Certificate of Coverage

Coinsurance Dental Plan

anthem.com

Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente que aparece al dorso de su tarjeta de identificación o en el folleto de inscripción.

Anthem BlueCross BlueShield

33903CTMENABS 11/12

Form: 1043 (1/2013)

Anthem BlueCross BlueShield
108 Leigus Road, Wallingford, CT 06492

COINSURANCE DENTAL

Issued By:
Anthem Blue Cross and Blue Shield
108 Leigus Road
Wallingford, CT 06492

Vernon Board of Education
Firm #005241-046

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2011-2012 MANDATES AMENDMENT

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

Flexible Dental
Full Dental Plan
Coinsurance Dental Plan
PPO Preventive Dental Plan
PPO Preventive Plus Dental Plan
USA Dental Plan

including any affected riders, endorsements or other amendments thereto, (hereinafter collectively, ”Certificate”) issued by ”Anthem BCBS” as required by law. This Amendment is to be attached and form a part of your Certificate. This Amendment does not extend, vary, change, or waive any of the terms, benefits, exclusions, limitations, or conditions in the Certificate except as shown in this Amendment.

Dental Services or Procedures

Dental Benefits – : The Dental Benefits section of the your Dental Certificate is hereby amended with the addition of the following:

IMPORTANT: If you opt to receive dental services or procedures that are not covered benefits under this plan, a participating dental provider may charge you his or her usual and customary rate for such services or procedures. Prior to providing you with dental services or procedures that are not covered benefits, the dental provider should provide you with a treatment plan that includes each anticipated service or procedure to be provided and the estimated cost of each such service or procedure. To fully understand your coverage, you may wish to review your evidence of coverage document.

INTRODUCTION

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

Member Services / Customer Service

For information and assistance, a Member may call or write Anthem BCBS's Member Services / Customer Service.

Questions?	Member Services / Customer Service is available to explain policies and procedures; and answer questions about available benefits or services.
Suggestions, Concerns, or Complaints:	We hope that you will always be satisfied with the level of service provided to you and your family. We realize, however, that there may be times when problems arise and miscommunications occur which may lead to feelings of dissatisfaction. As a Member, you have the right to express any dissatisfaction, suggestions, or concerns to us. Please contact Member Services / Customer Service to tell us your problem and we will work to resolve it for you as quickly as possible.
Member Services / Customer Service Telephone Number:	Toll free in and outside of Connecticut – 1 (800) 545-0948 The Member Services / Customer Service telephone number is also on your Identification (ID) Card.
Home Office Address:	You may visit our home office during normal business hours Anthem Blue Cross and Blue Shield 108 Leigus Road, Wallingford, CT 06492
Normal Business hours:	Monday through Friday – 8:00 a.m. to 5:00 p.m.

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

How to Obtain Language Assistance

Anthem BCBS is committed to communicating with our Members about their health plan, regardless of their language. Anthem BCBS employs a language line interpretation service for use by all of our Member Services / Customer Service call centers. Simply call the Member Services / Customer Service phone number on the back of your ID card and a representative will be able to assist you. Translation of written materials about your benefits can also be requested by contacting Member Services / Customer Service. TTY/TDD services also are available by dialing 711. A special operator will contact Anthem to help with member needs.

SCHEDULE OF DENTAL BENEFITS

Coinsurance Dental Services

BENEFITS	IN-NETWORK SERVICES
COINSURANCE BASIC BENEFITS	80% of the Maximum Allowable Amount

COVERED SERVICES	IN-NETWORK SERVICES
Oral examination, including Treatment Plan	
Bitewing x-rays	1 series of 2 per Member per Calendar Year
Periapical x-rays	
Topical fluoride application	2 per Member per Calendar Year for Members under age 19
Prophylaxis (cleaning) or periodontal maintenance procedure	Combination of 2 per Member per Calendar Year
Relining of dentures	1 per Member in any 2 consecutive years
Repairs of broken removable dentures	1 repair per Member per Calendar Year
Palliative emergency treatment	
Routine fillings	1 per tooth surface in any consecutive 12-month period
Stainless steel crowns (primary teeth)*	1 per tooth in 5 years
Simple extractions**	
Endodontics, including pulpotomy, direct pulp capping and root canal therapy (excluding restoration)	

* Payment for an inlay, onlay or crown will equal the amount payable for a three-surface amalgam filling when the Member is not covered by Rider A - Additional Basic Benefits.

** Payment for a surgical extraction or a hemisection with root removal will equal the amount payable for a simple extraction when the Member is not covered by Rider A - Additional Basic Benefits.

Participating Dentist Benefits

Anthem BCBS will pay the lesser of 80% of the Dentist's usual charge or 80% of the Maximum Allowable Amount as determined by Anthem BCBS. The Participating Dentist will accept Anthem BCBS's payment in full and make no additional charge to the Member, except as otherwise specified in this Section.

Non-Participating Dentist Benefits

Anthem BCBS will pay 80% of the Maximum Allowable Amount as determined by Anthem BCBS. The Member is responsible for any difference between the amount paid by Anthem BCBS and the fee charged by the Dentist.

DEFINITIONS

ACTIVELY AT WORK: The term Actively At Work means the employee must work at the employer group's place of business or at such place(s) as normal business requires. The employee must perform all duties of the job as required of a full-time, employee working 15 or more hours per week on a regularly scheduled basis (unless otherwise agreed upon by Anthem BCBS and the Policyholder). Eligible employees who do not satisfy the criteria, solely due to a health-related reason, are considered Actively At Work for purposes of initial eligibility under the Benefit Program.

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.

BENEFIT PERIOD: The term Benefit Period means the consecutive extent of time for which benefits are payable. Unless otherwise defined as a period of days in the Schedule of Benefits, the Benefit Period is the period established in the Policy Section: Acceptance.

