- Home health aide services. You must be receiving skilled nursing or therapy. Services must be given by appropriately trained staff working for the Home Health Care Provider. Other organizations may give services only when approved by us, and their duties must be assigned and supervised by a professional nurse on the staff of the Home Health Care Provider or other Provider as approved by us.

- Therapy Services
- Medical supplies
- Durable medical equipment
- Hospice care provided in the home.

While some services may be provided in your home, they will be covered as any other service of your Plan (e.g. Prosthetics will be covered under your "Prosthetics" benefit).

All services must be authorized by us as outlined in the "Getting Approval for Benefits".

Limits. No benefits will be payable for the following:

- Custodial Care.
- Convalescent care.
- Domiciliary care.
- Rest home care.
- Services given by registered nurses and other health workers who are not employees of or working under an approved arrangement with a Home Health Care Provider.
- Private duty nursing.
- Food, housing, homemaker services and home delivered meals.

16. Rehabilitation Services

Benefits include services in a Hospital, freestanding Facility, Skilled Nursing Facility, or in an outpatient day rehabilitation program.

Covered Services involve a coordinated team approach and several types of treatment, including skilled nursing care, physical, occupational, and speech therapy, and services of a social worker or psychologist.

To be Covered Services, rehabilitation services must involve goals you can reach in a reasonable period of time. Benefits will end when treatment is no longer Medically Necessary and you stop progressing toward those goals.

Your Plan includes coverage for the services described below. To be a Covered Service, the therapy must improve your level of function within a reasonable period of time. Covered Services include:

- Physical therapy – The treatment by physical means to ease pain, restore health, and to avoid disability after an illness, injury, or loss of an arm or a leg. It includes hydrotherapy, heat, physical agents, bio-mechanical and neuro-physiological principles and devices. It does not include massage therapy services at spas or health clubs.

- Speech therapy and speech-language pathology (SLP) services – Services to identify, assess, and treat speech, language, and swallowing disorders in children

and adults. Therapy will develop or treat communication or swallowing skills to correct a speech impairment.

- Occupational therapy – Treatment to restore a physically disabled person's ability to do activities of daily living, such as walking, eating, drinking, dressing, using the toilet, moving from a wheelchair to a bed, and bathing. It also includes therapy for tasks needed for the person's job. Occupational therapy does not include recreational or vocational therapies, such as hobbies, arts and crafts.

- Chiropractic / Osteopathic / Manipulation therapy – Includes therapy to treat problems of the bones, joints, and the back. The two therapies are similar, but chiropractic therapy focuses on the joints of the spine and the nervous system, while osteopathic therapy also focuses on the joints and surrounding muscles, tendons and ligaments.

- Early Intervention Services – Services from birth to age three for early intervention Covered Services for a Member and his/her family members provided as part of an individualized family service plan.

- Cardiac Rehabilitation – Medical evaluation, training, supervised exercise, and psychosocial support to care for you after a cardiac event (heart problem). Benefits do not include home programs, on-going conditioning, or maintenance care.

- Chemotherapy – Treatment of an illness by chemical or biological antineoplastic agents.

- Dialysis – Services for acute renal failure and chronic (end-stage) renal disease, including hemodialysis, home intermittent peritoneal dialysis (IPD), home continuous cycling peritoneal dialysis (CCPD), and home continuous ambulatory peritoneal dialysis (CAPD). Covered Services include dialysis treatments in an outpatient dialysis Facility. Covered Services also include home dialysis and training for you and the person who will help you with home self-dialysis.

- Infusion Therapy – Nursing, durable medical equipment and Drug services that are delivered and administered to you through an I.V. in your home. Also includes Total Parenteral Nutrition (TPN), Enteral nutrition therapy, antibiotic therapy, Intravenous and oral antibiotic therapy for the treatment of Lyme Disease , pain care and chemotherapy. May include injections (intra-muscular, subcutaneous, continuous subcutaneous).

- Pulmonary Rehabilitation – Includes outpatient short-term respiratory care to restore your health after an illness or injury.

- Radiation Therapy – Treatment of an illness by x-ray, radium, or radioactive isotopes. Covered Services include treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources), materials and supplies needed, and treatment planning.

- Respiratory Therapy – Includes the use of dry or moist gases in the lungs, nonpressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication, continuous positive pressure ventilation (CPAP); continuous negative pressure ventilation (CNP); chest percussion; therapeutic use of medical gases or Drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers; broncho-pulmonary drainage and breathing exercises.

