Anthem.
BlueCross BlueShield

Individual and Family Health Care Plans
for Connecticut

Our plans fit your plans

Anthem Premier
Anthem SmartSense®

Why do you need health care coverage?

These days, an average stay in the hospital can cost more than $20,000.** The financial risk you take without health coverage just isn't worth it. Not only does health care coverage help you stay healthy, it also gives you added security, because you know you have help to protect against the high cost of unexpected medical bills.

Our plans help fit the way you live

In a world that's constantly changing, one thing's for certain: it's important to have health care coverage you can depend on — coverage designed to help fit your budget, and your way of life.

Since 1936, Anthem Blue Cross and Blue Shield has provided health care coverage and security to our Connecticut neighbors.

You're in charge of your health and budget, and our individual health care plans help keep it that way. We still offer a wide range of coverage options as unique as you are. And if you have any questions, we're here to help.

Experience you can rely on

Anthem is committed to helping simplify your life and improving your health. That's why we offer:

- **One of the largest provider networks in Connecticut.** With over 10,000 PPO doctors and almost 30 hospitals* throughout the state, chances are your doctor is one of ours.
- **Coverage that travels with you.** No matter where life takes you, your health coverage goes with you. And the BlueCard® program makes it easy to access providers throughout the country.
- **A choice of plans to help fit your budget and lifestyle.** No matter where you are in life, we've got a plan designed to help fit your health coverage needs, as well as your budget.

*BCBSA Provider Data Counts, 2012.

**Based on 2008 weighted national estimates from HCUP Nationwide Inpatient Sample (NIS), Agency for Healthcare Research and Quality (AHRQ), based on data collected by individual states and provided to AHRQ by the states. (Average stay of 3.8 days; average cost to uninsured of $22,512.)

Some definitions so we're all on the same page

Network Discounts: With Anthem, you have access to one of the largest provider networks in the state. These network (or participating) providers have agreed to accept lower costs for their covered services to Anthem members — similar to volume discounts. These negotiated costs help reduce the overall cost of covered medical services, including your share of those costs.

This is true whether you are paying the entire cost for covered services (such as while you are meeting your deductible), or whether we are sharing the cost. With over 10,000 PPO doctors and almost 30 hospitals,* chances are your provider already participates. Just visit a network provider to take advantage of the savings.

With our PPO plans, you can always choose to receive services outside the network, but your share of the cost will be greater.

Cost Sharing: The costs of medical care today can be staggering. Health care coverage from Anthem can help protect you against these high costs. With most health care coverage, you pay a monthly premium, then you share some of the cost of covered medical care with the company that provides your health care coverage. The level of cost sharing you choose directly impacts your premium amount. The more you are willing to share in the cost, the lower your premium. With Anthem, you can choose your level of protection and the level of cost sharing that works best for your health care needs and budget.

Deductible is the amount you have to pay each calendar year for covered services before your health care plan starts paying. Amounts met toward the deductible do not carry over from year to year. For some services, the plan will even begin to pay before the deductible is met. Usually, the higher a plan's deductible, the lower the premium. In some cases, you may also have a separate deductible for certain services such as prescription drugs. Network and non-network deductibles are separate and do not accumulate toward each other.

Coinsurance is the percentage of the cost of covered services that you will be responsible for, after your annual deductible is met. With some plans, you have a choice of coinsurance levels. Much like your deductible, selecting a higher coinsurance typically lowers your monthly premium because it increases your share of the cost.

Copayment is a specific dollar amount you have to pay for certain covered services.

Out-Of-Pocket Maximum is the most that you would pay in a calendar year for deductible and coinsurance for in-network covered services. Once you reach this maximum, the plan pays at 100% for most network services for the rest of the calendar year. There is a separate out-of-pocket maximum for non-network services. Network and non-network out-of-pocket maximums are separate and do not accumulate toward each other.

Prescription Drugs are medications that must be authorized for use by your doctor. Anthem offers varying levels of prescription drug coverage. Depending on the plan, you may have coverage for generic drugs or generic and brand-name drugs.

Generic Drugs are prescription drugs that typically have been in use for some time and can be manufactured and distributed by numerous companies, so their cost is usually much lower. Generic drugs must, by law, contain the same active ingredients as their brand-name equivalent and have the same clinical benefit.

Brand-Name Drugs are prescription drugs that are manufactured and marketed under a registered name. They are usually patented and may be exclusively offered by certain manufacturers.

Tiers represent a cost level within the generic and brand-name prescription drug categories. The prescription drug coverage under your health care plan will differ for each of these tiers. Not all products have this tiering.

- *Tier 1*: Generally includes generic drugs and a few lower cost brand-name drugs.
- *Tier 2*: Generally includes generic and higher cost brand-name drugs.
- *Tier 3*: Includes the highest cost brand-name drugs.

Formulary is a list of prescription drugs our health care plans cover. They may include generic, preferred brand-name and specialty drugs that have been rigorously reviewed and selected by a committee of practicing doctors and clinical pharmacists for their quality and effectiveness. We've negotiated lower prices on these formulary drugs, so you'll save when your doctor prescribes medication from our formularies. There can be different formularies for different health care plans.

*BCBSA Provider Data Counts, 2012.

Anthem Premier

Is this the right plan for you?

Anthem Premier health care plans offer our highest level of benefits for a variety of services. Great for families or for individuals looking for richer benefits, Anthem Premier provides a number of benefits before the deductible, and strong coverage for prescription drugs.

Anthem Premier Plan Highlights

Anthem Premier offers robust benefits for both routine and unexpected medical care. Compared to our other plans, Anthem Premier has lower coinsurance levels across all deductibles offered. This added value helps lower your share of the cost once you satisfy your deductible.

Features:

- Coverage for doctors' office visits, with predictable copayment, before the deductible.
- Pays the first $50 toward network annual routine vision screening, per member.
- Preventive care benefits that help you focus on staying healthy.

You should know:

- Maternity benefits are not available with this plan.
- Anthem Premier has our highest level of benefits available, so the premiums are typically more than our other plans.
- Network and non-network deductibles are separate and do not accumulate toward each other. Network and non-network out-of-pocket maximums are separate and do not accumulate toward each other.

Prescription drug coverage

Anthem Premier offers broad prescription drug coverage including benefits for generic and brand-name drugs. There is a separate deductible for Tier 2 and 3 drugs.

You will receive the highest level of benefits by asking your physician to prescribe a generic drug whenever possible. If you choose to purchase a brand-name drug when a generic drug is available, you will be responsible for the difference in the cost between brand-name and generic, plus your copayment or coinsurance.

See your Benefit Guide for more details.

How to customize your Anthem Premier Plan

With Anthem Premier, you have choice and flexibility to change the plan to better meet your needs. Anthem Premier offers a choice of:

Deductible: Anthem Premier deductibles range from $500 to $10,000. You can usually lower your premium by choosing a higher deductible. Simply choose the deductible and premium combination that works best for you.

Coinsurance: Anthem Premier offers a choice of coinsurance options, including one with no coinsurance at all for most care, depending on the deductible you choose. The zero coinsurance options typically have higher deductibles, which can lower your premium in most cases.

Anthem. BlueCross BlueShield

Benefit Guide for Connecticut

Benefits	Anthem Premier							
Calendar Year Deductible	**Your Choices**							
Individual Policy — NETWORK:	$500	$1,500	$2,500	$2,500	$3,500	$5,000	$7,500	$10,000
Individual Policy — NON-NETWORK:	$500	$1,500	$2,500	$2,500	$3,500	$5,000	$7,500	$10,000
Family Policy — NETWORK:	$1,000	$3,000	$5,000	$5,000	$7,000	$10,000	$15,000	$20,000
Family Policy — NON-NETWORK:	$1,000	$3,000	$5,000	$5,000	$7,000	$10,000	$15,000	$20,000
Network Coinsurance Options	20%*	20%*	20%*	0%*	0%*	0%*	0%*	0%*
Calendar Year Out-of-Pocket Maximum	**Add Your Chosen Deductible to the Amount Below**							
Individual Policy — NETWORK:	$3,000	$3,000	$3,000	$0	$0	$0	$0	$0
Individual Policy — NON-NETWORK:	$7,500	$7,500	$7,500	$7,500	$7,500	$7,500	$7,500	$7,500
Family Policy — NETWORK:	$6,000	$6,000	$6,000	$0	$0	$0	$0	$0
Family Policy — NON-NETWORK:	$15,000	$15,000	$15,000	$15,000	$15,000	$15,000	$15,000	$15,000
How family deductibles and family out-of-pocket maximums work	For family plans (with two or more members) any combination of family members can meet or contribute toward the family deductible or family out-of-pocket maximum. However, no individual member can contribute more than their individual deductible or out-of-pocket maximum.							
Lifetime Maximum	None							
Covered Services	**Your Share of Costs** (after deductible, unless waived or not subject to deductible)							
Doctors' Office Visits	**NETWORK (deductible waived):** **$30 Copay** for primary care physician; **$40 Copay** for specialist. **NON-NETWORK:** **30% Coinsurance**							
Professional and Diagnostic Services (X-ray, lab, anesthesia, surgeon, etc.)	**NETWORK:** **20%** or **0% Coinsurance**[1] **NON-NETWORK:** **30% Coinsurance**							
Inpatient Services (overnight hospital/facility stays)	**NETWORK:** **20%** or **0% Coinsurance**[1] **NON-NETWORK:** **30% Coinsurance**							
Outpatient Services (without overnight hospital/facility stays)	**NETWORK:** **20%** or **0% Coinsurance**[1] **NON-NETWORK:** **30% Coinsurance**							
Emergency Room Services	**NETWORK:** **20%** or **0% Coinsurance**[1] **NON-NETWORK:** **20%** or **0% Coinsurance**[1]							
Preventive Care Services	**Includes preventive services recommended by the United States Preventive Services Task Force, including well child care, immunizations, PSA screenings, pap tests, and more.** **NETWORK:** **0% Coinsurance**, not subject to deductible **NON-NETWORK:** **30% Coinsurance**							
Maternity	Not Covered							
Optional Coverage (at additional cost)	None							
Prescription Drug Coverage	**Anthem Premier**							
Retail Drugs (and Mail Order Drugs when available)	Separate $200 deductible per member. **NETWORK:** ◦ **Tier 1 Drugs (deductible waived):** Retail (30 day supply): **$15 Copay**; Mail Order (90 day supply): **$30 Copay** ◦ **Tiers 2 and 3: 40% Coinsurance** for either Retail (30 day supply) or Mail Order (90 day supply). Up to $10,000 annual Prescription Drug out-of-pocket maximum per member. **NON-NETWORK:** ◦ **50% Coinsurance** up to the maximum allowable amount. Member is responsible for difference between Anthem allowable charge and actual cost of drug.							
Optional Drug Coverage (when available)	Not applicable; Anthem Premier already includes enhanced drug coverage.							
Other Covered Benefits include but are not limited to:	Ambulance, Chiropractic Care, Durable Medical Equipment, Home Health and Hospice Care, Mental Health, Physical/Occupational Therapy, Substance Abuse, Speech Therapy, Urgent Care, Routine Vision Exam							
IMPORTANT: This Benefit Guide is intended to be a brief outline of coverage and is not intended to be a legal contract. The entire provisions of benefits, limitations and exclusions are contained in the Contract/Certificate. In the event of a conflict between the Contract/Certificate and this Benefit Guide, the terms of the Contract/Certificate will prevail.	*Your coinsurance will be higher with a non-network provider. 1 Coinsurance is designated by the plan you choose. NOTE: Network and non-network deductibles are separate and do not accumulate toward each other. Network and non-network out-of-pocket maximums are separate and do not accumulate toward each other.							