BENEFIT PROGRAM: The term Benefit Program means the program of Dental Care benefits identified on the cover page of this Policy and described herein.

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

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

C.G.S.: The term C.G.S. means Connecticut General Statutes, as amended from time to time.

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

COST SHARE (COST SHARING): The term Cost-Share means the amount which the Member is required to pay for Covered Services.

COVERED PERSON: The term Covered Person means an Eligible Person as defined in the Eligibility Section, who has been accepted for membership under this Policy.

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

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

CREDITABLE COVERAGE (PROOF OF PRIOR COVERAGE): The term Creditable Coverage means health coverage provided through an individual policy, a self-funded or fully insured group health plan offered by a public or private employer, Medicare, Medical Assistance, General Assistance Medical Care, the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), Federal Employees Health Benefit Plan (FEHBP),

Medical Care Program of the Indian Health Service of a tribal organization, a state health benefit risk pool, a State Children's Health Insurance Program (S-CHIP), a qualified Public Health Plan or a Peace Corp health plan.

DENTAL CONSULTANT: The term Dental Consultant means a Dentist who has agreed to provide consulting services in connection with a covered dental treatment or service.

DENTAL EMERGENCY: The term Dental Emergency means acute pain or a condition requiring immediate treatment of the oral condition but does not produce a definitive cure including, but not limited to, any diagnostic and palliative procedures to:

a. stop bleeding;
b. open and clean an infection; and/or
c. relieve pain.

DENTIST: The term Dentist means any licensed Dentist (D.D.S., D.M.D.) who is actively engaged in the practice of Dentistry, including but not limited to the following:

a. **Endodontist:** a Dentist whose practice is limited to treating disease and injuries of the pulp and associated periradicular conditions.
b. **Periodontist:** a Dentist whose practice is limited to the treatment of diseases of the supporting and surrounding tissues of the teeth.
c. **Prosthodontist:** a Dentist whose practice is limited to the restoration of the natural teeth and/or the replacement of missing teeth with artificial substitutes.

DENTISTRY: The term Dentistry (Dental Care) means:

a. the diagnosis and treatment of diseases or lesions of the mouth and surrounding and associated structures;
b. replacement of lost teeth by artificial ones;
c. the diagnosis or correction of malposition of the teeth; or
d. the furnishing, supplying constructing, reproducing or repairing any prosthetic denture, bridge appliance or any other structure to be worn in the mouth; or the placement or adjustment of such appliance or structure in the human mouth.

DEPENDENT: The term Dependent means an Eligible Dependent as defined in the Policy Section: Eligibility.

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

ELIGIBILITY: The term Eligibility means qualifying for coverage according to the Policy description of Eligible Person or Eligible Dependent.

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

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

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

   1. Cannot be legally marketed in the United States without the final approval of the Food and Drug Administration ("FDA") or any other state or federal regulatory agency and such final approval has not been granted; or

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

3. Is provided as part of a clinical research protocol or clinical trial or is provided in any other manner that is intended to evaluated the safety, toxicity or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply as Experimental or Investigational or otherwise indicate that the safety, toxicity or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply is under evaluation.

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

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

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

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

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

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

1. Published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or

2. Evaluations of national medical associations, consensus panels. And other technology evaluation bodies; or

3. Documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of drug; biologic; device; diagnostic; product; equipment; procedure; treatment; service; or supply; or

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

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

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

7. Medical records; or

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

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

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

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

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

a. Participating Dentist: Except as otherwise provided by law, an amount agreed upon by Anthem BCBS and a Participating Dentist as full compensation for Covered Services provided to a Member. When applicable, it is the Member's obligation to pay cost-shares as a component of this Maximum Allowable Amount. The amount Anthem BCBS will pay for Covered Services will be the Maximum Allowable Amount or the billed charges, whichever is lower.

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

It is the Member’s obligation to pay Cost-Shares as a component of this Maximum Allowable Amount and amounts in excess of the Maximum Allowable Amount. Please note that the Maximum Allowable Amount may be greater or less than the Participating Dentist’s or Non-Participating Dentist’s billed charges for the Covered Services.

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

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

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

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

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

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

NON-PARTICIPATING DENTIST: The term Non-Participating Dentist means any appropriately licensed Dentist who is not a Participating Dentist under the terms of the Policy.

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

PARTICIPATING DENTIST: The term Participating Dentist means any appropriately licensed Dentist designated and accepted as a Participating Dentist by Anthem BCBS to provide Covered Services to Members under the terms of the Policy.

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

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

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

PROSTHETIC DEVICE: The term Prosthetic Device means any device or appliance replacing one or more missing teeth and/or required associated structures.

REMITTING AGENT: The term Remitting Agent means any individual, Covered Person, partnership, association or corporation which, as agent for the policyholder, has agreed to collect and remit to Anthem BCBS the premiums payable hereunder. Such Remitting Agent may be the Covered Person's Employer Group or may represent such Employer Group. In no case, however, shall the Remitting Agent be or be construed to be the agent of Anthem BCBS.

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

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

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

Anthem BCBS will determine if a Member is Totally Disabled under the terms of the Policy. The Covered Person must provide proof of continued disability if Anthem BCBS requests it.

TREATMENT PLAN: The term Treatment Plan means a written report showing the diagnosis and recommended treatment of any dental disease, defect or injury prepared for a Member by a Dentist as a result of any examination made by such Dentist while the Member is covered under this Policy. A Treatment Plan for pre-determination of benefits may be submitted if the anticipated Covered Services in a course of treatment exceed $200.