Limits. No benefits will be payable for Maintenance Therapy Rehabilitative treatment given when no further gains are clear or likely to occur, unless required under state or federal law. Maintenance therapy includes care that helps you keep your current level of function and prevents loss of that function, but does not result in any change for the better.

17. Ambulance Services

Medically Necessary ambulance services are a Covered Service when you are transported by a state licensed vehicle that is designed, equipped, and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals. This includes ground, water, fixed wing, and rotary wing air transportation.

And one or more of the following criteria are met:

- For ground ambulance, you are taken:
  - From your home, the scene of an accident or medical Emergency to a Hospital;
  - Between a Hospital and a Skilled Nursing Facility, or other approved Facility.

- For air or water ambulance, you are taken:
  - From the scene of an accident or medical Emergency to a Hospital;
  - Between a Hospital and an approved Facility.

Ambulance services covered as Additional Covered Services are subject to Medical Necessity reviews by us. Emergency ground ambulance services do not require precertification.

Benefits also include Medically Necessary treatment of a sickness or injury by medical professionals from an ambulance service, even if you are not taken to a Facility.

Ambulance services are not covered when another type of transportation can be used without endangering your health. Ambulance services for your convenience or the convenience of your family or Physician are not a Covered Service.

Other non-covered ambulance services include, but are not limited to, trips to:

- A Physician’s office or clinic;

- A morgue or funeral home.

Hospital to Hospital Transport

If you are moving from one Hospital to another, air ambulance will only be covered if using a ground ambulance would endanger your health and if the Hospital that first treats cannot give you the medical services you need. Certain specialized services are not available at all Hospitals. For example, burn care, cardiac care, trauma care, and critical care are only available at certain Hospitals. To be covered, you must be taken to the closest Hospital that can treat you. Coverage is not available for air ambulance transfers simply because you, your family, or your Provider prefers a specific Hospital or Physician.

18. Telehealth (Telemedicine)

    Covered Services that are appropriately provided by a Telehealth Provider in accordance with applicable legal requirements will be eligible for benefits under this Plan. Telehealth means the mode of delivering health care or other health services via information and communication technologies to facilitate the diagnosis, consultation and treatment, education, care management and self-management of a patient's physical and mental health. In-person contact between a health care Provider and the patient is not required for these services, and the type of setting where these services are provided is not limited. Telehealth does not include the use of facsimile, audio-only telephone, texting or electronic mail.

19. Preventive Care

    Preventive care includes screenings and other services for adults and children. All recommended preventive services will be covered as required by the Affordable Care Act (ACA) and applicable state law. This means many preventive care services are covered with no Deductible, Copayments or Coinsurance when you use participating Provider.

    Certain benefits for Members who have current symptoms or a diagnosed health problem may be covered under other benefits instead of this benefit, if the coverage does not fall within the state or ACA recommended preventive services.

    Covered Services fall under the following broad groups:

    a. Services with an “A” or “B” rating from the United States Preventive Services Task Force. Examples include screenings for:
        - Breast cancer,
        - Cervical cancer,
        - Colorectal cancer,
        - High blood pressure,
        - Type 2 Diabetes Mellitus,
        - Cholesterol,
        - Child and adult obesity.

b. Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
c. Preventive care and screenings for infants, children and adolescents as listed in the guidelines supported by the Health Resources and Services Administration;
d. Preventive care and screening for women as listed in the guidelines supported by the Health Resources and Services Administration, including:

- Women's sterilization treatments, and counseling.
- Women's contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants.
- Breastfeeding support, supplies, and counseling. Benefits for breast pumps are limited to one pump per pregnancy.
- Screenings and/or counseling, where applicable, including but not limited to; Gestational diabetes, Human Papillomavirus (HPV), sexually transmitted infections (STIs), Human immune-deficiency virus (HIV), and interpersonal and domestic violence.

e. Covered Services include the following services as required by state law:

- Mammograms, including mammograms provided by Breast Tomosynthesis (3D).
- Comprehensive Ultrasound screening of an entire breast or breasts if:
  - A mammogram demonstrates heterogeneous or dense breast tissue based on the Breast Imaging Reporting and Data System established by the American College of Radiology; or
  - A woman is believed to be at increased risk for breast cancer due to family history or prior personal history of breast cancer,
  - positive genetic testing, or
  - Other indications as is recommended by a woman's treating physician or advanced practice registered nurse, for
    - a woman who is forty years of age or older, who has a
    - Family history or prior personal history of breast cancer, or
    - Prior personal history of breast disease diagnosed through biopsy as benign.
- Magnetic resonance imaging of an entire breast or breasts in accordance with guidelines established by the American Cancer Society.

