Summary Booklet

for employees of

Regional School District #4
000352-110 HBP 003
111 HBP 003
112 HBP 002
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Full Dental Plan with Rider A

INTRODUCTION

This Summary Booklet describes generally this Benefit Program, which is funded by the **Regional School District #4** and for which Anthem Blue Cross and Blue Shield performs various administrative services.

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

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

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

In performing its obligations under the Administrative Services Only Agreement, it is understood that Anthem BCBS is not, nor shall it be deemed to be, acting as an “administrator” or “named fiduciary” of the Benefit Program as those terms are defined in ERISA and any regulations issued thereunder. The Employer Group is the “administrator” and “named fiduciary” of the Benefit Program as these terms are defined in ERISA. Except as expressly provided for in the Administrative Services Only Agreement and in this Summary Booklet, Anthem BCBS has no discretionary authority, control or responsibility with respect to the management or administration or assets, if any, of the Benefit Program.

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

All the defined terms used in this Summary Booklet have the meanings ascribed to them herein without reference to any of the definitions contained in the Administrative Services Only Agreement. The terms of this Summary Booklet shall govern and supersede any previous versions of this Summary

Booklet and any outlines or other summaries distributed by the Employer Group or Anthem BCBS with respect to the Benefit Program.

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

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

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

If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration, Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries of the Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution N.W., Washington, D.C. 20210.

You usually will be able to answer your benefits questions by referring to this Summary Booklet. If you need help with your membership, benefits or claims, call or write the Member Services Department, at Anthem Blue Cross and Blue Shield, dedicated to serving your group:

Member Services Department
Anthem Blue Cross and Blue Shield
P.O. Box 533
North Haven, CT 06473-4201

Toll-free statewide 1-800-233-4947
New Haven area (203) 985-6338
Out-of-State 1-800-233-4947

FULL DENTAL PLAN
WITH RIDER A

Issued By:

Anthem Health Plans, Inc. d/b/a
Anthem Blue Cross and Blue Shield
370 Bassett Road
North Haven, Connecticut 06473

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DEFINITIONS

Actively At Work: The term Actively At Work means the employee must work at the employer group's place of business or at such place(s) as normal business requires. The employee must perform all duties of the job as required of a full-time employee working 30 or more hours per week on a regularly scheduled basis. Eligible employees who do not satisfy the criteria, solely due to a health-related reason, are considered Actively At Work for purpose of initial Eligibility under the Benefit Program.

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

Benefit Period: The term Benefit Period means the consecutive extent of time for which benefits are payable. Unless otherwise defined as a period of days in the Schedule of Benefits, the Benefit Period shown in the Schedule of Benefits.

Benefit Program: The term Benefit Program and Program means the employee dental benefit plan of the Employer, administered by Anthem BCBS on behalf of the Employer, and described in this Summary Booklet.

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

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

Cost Share: The term Cost Share means the amount which the Covered Person is required to pay for Covered Services. When applicable, Cost Shares can be in the form of copayments, Coinsurance and/or Deductibles.

Covered Person: The term Covered Person means an Eligible Person as defined in the Eligibility Section, who has been accepted for membership under this Benefit Program and in whose name a membership identification card is issued.

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

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

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

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

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

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

1. stop bleeding;

2. open and clean an infection; and/or

3. relieve pain.

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

1. Endodontist: a Dentist whose practice is limited to treating disease and injuries of the pulp and associated periradicular conditions.

2. Periodontist: a Dentist whose practice is limited to the treatment of diseases of the supporting and surrounding tissues of the teeth.

3. Prosthodontist: a Dentist whose practice is limited to the restoration of the natural teeth and/or the replacement of missing teeth with artificial substitutes.

Dentistry: The term Dentistry (Dental Care) means:

1. the diagnosis and treatment of diseases or lesions of the mouth and surrounding and associated structures;

2. replacement of lost teeth by artificial ones;

3. the diagnosis or correction of malposition of the teeth; or

4. the furnishing, supplying constructing, reproducing or repairing any prosthetic denture, bridge appliance or any other structure to be worn in the mouth; or the placement or adjustment of such appliance or structure in the human mouth.