ELIGIBILITY

Eligible Person

An Eligible Person is:

1. a current employee who is employed full time, defined as working at least 15 hours a week on a regularly scheduled basis (unless otherwise mutually agreed upon by Anthem BCBS and the Policyholder) and who is Actively At Work on the date of eligibility for benefits for Covered Services is to be effective, or

2. a current employee who is not Actively At Work due to a work related injury and the employee is receiving Worker's Compensation benefits under the former employer's Worker's Compensation plan, or

3. a former employee who elects to continue enrollment as required by the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, or under the Connecticut Continuation Rights, C.G.S. 38a-554, or

4. a retiree of the Policyholder who meets the Policyholder's criteria for Eligibility for group coverage, who is entitled to group health coverage under a trust agreement or comparable agreement, and who is eligible for benefits for Covered Services under this Policy by mutual agreement of Anthem BCBS and the Policyholder.

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

Eligible Dependent

An Eligible Dependent is:

1. the lawful spouse of the Covered Person under a legally valid, existing marriage, or civil union, or

2. the unmarried, under age 25, dependent child of the Covered Person or lawful spouse, including a step-child, a child legally placed for adoption and a legally adopted child, or

3. the unmarried, under age 25, dependent child for whom the Covered Person or lawful spouse has been appointed by the court as legal guardian or for whom the Covered Person or lawful spouse has been designated as the responsible party under a Qualified Medical Child Support Order, or

4. a newborn infant of a Covered Person or enrolled Dependent who shall be eligible for benefits for Covered Services from birth through age 31 days under the Policy of their parent, subject to any applicable managed care or managed benefits provisions of this Policy. An infant age 32 days or over who meets the criteria in B.2. or B.3. is eligible for benefits for Covered Services as a dependent child, or

5. The unmarried, disabled dependent child of the Covered Person or lawful spouse. Disabled means that the child is incapable of sustaining employment by reason of physical or mental handicap. The disabled child may continue as a Dependent beyond the age limit set forth in this Policy provided:

a. proof of disability is submitted and accepted by Anthem BCBS within 31 days of the date the child's Eligibility for benefits for Covered Services would have terminated in the absence of such disability for whom Anthem BCBS may require proof of disability no more than annually thereafter, and

b. the child became disabled prior to the age limit for a Dependent child set forth in the Policy under which the child was eligible for benefits for Covered Services, and

c. the child had comparable coverage as a dependent at the time of application for Eligibility for benefits for Covered Services, and

The dependent child age limits shall be extended beyond the aforementioned ages if Anthem BCBS and Policyholders have mutually agreed upon such an extension.

6. Qualified Medical Child Support Orders (QMCSO) - A Dependent child may become eligible for benefits for Covered Services as a consequence of a domestic relations order issued by a state court to a divorced parent who is a Member. Enrollment may be required even in circumstances in which the child was not previously enrolled under this Policy and might not otherwise be eligible for coverage. For further information concerning medical child support orders, and the employer group's procedures for implementing such orders, the Member should contact the employer group's benefits coordinator or the administrator of the employer group's health care benefits plan.

Initial Date Of Eligibility And Effective Date

1. If an annual open enrollment period is mutually agreed to by Anthem BCBS and the Policyholder, applications from Eligible Persons and their dependents shall be effective as of the Policy renewal date provided such applications are submitted and accepted by Anthem BCBS in advance of the renewal date. Applications received or accepted after the renewal date shall not be considered until the next annual open enrollment period.

2. Applications from newly Eligible Persons and newly Eligible Dependents may be submitted in advance of the initial date of Eligibility; however, benefits of Covered Services shall not be effective prior to the initial date of Eligibility. Applications received or accepted by Anthem BCBS more than 31 days from the initial date of Eligibility shall not be considered until the next annual open enrollment period.

   The initial date of Eligibility of newly Eligible Persons and newly Eligible Dependents are as follows:

   a. New hires and their dependents are initially eligible on the first of the month following the employee's completion of 30 days of being Actively AT Work (unless a different waiting period has been mutually agreed upon by Anthem BCBS and the Policyholder).

   b. New spouses and new step-children are initially eligible the first of the month following the date of the marriage of the new spouse to the Covered Person, provided Anthem BCBS receives an application for coverage Anthem BCBS must receive an applicable for coverage within 30 days of the marriage.

   c. Newborn children of the Covered Person or lawful spouse are initially eligible as of the moment of birth. For coverage to continue beyond the first 31 days of life Anthem BCBS must receive an application for coverage within 31 days of the child's birth.

   d. Newly adopted children and children placed for adoption are initially eligible as of the date they enter the household of the Covered Person or lawful spouse. For coverage to continue beyond the first 31 days following placement Anthem BCBS must receive an application for coverage within 31 days of placement.

   e. Dependent children for whom the Covered Person or lawful spouse has been appointed by the court of law as legal guardian or the responsible party under a Qualified Medical Child Support Order are initially eligible as of the date of the court order is in effect. For coverage to continue beyond the first 30 days

following the appointment, Anthem BCBS must receive an application for coverage within 30 days of the date the court order is in effect.

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

3. A Member shall complete and submit to Anthem BCBS such applications or other forms or statements as Anthem BCBS may reasonably request. A Member guarantees that all information contained therein shall be true, correct, and complete to the best of the Member's knowledge and belief and the Member accepts that all rights to benefits under this Policy are conditional upon said guarantees. No statement by the Member in his or her application shall void Eligibility or be used in any legal proceeding unless such application or an exact copy thereof is included in or attached to any Certificate of Coverage.

Eligibility Requirements

1. The Policyholder agrees that retroactive credits, additions, deletions or refunds must be approved by Anthem BCBS.

2. The Policyholder agrees upon request to furnish to Anthem BCBS such information as may be required for underwriting review and to permit an audit of employment records by Anthem BCBS representatives to ensure compliance with underwriting requirements.