Anthem SmartSense®

Is this the right plan for you?

Anthem SmartSense was designed to offer affordable, solid protection without a lot of bells and whistles that may not be important to you.

Anthem SmartSense Plan Highlights

Anthem SmartSense offers affordable price options, solid protection that covers many essentials, and even some immediate benefits before the deductible.

Features:

- Coverage for the first three doctors' office visits with predictable copayment.
- Preventive care benefits that help you focus on staying healthy.
- Choice of prescription drug coverage options.

You should know:

- Maternity benefits are not available with this plan.
- After the first three doctors' office visits, all other visits are covered after your deductible and/or coinsurance.
- Generic drugs are available before the deductible, with a copayment or coinsurance.
- Network and non-network deductibles are separate and do not accumulate toward each other. Network and non-network out-of-pocket maximums are separate and do not accumulate toward each other.

Prescription drug coverage

Anthem SmartSense includes coverage for generic and preferred drugs. For non-preferred and specialty drugs, the Anthem negotiated discount applies.

For an additional cost, you can upgrade the Anthem SmartSense prescription benefit and extend coverage for non-preferred and specialty drugs.

You will receive the highest level of benefits by asking your physician to prescribe a generic drug whenever possible. If you choose to purchase a brand-name drug on the formulary, when a generic drug is available, you will be responsible for the difference in the cost between brand-name and generic, plus your copayment or coinsurance.

See your Benefit Guide for more details.

How to customize your Anthem SmartSense Plan

With Anthem SmartSense, you have some choice and flexibility to change the plan to better meet your needs. Anthem SmartSense offers a choice of:

Deductible: Anthem SmartSense deductibles range from $750 to $12,000. You can usually lower your premium by choosing a higher deductible. Simply choose the deductible and premium combination that works best for you.

Coinsurance: Anthem SmartSense offers a choice of coinsurance levels depending on the deductible you choose. Choosing a higher deductible can take your coinsurance for covered services to zero if you'd like to pay more toward your calendar year deductible first.

Prescription Drug Benefit: You can customize your plan by selecting the Optional Enhanced Prescription Drug coverage, as described in your Benefit Guide.

Benefits	Anthem SmartSense®									
Calendar Year Deductible	**Your Choices**									
Individual Policy — NETWORK:	$750	$1,500	$2,500	$2,500	$3,500	$3,500	$5,000	$7,500	$10,000	$12,000
Individual Policy — NON-NETWORK:	$750	$1,500	$2,500	$2,500	$3,500	$3,500	$5,000	$7,500	$10,000	$12,000
Family Policy — NETWORK:	$1,500	$3,000	$5,000	$5,000	$7,000	$7,000	$10,000	$15,000	$20,000	$24,000
Family Policy — NON-NETWORK:	$1,500	$3,000	$5,000	$5,000	$7,000	$7,000	$10,000	$15,000	$20,000	$24,000
Network Coinsurance Options	30%*	30%*	30%*	50%*	30%*	50%*	30%*	30%*	0%*	0%*
Calendar Year Out-of-Pocket Maximum	**Add Your Chosen Deductible to the Amount Below**									
Individual Policy — NETWORK:	$4,000	$4,000	$3,000	$4,000	$3,000	$4,000	$3,000	$3,000	$0	$0
Individual Policy — NON-NETWORK:	$7,500	$7,500	$7,500	$7,500	$7,500	$7,500	$7,500	$7,500	$7,500	$7,500
Family Policy — NETWORK:	$8,000	$8,000	$8,000	$8,000	$8,000	$8,000	$8,000	$8,000	$0	$0
Family Policy — NON-NETWORK:	$15,000	$15,000	$15,000	$15,000	$15,000	$15,000	$15,000	$15,000	$15,000	$15,000
How family deductibles and family out-of-pocket maximums work	For family plans (with two or more members) any combination of family members can meet or contribute toward the family deductible or family out-of-pocket maximum. However, no individual member can contribute more than their individual deductible or out-of-pocket maximum.									
Lifetime Maximum	None									

Covered Services	Your Share of Costs (after deductible, unless waived or not subject to deductible)
Doctors' Office Visits	**NETWORK:** ◦ **Office Visit Copay for first 3 yearly visits: $30 Copay**, deductible waived, for primary care physician or specialist visits. ◦ **Office Visit Coinsurance for remaining visits: 30%** or **50%** or **0% Coinsurance**[1] **NON-NETWORK: 50% or 30% Coinsurance**[1]
Professional and Diagnostic Services (X-ray, lab, anesthesia, surgeon, etc.)	**NETWORK: 30%, 50% or 0% Coinsurance**[1] **NON-NETWORK: 50% or 30% Coinsurance**[1]
Inpatient Services (overnight hospital/facility stays)	**NETWORK: 30%, 50% or 0% Coinsurance**[1] **NON-NETWORK: 50% or 30% Coinsurance**[1]
Outpatient Services (without overnight hospital/facility stays)	**NETWORK: 30%, 50% or 0% Coinsurance**[1] **NON-NETWORK: 50% or 30% Coinsurance**[1]
Emergency Room Services	**NETWORK: 30%, 50% or 0% Coinsurance**[1] **NON-NETWORK: 50%, 30% or 0% Coinsurance**[1]
Preventive Care Services	**Includes preventive services recommended by the United States Preventive Services Task Force, including well child care, immunizations, PSA screenings, pap tests, and more.** **NETWORK: 0% Coinsurance**, not subject to deductible **NON-NETWORK: 50% or 30% Coinsurance**[1]
Maternity	Not Covered
Optional Coverage (at additional cost)	Enhanced Drug Coverage

Prescription Drug Coverage	Anthem SmartSense
Retail Drugs (and Mail Order Drugs when available)	**Standard Drug Coverage:** Separate $250 per person deductible for Tier 2 preferred brand drugs. **NETWORK:** ◦ **Tier 1 Drugs: $15 Copay**; deductible waived. ◦ **Tier 2 Drugs: 40%** or **50% Coinsurance**[1] ◦ **Tier 3 Drugs:** Member is responsible for entire cost after Anthem negotiated discount. **NON-NETWORK:** ◦ **50% Coinsurance** up to the maximum allowable amount. Member is responsible for difference between Anthem allowable charge and actual cost of the drug.
Optional Drug Coverage (when available)	**Enhanced Drug Coverage:** Separate $200 per person deductible. **NETWORK:** ◦ **Tier 1 Drugs (deductible waived):** Retail (30 day supply): **$15 Copay**; Mail Order (90 day supply): **$30 Copay.** ◦ **Tiers 2 and 3: 40% Coinsurance** or **50% Coinsurance** (with $2500/50% or $3,500/50%) for either Retail (30 day supply) or Mail Order (90 day supply). Up to $10,000 annual Prescription Drug out-of-pocket maximum per member. **NON-NETWORK:** ◦ **50% Coinsurance** up to the maximum allowable amount. Member is responsible for difference between Anthem allowable charge and actual cost of the drug.
Other Covered Benefits include but are not limited to:	Ambulance, Chiropractic Care, Durable Medical Equipment, Home Health and Hospice Care, Mental Health, Physical/Occupational Therapy, Substance Abuse, Speech Therapy, Urgent Care

IMPORTANT: This Benefit Guide is intended to be a brief outline of coverage and is not intended to be a legal contract. The entire provisions of benefits, limitations and exclusions are contained in the Contract/Certificate. In the event of a conflict between the Contract/Certificate and this Benefit Guide, the terms of the Contract/Certificate will prevail.

*Your coinsurance will be higher with a non-network provider.

1 Coinsurance is designated by the plan you choose.

NOTE: Network and non-network deductibles are separate and do not accumulate toward each other. Network and non-network out-of-pocket maximums are separate and do not accumulate toward each other.

Choose your doctor and compare your health care costs at anthem.com.

Manage your health care coverage in a simple and easy way at anthem.com. Once you're a member, all you have to do is register at anthem.com and start feeling better about your choices with features like:

- *Find a Doctor:* Use our online Provider Directory to find hospitals, pharmacies and other specialists in your area - and check whether they are cost-saving network providers – all at the click of a mouse.
- *Anthem Care Comparison:* Save time and money by comparing the quality and safety of providers as well as the cost of common procedures at health care facilities in your area.
- *Zagat Health Surveys:* See what other patients have said about the doctors and hospitals you're considering. Add your own doctor recommendation, too!