Dependent: The term Dependent means an Eligible Dependent as defined in the Eligibility Section of this Summary Booklet.

Description of Benefits: The term Description of Benefits means the document which describes for the Employer the Benefit Program.

Effective Date: The term Effective Date means the date upon which the Covered Person is eligible to receive benefits under the Benefit Program as provided in the Eligibility Section.

Eligibility: The term Eligibility means qualifying for coverage according to the Summary Booklet's description of Eligible Person or Eligible Dependent.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

7. Medical records; or

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

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

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

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

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

1. Participating Dentist: Except as otherwise provided by law, an amount agreed upon by Anthem BCBS and a Participating Dentist as full compensation for Covered Services provided to a Covered Person. When applicable, it is the Covered Person's obligation to pay Cost Shares as a component of this

Maximum Allowable Amount. The amount Anthem BCBS will pay on behalf of Employer for Covered Services will be the Maximum Allowable Amount or the billed charges, whichever is lower.

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

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

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

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

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

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

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

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

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

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

7. Not Experimental or Investigational;

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

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

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

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

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

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

Non-Participating Dentist: The term Non-Participating Dentist means any appropriately licensed Dentist who is not a Participating Dentist under the terms of this Benefit Program.

Open Enrollment Period: The term Open Enrollment Period means the period of time during which an employer group allows employees to select group dental coverage.

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

Participating Dentist: The term Participating Dentist means any appropriately licensed Dentist designated and accepted as a Participating Dentist by Anthem BCBS to provide Covered Services to Covered Persons under the terms of this Benefit Program.

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

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

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

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

Provider: The term Provider means any appropriately licensed or certified health care professional providing health care services or supplies which are Covered Services under the terms of this Benefit Program.

Rider: The term Rider means an additional benefit of this Benefit Program, which has been purchased by the Employer Group.

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

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

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

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

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

Anthem BCBS will determine if a Covered Person is Totally Disabled under the terms of this Benefit Program. The Covered Employee will provide proof of continued disability if Anthem BCBS requests it.

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

ELIGIBILITY

A. ELIGIBLE PERSON An Eligible Person is:

1. a current employee who is employed full time, defined as working at least 30 hours a week on a regularly scheduled basis (unless otherwise mutually agreed upon by Anthem BCBS and the Employer) and who is Actively At Work on the date Eligibility for benefits for Covered Services is to be effective, or

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

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

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

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

B. ELIGIBLE DEPENDENT An Eligible Dependent is:

1. the lawful spouse of the Eligible Person under a legally valid, existing marriage, or

2. the unmarried, under age 25, Dependent child of the Eligible Person or lawful spouse, including a stepchild, a child legally placed for adoption and a legally adopted child, or

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

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

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

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

   (b) the child became disabled prior to the age limit for a Dependent child set forth in the Benefit Program under which the child was eligible for benefits for Covered Services; and

   (c) the child had comparable coverage as a Dependent at the time of application for Eligibility for benefits for Covered Services under this Benefit Program.

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

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

C. INITIAL DATE OF ELIGIBILITY AND EFFECTIVE DATE

1. If an annual Open Enrollment Period is mutually agreed to by Anthem BCBS and the Employer, applications from Eligible Persons and their Dependents shall be effective as of the Benefit Program renewal date provided such applications are submitted and accepted by Anthem BCBS in advance of the renewal date. Applications received or accepted after the renewal date shall not be considered until the next annual Open Enrollment Period.

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

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

   (a) New hires and their Dependents are initially eligible on the first of the month following date of hire.

(b) New spouses and new stepchildren are initially eligible the first of the month following the date of the marriage of the new spouse to the Eligible Person provided Anthem BCBS receives an application for coverage. Anthem BCBS must receive an application for coverage within 30 days of the marriage.

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

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

(e) Dependent children for whom the Eligible Person or lawful spouse has been appointed by a court of law as legal guardian or the responsible party under a Qualified Medical Child Support Order are initially eligible as of the date the court order is in effect. For coverage to continue beyond the first 30 days following the appointment, Anthem BCBS must receive an application for coverage within 30 days of the date the court order is in effect.