You may call Member Services at the number on your Identification Card for more details about these services or view the federal government's web sites, https://www.healthcare.gov/what-are-my-preventive-care-benefits, http://www.ahrq.gov, and http://www.cdc.gov/vaccines/acip/index.html.

20. Infertility Services

Infertility services are the medically Necessary expenses of the diagnosis and treatment of infertility.

Covered Services include:

a. Diagnostic tests to find the cause of infertility, such as diagnostic laparoscopy, endometrial biopsy, and semen analysis.
b. Services to treat the underlying medical conditions that cause infertility (e.g., endometriosis, obstructed fallopian tubes, and hormone deficiency).
c. Covered Services also include Ovulation induction, Intrauterine insemination, in-vitro fertilization, GIFT (gamete intrafallopian transfer), or ZIFT (zygote intra-fallopian transfer), and low tubal ovum transfer. However the following limitations apply:

    - Ovulation induction coverage is limited to a lifetime maximum* of 4 cycles;
    - Intrauterine insemination is limited to a lifetime maximum* of 3 cycles; and
    - In-vitro, GIFT, ZIFT and low tubal ovum transfer is limited to a lifetime maximum* of two cycles combined with not more than two embryo implantations per cycle-with each fertilization or transfer counting as one cycle.

*Lifetime maximum for infertility services apply when Member has been continuously covered under this Plan. Benefits for infertility services covered under a prior Plan will not apply to the infertility lifetime maximum.

Important Note: Although this Plan offers limited coverage of certain infertility services, it does not cover all forms of infertility treatment.

21. Reconstructive Surgery

Benefits include reconstructive surgery to correct significant deformities caused by congenital or developmental abnormalities, illness, injury or an earlier treatment in order to create a more normal appearance. Benefits include surgery performed to restore symmetry after a mastectomy. Reconstructive services needed as a result of an earlier treatment are covered only if the first treatment would have been a Covered Service under this Plan.

Note: This section does not apply to orthognathic surgery. See the "Oral Surgery" section above for that benefit.

Reconstructive surgeries, procedures and services:

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

- Medically Necessary due to accidental injury; or
- Medically Necessary for reconstruction or restoration of a functional part of the body following a covered surgical procedure for disease or injury; or
- Medically Necessary to restore or improve a bodily function; or

- Medically Necessary to correct a birth defect for covered dependent children who have functional physical deficits due to a birth defect. Corrective surgery for children who do not have functional physical deficits due to a birth defect is not covered under any portion of this Booklet; or
- Medically Necessary due to a mastectomy in accordance with the Women's Health and Cancer Rights Act of 1998 (see below).

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

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

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

Breast Implant Removal Notice

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

Mastectomy Notice

A Member who is getting benefits for a mastectomy or for follow-up care for a mastectomy and who chooses breast reconstruction, will also get coverage for:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to give a symmetrical appearance; and
- Prostheses and treatment of physical problems of all stages of mastectomy, including lymphedemas.

Members will have to pay the same Deductible, Coinsurance, and/or Copayments that normally apply to surgeries in this Plan.

22. Clinical Trials and Routine Patient Care Costs:

A. Clinical Trials

Benefits include coverage for services, such as routine patient care costs, given to you as a participant in an approved clinical trial if the services are Covered Services under this Plan. An "approved clinical trial" means a phase I, phase II, phase III, or phase IV clinical trial that studies the prevention, detection, or treatment of cancer or other life-threatening conditions. The term life-threatening condition means any disease or condition from which death is likely unless the disease or condition is treated.

Benefits are limited to the following trials:

a. Federally funded trials approved or funded by one of the following:

i. The National Institutes of Health.
ii. The Centers for Disease Control and Prevention.
iii. The Agency for Health Care Research and Quality.
iv. The Centers for Medicare & Medicaid Services.
v. Cooperative group or center of any of the entities described in (i) through (iv) or the Department of Defense or the Department of Veterans Affairs.
vi. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
vii. In any of the following below if the study or investigation has been reviewed and approved through a system of peer review that the Secretary of Health and Human Services determines 1) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and 2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

- The Department of Veterans Affairs.
- The Department of Defense.
- The Department of Energy.

b. Studies or investigations done as part of an investigational new drug application reviewed by the Food and Drug Administration;

c. Studies or investigations done for drug trials which are exempt from the investigational new drug application.