3. C.G.S. Section 38a-541 requires that when both the Eligible Person and spouse are employed by the same employer and by reason of employment both participate in the group insurance plan, the benefits described in this Policy will be available to each spouse both as a dependent and as an employee. In no event shall benefits provided under this Policy exceed 100% of charges for covered expenses or services.

4. If the Covered Person is not Actively at Work on the date upon which coverage would otherwise become effective for the Covered Person, the Effective Date of coverage for that Covered Person and Dependents will be deferred until the date that the employee is Actively AT Work.

5. Anthem BCBS has the right to terminate this Policy pursuant to the General Provisions Section, of this Policy, Subsection D.1. of this Policy, if the Policyholder at any time does not meet the eligibility requirements specified in paragraph D.1. above.

DENTAL BENEFITS

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

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

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

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

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

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

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

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

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

Dental Provisions

Benefit Program Description

The following provisions apply to the Dental Benefits under this Plan.

1. The Member is guaranteed the Maximum Allowable Amount when Covered Services are rendered by a Participating Dentist.

2. Benefit maximums are shown on the Schedule of Benefits.

3. Subject to the applicable Co-Pay amounts, the maximum amount of benefits payable for each Member in a Calendar Year is shown in the Schedule of Benefits.

The Dental Benefits listed in the Schedule of Benefits are subject to the following qualifications:

1. Initial Oral Examinations, Diagnosis, and Full Mouth Series of X-rays or Panoramic X-ray with or without Bitewings – Anthem BCBS will provide benefits once per Member in any three consecutive Calendar Years.

2. Topical Fluoride Application for Member under Age 19. Anthem BCBS will provide benefits for two per Member per Calendar Year.

3. Bitewing X-rays – One series of two Bitewing X-rays per Member per Calendar Year.

4. Periapical X-rays.

5. Prophylaxis (cleaning) or Periodontal Maintenance Procedure, including oral hygiene instruction: Twice per Member per Calendar Year. Benefits for Covered Services will not be provided for a combination of more than two (1 prophylaxis and 1 periodontal maintenance procedure or 2 prophylaxis or 2 periodontal maintenance procedures) in the same Calendar Year.

6. Palliative Emergency Treatment – Anthem BCBS will provide benefits for the following services, when rendered on a non-scheduled, emergency basis (not payable when other services are performed on the same date):

   Placement of sedative dressings;
   Treatment of acute oral infections;
   Prescribing of drugs for pain and/or infection;
   Opening of pulp chamber to relieve pain (not part of endodontic procedure).

7. Fillings – Anthem BCBS will provide benefits for the following:

   Amalgam restoration: one per tooth in any consecutive twelve-month period.

8. Endodontics, including Pulpotomy and Direct Pulp Capping and Root Canal Treatment – Anthem BCBS will provide benefits for pulpotomy and direct pulp capping but not when a root canal or extraction is performed on the same tooth within three months. Anthem BCBS will provide benefits for root canal treatment once per tooth in a Member's lifetime.

9. Relining of Dentures – Anthem BCBS will provide benefits once per Member in any two consecutive Calendar Years for a denture reline. Anthem BCBS will not provide benefits for a denture reline within the first twelve months following placement.

10. Repair of Dentures – Anthem BCBS will provide benefits once per Member in any one Calendar Year for a simple denture repair. Anthem BCBS will not provide benefits for extensive reconstruction for the addition of teeth to an existing denture, unless the Member is enrolled in Amendatory Rider B.

11. Stainless Steel Crowns – Anthem BCBS will provide benefits for stainless steel crowns placed on primary teeth.

Other Provisions

1. If during the course of treatment, a case is transferred from one Dentist to another Dentist, or if more than one Dentist renders services for one procedure, Anthem BCBS will provide benefits only in the amount it would have paid if one Dentist had rendered the services.

2. Anthem BCBS reserves the right to review any of the services (s) on a submitted claim to determine which service(s) is/are Covered Services, which service(s) is/are eligible for reimbursement and the applicable amount of reimbursement for such Covered Service(s).

EXCLUSIONS, CONDITIONS AND LIMITATIONS

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

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

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

A. Anthem BCBS will provide benefits only for services:

1. specifically described in this Policy;
2. rendered or ordered by a Dentist;
3. within the scope of the Dentist's licensure; and
4. (4) which constitute Medically Necessary Care for the proper diagnosis and treatment of the Member.

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

Duplicate Coverage and Other Third Party Liability

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

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

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

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

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

- Medicare: If a Member is eligible for Medicare, and still covered under this Policy, Anthem BCBS will provide the benefits of this Policy, except as required by law. However, these benefits will be reduced to

an amount which, when added to the benefits received pursuant to Medicare, may equal, but not exceed the actual charges for services covered in whole or in part by either this Policy or Parts A and B of Medicare.

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

1. House calls.

2. Any services for or related to the diagnosis, care or treatment of temporomandibular joint dysfunction, (TMJ or TMD).

3. Orthognathic surgery.

4. Use of any Experimental or Investigational diagnosis, treatment, procedure, facility, equipment, drugs, drug usage, devices or supplies. Any service associated with or as follow-up to any of the above is not a Covered Service.

5. Replacement of Prosthetic Devices due to loss or theft.

6. Application of sealants, regardless of reason.

7. General anesthesia (deep sedation) and intravenous sedation.

8. Any hospital or inpatient facility fee resulting from services performed in a hospital or inpatient facility.

9. Cosmetic surgery or services performed solely to improve appearance and not designed to restore body function or to correct deformity resulting from the treatment of malignancy or physical trauma.