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

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

D. ELIGIBILITY REQUIREMENTS

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

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

3. When both the Eligible Person and spouse are employed by the same employer and by reason of employment both participate in the group insurance plan, the benefits described in this Summary Booklet will be available to each spouse both as a dependent and as an employee. In no event shall benefits provided under this Benefit Program exceed 100% of charges for covered expenses or services.

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

5. Anthem BCBS has the right to terminate this Benefit Program pursuant to the General Provisions Section of this Summary Booklet if the Employer at any time does not meet the Eligibility Requirements.

SCHEDULE OF DENTAL BENEFITS

BENEFITS

Full Service – Full Service Basic Benefits - 100% of the Maximum Allowable Amount

COVERED SERVICES

Oral examination, including Treatment Plan

Bitewing x-rays – 1 series of 2 per Covered Person per Calendar Year

Periapical x-rays

Topical fluoride application for
Covered Persons under age 19 – 2 per Covered Person per Calendar Year

Prophylaxis (cleaning) or periodontal maintenance procedure – 1 prophylaxis and 1 periodontal maintenance procedure or 2 prophylaxis or 2 periodontal maintenance procedures per Covered Person per Calendar Year

Relining of dentures – 1 per Covered Person in any 2 consecutive years

Repairs of broken removable dentures – 1 repair per Covered Person per Calendar Year

Palliative emergency treatment

Routine fillings – 1 per tooth surface in any consecutive 12-month period

Stainless steel crowns (primary teeth)*

Simple extractions**

Endodontics, including pulpotomy, direct pulp capping and root canal therapy (excluding restoration)

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

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

PARTICIPATING DENTIST BENEFITS

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

NON-PARTICIPATING DENTIST BENEFITS

Anthem BCBS will pay on behalf of Employer the Maximum Allowable Amount as determined by Anthem BCBS. The Covered Person is responsible for any difference between the amount paid by Anthem BCBS and the fee charged by the Dentist.

DENTAL BENEFITS

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

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

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

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

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

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

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

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

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

Subject to the Exclusions, Conditions and Limitations and Schedules of Eligibility and Benefits of this Benefit Program, a Covered Person is entitled to benefits for Covered Services as described in this Dental Benefits Section for Medically Necessary Care when prescribed or ordered by a Dentist. These Dental Benefits apply separately to each Covered Person.

The following provisions apply to the Dental Benefits under this Plan only when reflected on your Schedule of Benefits. Please refer to your Schedule of Benefits to confirm that the following dental services are Covered Services.

A. DENTAL PROVISIONS

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

1. Initial Oral Examination, Diagnosis and Full Mouth Series of X-rays or Panoramic X-ray with or without Bitewings - Anthem BCBS will provide benefits on behalf of Employer once per Covered Person in any three consecutive Calendar Years.

2. Topical Fluoride Application for Covered Persons under age 19. Anthem BCBS will provide benefits on behalf of Employer for two per Covered Person per Calendar Year.

3. Bitewing X-rays - Anthem BCBS will provide benefits on behalf of Employer once per Covered Person per Calendar Year for a series of two bitewing x-rays.

4. Periapical X-rays - Anthem BCBS will provide benefits on behalf of Employer.

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

6. Relining of Dentures - Anthem BCBS will provide benefits on behalf of Employer once per Covered Person in any two consecutive Calendar Years for a denture reline. Anthem BCBS will not provide benefits on behalf of Employer for a denture reline within the first twelve months following placement.

7. Repair of Dentures - Anthem BCBS will provide benefits on behalf of Employer once per Covered Person in any one Calendar Year for a simple denture repair. Anthem BCBS will not provide benefits on behalf of Employer for extensive reconstruction or for the addition of teeth to an existing denture, unless the Covered Person is enrolled in Rider B - Prosthodontics. Anthem BCBS will not provide benefits on behalf of Employer for a denture repair within the first twelve months following replacement.