Routine patient care costs include items, services, and drugs provided to you in connection with an approved clinical trial that would otherwise be covered by this Plan.

All requests for clinical trials services, including services that are not part of approved clinical trials will be reviewed according to our Clinical Coverage Guidelines, related policies and procedures.

Your Plan is not required to provide benefits for the following services. We reserve our right to exclude any of the following services:

a. The Investigational item, device, or service; or

b. Items and services that are given only to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or

c. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;

d. Any item or service that is paid for, or should have been paid for, by the sponsor of the trial.

Routine Patient Care Costs in connection with Clinical Trials shall include Medically Necessary health care services that are incurred as a result of treatment rendered to a Member for purposes of a Clinical Trial that would otherwise be covered if such services were not rendered in conjunction with a Clinical Trial. Such services shall include those rendered by a Physician, diagnostic or laboratory tests, hospitalization, or other services provided to the Member during the course of treatment in Clinical Trial and Coverage for Routine Patient Care Costs incurred for off-label drug prescriptions in accordance with Connecticut Law. Hospitalization shall, for Routine Patient Care Costs, include treatment at nonparticipating facility if such treatment is not available by a participating facility and not eligible for reimbursement by the sponsors of such clinical trial; Hospitalization at a nonparticipating facility will be rendered at no greater cost-share to the insured person than if such treatment was available at a participating facility, all applicable cost-shares will apply.

Routine Patient Care Costs shall not include:

a. 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;

b. The cost of a non-health care service that an insured person may be required to receive as a result of the treatment being provided for the purposes of the Clinical Trial;

c. Facility, ancillary, professional services and drug costs that are paid for by grants or funding for the Clinical Trial;

d. Costs of services that (A) are inconsistent with widely accepted and established regional or national standards of care for a particular diagnosis, or (B) are performed specifically to meet the requirements of the Clinical Trial;

e. Costs that would not be covered under this Plan for non-investigational treatments, including items excluded from coverage under the Plan; and

f. Transportation, lodging, food or any other expenses associated with travel to or from a facility providing the Clinical Trial, for the insured person or any family member or companion.

C. Reimbursement for Additional Covered Services – Maximum Allowed Amount

1. General

This section describes how we determine the amount of reimbursement for the Additional Covered Services defined herein. Reimbursement for services rendered by participating and nonparticipating Providers is based on this Certificate's Maximum Allowed Amount for the covered service that you receive.

The Maximum Allowed Amount for this Certificate is the maximum amount of reimbursement we will allow for services and supplies:

- That meet our definition of Additional Covered Services, to the extent such services and supplies are covered under your Booklet and are not excluded;
- That are Medically Necessary; and
- That are provided in accordance with all applicable preauthorization, utilization management or other requirements set forth in your Booklet.

You will be required to pay a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Copayment or Coinsurance. In addition, when you receive Additional Covered Services from a nonparticipating Provider, you may be responsible for paying any difference between the Maximum Allowed Amount and the Provider's actual charges. This amount can be significant.

When you receive Additional Covered Services from a Provider, we will, to the extent applicable, apply claim processing rules to the claim submitted for those Covered Services. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the procedure and diagnosis codes included in the claim. Applying these rules may affect our determination of the Maximum Allowed Amount. Our application of these rules does not mean that the Additional Covered Services you received were not Medically Necessary. It means we have determined that the claim was submitted inconsistent with procedure coding rules and/or reimbursement policies. For example, your Provider may have submitted the claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed. When this occurs, the Maximum Allowed Amount will be based on the single procedure code rather than a separate Maximum Allowed Amount for each billed code.

Likewise, when multiple procedures are performed on the same day by the same Provider, or other healthcare professional, we may reduce the Maximum Allowed Amounts for those secondary and subsequent procedures because reimbursement at 100% of the Maximum Allowed Amount for those procedures would represent duplicative

payment for components of the primary procedure that may be considered incidental or inclusive.

2. Provider Network Status

   The Maximum Allowed Amount may vary depending upon whether the Provider is an participating or nonparticipating.

   A participating Provider is a Provider who has a participation contract with us. For Additional Covered Services performed by a participating Provider, the Maximum Allowed Amount for this plan is the rate the Provider has agreed with us to accept as reimbursement for the Covered Services. Because participating Providers have agreed to accept the Maximum Allowed Amount as payment in full for those Covered Services, they should not send you a bill or collect for amounts above the Maximum Allowed Amount. However, you may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Copayment or Coinsurance.