Register today at anthem.com and have a wealth of health information right at your fingertips.

Get a free look with a money-back guarantee!

After you enroll in a plan offered by Anthem, you will receive a Certificate that explains the exact terms and conditions of coverage, including the plan's exclusions and limitations. You will have 10 days to examine your plan's features. During that time, if you are not fully satisfied, you may cancel your policy and your premiums will be refunded, less any claims that were already paid.

Additional information

Because we're dedicated to making the application process simple, you can apply through the mail, online or over the phone.

Who can apply?

All individual plans are available to:

- Connecticut residents
- Applicants who are between 19 and 64 years of age.
- Married couples and domestic partners that meet eligibility requirements may apply.
- Families with dependent children under age 26 are eligible.

Those applying must submit:

- An Enrollment Application
- Health Statement
- Your first month's premium

These health plans are medically underwritten. This means your premium and acceptance is based on a review of your medical history. The Subscriber Certificate will be mailed to you once you are a member.

Sign up for our easy, no hassle payment option.

No matter which plan option you choose, we'll make it easy for you to make your monthly premium payments.

Through our Electronic Fund Transfer (EFT) program, we automatically withdraw funds from your bank account each month for the required premium amount. No check writing. No postage costs. No coverage lapse because you forgot to mail the payment. See ... we said we make it easy.

Sound good? Then complete the billing section of the Enrollment Application. If applying online, sign up for EFT while completing the online application.

If you have questions or want more details about your options, call your Anthem Sales Representative or Agent today!

Individual health coverage. Your plans. Your choices.

Make sure you have all the facts.

After 9/23/12, to view a Summary of Benefits and Coverage please visit www.healthcare.gov.

This brochure is only one piece of your plan information. Please make sure you have all the facts about the benefits offered by the plans described — including what's covered, and what isn't. This policy has exclusions, limitations, and terms under which the policy may be continued in force or discontinued. For costs and complete details of the coverage, contact your insurance agent, Anthem, or visit us on the web. You may also see the enclosed Coverage Details. This document should be included with your information kit, or if you have printed this from your computer, it should be at the end of this document. If you don't have this document, be sure to contact your Anthem Sales Representative or Agent.

This brochure is intended as a brief summary of benefits and services; it is not your Contract/Certificate. If there is any difference between this brochure and your Contract/Certificate, the provisions of the Contract/Certificate will prevail. Benefits and premiums are subject to change.

This summary of benefits complies with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits.

Ready to enroll?

Call your Anthem Sales Representative or Agent today!

Anthem.
BlueCross BlueShield

Individual and Family Health Care Plans for Connecticut

Connecticut Coverage Details

Things you need to know before you buy...

Anthem. BlueCross BlueShield

Anthem Premier, Anthem SmartSense® and Lumenos® HSA Plus

Before choosing a health care plan, please review the following information along with the other materials enclosed.

The plans outlined in this document are Major Medical Expense Coverage. Policies of this category are designed to provide, to persons insured, coverage for major hospital, medical, and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services, and out-of-hospital care, subject to any deductibles, co-payment provisions, or other limitations which may be set forth in the policy.

Who can apply?

To be eligible for membership as a policyholder, the applicant must:

1. Be a resident of Connecticut;
2. Be between 19 and 64 years of age;
3. Not have any other type of health insurance. If the applicant has other insurance coverage in-force, he or she must replace that coverage;
4. Agree to pay for the cost of premium that Anthem Blue Cross and Blue Shield (Anthem) requires; and
5. Satisfy the following requirements to guarantee renewability:
   a) Eligibility criteria continues to be met;
   b) There are no acts, practices or omissions that constitute fraud or intentional misrepresentation of material fact found on the application;
   c) Membership has not been terminated by Anthem under the terms of this policy.

If an individual is under 26 years of age and is covered either by his or her parents or guardians as defined by the State of Connecticut, he or she is eligible for coverage provided he or she meets eligibility criteria specified in the Eligibility policy stated above. Anthem requires the parent/guardian to sign the applications as the applicant for the insured. Married couples and domestic partners that meet eligibility requirements may also apply. Families with dependent children under age 26 are eligible as well.

Please note: For HSA-qualified health plans, while the health plan recognizes domestic partners, the IRS does not. Therefore, if you want to contribute to an HSA, you will need to enroll in two separate individual health plans.

Renewal/termination of coverage

Membership will not be terminated solely due to medical risk factors, such as health status or current or past medical conditions. We may not renew your coverage for the following reasons:

1. Nonpayment of required premiums.
2. Any act, practice or omission that constitutes fraud or intentional misrepresentation of material fact found on the application.
3. If all policies of the same form number are not renewed. Any such action will be in accordance with applicable state and Federal laws.

Pre-Existing Conditions

For applicants age 19 and older, this plan does not cover Pre-Existing Conditions diagnosed or treated during the 12 months immediately preceding your Effective Date. The Pre-Existing Condition Limitation Period may last up to 12 months from your Enrollment Date. Credit from prior Creditable Coverage will be applied, if applicable, to reduce your specific Pre-Existing Condition Limitation Period. You will be notified in writing by Anthem exactly how many months you will be subject to this exclusion.

Premium Rates

The amount, time and manner of payment of premiums shall be determined by Anthem and shall be subject to the approval of the State of Connecticut Insurance Department.

In the event of any change in premium, the Subscriber will be given notice of at least 30 days prior to such change. Payment of the premium by the Subscriber shall serve as notice of the Subscriber's acceptance of the change.

Utilization Management and Case Management

Our Utilization Management (UM) services offer a structured program that monitors and evaluates member care and services. The UM clinical team, which is made up of health care professionals who hold active professional licenses and certificates, perform the prior authorization, concurrent and retrospective review processes explained below. The UM team follows criteria to assist in decisions regarding requests for health care and other covered benefits, and complies with specific time frames to ensure requests are handled in a timely manner. Our case management services help you to better understand and manage your health conditions.

Prior Authorization / Pre-Admission Review

Prior Authorization (also known as pre-service or pre-admission review) is the process of reviewing a request for a medical procedure or service before it takes place. The review occurs to ensure that: 1) the procedure is medically necessary; and 2) the procedure meets your health care plan's specific guidelines prior to being performed. Requests for Prior Authorization may include, but are not limited to:

- inpatient hospitalizations
- outpatient procedures
- diagnostic procedures
- therapy services
- durable medical equipment

Prior Authorization is required for all elective inpatient admissions and certain outpatient services. The review process evaluates medical necessity and the best level of care, and assigns an expected length of stay if needed.

Concurrent Review

Concurrent review is an ongoing evaluation of a member's hospital stay, as well as ongoing extensions of services that may be needed (such as acute care facilities, skilled nursing facilities, acute rehabilitation facilities and home health care services). The review includes physicians and member-assigned health care professionals (or member authorized representative), and takes place by telephone, electronically and/or on-site.

Concurrent review uses pre-set decision criteria in order to approve medical care (deemed to be medically necessary) and assign the right level of care for continued medical treatment. Review decisions are based on the medical information obtained at the time of the review. Concurrent review also helps to coordinate care with behavioral health programs.

Retrospective Review

The retrospective review process consists of obtaining information to determine medical necessity as it relates to services provided without approval or notice ahead of time (e.g., without pre-service notification). Relevant clinical information is required for the retrospective review process. Review decisions are based only on the medical information the doctor or other provider had at the time the member received medical care.

Case Management

Case managers are licensed health care professionals who work with you to help you understand your benefits and support your health care needs. The case manager works with you and your doctor to help you better understand and manage your health conditions.

What Our Individual Health Plans Do Not Cover

The following limitations and exclusions will help you understand what your health care plan does not include. These are just some of the plans' limitations and exclusions. In addition to the other limitations, conditions and exclusions set forth elsewhere, no benefits will be provided for expenses related to the services, supplies, conditions or situations described in this section. These items and services are not covered even if you receive them from your Provider or according to your Provider's Referral. If a service is not covered, then all services performed in conjunction with that service are not covered. Anthem is the final authority for determining if services or supplies are covered and/or Medically Necessary.

Exclusions

- Any services that is not medically necessary
- Alternative Medicines or Complementary Medicine
- Amounts That Exceed the Maximum Allowable Benefit
- Biofeedback Services
- Care Furnished by a Family Member
- Care Received When You Are Not Covered Under This Policy
- Chelating Agents
- Care or Complications Related To Non-covered Services
- Chiropractic Services (Except as stated in Covered Services)
- Claims submitted 12 or months after the date of service
- Convenience Services
- Cosmetic Services
- Custodial or Convalescent Care
- Dental Services
- Disease or Injury Sustained as a Result of War or Participation in Riot or Civil Disobedience
- Domiciliary Care
- Educational, Instructional, Vocational Services and Developmental Disability Services
- Experimental/Investigational Services
- Food and Food Supplements. (Except as required by applicable law)
- Foot Care, Foot Orthotics and Corrective Shoes
- Free Care
- Government Programs
- Health club memberships
- Hospitalization and Other Services Related to Noncovered Care
- Human organ transplants other than those listed in the Subscriber Contract as covered benefits
- Male sterilization
- Medications related to travel
- Missed Appointments
- Maternity Services (Except as stated in Covered Services)
- Nonmember Biological Parents
- Nutritional and/or dietary supplements (Except as required by applicable law)
- Pre-existing Conditions Exclusion Period for Members age 19 and older
- Preventive Care (Except as required by applicable law)
- Private Duty Nurses
- Processing Fees
- Radial keratotomy or other surgery to correct vision
- Rehabilitation Services (Except as stated in Covered Services)
- Reversal of Voluntary Sterilization
- Services Not Specified as Covered
- Sex Change Treatment
- Smoking Cessation Drugs, Programs or Services.
- Surrogate Parenting
- Transportation (Except as stated in Covered Services)
- Temporamandibular Joint Syndrome (TMJ)
- Vision Care

- Wigs (Except as required by law)
- Workers' Compensation
- Weight loss programs

Limitations

- Hearing Aid — 1 hearing aid per ear within a 24 month period for 12 years and under
- Home Health Care/Respiratory Services — 100 visits per calendar year
- Chiropractic Therapy — 15 visits per calendar year
- Physical Therapy/Occupational Therapy 20 visits combined per calendar year
- Speech Therapy 20 visits per calendar year
- Skilled Nursing Benefits 100 days per calendar year
- Specialty Facility 60 days per calendar year
- Early Intervention Services — $6,400 per member per calendar year and $19,200 per child over a 3 year period
- Routine Pap Test — 1 per member per calendar year
- Routine PSA Test — 1 per member per calendar year
- Cardiac Therapy Phase I and Phase II- 36 visits per episode
- Allergy Visits 80 visits in 3 year period
- Specialized Formula — up to age 12
- Wigs — $350 limit (as stated in contract)

In addition our Premier plan limits

- Routine vision exams — 1 per member per 12 months up to $50

Your Rights and Responsibilities

We are committed to:

- Recognizing and respecting you as a member.
- Encouraging your open discussions with your health care professionals and providers.
- Providing information to help you become an informed health care consumer.
- Providing access to health benefits and our network providers.
- Sharing our expectations of you as a member.