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

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

9. Fillings - Amalgam restorations: one per tooth surface in any consecutive twelve-month period.

10. Stainless Steel Crowns - Anthem BCBS will provide benefits on behalf of Employer for stainless steel crowns placed on primary teeth.

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

B. OTHER PROVISIONS

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

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

DENTAL - ADDITIONAL BASIC BENEFITS (RIDER A)

It is agreed this Benefit Program is amended as follows:

A. In addition to the services listed in the Schedule of Dental Benefits, Anthem BCBS will provide benefits on behalf of Employer for the following:

Inlays (not part of bridge)	1 per tooth every 5 Calendar Years
Onlays (not part of bridge)	1 per tooth every 5 Calendar Years
Crowns (not part of bridge)	1 per tooth every 5 Calendar Years
Space Maintainers	
Oral surgery consisting of:	

- fracture and dislocation treatment;
- diagnosis and treatment of cyst and abscesses;
- surgical extractions and impaction; and
- Apicoectomy.

B. The dental services listed above are subject to the following qualifications:

1. Individual crowns, inlays and onlays - Anthem BCBS will provide benefits on behalf of Employer for these procedures only when fillings would not be satisfactory for the retention of the tooth, as determined by Anthem BCBS.

2. Crowns: One per tooth every 5 years.

   On anterior or bicuspid teeth, benefits will be available on behalf of Employer for porcelain or porcelain fused to metal crowns when determined to be a Covered Service by Anthem BCBS. On a molar, benefits will be available on behalf of Employer for a metal crown only and when determined to be a Covered Service by Anthem BCBS.

3. Anthem BCBS will not provide benefits on behalf of Employer for a replacement which is provided less than five years following a placement or replacement which was covered under this Benefit Program. Anthem BCBS will not provide benefits for individual crowns, inlays or onlays placed to alter vertical dimension, for the purpose of precision attachment of dentures, or when they are splinted together for any reason.

C. If the Covered Person is not covered by the Dental Prosthodontics - Rider B, benefits will be provided on behalf of Employer for the following types of crowns, inlays or onlays, but only when there is clinical evidence that fillings would not be satisfactory for the retention of the tooth and the service is an initial placement. There is no coverage for replacement of an existing bridge. (Anthem BCBS will make the determination on behalf of Employer.):

   One tooth on either side or two teeth on one side of a replacement for missing teeth, as part of a fixed bridge.

   No benefits will be provided for the tooth replacements.

Space maintainers - Benefits will be provided for devices to preserve space due to premature loss of primary teeth, but not for interceptive orthodontic devices. Benefits will be provided for up to two devices per Covered Person per lifetime.

PARTICIPATING DENTIST BENEFITS

Anthem BCBS will pay on behalf of Employer the lesser of 50% of the Dentist's usual charge or 50% of the Maximum Allowable Amount as determined by Anthem BCBS on behalf of Employer. Except for those services described in Section B.2. above, the Participating Dentist will accept the allowance upon which the payment is based as payment in full and will make no additional charge to the Covered Person except for the remaining Coinsurance balance.

NON-PARTICIPATING DENTIST BENEFITS

Anthem BCBS will pay on behalf of Employer 50% of the Maximum Allowable Amount as determined by Anthem BCBS. The Covered Person is responsible for any difference between the amount paid by Anthem BCBS and the fee charged by the Dentist.

Except as amended, this Benefit Program remains unchanged.

EXCLUSIONS, CONDITIONS AND LIMITATIONS

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

Please remember, this plan does not cover any service or supply not specifically listed as a covered service in this Summary Booklet. The following list of exclusions is not a complete list of all services, supplies, conditions or situations that are not covered services. If a service is not covered, than all services performed in conjunction with that service are not covered.

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

A. Anthem BCBS will provide benefits on behalf of the Employer only for services: (1) specifically described in this Summary Booklet; (2) rendered or ordered by a Dentist; (3) within the scope of the Dentist's licensure; and (4) which constitute Medically Necessary Care for the proper diagnosis and treatment of the Covered Person.