   Providers who have not signed any contract with us and are not in any of our networks are nonparticipating Providers, subject to Blue Cross Blue Shield Association rules governing claims filed by certain ancillary providers.

   For Emergency services You receive from a nonparticipating Provider, the Maximum Allowed Amount for this plan will be one of the following as determined by us:

   - The amount the insured's health care plan would pay for such services if rendered by an In-Network health care provider;
   - The usual, customary and reasonable rate for such services, ("Usual, customary and reasonable rate" means the eightieth percentile of all charges for the particular health care service performed by a health care provider in the same or similar specialty and provided in the same geographical area, as reported by FAIR Health, Inc); or
   - The amount Medicare would reimburse for such services.

   For Covered Services You receive from a nonparticipating Provider, the Maximum Allowed Amount for this Booklet will be one of the following as determined by us:

   - An amount based on our managed care fee schedules used with In-Network Providers, which we reserve the right to modify from time to time; or

   - An amount based on reimbursement or cost information from the Centers for Medicare and Medicaid Services (“CMS”). When basing the Maximum Allowed amount upon the level or method of reimbursement used by CMS, Anthem will update such information, which is unadjusted for geographic locality, no less than annually; or

   - An amount based on information provided by a third party vendor, which may reflect one or more of the following factors: (1) the complexity or severity of

treatment; (2) level of skill and experience required for the treatment; or (3) comparable Providers' fees and costs to deliver care, or

- An amount negotiated by us or a third party vendor which has been agreed to by the Provider. This may include rates for services coordinated through case management, or

- An amount based on or derived from the total charges billed by the Out-of-Network Provider.

For Covered Services rendered outside Anthem's Service Area by nonparticipating Providers, claims may be priced using the local Blue Cross Blue Shield plan's non-participating provider fee schedule / rate or the pricing arrangements required by applicable state or federal law. In certain situations, the Maximum Allowed Amount for out of area claims may be based on billed charges, the pricing we would use if the healthcare services had been obtained within the Anthem Service Area, or a special negotiated price.

Unlike participating Providers, Out-of-Network Providers may send you a bill and collect for the amount of the Provider's charge that exceeds our Maximum Allowed Amount. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the Provider charges. This amount can be significant.

D. Getting Approval for Benefits

Your Plan includes the process of Utilization Review to decide when services are Medically Necessary or Experimental/Investigational as those terms are defined in this Booklet. Utilization Review aids the delivery of cost-effective health care by reviewing the use of treatments and, when proper, level of care and/or the setting or place of service that they are performed. Utilization review by Anthem BCBS under this Contract only applies to the Additional Covered Services provide herein.

Coverage for or payment of the service or treatment reviewed is not guaranteed even if we decide your services are Medically Necessary. For benefits to be covered, on the date you get service:

- You must be eligible for benefits;
- Premium must be paid for the time period that services are given;
- The service or supply must be a covered service under your benefit plan;
- The service cannot be subject to an Exclusion under your benefit plan; and
- You must not have exceeded any applicable limits under your benefit plan.

1. Medical Necessity (Medically Necessary)

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

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

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

For the purpose of this subsection “not more costly” means services is cost-effective compared to alternative interventions, including no intervention or the same intervention in an alternative setting. Cost-effective does not always mean lowest cost. It does mean that as to the diagnosis or treatment of the Member’s illness, injury or disease, the service is: (1) not more costly than an alternative service or sequence of services that is medically appropriate, or (2) the service is performed in the least costly setting that is medically appropriate. For example we will not provide coverage for an inpatient admission for surgery if the surgery could have been performed on an outpatient basis or an infusion or injection of a specialty drug provided in the outpatient department of a hospital if the drug could be provided in a Physician’s office or the home setting.

2. Access to Obstetrical and Gynecological (ObGyn) Care

You do not need prior authorization from us or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a health care professional who specializes in obstetrics or gynecology.

Important Note About Maternity Admissions: Under federal law, we may not limit benefits for any Hospital length of stay for childbirth for the mother or newborn to less than 48 hours after vaginal birth, or less than 96 hours after a cesarean section (C-section). However, federal law as a rule does not stop 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 hours, as applicable. Should a mother and newborn be discharged earlier than the 48 hours, or 96 hours, as applicable, coverage will include a follow-up visit within 48 hours of discharge and an additional follow-up visit within 7 days of discharge. In any case, as provided by federal law, we may not require a Provider to get authorization from us before prescribing a length of stay which is not more than 48 hours for a vaginal birth or 96 hours after a C-section.