10. Any services for or related to a self-inflicted injury.

11. Any services for or related to an injury or condition for which benefits exist under Worker's Compensation or occupational disease.

12. Any services for or related to a dental treatment which is provided by a federal or state agency.

13. Benefits for services resulting from war or any act of war, whether declared or undeclared, or while in the armed forces of any country.

14. Benefits for services which are covered under Medicare or the Social Security Act.

15. Any service or supply performed without functional or pathological need.

16. Myofunctional therapy.

17. Removal of third molar (wisdom teeth) where there is no evidence of disease.

18. Any supplies intended for home use (e.g. toothbrush, dental floss, mouthwash, irrigators).

19. Any services received from a dental or medical department maintained by an employer, a mutual benefit association, labor union, trustee or other similar person or group.

20. Any services for which the Member incurs no liability, or which are services ordinarily performed by a physician (M.D.), or charges which would not have been made if insurance was unavailable.

21. Any services related to congenital malformations, deformities and deficiencies.

22. Any services, treatment or supplies furnished by or at the direction of any government, state or political subdivision.

23. Lost or stolen dentures or denture application.

24. Gold foil restorations.

25. Temporary appliances or services, such as crown or tooth preparation and temporary fillings, crowns, bridges, and dentures.

26. Any services that are rendered in a manner contrary to accepted dental practice, as determined by Anthem BCBS in its sole discretion.

27. Any services which are performed due to occlusal wear, erosion, abrasion, and/or surface defects of the teeth or to alter or correct vertical dimensions.

28. Implants and/or crowns and fixed bridgework placed on implants.

29. Pins, fillings and build-ups and/or post and cores which are placed under crown or bridge abutments.

30. Any services rendered by a Dentist to himself or herself or services rendered to his or her immediate family including parents, spouse and children.

31. Extensive reconstruction to denture bases involving any attachments and/or complete rebasing.

32. Prescription drugs.

33. Services or procedures which are not completed prior to submission of the claim.

34. Periodontal splinting or crowns splinted together for any reason.

35. Space maintainers for any reason other than premature loss of primary teeth.

36. Charges made by other than a dentist or for dental treatment by other than a dentist, except in the event of cleaning or scaling of teeth which is performed b a licensed dental hygienist and such treatment is furnished under the supervision and direction of a dentist.

37. Charges incurred while the Member was not covered under the Policy.

38. Any dental services payable under any other coverage provided under this Policy, or under any other plan provided by Anthem BCBS or employer of the Member or dependent in respect to whom such expenses would have otherwise been covered Dental Benefits under this Policy.

39. Charges incurred for the failure to keep a scheduled appointment with the Dentist.

40. Instruction for oral care such as hygiene or diet.

41. Charges by a Dentist for completing dental forms.

42. Tooth implantation or reimplantation

43. Tissue biopsy.

44. Surgical repositioning.

45. Vestibuloplasty.

46. Excision of bone tissue.

47. Surgical incisions.

48. Diagnostic casts and photographs.

49. Removable and fixed appliances to control harmful habits (i.e. thumb sucking, tongue thrusting).

50. Occusal adjustments.

51. Any items or procedures not specifically listed in this Policy.

52. Replacement of fixed or removable Prosthetic Devices which are less than five years old (if Plan specifies coverage for prosthodontics).

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

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

E. In addition to the list of dental benefit exclusions above, the following exclusions also apply:

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

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

3. Anthem BCBS will not provide benefits for any and all expenses related to cosmetic surgery or procedures performed primarily to improve appearance and not designed to restore body function or to correct deformity resulting from the treatment of malignancy or physical trauma; unless otherwise determined by Anthem BCBS to be Medically Necessary.

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

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

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

7. No benefits will be provided for Covered Services rendered before the Member's Effective Date under this Policy.

8. If subject to an approved Treatment Plan in the Schedule of Benefits, only services rendered in accordance with the Treatment Plan are Covered Services.

9. No benefits will be available for maintenance care which is 1) treatment provided for the Member's continued well-being by preventing deterioration of the Member's chronic clinical condition; and 2)

maintenance of an achieved stationary status which is a point where little or no measurable objective improvement in musculo-skeletal function is effectuated despite therapy.

10. Reimbursement of benefits for procedures billed under unspecified Physician's Current Procedural Terminology (CPT) or Dentist's American Dental Association (ADA) codes will be denied.

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

COORDINATION OF BENEFITS

All benefits provided under this Policy are subject to Coordination of Benefits as described in this Section.

Definitions

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

CLAIM DETERMINATION PERIOD: The term Claim Determination Period means a Calendar Year. This period will not begin before or extend after the period in which a Member was covered by this Policy.

COVERED SERVICE: For the purposes of this Section, the Meaning of Covered Service is amended to include services covered in whole or in part under any plan in which a Member is enrolled. The reasonable cash value of each Covered Service will be deemed the benefit. Benefits payable under other Plans include Benefits that would have been payable if a claim had been made.

PLAN: For the purposes of this Section, the meaning of Plan is amended to include a description of how it is applied. The term Plan is applied separately, with respect to each arrangement for benefits or services and to that portion of any arrangement which reserves the right to take the benefits or services of other Plans into consideration, in the determination of benefits, whole or in part.

Conditions And Rules For Coordination Of Benefits

For Covered Services received during any claim Determination Period, payable under this Policy and any other Plan, the following conditions apply:

1. Anthem BCBS will reduce its benefit payment by the amount in which payable benefits exceed the charges for Covered Services.

2. If another Plan contains a provision of coordination of its benefits with this Policy such that the benefits of this Policy are to be determined first, Anthem BCBS will pay benefits according to this Policy's rules without regard to the other Plan's benefits.