B. Except as specifically provided in this Summary Booklet or in any Rider attached to this Summary Booklet, no benefits will be provided under the Benefit Program for the following:

1. Duplicate Coverage and Other Third Party Liability

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

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

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

d. Duplicate Coverage: If the Covered Person is enrolled in another Plan, benefits will be subject to the Coordination of Benefits provisions of this Summary Booklet.

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

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

C. Services Specifically Excluded: Anthem BCBS will provide on behalf of the Employer only the benefits which are described in this Summary Booklet. Benefits which are not provided include, but are not limited to:

1. House calls;

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

3. Orthognathic surgery;

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

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

6. Application of sealants, regardless of reason unless otherwise specified. If the policy specifies coverage, sealants will only be covered on non-carious, permanent first and second molars;

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

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

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

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

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

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

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

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

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

16. Myofunctional therapy;

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

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

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

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

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

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

23. Lost or stolen dentures or denture duplication;

24. Gold foil restorations;

25. Temporary appliances and services, such as tooth preparations, temporary fillings, bridges and dentures and temporary crowns, except as provided in the Dental Benefits;

26. Any services, as determined by Anthem BCBS on behalf of Employer, that are rendered in a manner contrary to accepted dental practice;

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

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

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

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

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

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

33. Prescription drugs;

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

35. Periodontal splinting or crowns splinted together for any reason;

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

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

38. Charges incurred while the Covered Person was not covered under the Benefit Program;

39. Any dental services payable under any other coverage provided under this Benefit Program, or under any other Plan provided by Anthem BCBS or employer of the Covered Person or Dependent in respect to whom such expenses would have otherwise been covered dental benefits under this Benefit Program;

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

41. Instruction for oral care such as hygiene or diet;

42. Charges by a Dentist for completing dental forms;

43. Tooth implantation or re-implantation;

44. Tissue biopsy;

45. Surgical repositioning;

46. Vestibuloplasty;

47. Excision of bone tissue;

48. Surgical incisions;

49. Diagnostic casts and photographs;

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

51. Occlusal adjustments; or

52. Any items or procedures not specifically listed in this Benefit Program.

Any exclusion above will not apply to the extent that:

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

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

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

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

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

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

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

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

No benefits will be provided for Covered Services rendered before the Covered Person's Effective Date under this Benefit Program.

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

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

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

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

COORDINATION OF BENEFITS

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

Definitions

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

Claim Determination Period: The term Claim Determination Period means a Calendar Year. This period will not begin before or extend after the period in which a Covered Person was covered by this Benefit Program.

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

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

CONDITIONS AND RULES FOR COORDINATION OF BENEFITS

A. For Covered Services received during any Claim Determination Period, payable under this Benefit Program and any other Plan, the following conditions apply:

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

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

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

other than a Dependent.

as a Dependent of a person whose date of birth, month and day, excluding year of birth, occurs earlier in the Calendar Year. If both parents have the same birthday, the benefits of the Plan

which covered the parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.

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

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

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

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

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

Benefits are payable first under this Benefit Program if the benefits of this Summary Booklet covered the Covered Person whose expense the claim is based on for the longer period of time, except when this Benefit Program covers Covered Persons who are laid-off or retired.

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

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

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

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

FACILITY OF PAYMENT

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

RIGHT OF RECOVERY

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

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

GENERAL PROVISIONS

BENEFITS TO WHICH COVERED PERSONS ARE ENTITLED

Anthem BCBS's sole obligation is to administer, on behalf of the Employer, the benefits specified in this Benefit Program.

No person other than a Covered Person is entitled to receive benefits under the Benefit Program. All benefits (including payments) due or to become due are personal to the Covered Person and are not assignable or transferable by the Covered Person to any other person.

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

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

RECORDS OF COVERED PERSON ELIGIBILITY AND CHANGES IN COVERED PERSON ELIGIBILITY

1. Clerical errors or reasonable delays in recording or reporting dates will not invalidate coverage which would otherwise be in force or continue coverage which would otherwise terminate.