You have the right to:

- Participate with your health care professionals and providers in making decisions about your health care.
- Receive the benefits for which you have coverage.
- Be treated with respect and dignity.
- Have privacy for your personal health information, consistent with state and federal laws, and our policies.
- Receive information about our organization and services, our network of health care professionals and providers, and your rights and responsibilities.
- Candidly discuss with your physicians and providers appropriate or medically necessary care for your condition, regardless of cost or benefit coverage.
- Make recommendations regarding the organization's members' rights and responsibilities policies.
- Voice complaints or appeals about: our organization, any benefit or coverage decisions we (or our designated administrators) make, your coverage, or care provided.
- Refuse treatment for any condition, illness or disease without jeopardizing future treatment, and be informed by your physician(s) of the medical consequences.
- Participate in matters of the organization's policy and operations.
- For assistance at any time, contact your local insurance department:

  Phone: **800-203-3447**
  Write: State of Connecticut Insurance Department
  P.O. Box 816
  Hartford, CT 06142-0816

You have the responsibility to:

- Choose a participating primary care physician if required by your health benefit plan.
- Treat all health care professionals and staff with courtesy and respect.
- Keep scheduled appointments with your doctor, and call the doctor's office if you have a delay or cancellation.
- Read and understand to the best of your ability all materials concerning your health benefits, or ask for help if you need it.
- Understand your health problems and participate, along with your health care professionals and providers, in developing mutually agreed upon treatment goals to the degree possible.
- Supply, to the extent possible, information that we and/or your health care professionals and providers need in order to provide care.
- Follow the plans and instructions for care that you have agreed on with your health care professional and provider.
- Tell your health care provider if you do not understand your treatment plan or what is expected of you.
- Follow all health benefit plan guidelines, provisions, policies and procedures.
- Let our Customer Service department know if you have any changes to your name, address, or family members covered under your policy.
- Provide us with accurate and complete information needed to administer your health benefit plan, including other health benefit coverage and other insurance benefits you may have in addition to your coverage with us.

We are committed to providing quality benefits and customer service to our members. Benefits and coverage for services provided under the benefit program are governed by the Subscriber Agreement and not by this Member Rights and Responsibilities statement.

Access to the MIB

Information regarding your insurability will be treated as confidential. Anthem or its reinsurers may, however, make a brief report thereon to MIB, a not-for-profit membership organization of insurance companies that operates an information exchange on behalf of its members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you MIB will arrange disclosure of any information it may have in your file. Please contact MIB at **866-692-6901** (TTY: **886-346-3642**). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act.

The address of MIB's Information Office is

50 Braintree Hill Park, Suite 400
Braintree, MA 02184-8734

Information for consumers about MIB may be obtained on its website, at **www.mib.com**.

Anthem, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

Notices of Privacy Practices

We've combined a couple of required annual notices. Please take a few minutes to read about:

- State notice of privacy practices
- Health Insurance Portability and Accountability Act (HIPAA) notice of privacy practices
- Breast reconstruction surgery benefits

State Notice of Privacy Practices

As mentioned in our HIPAA notice, we must follow state laws that are stricter than the federal HIPAA privacy law. This notice explains your rights and our legal duties under state law. This applies to life insurance benefits, in addition to health, dental and vision benefits that you may have.

Your Personal Information

We may collect, use and share your nonpublic personal information (PI) as described in this notice. PI identifies a person and is often gathered in an insurance matter. We may collect PI about you from other persons or entities, such as doctors, hospitals or other carriers. We may share PI with persons or entities outside of our company — without your OK in some cases. If we take part in an activity that would require us to give you a chance to opt out, we will contact you. We will tell you how you can let us know that you do not want us to use or share your PI for a given activity. You have the right to access and correct your PI. Because PI is defined as any information that can be used to make judgments about your health, finances, character, habits, hobbies, reputation, career and credit, we take reasonable safety measures to protect the PI we have about you. A more detailed state notice is available upon request.

HIPAA Notice of Privacy Practices

This notice describes how health, vision and dental information about you may be used and disclosed, and how you can get access to this information with regard to your health benefits. Please review it carefully. We keep the health and financial information of our current and former members private, as required by law, accreditation standards and our rules. This notice explains your rights. It also explains our legal duties and privacy practices. We are required by federal law to give you this notice.

Your Protected Health Information

We may collect, use and share your Protected Health Information (PHI) for the following reasons and others as allowed or required by law, including the HIPAA Privacy rule:

For payment: We use and share PHI to manage your account or benefits; or, to pay claims for health care you get through your plan. For example, we keep information about your premium and deductible payments. We may give information to a doctor's office to confirm your benefits.

For health care operations: We use and share PHI for our health care operations. For example, we may use PHI to review the quality of care and services you get. We may also use PHI to provide you with case management or care coordination services for conditions like asthma, diabetes or traumatic injury.

For treatment activities: We do not provide treatment. This is the role of a health care provider, such as your doctor or a hospital. But, we may share PHI with your health care provider so that the provider may treat you.

To you: We must give you access to your own PHI. We may also contact you to let you know about treatment options or other health-related benefits and services. When you or your dependents reach a certain age, we may tell you about other products or programs for which you may be eligible. This may include individual coverage. We may also send you reminders about routine medical checkups and tests.

To others: You may tell us in writing that it is OK for us to give your PHI to someone else for any reason. Also, if you are present and tell us it is OK, we may give your PHI to a family member, friend or other person. We would do this if it has to do with your current treatment or payment for your treatment. If you are not present, if it is an emergency, or you are not able to tell us it is OK, we may give your PHI to a family member, friend or other person if sharing your PHI is in your best interest.

As allowed or required by law: We may also share your PHI, as allowed by federal law, for many types of activities. PHI can be shared for health oversight activities. It can also be shared for judicial or administrative proceedings, with public health authorities, for law enforcement reasons, and with coroners, funeral directors or medical examiners (about decedents). PHI can also be shared with organ donation groups for certain reasons, for research, and to avoid a serious threat to health or safety. It can be shared for special government functions, for Workers' Compensation, to respond to requests from the U.S. Department of Health and Human Services, and to alert proper authorities if we reasonably believe that you may be a victim of abuse, neglect, domestic violence or other crimes. PHI can also be shared as required by law. If you are enrolled with us through an employer-sponsored group health plan, we may share PHI with your group health plan. We and/or your group health plan

may share PHI with the sponsor of the plan. Plan sponsors that receive PHI are required by law to have controls in place to keep it from being used for reasons that are not proper.

Authorization: We will get an OK from you in writing before we use or share your PHI for any other purpose not stated in this notice. You may take away this OK at any time, in writing. We will then stop using your PHI for that purpose. But, if we have already used or shared your PHI based on your OK, we cannot undo any actions we took before you told us to stop.

Genetic Information: If we use or disclose PHI for underwriting purposes, we are prohibited from using or disclosing PHI that is the genetic information of an individual for such purposes.

Your Rights

Under federal law, you have the right to:

- Send us a written request to see or get a copy of certain PHI, or ask that we correct your PHI that you believe is missing or incorrect. If someone else (such as your doctor) gave us the PHI, we will let you know so you can ask him or her to correct it.
- Send us a written request to ask us not to use your PHI for treatment, payment or health care operations activities. We are not required to agree to these requests.
- Give us a verbal or written request to ask us to send your PHI using other means that are reasonable. Also, let us know if you want us to send your PHI to an address other than your home if sending it to your home could place you in danger.
- Send us a written request to ask us for a list of certain disclosures of your PHI. Call Customer Service at the phone number printed on your identification (ID) card to use any of these rights. Customer Service representatives can give you the address to send the request. They can also give you any forms we have that may help you with this process.

How We Protect Information

We are dedicated to protecting your PHI, and have set up a number of policies and practices to help make sure your PHI is kept secure. We keep your oral, written and electronic PHI safe using physical, electronic, and procedural means. These safeguards follow federal and state laws. Some of the ways we keep your PHI safe include securing offices that hold PHI, password-protecting computers, and locking storage areas and filing cabinets. We require our employees to protect PHI through written policies and procedures. These policies limit access to PHI to only those employees who need the data to do their job. Employees are also required to wear ID badges to help keep people who should not have access out of areas where sensitive data is kept. Also, where required by law, our affiliates and nonaffiliates must protect the privacy of data we share in the normal course of business. They are not allowed to give PHI to others without your written OK, except as allowed by law.

Potential Impact of Other Applicable Laws

HIPAA (the federal privacy law) generally does not preempt, or override, other laws that give people greater privacy protections. As a result, if any state or federal privacy law requires us to provide you with more privacy protections, then we must also follow that law in addition to HIPAA.

Complaints

If you think we have not protected your privacy, you can file a complaint with us. You may also file a complaint with the Office for Civil Rights in the U.S. Department of Health and Human Services. We will not take action against you for filing a complaint.