3. Benefits are payable first, according to the following rules, when the benefits of a Plan cover a Member as:

    a. other than a Dependent.

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

       The use of the earlier birthday will apply except when the Member is a child Dependent of divorced or separated parents in which a court decree or custody overrides this rule.

    c. as the child Dependent of a Member to which a court decree places the financial responsibility for medical, dental and other health care.

    d. as the child Dependent of a Member with custody of the child, in the event of no court decree and no remarriage of the Member.

e. as the child Dependent of a Member with custody who has remarried, the following benefit priority applies: the Member (parent with custody), the stepparent (spouse of Member with custody); then the parent without custody.

4. When the determination for payment of benefits cannot be clearly made based on rules 3. a through e, above, the following rule of duration applies:

   Benefits are payable first under this Policy if the benefits of this Policy covered the Member whose expense the claim is based on for the longer period of time, except when this Policy covers Members who are laid-off or retired.

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

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

Right To Receive And Release Necessary Information

Information is obtained or released in the determination and implementation of the Coordination of Benefits Section of this Policy, or that of another Plan. Anthem BCBS may without notice to the Member and without the Member's consent, release or obtain information which Anthem BCBS feels is necessary from another Plan, organization, or person. Any Member claiming benefits under this Policy must furnish information to Anthem BCBS which Anthem BCBS determines is necessary for the Coordination of Benefits.

Facility Of Payment

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

Right Of Recovery

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

2. The Covered Person personally and on behalf of his or her Dependents will, upon request, execute and deliver such documents as may be required and do whatever else is necessary to secure Anthem BCBS's rights to recover excess payments. The Covered Person's failure to comply may result in a withdrawal of benefits already provided or a denial of benefits requested.

GENERAL PROVISIONS

Entire Policy - Changes Or Amendments

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

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

Benefits To Which Members Are Entitled

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

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

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

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

Records Of Member Eligibility And Changes In Member Eligibility

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

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

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

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

Termination Of The Policy

1. This Policy may be terminated in accordance with applicable law at the option of the Policyholder without cause upon delivery of 15 days prior written notice to the other party, to be effective the first of the month following the expiration of the 15 day notice period.

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

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

4. Anthem BCBS may not renew this Policy in the event the Policyholder fails to meet the participation or contributory requirements stated in the Group Health Care Benefits Contract and as stated below: during the policy period for more than 60 continuous days.

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

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

   Participation Requirements

   A. 1-50 Eligible Employees

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

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

   Participation Requirement:

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

   *exclusive of employees waiving coverage due to spousal coverage

   B. 51+ Eligible Employees

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

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

Participation Requirement:

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

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

6. During the first two years following the effective date of the policy, Anthem BCBS may rescind, cancel or limit the Benefit Program if Anthem BCBS, determines after completing underwriting, there was information submitted by or omitted on behalf of the Employer Group during the initial application and enrollment process, and such information was material to the acceptance of the application at the time submitted to Anthem BCBS. Such information may include, but is not limited to, information regarding eligibility of the Employer Group or any Members to receive coverage under the Benefit Program. The date of rescission shall be the Effective Date of the Benefit Program.

7. The termination, expiration, non-renewals or cancellation of the Group Health Care Benefits Contract by the Contractholder or Anthem BCBS will automatically result in the termination of each Covered Person's or Dependent's right to coverage and benefits under this Benefit Program.

Grace Period

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

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

Termination Of Member's Coverage Under The Policy

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

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

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

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

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

   - marries; or
   - is no longer dependent on the Covered Person for support; or
   - reaches the limiting age allowed under the Policy unless the child is physically or mentally handicapped; or
   - reaches the limiting age allowed for a full-time student at a recognized college, university or trade school, or whichever event occurs first.

   It is the sole responsibility of the Covered Person to notify Anthem BCBS of any change in a Dependent's status.

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

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

4. The Policyholder must give the Members 15 days prior notice in the event this Policy is canceled or discontinued. If other coverage is substituted for this Policy, the Policyholder must notify the Covered Person.

5. Following the effective date of the policy, Anthem BCBS may rescind, cancel or limit the Benefit Program; if the Member has submitted false information to Anthem BCBS, or omitted information during the application and enrollment process concerning eligibility, insurability or health status and such information was material to the underwriting of the application at the time submitted and acceptance by Anthem BCBS of that application for coverage.

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

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

   In the event that Anthem BCBS failed to complete underwriting with respect to health status prior to the acceptance of the application for coverage by Anthem BCBS, Anthem BCBS must obtain prior approval from the Insurance Department to rescind, cancel or limit the policy. The Benefit Program may not be rescinded, cancelled or limited more than 2 years after the effective date of the policy. The date of rescission shall be the Effective Date of the Benefit Program.

Continuation Options

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

1. Connecticut Continuation Rights, C.G.S. Section 38a-538 and 38a-554

   a. As provided by Connecticut law, (Connecticut Continuation Rights, C.G.S. Section 38a-538 and 38a-554) the Policyholder shall allow a Member and his or her Dependents who become ineligible for continued participation under this Policy to elect to continue coverage as described below.

- Upon termination of the Covered Person's employment, other than as a result of death or the gross misconduct of the Covered Person, the Covered Person and his or her Dependent may continue coverage until the end of 18 months following the day on which he or she ceased to be eligible for coverage under this Policy;

- Upon the Covered Person's death, his or her Dependent may continue coverage until the end of 36 months following the day on which they ceased to be eligible for coverage under this Policy;

- Upon dissolution of the Covered Person's marriage, his or her Dependent may continue coverage until the end of 36 months following the day on which they ceased to be eligible for coverage under this Policy.