Precertification is not required for an Emergency or an Emergency Medical Condition. “Emergency”, or “Emergency Medical Condition” means a medical or behavioral health condition of recent onset and sufficient severity, including but not limited to, severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that not

getting immediate medical care could result in: (a) placing the patient's health or the health of another person in serious danger or, for a pregnant women, placing the women's health or the health of her unborn child in serious danger; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part. Such conditions include but are not limited to, chest pain, stroke, poisoning, serious breathing problems, unconsciousness, severe burns or cuts, uncontrolled bleeding, or seizures and such other acute conditions as may be determined to be Emergencies by us.

3. Types of Reviews Applicable to Your Plan

- **Continued Stay / Concurrent Review -** A Utilization Review of a service, treatment or admission for a benefit coverage determination which must be done during an ongoing stay in a facility or course of treatment.

  Continued Stay / Concurrent Reviews may be considered urgent when, in the view of the treating Provider or any Physician with knowledge of your medical condition, without such care or treatment, your life or health or your ability to regain maximum function could be seriously threatened or you could be subjected to severe pain that cannot be adequately managed without such care or treatment. Urgent reviews are conducted under a shorter timeframe than standard reviews.

- **Post-service Review –** A review of an admission for a benefit coverage that is conducted after the service has been provided. Post-service reviews are done for an admission in which we have a related clinical coverage guideline and are typically initiated by us.

4. Reviewing Where Services Are Provided

A service must be Medically Necessary to be a covered service. When level of care, setting or place of service is reviewed, services that can be safely given to you in a lower level of care or lower cost setting / place of care, will not be Medically Necessary if they are given in a higher level of care, or higher cost setting / place of care. This means that a request for a service may be denied because it is not Medically Necessary for the service to be provided where it is being requested. When this happens the service can be requested again in another place and will be reviewed again for Medical Necessity. At times a different Provider or Hospital may need to be used in order for the service to be considered Medically Necessary. Examples include, but are not limited to: A service may be denied on an inpatient basis at a Hospital but may be approvable if provided on an outpatient basis at a Hospital.

Utilization Review criteria will be based on many sources including medical policy and clinical guidelines. Anthem may decide that a treatment that was asked for is not Medically Necessary if a clinically equivalent treatment that is more cost effective is available and appropriate. "Clinically equivalent" means treatments that for most Members, will give you similar results for a disease or condition.

5. How Decisions are Made

We use our clinical coverage guidelines, such as medical policy, clinical guidelines, and other applicable policies and procedures to help make our Medical Necessity decisions. Medical policies and clinical guidelines reflect the standards of practice and medical interventions identified as proper medical practice. We reserve the right to review and update these clinical coverage guidelines from time to time.

You are entitled to ask for and get, free of charge, reasonable access to any records concerning your request. To ask for this information, call the Precertification phone number on the back of your Identification Card.

If you are not satisfied with our decision under this section of your benefits, please refer to the "Grievance and External Review Procedures" section to see what rights may be available to you.

6. Decision and Notice Requirements

We will review requests for benefits according to the timeframes listed below. The timeframes and requirements listed are based on state and federal laws. Where state laws are stricter than federal laws, we will follow state laws. If you live in and/or get services in a state other than Connecticut, other state-specific requirements may apply. You may call the phone number on the back of your Identification Card for more details.

Type of Review	**Timeframe Requirement for Decision and Notification**
Request for Medical Services	
Urgent Continued Stay / Concurrent Review when request is received more than 24 hours before the end of the previous authorization	24 hours from the receipt of the request
Urgent Continued Stay / Concurrent Review when request is received less than 24 hours before the end of the previous authorization or no previous authorization exists	72 hours from the receipt of the request
Non-urgent Continued Stay / Concurrent Review for ongoing outpatient treatment	15 calendar days from the receipt of the request
Post-service Review	30 calendar days from the receipt of the request

Request for Mental Health and Substance Abuse Services	
Urgent Continued Stay / Concurrent Review	24 hours from the receipt of the request
Non-urgent Continued Stay / Concurrent Review for ongoing outpatient treatment	15 calendar days from the receipt of the request
Post-service Review	30 calendar days from the receipt of the request

If more information is needed to make our decision, we will tell the requesting Provider of the specific information needed to finish the review. If we do not get the specific information we need by the required timeframe, we will make a decision based upon the information we have.