Contact Information

Please call Customer Service at the phone number printed on your ID card. Representatives can help you apply your rights, file a complaint or talk with you about privacy issues.

Copies and Changes

You have the right to get a new copy of this notice at any time. Even if you have agreed to get this notice by electronic means, you still have the right to a paper copy. We reserve the right to change this notice. A revised notice will apply to PHI we already have about you, as well as any PHI we may get in the future. We are required by law to follow the privacy notice that is in effect at this time. We may tell you about any changes to our notice in a number of ways. We may tell you about the changes in a member newsletter or post them on our website. We may also mail you a letter that tells you about any changes.

Breast Reconstruction Surgery Benefits

If you ever need a benefit-covered mastectomy, we hope it will give you some peace of mind to know that your Anthem benefits comply with the Women's Health and Cancer Rights Act of 1998, which provides for:

- Reconstruction of the breast(s) that underwent a covered mastectomy
- Surgery and reconstruction of the other breast to restore a symmetrical appearance
- Prostheses and coverage for physical complications related to all stages of a covered mastectomy, including lymphedema

All applicable benefit provisions will apply, including existing deductibles, copays and/or coinsurance.

The content of this document is not a legal policy or contract. It is intended as a quick reference to inform you about the health plans, programs and services available to individuals from Anthem in Connecticut. Please refer to your contract documents to determine your rights to benefits and coverage, as well as your obligations under the health plan you purchase.

Selecting health coverage is an important decision.

To assist you, we supply the following for the plans under consideration: Brochure, Coverage Details, Enrollment Application and Health Statement. If you did not receive one or more of these materials, please contact your Anthem agent to request them.

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Anthem Blue Cross and Blue Shield
Major Medical Expense Coverage
OUTLINE OF COVERAGE
underwritten by Anthem Blue Cross and Blue Shield Insurance
370 Bassett Road, North Haven, Connecticut, 06473
1-800-331-0150

Anthem Premier
Subscriber Agreement

Premier $500-$10,000 Deductible

Read your policy carefully – This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is therefore, important that you **READ YOUR POLICY CAREFULLY!**

Major Medical Expense Coverage – Policies of this category are designed to provide, to persons insured, coverage for major hospital, medical, and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services, and out-of-hospital care, subject to any deductibles, co-payment provisions, or other limitations which may be set forth in the policy.

ANTHEM PREMIER

COVERED SERVICE	IN-NETWORK SERVICES	OUT-OF-NETWORK SERVICES
Individual Deductible	$500-$10,000	$500-$10,000
Family Deductible	$1,000-$20,000	$1,000-$20,000
Member Coinsurance	0-20%	30%
Member Out-of-Pocket Maximum (includes the Deductible)	$3,500-$10,000 individual $7,000-$20,000 family	$8,000-$17,500 individual $16,000-$35,000 family
PREVENTIVE SERVICES		
Routine Well Child Care:	No Cost-Share Deductible Waived	Deductible & Coinsurance
Routine Adult Physical Examinations:	No Cost-Share Deductible Waived	Deductible & Coinsurance
Routine Pap Test One per Member per Calendar Year.	No Cost-Share Deductible Waived	Deductible & Coinsurance
Routine Colorectal Cancer screenings (per guidelines established by the American College of Gastroenterology/ American Cancer Society).	No Cost-Share Deductible Waived	Deductible & Coinsurance
Routine Mammography	No Cost-Share Deductible Waived	Deductible & Coinsurance
Routine Prostate Exam (digital)	No Cost-Share Deductible Waived	Deductible & Coinsurance
Routine Prostate Specific Antigen (PSA) Test One per Member per Calendar Year.	No Cost-Share Deductible Waived	Deductible & Coinsurance
Other Routine Care - for lab, x-rays, immunizations, and vaccinations (services other than Mammograms, Pap Tests, PSA & Digital Rectal Exams and Colorectal Cancer Screenings).	No Cost-Share Deductible Waived	Deductible & Coinsurance

HOSPITAL SERVICES		
Inpatient Admissions	Deductible & Coinsurance	Deductible & Coinsurance
Outpatient Hospital Services	Deductible & Coinsurance	Deductible & Coinsurance
Ambulatory Surgical Center (includes colonoscopy)	Deductible & Coinsurance	Deductible & Coinsurance
DIAGNOSTIC SERVICES		
Diagnostic Services (Outpatient lab/x-ray, surgery, radiation, and anesthesia)	Deductible & Coinsuranc	Deductible & Coinsurance
THERAPY SERVICES		
Outpatient Physical and Occupational Therapy Limited to a benefit maximum of a combined 20 visits per Member per Calendar Year, combined In-Network and Out-of-Network.	Deductible & Coinsurance	Deductible & Coinsurance
Outpatient Speech Therapy Limited to a benefit maximum of 20 visits per Member per Calendar Year, combined In-Network and Out-of-Network.	Deductible & Coinsurance	Deductible & Coinsurance
Manual Medical Intervention (Spinal Manipulation) Limited to a benefit maximum of 15 visits per Member per Calendar Year, combined In-Network and Out-of-Network.	$30 PCP Copayment per visit; $40 SCP Copayment per visit Deductible waived	Deductible & Coinsurance
Other Therapy Services: Outpatient cardiac rehabilitation therapy up to 36 visits per cardiac episode. Radiation therapy: Electroshock Therapy. Kidney Dialysis in a Hospital or free-standing dialysis center.	Deductible & Coinsurance	Deductible & Coinsurance

Allergy Office Visit/Testing/Injections Allergy Injection. Immunotherapy or other therapy treatments to a maximum of 80 visits In and Out-of-Network combined over a 3 Calendar Year period.	Deductible & Coinsurance	Deductible & Coinsurance
MEDICAL EMERGENCY / URGENT CARE SERVICES		
Emergency Room Treatment		
Emergency	Deductible & Coinsurance	Deductible and In-Network Coinsurance
Non-emergency	Deductible & Coinsurance	Deductible & Coinsurance
Urgent Care Services	Deductible & Coinsurance	Deductible and In-Network Coinsurance
Ambulance Maximum for land: Paid according to the Department of Public Health Ambulance Service Rate Schedule Maximum for air: Paid according to the Department of Public Health Ambulance Service Rate Schedule.	Deductible & Coinsurance	Deductible & Coinsurance
PHYSICIAN MEDICAL/ SURGICAL SERVICES		
Medical Office Visit only **Note**: The Office Visit Copay does not apply to the Out-of-Pocket Maximum. The Office Visit Copay is still required even after the Out-of-Pocket Maximum has been met.	$30 PCP;$40 SCP Copayment Deductible waived	Deductible & Coinsurance
Services of a Physician or Surgeon (other than a medical office visit)	Deductible & Coinsurance	Deductible & Coinsurance

MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES		
Outpatient treatment for Mental Health Care and Substance Abuse Care	$30 PCP;$40 SCP Copayment Deductible Waived	Deductible & Coinsurance
Inpatient Hospital Services In a Hospital or Residential Treatment Center for Mental Health Care	Deductible & Coinsurance	Deductible & Coinsurance
Inpatient Rehabilitation treatment for Substance Abuse Care In a Hospital or Substance Abuse Treatment Facility	Deductible & Coinsurance	Deductible & Coinsurance
OTHER MEDICAL SERVICES		
Early Intervention Services (from birth to age 3) Benefit maximums: $6,400 per child per Calendar Year; $19,200 per child over a period of 3 years (aggregate)	No Cost-Share	Deductible & Coinsurance
Skilled Nursing Facility Up to 100 days per Calendar Year combined In-Network and Out-of-Network.	Deductible & Coinsurance	Deductible & Coinsurance
Human Organ and Tissue Transplant Services	Deductible & Coinsurance	Deductible & Coinsurance
Home Health Care Nursing and therapeutic services. Home health aide services. (includes outpatient respiratory services) Limit is 100 combined visits per Calendar Year, In-Network and Out-of-Network combined *After the $50 Deductible has been met, the Member shall pay the applicable Coinsurance. The Deductible for Home Health Care benefits accrues towards the Member's annual Deductible, but only the separate Home Health Care deductible must be met before the Plan starts to pay benefits for Home Health Care.	Deductible* & 20% Coinsurance	Deductible* & 25% Coinsurance
Infusion Therapy	Deductible & Coinsurance	Deductible & Coinsurance

Durable Medical Equipment (Includes certain diabetic supplies when obtained from a Non-Network Pharmacy.) Hearing Aids for Children age 12 and under: 1 hearing aid per member every 24 months Wig benefits are limited to a total of $350 per Member per Calendar Year for alopecia medicamentosa In and Out-of-Network combined. No Member Cost-Share.	Deductible & Coinsurance	Deductible & Coinsurance
Infertility Services (Please refer to the "Other Provisions" section of this Subscriber Agreement.) **Outpatient Hospital** **Inpatient Hospital** **Infertility Drugs (with infertility diagnosis)** The maximum supply of a drug for which benefits will be provided when dispensed under any one prescription is a 30 day supply or a 100 unit dose, whichever is greater.	Same as Outpatient Hospital Cost-Share Same as Inpatient Hospital Cost-Share Deductible & Coinsurance	Deductible & Coinsurance Deductible & Coinsurance Deductible & Coinsurance
Ostomy Related Services	Deductible & Coinsurance	Deductible & Coinsurance
Hospice Care	Deductible & Coinsurance	Deductible & Coinsurance
Specialized Formula and low protein modified food for treatment of metabolic disease Note for children up to age 12	Deductible & Coinsurance	Deductible & Coinsurance
OTHER		
Penalty for Failure to Prior Authorize Covered Services Please note that the combined penalty amount for Facility Benefit and the Admitting Physician Benefit will be no greater than $500.	$200 Hospital and 25% Physician (of Maximum Allowable Amount (MAA)	$200 Hospital and 25% Physician (of Maximum Allowable Amount (MAA)

Prescription Drug Deductible $200 in and out-of-network combined per Member per Calendar Year		
Retail up to a 30 day supply		
Tier 1 Generic Drugs (deductible waived)	$15 Copayment	50% Coinsurance
Tier 2 Preferred Brand	40% Coinsurance*	50% Coinsurance
Tier 3 Non –Preferred Brand and Specialty Drugs	40% Coinsurance*	50% Coinsurance
Mail Order up to a 90 day supply		
Tier 1 Generic Drugs (deductible waived)	$30 Copayment	50% Coinsurance
Tier 2 Preferred Brand	40% Coinsurance*	50% Coinsurance
Tier 3 Non –Preferred Brand	40% Coinsurance*	50% Coinsurance
Note: Generic RX required if available. If brand name drug is purchased when generic was available, the member pays the applicable copay/coinsurance plus the difference between the brand and generic	*Note: Up to an annual $10,000 in-network Out of Pocket per member. Once annual Out-of-Pocket maximum is met then member pays 0% of the Maximum Allowable Amount (MAA).	Note: Member pays difference between total charge and Anthem Maximum Allowable Amount (MAA) and Member is responsible for filing the claim.