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

b. Upon the Covered Person's absence from employment due to illness or injury, a Member and his or her Dependents may continue during the course of such illness or injury or for up to 12 months from the beginning of such absence.

c. Upon termination of the Policy by the Policyholder or Anthem BCBS, benefits for Covered Services for a Member who was Totally Disabled on the date of termination shall be continued without premium payment during the continuance of such disability for a period of 12 months following the month in which the Policy was terminated, provided the claim is submitted within one year of termination of the Policy.

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

e. A Member is required to provide timely notice to the Policyholder of his or her election to continue coverage. Except as provided in (c) above, a Member who continues coverage may be required to remit the applicable premium payment to the Policyholder. Payment of such premiums need not be made on behalf of the Member by the Policyholder if they are not received by the Policyholder on a timely basis. Failure of the Member to remit such premium may result in termination.

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

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

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

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

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

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

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

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

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

i. The Member becomes eligible for benefits under another group health plan as a result of employment, re-employment, or marriage, except when the new plan contains any exclusion or limitation relating to any pre-existing condition of the Member; or

ii. The premium for continuation of coverage is not paid on time; or

iii. The Member becomes entitled to Medicare benefits; or

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

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

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

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

- The 24 months beginning on the first date of your absence from work; or
- The day after the date on which you fail to apply for or return to a position of employment.

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

Notice Of Claim

1. Anthem BCBS will not be liable under this Policy unless proper notice is furnished to Anthem BCBS that Covered Services have been rendered to a Member. Written notice must be given within 60 days after completion of the Covered Services. The notice must include the data necessary for Anthem BCBS to determine benefits. An expense will be considered incurred on the date the service or supply was received.

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

Information Practices Notice

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

- Anthem BCBS may collect personal information about a Member from persons or entities other than the Member.

- Anthem BCBS may disclose Member information to persons or entities outside of Anthem BCBS without Member authorization in certain circumstances.

- A Member has a right of access and correction with respect to all personal information collected by Anthem BCBS.

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

Limitation Of Actions

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

Payment Of Benefits

1. Anthem BCBS will make payments directly to the Providers. However, except as otherwise provided for in any Provider agreement, Anthem BCBS reserves the right to make payments directly to either the Member or the Covered Person, in Anthem BCBS's discretion. In the absence of a participating agreement, and one parent or custodian who has custody of a minor Dependent child, Anthem BCBS will make payments to that custodial parent or custodian in accordance with applicable Connecticut Law.

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

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

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

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

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

7. Whenever Anthem BCBS has made payments for Covered Services either in error or in excess of the Maximum Allowable Amount of payment necessary to satisfy the provisions of this Policy, irrespective of to whom paid, Anthem BCBS has the right to recover these payments from one or more of the following: any persons to or for whom such payments were made, any insurance companies or any other organizations. Anthem BCBS's right to recover may include subtracting from future benefit payments the amount Anthem BCBS has paid in error or in excess. The Covered Person personally and on behalf of his or her Dependents will, upon request, execute and deliver such documents as may be required and do whatever else is necessary to secure Anthem BCBS's rights to recover any erroneous or excess payments.

Claim Overpayments

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

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

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

Claim Denials

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

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

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

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

Member/Provider Relationship

1. The choice of a Provider is solely the Policyholder's.

2. The choice of a Provider is solely the Member's.

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

4. The use or non-use of an adjective such as "Non-Participating" in modifying the term Provider is not a statement as to the ability of the Provider.

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

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

Agency Relationships

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

Certificate Of Coverage

Anthem BCBS will provide a Certificate of Coverage, that describes this Policy's benefits and claim filing instructions, to the Policyholder for delivery to Covered Persons. In the event of conflict between the Policy and the Certificate of Coverage, the Policy will prevail.

Identification Cards

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

Applicable Law

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

Member Rights

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

Notice

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

GRIEVANCE AND EXTERNAL REVIEW PROCESS

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 / Customer Service, please call the number on the back of your Identification Card. In addition, information about the following the Grievance and External Review Procedures, also known as the Appeal Process, may be obtained by contacting Member Services / Customer Service.

Rights Available to Members

If you don't agree with our adverse determination you have the right to ask for a grievance. You must ask for a grievance within 180 calendar days from the date you were notified of our adverse determination. You, your provider, or any other person you choose, may ask for a grievance on your behalf. They may also help you during the grievance process. If you ask someone to represent or help you, please give them a signed authorization to include with the grievance.

Whether or not you use the grievance rights available to you, you may contact the Consumer Affairs Unit of the Connecticut Insurance Department or the Connecticut Office of the Health Care Advocate at any time. You may contact the Consumer Affairs Unit of the Connecticut Insurance Department at the following address: P.O. Box 816, Hartford, CT 06142-0816. You may also reach them by phone locally at 860-297-3900, toll free at 800-203-3447 or by e-mail at cid.ca@ct.gov. You may contact the Connecticut Office of the Health Care Advocate at the following address: P.O. Box 1543, Hartford, CT 06144. You may also reach them by phone at 866-466-4446 or by e-mail at Healthcare.advocate@ct.gov.

How do I ask for a standard grievance?

You may ask for a grievance for services you have not had (prospective or pre-service), for services you are receiving (concurrent) or for services you have received (retrospective or post-service). You may also ask for a grievance about a rescission of coverage. You must ask for a standard grievance by writing to the following address: Grievances and Appeals, Anthem BCBS, P. O. Box 9274, Oxnard, CA 93031-9274. Grievances of medical necessity determinations are resolved within 30 calendar days from the date we receive the request. Grievances not based on medical necessity are resolved within 20 business days from the date we receive the request. We'll respond to all grievances in writing.

How do I ask for an expedited grievance?