We will notify you and your Provider of our decision as required by state and federal law. Notice may be given by one or more of the following methods: verbal, written, and/or electronic.

F. Grievance and External Review Procedures

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

1. Member Services

You may have questions about your health benefit plan. If you need help you can call or write Member Services.

Questions?	Member Services is available to explain policies and procedures; and answer your questions about membership, benefits, or claims.
Member Services Number:	Toll free in and outside of Connecticut – 1 (800) 633-6673 This number can always be found on the back of your Identification Card
Home Office Address:	You may write or visit our home office during normal business hours at Anthem Blue Cross Blue Shield, Member Services, 108 Leigus Road, Wallingford, CT 06492

Normal Business hours:	Monday through Friday – 8:00 a.m. to 5:00 p.m.
What you will need when you call:	Please have your Identification Card with your ID number on hand. If your question involves a claim; we will need to know the date(s) of service, the name of the Provider, and the charges involved.

2. Rights Available to Members

You may ask for and get copies of all documents including the actual benefit provision, guideline, protocol or other similar criterion on which an adverse coverage decision was based. If you prefer, any other person you choose may ask for this information. We will send this information within five business days after receiving your request. We will send this information within one calendar day after receiving your request about a final adverse coverage decision for:

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

We will send the information by fax, electronic means or any other fast method.

If you don't agree with our coverage decision, you have the right to ask for a grievance. The review of your grievance may change our previous coverage decision.

3. Other Helpful Resources

Whether or not you use the grievance rights available to you, you may contact the Consumer Affairs Division of the Connecticut Insurance Department or the Connecticut Office of the Health Care Advocate at any time. You may also benefit from free assistance with filing a grievance.

Consumer Affairs Division of the Connecticut Insurance Department

Address:	P.O. Box 816 Hartford, CT 06142-0816
Phone:	860-297-3900 (local) 800-203-3447 (toll-free)
Email:	insurance@ct.gov

Connecticut Office of the Health Care Advocate

Address:	P.O. Box 1543 Hartford, CT 06144
Phone:	866-466-4446 (toll-free)
Email:	Healthcare.advocate@ct.gov

4. If You Have a Complaint or An Appeal

We want your experience with us to be as positive as possible. There may be times, however, when you have a complaint, problem, or question about your plan or a service you have received. In those cases, please call Member Services at the phone number on your ID card. We will try to resolve your complaint informally. If you are not satisfied with the resolution of your complaint, you have the right to file a grievance (also known as an appeal). You must file a grievance within 180 calendar days from the date you get a decision from us that you do not agree with. The review of your grievance may change our previous coverage decision.

Include the following details with your grievance if you have them:

- The member's name and ID number;
- The name of the provider who will or has provided care;
- The date(s) of service;
- The claim or reference number for the specific decision with which you don't agree;
- The specific reason(s) why you don't agree with the decision; and
- Any written comments, documents or other relevant information to support the request.

At any time, you can name someone to act for you. You must do this in writing.

To file a grievance, you, your doctor, or any person you choose (your authorized representative) can request a grievance in writing or by calling Member Services at the phone number on your ID card. Your grievance should be sent to one of the following addresses:

For Medical Issues:
Anthem Blue Cross and Blue Shield
Grievances and Appeals
P.O. Box 1038
North Haven, CT 06473-4201

For Mental Health and Substance Abuse Issues:
Anthem Blue Cross and Blue Shield
Grievances and Appeals
P.O. Box 2100
North Haven, CT 06473-4201

5. How are Grievances Handled?

If your grievance is based on medical necessity, the appropriate clinical peer will review it. A clinical peer is a doctor or other health care professional who holds a non-restricted license in a state of the United States and in the same or similar specialty as typically manages the medical condition, procedure or treatment under review. For a substance use or mental health disorder, the clinical peer will have additional qualifications. All relevant information given to us by you or on your behalf will be reviewed regardless of

whether it was considered at the time the initial decision was made. If your grievance involves a substance use or mental health disorder, we will use the required criteria to review your request.

If your grievance is not based on medical necessity, we will send it for appropriate administrative review.

We may reach out to any providers who may have additional information to support your grievance. The reviewers will not have been involved in the initial decision. They also will not be a subordinate (in a lower position) of the person who made the initial decision.

Before issuing a decision on a grievance of an adverse coverage decision based on medical necessity, we will give you, free of charge, any new or additional evidence relied upon or scientific or clinical rationale. We will give you this information in advance of the grievance resolution date. This will allow you a reasonable amount of time to respond before that date.