Note: Separate Deductible for In and Out-of-Network.

Note: Separate Out of Pocket for In and Out-of-Network.

Note: The Out-of-Pocket Maximum includes the Deductible but does not include any Copayments.

Note: Copayments and prescription drugs DO NOT accumulate toward the Deductible or Out-of-Pocket Maximum.

Note: **Aggregate Family Deductible**: Once two or more covered person's allowable charges that applied to their individual Deductible amount combine to equal the Aggregate Family Deductible, then no other individual Deductible needs to be met for the Calendar Year. However, no one person can contribute more than the individual Deductible to the Aggregate Family Deductible.

Note: **Aggregate Out-of-Pocket Maximum** - Once two or more covered person's allowable charges that applied to their Individual Out-of-Pocket Maximum amount combine to equal the Aggregate Out-of-Pocket Maximum, then no other individual Out-of-Pocket Maximum needs to be met for the Calendar Year. However, no one person can contribute more than the Individual Out-of-Pocket Maximum to the Aggregate Out-of-Pocket maximum.

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

Pre-Existing Condition Limitation Exclusion (for Members age 19 and older) This Subscriber Agreement does not cover charges for Pre-Existing Conditions diagnosed or treated during the 12 months immediately preceding the original Effective Date of continuous coverage during the Pre-Existing Condition Limitation Period. The Pre-Existing Condition Limitation Period may last up to 12 months from your Enrollment Date. Credit from prior Creditable Coverage will be applied if applicable to reduce your specific Pre-Existing Condition Limitation Period. You will be notified in writing by Anthem BCBS exactly how many months you will be subject to this exclusion. Please refer to the Pre-Existing Condition Exclusion Provision section for additional information.

EXCLUSIONS AND LIMITATIONS

1. Benefits for services which are not:
    a. specifically described in the Subscriber Agreement
    b. rendered or ordered by a Physician
    c. within the scope of the Physician's, Provider's or Hospital's licensure; and
    d. Medically Necessary Care for the proper diagnosis and treatment of the Member.
2. Benefits may be reduced or denied if subject to the Managed Benefits – Managed Care Guidelines. Any reduced or denied benefits paid by the Member do not apply toward the Cost-Share Maximums shown in the Schedule of Benefits.
3. Benefits for services rendered before the Member's Effective Date under this Benefit Program.
4. Benefits for services rendered after the person's Benefit Program has been rescinded, suspended, cancelled, interrupted or terminated. Any person obtaining services after his or her Benefit Program is rescinded, suspended, cancelled, interrupted or terminated for any reason will be solely responsible for payment of such services.
5. Care for conditions which are required by State or Local law to be treated in a public facility.
6. Services and care in a Veteran's Hospital or any Federal Hospital, except as may be otherwise required by law.
7. Services covered in whole or in part by public or private grants.
8. Services required by third parties, including but not limited to: school, employment, summer camp and premarital physicals and related tests.
9. Studies related to pregnancy except for significant medical reasons.
10. Simplified or self-administered tests and multiphasic screening.
11. Cosmetic Surgeries, procedures and services performed primarily to improve appearance and not otherwise determined by Anthem BCBS to meet the coverage criteria for reconstructive surgeries, procedures and services as set forth in this Subscriber Agreement.
12. Dental diagnosis, care, treatment, x-rays, or Appliances, for any of the diseases or lesions of the oral cavity, its contents or contiguous structures, the extraction of teeth, the correction of malpositions of the teeth and jaw, or for pain, deformity, deficiency, injury or physical condition of teeth, unless otherwise provided for in this Subscriber Agreement.
13. Surgical and non-surgical examination, diagnosis, including invasive (internal) and non-invasive (external) procedures and tests, and all services related to diagnosis and treatment, both medical and surgical, of temporomandibular joint dysfunction or syndrome also called myofascial pain dysfunction or craniomandibular pain syndrome. This exclusion includes but is not limited to the following: contrast and non-contrast imaging, arthroscopic and open surgical procedures, physical therapy, and appliance therapy such as occlusal Appliances (splints) or adjustments.
14. Routine foot care in the absence of systemic or vascular disease affecting the foot, including hygienic care, treatment of corns or calluses, services performed in conjunction with fitting of supportive or comfort devices for the foot or other foot care.
15. Services for Custodial Care, Chronic Care and/or Maintenance Care. Including without limitation, Methadone and Suboxone maintenance or any other similar maintenance therapy program and its related testing, supplies, visits and treatment.
16. Prenatal medical conferences with a pediatrician regarding an unborn child unless the visit is the result of a medical referral.
17. Charges for the Member's room and board when the Member has a leave of absence from the Hospital, Substance Abuse Treatment Facility or other Inpatient Facility.

18. Drugs or medications, legend and over-the-counter, prescribed for use as an Outpatient, except as otherwise stated herein.
19. Sperm collection and preservation, all services related to surrogate parenting arrangements and preparatory treatment.
20. Evaluation, treatment, procedures and Prescription Drugs related to and performance of sex-change operations including follow-up treatment, care and counseling.
21. Obstetrical care or pregnancy, delivery, prenatal and postpartum care, including Inpatient care for a female Member.
22. No benefits are available for sterilization.
23. Vaccines other than routine immunizations or those needed for travel.
24. Services, medical supplies or supplies not specifically listed as Covered Services. These include but are not limited to educational therapy, marital counseling, sex therapy, weight control programs, nutritional programs and exercise programs.
25. No benefits are available for any service, care, procedure or program for weight or appetite control, weight loss, weight management or for control of obesity even if the weight or obesity aggravates another condition.
26. Experimental or Investigational treatment, procedure, facility, equipment, drugs, devices or supplies. Any services associated with or as follow-up to any of the above is not a Covered Service.
27. Any treatment, procedure, facility, equipment, drug, device or supply which requires Federal or other governmental agency approval not granted at the time services are rendered. Any service associated with, or as follow-up to, any of the above is not a Covered Service.
28. Any services by a Physician or Provider to himself or herself or for services rendered to his or her parent, spouse, children, grandchildren or any other immediate family Member or relation, even if a Participating Physician or Participating Provider Services which the Member or Anthem BCBS is not legally required to pay.
29. Wigs, except as noted in the Covered Services Section.
30. Inpatient services which can be properly rendered as Outpatient services.
31. Disease contracted or injuries resulting from war.
32. Charges after the Provider's or Hospital's regular discharge hour on the day indicated for the Member's discharge by his/her Physician.
33. Charges in excess of the Maximum Allowable Amount.
34. Supervisory care by a Physician for a Member who is mentally or physically disabled and who is not under specific medical, surgical or psychiatric treatment to reduce the disability to the extent necessary to enable the patient to live outside an institution providing medical care; or when despite such treatment, there is no reasonable likelihood that the disability will be so reduced.
35. Travel, whether or not recommended by a Physician.
36. Certain pulmonary function tests which in the opinion of Anthem BCBS do not meet the definition of a covered diagnostic laboratory test.
37. Services or procedures rendered without regard for specific clinical indications, routinely for groups or individuals or which are performed solely for research purposes.
38. Services or procedures which have become obsolete or are no longer medically justified as determined by appropriate medical specialties.
39. Radiation therapy as a treatment for acne vulgaris.
40. Methadone and Suboxone maintenance or any other similar maintenance therapy program and its related testing, supplies, visits, and treatment.
41. Services rendered by a Physician in the employ of a Home (e.g. Skilled Nursing Facility) do not qualify as Home & Office Care.
42. The following is a list of procedures which are not covered:
    1. Allogeneic or Syngeneic Bone Marrow Transplant or other forms of stem cell rescue and stem cell infusion (with or without high dose chemotherapy and/or radiation) are those with a donor other than the patient. They are not covered except in the following cases:

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

            *Severe aplastic anemia

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

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

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

    a. Non-Hodgkin's lymphoma, high grade, first or subsequent remission. No morphological evidence of bone marrow involvement should be evident.
    b. Hodgkin's disease as defined above with an absence of bone marrow involvement.
    c. Acute nonlymphocytic leukemia in second remission, in which no HLA matched donor exists or an allogeneic transplant is inappropriate.
    d. Acute lymphocytic leukemia in second remission, in which no HLA matched donor exists or an allogeneic transplant is inappropriate.
    e. Retinoblastoma, adjuvant setting after successful induction (consolidation).
    f. Neuroblastoma, adjuvant setting after successful induction (consolidation).

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

43. Surrogacy. Costs associated with surrogate parenting or gestational carriers are not covered. Services or supplies provided to a person not covered under the Subscriber Agreement in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).
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45. Nutritional and/or dietary supplements, except as provided in this Subscriber Agreement or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either a written Prescription or dispensing by a licensed Pharmacist.

46. Health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a Physician.
47. Preventive Care other than as described in the Schedule of Benefits.
48. Private duty nursing.
49. Maternity care and related services except for complications of pregnancy.
50. Vision care, unless specifically shown as covered in the Schedule of Benefits.
51. Reversal of Voluntary Sterilization. We do not provide benefits for services to reverse voluntarily induced sterility.