TERMINATION OF COVERED PERSON'S COVERAGE UNDER THE BENEFIT PROGRAM

1. A Dependent child will cease to be covered under this Benefit Program on the first of the month following the month in which he or she:

a. marries; or

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

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

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

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

2. A Dependent spouse will cease to be covered under this Benefit Program upon the first day of the month following a divorce or annulment.

3. Termination of the Agreement between Employer and Anthem BCBS automatically terminates all of the Covered Person's coverage in accordance with the terms of said Agreement.

CONTINUATION OPTIONS

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

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

   a. Continuation of coverage for up to 36 months shall be available for an enrolled Dependent following:
      (i) The death of the Covered Person;

      (ii) The legal separation or divorce from the Covered Person;

      (iii) The Covered Person's entitlement for Medicare;

      (iv) The attainment of the limiting age for an enrolled Dependent child or student.

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

      (i) The Covered Person's reduction in work hours;

      (ii) The Covered Person's voluntary resignation;

      (iii) Lay-off or termination of the Covered Person for any reason (other than gross misconduct).

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

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

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

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

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

c. The Covered Person becomes entitled to Medicare benefits; or

d. The Employer no longer provides group health coverage for any of its employees.

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

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

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

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

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

NOTICE OF CLAIM

1. Anthem BCBS will not be obligated to process on behalf of Employer any claim for benefits for Covered Services under the Benefit Program unless proper notice is furnished to Anthem BCBS that Covered Services have been rendered to a Covered Person. Written notice must be given within 60 days after completion of the Covered Services. The notice must include the data necessary for Anthem BCBS to determine benefits. An expense will be considered incurred on the date service or supply was received.2. Failure to give notice to Anthem BCBS within the time specified will not reduce any benefit if it is shown that the notice was given as soon as reasonably possible, but in no event will Anthem BCBS be required to accept notice more than two years after Covered Services are received.

INFORMATION PRACTICES NOTICE

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

- Anthem BCBS may collect personal information about a Covered Person from persons or entities other than the Covered Person.
- Anthem BCBS may disclose Covered Person information to persons or entities outside of Anthem BCBS without Covered Person authorization in certain circumstances.
- A Covered Person has a right of access and correction with respect to all personal information collected by Anthem BCBS BCS.
- A more detailed notice will be furnished to you upon request.

LIMITATION OF ACTIONS

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

PAYMENT OF BENEFITS

1. Anthem BCBS is authorized to make payments on behalf of Employer directly to Providers furnishing Covered Services for which benefits are provided under the Benefit Program. However, except as otherwise provided for in any participating agreement, Anthem BCBS reserves the right to make payments on behalf of Employer directly to either the Covered Person or the Covered Employee at Anthem BCBS's discretion. In the absence of a participating agreement, and one parent or custodian who has custody of a minor child Dependent, Anthem BCBS will make payments on behalf of Employer to that custodial parent or custodian.

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

3. The Covered Person must advise the Provider that he or she is covered under the Benefit Program when arrangements for services are made or as soon as reasonably possible thereafter.

4. Anthem BCBS will not routinely issue a benefit payment on behalf of the Employer under the Benefit Program of less than $1.00 except upon written request from the Covered Person.

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

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

receipt of the requested information. Covered Persons should submit the requested information within forty-five (45) days of receipt of the request.

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

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

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

   CLAIM DENIALS

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

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

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

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

COVERED PERSON/PROVIDER RELATIONSHIP

1. The choice of a Provider Network is solely the Employers'.

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

3. Anthem BCBS does not furnish Covered Services, but only provides benefits on behalf of Employer for Covered Services received by Covered Persons. Anthem BCBS is not liable for any act or omission of any Provider. Anthem BCBS administers the Benefit Program for Employer and has no responsibility for a Provider's failure or refusal to render Covered Services to a Covered Person.

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

5. Anthem BCBS does not make medical judgments. Anthem BCBS only administers the benefits available under this Benefit Program on behalf of Employer.

6. Anthem BCBS’s sole obligation is to administer the Benefit Program in accordance with the agreement between Anthem BCBS and Employer. No action at law based upon or arising out of the Provider-patient relationship will be maintained against Anthem BCBS.