6. Standard (Non-urgent) Grievance

You may ask for a standard grievance (a grievance that is not urgent) for a coverage decision you don't agree with. You can also ask for a standard grievance for a rescission (ending or canceling) of coverage. Your request must be in writing. In your request, please let us know that you are asking for a grievance. Include any additional information you have to support your request.

We will respond to a grievance for a medical necessity decision within 30 calendar days from the date we get the request. If the decision is not based on medical necessity, we will respond within 20 business days from the date we get the request. Our response will be in writing.

7. Urgent (Expedited) Grievances

An urgent grievance is available if you have not had or are currently receiving services and the timeframe of a standard grievance review could:

- Seriously jeopardize (harm) your life or health;
- Jeopardize your ability to regain maximum function; or
- In the opinion of a health care professional with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the health care service or treatment being requested.

We will let you know our decision within 72 hours of receiving a request for an urgent grievance described in this section. We will let you know our decision by phone, fax, or any other available means.

For urgent grievances related to Mental Health and Substance Abuse disorders please see the next section.

While you may file an urgent grievance in writing, we encourage you to call Member Services with this type of request. This will help us handle the review fast.

8. Mental Health Disorder and Substance Use Disorder

An urgent grievance is also available for:

- Substance use disorder or co-occurring mental health disorder; or
- Inpatient services, partial hospitalization, residential treatment, or intensive outpatient services needed to keep a covered person from requiring an inpatient setting in connection with a mental health disorder.

We will let you know our decision within 24 hours of receiving a request for an urgent grievance described in this section. We will let you know our decision by phone, fax, or any other available means.

While you may file an urgent grievance in writing, we encourage you to call Member Services with this type of request. This will help us handle the review fast.

9. External Review

External Review with the Connecticut Insurance Department

If we deny your request for coverage for a health care service or treatment, you may have the right to have our decision reviewed by health care professionals who have no association with us. You may file for external review with the Office of the Insurance Commissioner if a coverage decision involves making judgment as to the medical necessity appropriateness, health care setting, level of care or effectiveness of the health care service or treatment requested. You may file for an external review at any time within 120 days of the date you get an adverse or final adverse decision.

Bypassing Anthem Blue Cross and Blue Shield's internal grievance process:

You may be able to bypass our internal grievance process and file a request for an expedited external review with the Connecticut Insurance Department within 120-days of the date you get a decision from us that you don't agree with if any of the following circumstances apply:

- If the covered person has a medical condition for which the time period for completion of an expedited internal review of a grievance involving an adverse determination would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function, the covered person or the covered person's authorized representative may file a request for an expedited external review; or
- If the adverse determination involves a denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational and the covered person's treating health care professional certifies in writing that such recommended or requested health care service or treatment would be significantly less effective if not promptly initiated; or

- We the health carrier failed to strictly adhere to the requirements with respect to receiving and resolving grievances involving an adverse determination, the covered person shall be deemed to have exhausted the internal grievance process of such health carrier and may file a request for an external review, regardless of whether the health carrier asserts that it substantially complied with the requirements of this section, or that any error it committed was de minimis.
- We the health carrier have waived our internal grievance process.

You, or your provider acting on your behalf with your consent, may also simultaneously file a request for an internal grievance and an urgent external review with the Connecticut Insurance Department Consumer Affairs Unit. You can request an external review if you meet any of the above requirements otherwise you must wait until Denial of the Health Carriers first level of internal appeal. Please contact the State of Connecticut Insurance Department for more information:

	Connecticut Insurance Department
Address:	P.O. Box 816
	Hartford, CT 06142-0816
Phone:	1-860-297-3910 (local)
	1-800-203-3447 (toll-free)

If you ask for an urgent external review with the Connecticut Insurance Department at the same time as an urgent grievance with us, the Independent Review Organization (IRO) assigned to your review by the Insurance Commissioner will decide if you must finish the urgent internal review with us before moving forward with the urgent external review.

An External Review Guide and application are available on the Department's website, www.ct.gov/cid.

10. Requirement to file an Appeal before filing a lawsuit

No lawsuit or legal action of any kind related to a benefit decision may be filed by you in a court of law or in any other forum, unless it is commenced no earlier than 60 days after we receive the claim or other request for benefits and within three years of our final decision on the claim or other request for benefits. If we decide an appeal is untimely, our latest decision on the merits of the underlying claim or benefit request is the final decision date. You must exhaust our internal appeals process before filing a lawsuit or other legal action of any kind against us.

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