PREMIUM RATES

The amount, time and manner of payment of Premiums shall be determined by Anthem BCBS and shall be subject to the approval of the State of Connecticut Insurance Department.

In the event of any change in Premium, the Subscriber will be given notice at least 30 days prior to such change. Payment of the Premium by the Subscriber of contributions shall serve as notice of the Subscriber's acceptance of the change.

RENEWAL PROVISION

We will renew your Subscriber Agreement each time you send us the premium. Payment must be made on or before the due date or during the month that follows. Your Subscriber Agreement stays in force during this time. We can refuse to renew your Subscriber Agreement only when we refuse to renew all form number 10232CT Subscriber Agreements in our state. Nonrenewal will not affect an existing claim.

Anthem Blue Cross and Blue Shield
Major Medical Expense Coverage
OUTLINE OF COVERAGE
underwritten by Anthem Blue Cross and Blue Shield Insurance
370 Bassett Road, North Haven, Connecticut, 06473
1-800-331-0150

Anthem SmartSense
Subscriber Agreement

SmartSense $750-$12,000 Deductible

Read your policy carefully – This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is therefore, important that you **READ YOUR POLICY CAREFULLY!**

Major Medical Expense Coverage – Policies of this category are designed to provide, to persons insured, coverage for major hospital, medical, and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services, and out-of-hospital care, subject to any deductibles, co-payment provisions, or other limitations which may be set forth in the policy.

ANTHEM SMARTSENSE

COVERED SERVICE	IN-NETWORK SERVICES	OUT-OF-NETWORK SERVICES
Individual Deductible	$750- $12,000	$750 -$12,000
Family Deductible	$1,500 -$24,000	$1,500 -$24,000
Member Coinsurance	0%-50%	30%-50%
Member Out-of-Pocket Maximum (includes the Deductible)	$4,750 $12,000 individual $9,500-$24,000 family	$8,250 -$19,500 individual $16,500-$39,000 family
PREVENTIVE SERVICES		
Routine Office Visit	No Cost-Share Deductible waived	Deductible & Coinsurance
Routine Pap Test 1 per Member per Calendar Year	No Cost-Share Deductible waived	Deductible & Coinsurance
Routine Colorectal Cancer screenings (per guidelines established by the American College of Gastroenterology/ American Cancer Society).	No Cost-Share Deductible waived	Deductible & Coinsurance
Routine Mammography	No Cost-Share Deductible waived	Deductible & Coinsurance
Routine Prostate Exam (digital)	No Cost-Share Deductible waived	Deductible & Coinsurance
Routine Prostate Specific Antigen (PSA) Test One per Member per Calendar Year	No Cost-Share Deductible waived	Deductible & Coinsurance
HOSPITAL SERVICES		
Inpatient Admissions	Deductible & Coinsurance	Deductible & Coinsurance
Outpatient Hospital Services	Deductible & Coinsurance	Deductible & Coinsurance
Ambulatory surgical center (includes colonoscopy)	Deductible & Coinsurance	Deductible & Coinsurance

DIAGNOSTIC SERVICES		
Diagnostic Services (Outpatient lab/x-ray, surgery, radiation, and anesthesia)	Deductible & Coinsurance	Deductible & Coinsurance
THERAPY SERVICES		
Outpatient Physical and Occupational Therapy Limited to a benefit maximum of a combined 15 visits per Member per Calendar Year, combined In-Network and Out-of-Network.	Deductible & Coinsurance	Deductible & Coinsurance
Outpatient Speech Therapy Limited to a benefit maximum of 15 visits per Member per Calendar Year, combined In-Network and Out-of-Network.	Deductible & Coinsurance	Deductible & Coinsurance
Manual Medical Intervention (Spinal Manipulation) Visits 1-3 (applies to total doctor visit copayment limit per member per Calendar Year) (Deductible does not apply when there is a copayment) Visit 4 and over Limited to a benefit maximum of 10 visits per Member per Calendar Year, combined In-Network and Out-of-Network.	$30 Copayment per visit for the first three visits per Calendar Year; Deductible & Coinsurance	Deductible & Coinsurance
Other Therapy Services: Outpatient cardiac rehabilitation therapy up to 36 visits per cardiac episode. Radiation therapy: Electroshock Therapy. Kidney Dialysis in a Hospital or free-standing dialysis center.	Deductible & Coinsurance	Deductible & Coinsurance

Allergy Office Visits		
Visits 1-3 (Deductible does not apply when there is a Copayment)	$30 Copayment per visit for the first three visits per Calendar Year;	Deductible & Coinsurance
Visits 4 and over	Deductible & Coinsurance	Deductible & Coinsurance
Allergy Injection. Immunotherapy or other therapy treatments to a maximum of 80 visits In and Out-of-Network combined over a 3 Calendar Year period.		
Allergy Testing and Injections	Deductible & Coinsurance	Deductible & Coinsurance
MEDICAL EMERGENCY / URGENT CARE SERVICES		
Emergency Room Treatment		
Emergency	Deductible &Coinsurance	Deductible and In-Network Coinsurance
Non-emergency	Deductible & Coinsurance	Deductible & Coinsurance
Urgent Care Services	Deductible & Coinsurance	Deductible and In-Network Coinsurance
Ambulance Maximum for land: Paid according to the Department of Public Health Ambulance Service Rate Schedule Maximum for air: Paid according to the Department of Public Health Ambulance Service Rate Schedule.	Deductible & Coinsurance	Deductible & Coinsurance

PHYSICIAN MEDICAL/ SURGICAL SERVICES		
Medical Office Visit only **Visits 1-3** (Deductible does not apply when there is a copayment)	$30 Copayment per visit for the first three visits per Calendar Year;	Deductible & Coinsurance
Visits 4 and over **Note:** Office visits subject to the Copayment are limited to a maximum of 3 per Member per Calendar Year. Any additional office visits exceeding the maximum will be subject to the Deductible & Coinsurance. **Note:** The Office Visit Copay does not apply to the Out-of-Pocket Maximum. The Office Visit Copay is still required even after the Out-of-Pocket Maximum has been met.	Deductible & Coinsurance	Deductible & Coinsurance
Services of a Physician or Surgeon (other than a medical office visit)	Deductible & Coinsurance	Deductible & Coinsurance
MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES		
Outpatient treatment for Mental Health Care and Substance Abuse Care **Visits 1-3** (Deductible does not apply when there is a copayment)	$30 Copayment per visit for the first three visits per Calendar Year;	Deductible & Coinsurance
Visits 4 and over	Deductible & Coinsurance	Deductible & Coinsurance
Inpatient Hospital Services In a Hospital or Residential Treatment Center for Mental Health Care	Deductible &Coinsurance	Deductible & Coinsurance
Inpatient Rehabilitation treatment for Substance Abuse Care In a Hospital or Substance Abuse Treatment Facility.	Deductible & Coinsurance	Deductible & Coinsurance

OTHER MEDICAL SERVICES		
Early Intervention Services (from birth to age 3) Benefit maximums: $6,400 per child per Calendar Year; $19,200 per child over a period of 3 years (aggregate)	No Cost-Share	Deductible & Coinsurance
Skilled Nursing Facility up to 100 days per Calendar Year combined In-Network and Out-of-Network.	Deductible & Coinsurance	Deductible & Coinsurance
Human Organ and Tissue Transplant Services	Deductible & Coinsurance	Deductible & Coinsurance
Home Health Care Nursing and therapeutic services. Home health aide services. (includes outpatient respiratory services) Limit is 100 visits per Member per Calendar Year, combined In-Network and Out-of-Network *After the $50 Deductible has been met, the Member shall pay the applicable Coinsurance. The Deductible for Home Health Care benefits accrues towards the Member's annual Deductible, but only the separate Home Health Care deductible must be met before the Plan starts to pay benefits for Home Health Care.	Deductible* & 25% Coinsurance	Deductible* & 25% Coinsurance
Infusion Therapy	Deductible & Coinsurance	Deductible & Coinsurance
Durable Medical Equipment (Includes certain diabetic supplies when obtained from a Non-Network Pharmacy.) Hearing Aids for Children age 12 and under: 1 hearing aid per Member every 24 Months **Note: Wig benefit**s are limited to a total of $350 per Member per Calendar Year for alopecia medicamentosa. No member Cost-Share.	Deductible & Coinsurance	Deductible & Coinsurance

Infertility Services (Please refer to the "Other Provisions" section of this Subscriber Agreement.) **Outpatient Hospital** **Inpatient Hospital** **Infertility Drugs (with infertility diagnosis)** The maximum supply of a drug for which benefits will be provided when dispensed under any one prescription is a 30 day supply or a 100 unit dose, whichever is greater.	 Same as Outpatient Hospital Cost-Share Same as Inpatient Hospital Cost-Share Deductible & Coinsurance	 Deductible & Coinsurance Deductible & Coinsurance Deductible & Coinsurance
Ostomy Related Services	Deductible & Coinsurance	Deductible & Coinsurance
Hospice Care	Deductible & Coinsurance	Deductible & Coinsurance
Specialized Formula and low protein modified food for treatment of metabolic disease Note for children up to age 12	Deductible & Coinsurance	Deductible & Coinsurance
OTHER		
Penalty for Failure to Prior Authorize Covered Services Please note that the combined penalty amount for Facility Benefit and the Admitting Physician Benefit will be no greater than $500.	$200 Hospital and 25% Physician (of Maximum Allowable Amount (MAA)	$200 Hospital and 25% Physician (of Maximum Allowable Amount (MAA

Prescription Drug Deductible $250 combined in and out-of-network per Member per Calendar Year **Retail up to a 30 day supply**		
Tier 1 Generic Drugs (deductible waived)	$15 copayment	50% Coinsurance
Tier 2 Preferred Brand	40% Coinsurance	50% Coinsurance
Mail Order up to a 90 day supply		
Tier 1 Generic Drugs (deductible waived)	$30 copayment	50% Coinsurance
Tier 2 Preferred Brand	40% Coinsurance	50%Coinsurance
Note; Member will receive Anthem Discount and only pay to Maximum Allowable Amount for Non-Preferred Brand and Specialty Drugs Note: Generic RX required if available. If brand name drug is purchased when generic was available, the member pays the applicable copay/coinsurance plus the difference between the brand and generic.		Note: Member pays difference between total charge and Anthem Maximum Allowable Amount (MAA) and Member is responsible for filing the claim.