If you have not yet had services, or if you are now receiving services, a grievance may be handled in an expedited manner if you, or your provider, believe that the condition:

- could seriously jeopardize your life, health, or ability to regain maximum function; or
- would subject you to severe pain that cannot be adequately managed without care or treatment by waiting for the grievance to be resolved using standard grievance time frames.

To ask for an expedited grievance, you, your provider or your authorized representative can call Member Services / Customer Service at the phone number on your health plan identification card. A written request may also be sent to the following address: Grievances and Appeals, Anthem BCBS, P. O. Box 9274, Oxnard, CA 93031-9274. We'll respond to expedited grievance requests within 72 hours by phone, fax, or any other available means.

If you are a member of a fully funded health plan, you may ask for an expedited external review instead of, or at the same time as, exercising the expedited grievance process with us. To ask for this review, you, or your authorized representative, should send a written request to the Connecticut Insurance Department at the following address:

Attention External Review, P.O. Box 816, Hartford, CT 06142-0816. You may also send a written request by overnight mail to the following address: 153 Market Street, 7th Floor, Hartford, CT 06103. A copy of the External Review Guide and application are available on the Department's web site, www.ct.gov/cid. You may ask for an expedited external review when you receive an adverse determination if:

- you have a medical condition for which the time period for completing an expedited internal review would seriously jeopardize your health or your ability to regain maximum function; or
- coverage is denied because the service or treatment is experimental or investigational and your treating physician certifies in writing that the service or treatment would be significantly less effective if not promptly started and you have also filed a request for an expedited internal review.

You may ask for an expedited external review of the final adverse grievance determination if:

- you have a medical condition for which the time period for completing a standard external review would seriously jeopardize your life or health or your ability to regain maximum function;
- the determination concerns an admission, availability of care, continued stay or health care services for which you received emergency services but have not been discharged; or
- coverage was denied on the basis that the service or treatment is experimental or investigational and your treating health care professional certifies in writing that the service or treatment would be significantly less effective if not started promptly.

If an expedited external review is asked for at the same time as an expedited internal review, the Independent Review Organization (IRO) assigned to your review by the Insurance Commissioner will decide if you must complete the expedited internal review before moving forward with the expedited external review.

What should my grievance include?

You may include, if available, the following information with your grievance: the member's name and identification number; the name of the provider or facility who will or has provided care; date(s) of service; the claim or reference number for the specific determination with which you don't agree; and the specific reason(s) why you don't agree with the determination. You have the right, and we encourage you, to submit written comments, documents or other relevant information with your grievance.

How will my grievance be handled?

The appropriate administrative and/or clinical specialists will review your grievance. Relevant information submitted by you or on your behalf will be reviewed even if it was considered at the time the initial determination was made. We may contact providers who may have additional information to support your grievance. The reviewers will not have been involved in the initial determination. They also will not be a subordinate of the person who made the initial adverse determination. Before issuing a determination on a grievance of an adverse determination based upon medical necessity, we'll provide you, free of charge, with any new or additional evidence relied upon or scientific or clinical rationale. It will be provided in advance of the grievance resolution date. This will allow you a reasonable amount of time to respond before that date.

If I don't agree with my grievance determination, what other rights do I have?

You may ask for a voluntary second level grievance. You don't have to complete this voluntary level of review prior to asking for external review. If you don't ask for a voluntary second level grievance, the first level grievance response will be the final level of the internal grievance process. You have 60 calendar days from the date you receive the written first level grievance determination to ask for a voluntary second level grievance. To ask for this review, please send a written request, and any additional supporting documentation, to the following address: Grievances and Appeals, Second Level Grievance Panel, P.O. Box 1038, North Haven, CT 06473-4201. In your

written request, please let us know that you are asking for a voluntary grievance review. You may ask for an in-person presentation, phone conference, videoconference or conference by other form of acceptable technology. Voluntary grievances of medical necessity determinations are resolved within 30 calendar days from the date we receive the request. Voluntary grievances not based on medical necessity are resolved within 20 business days from the date we receive the request. The written determination will state the specific reason(s) for the determination and will reference the specific health benefit plan provisions on which the determination is based, if applicable. It will also include general information about other voluntary alternative dispute resolution options.

After completion of all mandatory levels of review, you, or your authorized representative, will receive information about the external review process administered through the Connecticut Insurance Department. We'll include an application with this information. If we fail to respond to a grievance involving medical necessity within the required timeframe, the internal grievance process will be considered exhausted and you can ask for an independent external review. External review requests must be submitted to the State of Connecticut Insurance Department within 120 days from the date of our final adverse determination to ask for the review. We'll also give you information about this right at the conclusion of the first level internal grievance.

The Connecticut Insurance Department external review process is not available to members who are covered under self-funded plans unless the self-funded plan has agreed, in writing, to utilize and be bound by, the determination of the Connecticut Insurance Department's external review process. It is also not available for adverse determinations of Workers' Compensation, Medicaid, Medicare or Medicare Risk program claims. If you are not sure which type of plan you are covered under, please contact your employer.

Please call Member Services / Customer service at the phone number on your health plan identification card for detailed information about the entire grievance process.

How do I get access to and copies of documents?

You are entitled to receive reasonable access to and copies of all documents including criteria, benefit provisions or guidelines, records and other information relied upon or used in connection with the adverse determination that is the subject of your benefit request. This information will be given to you for free upon request. If you prefer, any other person you authorize may ask for this information. We'll provide this information by fax, electronic means, or any other expeditious method within five business days after receiving a request. We'll provide this information using these methods within one calendar day after receiving a request regarding a final adverse determination about:

1. an admission, availability of care, continued stay, or health care service for which you received emergency services but have not been discharged from a facility; or
2. a denial of coverage based on a determination 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.