Buy Up Option		
Prescription Drugs Deductible $200 in and out-of-network combined per Member per Calendar Year **Retail up to a 30 day supply**		
Tier 1 Generic Drugs (deductible waived)	$15 copayment	50% Coinsurance
Tier 2 Preferred Brand	40% Coinsurance*	50% Coinsurance
Tier 3 Non –Preferred Brand and Specialty Drugs	40% Coinsurance*	50% Coinsurance
Mail Order up to a 90 day supply		
Tier 1 Generic Drugs (deductible waived)	$30 copayment	50% Coinsurance
Tier 2 Preferred Brand	40% Coinsurance*	50% Coinsurance
Tier 3 Non –Preferred Brand	40% Coinsurance*	50% Coinsurance
Note: Generic RX required if available. If brand name drug is purchased when generic was available, the member pays the applicable copay/coinsurance plus the difference between the brand and generic.	*Note: Up to an annual $10,000 in-network Out of Pocket per member. Once annual Out-of-Pocket maximum is met then member pays 0%.of the Maximum Allowable Amount (MAA).	Note: Member pays difference between total charge and Anthem Maximum Allowable Amount (MAA) and Member is responsible for filing the claim.

Note: Separate Deductible for In and Out-of-Network.

Note: Separate Out of Pocket for In and Out-of-Network.

Note: The Out-of-Pocket Maximum includes the Deductible but does not include any Copayments.

Note: Copayments and prescription drugs DO NOT accumulate toward the Deductible or Out-of-Pocket Maximum.

Note: **Aggregate Family Deductible**: Once two or more covered person's allowable charges that applied to their individual Deductible amount combine to equal the Aggregate Family Deductible, then no other individual Deductible needs to be met for the Calendar Year. However, no one person can contribute more than the individual Deductible to the Aggregate Family Deductible.

Note: **Aggregate Out-of-Pocket Maximum** - Once two or more covered person's allowable charges that applied to their Individual Out-of-Pocket Maximum amount combine to equal the Aggregate Out-of-Pocket Maximum, then no other individual Out-of-Pocket Maximum needs to be met for the Calendar Year.

However, no one person can contribute more than the Individual Out-of-Pocket Maximum to the Aggregate Out-of-Pocket maximum.

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

Pre-Existing Condition Limitation Exclusion (for Members age 19 and older) This Subscriber Agreement does not cover charges for Pre-Existing Conditions diagnosed or treated during the 12 months immediately preceding the original Effective Date of continuous coverage during the Pre-Existing Condition Limitation Period. The Pre-Existing Condition Limitation Period may last up to 12 months from your Enrollment Date. Credit from prior Creditable Coverage will be applied if applicable to reduce your specific Pre-Existing Condition Limitation Period. You will be notified in writing by Anthem BCBS exactly how many months you will be subject to this exclusion. Please refer to the Pre-Existing Condition Exclusion Provision section for additional information.

EXCLUSIONS AND LIMITATIONS

1. Benefits for services which are not:
    a. specifically described in the Subscriber Agreement
    b. rendered or ordered by a Physician
    c. within the scope of the Physician's, Provider's or Hospital's licensure; and
    d. Medically Necessary Care for the proper diagnosis and treatment of the Member.
2. Benefits may be reduced or denied if subject to the Managed Benefits – Managed Care Guidelines. Any reduced or denied benefits paid by the Member do not apply toward the Cost-Share Maximums shown in the Schedule of Benefits.
3. Benefits for services rendered before the Member's Effective Date under this Benefit Program.
4. Benefits for services rendered after the person's Benefit Program has been rescinded, suspended, cancelled, interrupted or terminated. Any person obtaining services after his or her Benefit Program is rescinded, suspended, cancelled, interrupted or terminated for any reason will be solely responsible for payment of such services.
5. Care for conditions which are required by State or Local law to be treated in a public facility.
6. Services and care in a Veteran's Hospital or any Federal Hospital, except as may be otherwise required by law.
7. Services covered in whole or in part by public or private grants.
8. Services required by third parties, including but not limited to: school, employment, summer camp and premarital physicals and related tests.
9. Studies related to pregnancy except for significant medical reasons.
10. Simplified or self-administered tests and multiphasic screening.
11. Cosmetic Surgeries, procedures and services performed primarily to improve appearance and not otherwise determined by Anthem BCBS to meet the coverage criteria for reconstructive surgeries, procedures and services as set forth in this Subscriber Agreement.
12. Dental diagnosis, care, treatment, x-rays, or Appliances, for any of the diseases or lesions of the oral cavity, its contents or contiguous structures, the extraction of teeth, the correction of malpositions of the teeth and jaw, or for pain, deformity, deficiency, injury or physical condition of teeth, unless otherwise provided for in this Subscriber Agreement.
13. Surgical and non-surgical examination, diagnosis, including invasive (internal) and non-invasive (external) procedures and tests, and all services related to diagnosis and treatment, both medical and surgical, of temporomandibular joint dysfunction or syndrome also called myofascial pain dysfunction or craniomandibular pain syndrome. This exclusion includes but is not limited to the following: contrast and non-contrast imaging, arthroscopic and open surgical procedures, physical therapy, and appliance therapy such as occlusal Appliances (splints) or adjustments.
14. Routine foot care in the absence of systemic or vascular disease affecting the foot, including hygienic care, treatment of corns or calluses, services performed in conjunction with fitting of supportive or comfort devices for the foot or other foot care.

15. Services for Custodial Care, Chronic Care and/or Maintenance Care. Including without limitation, Methadone and Suboxone maintenance or any other similar maintenance therapy program and its related testing, supplies, visits and treatment.
16. Prenatal medical conferences with a pediatrician regarding an unborn child unless the visit is the result of a medical referral.
17. Charges for the Member's room and board when the Member has a leave of absence from the Hospital, Substance Abuse Treatment Facility or other Inpatient Facility.
18. Drugs or medications, legend and over-the-counter, prescribed for use as an Outpatient, except as otherwise stated herein.
19. Sperm collection and preservation, all services related to surrogate parenting arrangements and preparatory treatment.
20. Evaluation, treatment, procedures and Prescription Drugs related to and performance of sex-change operations including follow-up treatment, care and counseling.
21. Obstetrical care or pregnancy, delivery, prenatal and postpartum care, including Inpatient care for a female Member.
22. No benefits are available for sterilization.
23. Vaccines other than routine immunizations or those needed for travel.
24. Services, medical supplies or supplies not specifically listed as Covered Services. These include but are not limited to educational therapy, marital counseling, sex therapy, weight control programs, nutritional programs and exercise programs.
25. No benefits are available for any service, care, procedure or program for weight or appetite control, weight loss, weight management or for control of obesity even if the weight or obesity aggravates another condition.
26. Experimental or Investigational treatment, procedure, facility, equipment, drugs, devices or supplies. Any services associated with or as follow-up to any of the above is not a Covered Service.
27. Any treatment, procedure, facility, equipment, drug, device or supply which requires Federal or other governmental agency approval not granted at the time services are rendered. Any service associated with, or as follow-up to, any of the above is not a Covered Service.
28. Any services by a Physician or Provider to himself or herself or for services rendered to his or her parent, spouse, children, grandchildren or any other immediate family Member or relation, even if a Participating Physician or Participating Provider Services which the Member or Anthem BCBS is not legally required to pay.
29. Wigs, except as noted in the Covered Services Section.
30. Inpatient services which can be properly rendered as Outpatient services.
31. Disease contracted or injuries resulting from war.
32. Charges after the Provider's or Hospital's regular discharge hour on the day indicated for the Member's discharge by his/her Physician.
33. Charges in excess of the Maximum Allowable Amount.
34. Supervisory care by a Physician for a Member who is mentally or physically disabled and who is not under specific medical, surgical or psychiatric treatment to reduce the disability to the extent necessary to enable the patient to live outside an institution providing medical care; or when despite such treatment, there is no reasonable likelihood that the disability will be so reduced.
35. Travel, whether or not recommended by a Physician.
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38. Services or procedures which have become obsolete or are no longer medically justified as determined by appropriate medical specialties.
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    1. Allogeneic or Syngeneic Bone Marrow Transplant or other forms of stem cell rescue and stem cell infusion (with or without high dose chemotherapy and/or radiation) are those with a donor other than the patient. They are not covered except in the following cases:

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

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*Acute nonlymphocytic leukemia in first or subsequent remission or early first relapse
*Myelodysplastic syndrome
*Secondary acute nonlymphocytic leukemia as initial therapy
*Acute lymphocytic leukemia in second or subsequent remission
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*Ewing's sarcoma
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*Osteopetrosis, infantile malignant
*Chediak-Higashi syndrome
*Congenital life-threatening neutrophil disorders to include Kostmann's syndrome, chronic granulomatous disease, and cartilage hair hypoplasia
*Diamond Blackfan syndrome
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*Primary thrombocytopathy including Glanzmann's syndrome
*Gaucher disease
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supervision, unless specifically listed as covered in this Subscriber Agreement. This exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) fasting programs. This exclusion does not apply to Medically Necessary treatments for morbid obesity

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48. Private duty nursing.
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RENEWAL PROVISION

We will renew your Subscriber Agreement each time you send us the premium. Payment must be made on or before the due date or during the month that follows. Your Subscriber Agreement stays in force during this time. We can refuse to renew your Subscriber Agreement only when we refuse to renew all form number 10233CT Subscriber Agreements in our state. Nonrenewal will not affect an existing claim.