AGENCY RELATIONSHIPS

The Employer is the agent of the Covered Person, not Anthem BCBS.

COVERED PERSON RIGHTS

A Covered Person shall have no rights or privileges except as specifically provided in this Summary Booklet.

AUTHORITY FOR DISCRETIONARY DECISIONS

Anthem BCBS, or anyone acting on its behalf, shall determine the administration of benefits and eligibility for participation in such a manner that has a rational relationship to the terms set forth herein. However, Anthem BCBS, or anyone acting on its behalf, has complete discretion to determine the administration of the Covered Person’s benefits. Anthem BCBS’s determination shall be final and conclusive and may include, without limitation, determination of whether the services, care, treatment, or supplies are Medically Necessary, Investigational/Experimental-Investigative, whether surgery is cosmetic, and whether charges are consistent with its Maximum Allowable Amount. However, a Covered Person may utilize all applicable Covered Person Appeals procedures.

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

COVERED PERSON APPEAL PROCESS

Questions may be posed about the Covered Person's health benefit plan. Since questions often can be handled informally, these questions may be addressed by contacting Member Service/Customer Service, utilizing the telephone number provided on the back of the Covered Person's Identification Card. In addition, information about the following Appeal process may be obtained by contacting Member Service/Customer Service.

The Appeal process is available to the Covered Person, the Covered Person's duly authorized representative, the Provider of record, or the Provider of record's duly authorized representative.

This Appeal process applies to any adverse utilization review determination (which is considered an adverse pre-service claim determination) or any adverse non-utilization review determination (which is considered an adverse post-service claim determination) under this Benefit Program. Utilization review determinations, such as prior authorization or concurrent review, are determinations where receipt of the benefit, in whole or part, is conditioned upon approval of the benefit in advance. Non-utilization review determinations concern issues relating to the Covered Person's Benefit Program, such as eligibility for benefits, coverage of claims or claims processing.

Appeal Process for Adverse Utilization Review Determinations

FIRST LEVEL APPEAL

If a utilization review determination is not satisfactory, this is considered an adverse determination and a First Level Appeal review of the adverse determination may be requested. The First Level Appeal review request can be initiated orally, electronically or in writing within one hundred eighty (180) days from the date the initial adverse determination is received. Written First Level Appeal review requests should be mailed to:

Appeals- First Level Appeal Review
Health Management Systems, Inc.
555 Middle Creek Parkway
Colorado Springs, CO. 80921-3634

A First Level Appeal review request should include copies of any additional documentation supporting the First Level Appeal.

A First Level Appeal determination will be issued in writing within fifteen (15) days from the date the First Level Appeal request is received. The written determination will be issued within five (5) business days from the date the Appeal decision is made. The written Appeal determination shall state the decision; the specific reason(s) for the decision with a citation to provisions of the Benefit Program on which the decision was based, if applicable; and general information about the next step in the Appeal process.

In the event of an emergency or a life-threatening situation, or when a claim involves urgent care, or when a Covered Person is denied benefits for an otherwise Covered Service on the grounds that it is Experimental and the Covered Person has been diagnosed with a condition that creates a life expectancy of less than two years, an expedited First Level Appeal review may be requested. A determination will be issued within one (1) business day from the date the expedited appeal request is received.
If the First Level Appeal determination is not satisfactory, a Covered Person of a fully insured health plan or a self-insured governmental health plan which is not subject to ERISA, who has been diagnosed with a condition that creates a life expectancy of less than two years and the denial is based on the grounds that the proposed service is Experimental, may seek information (including the application) regarding an external appeal process administered by the Insurance Department without completing the Second Level Appeal review request through Anthem Blue Cross and Blue Shield.

SECOND LEVEL APPEAL

If the First Level Appeal determination is not satisfactory, a Second Level Appeal review may be requested. The Second Level Appeal review request can be initiated orally, electronically or in writing to the Second Level Appeal Panel within sixty (60) days from the date the First Level Appeal determination is received. At this time, an in-person presentation, telephonic conference, or conference via other form

of acceptable technology may be requested and should be noted in the written Second Level Appeal request, if desired. Written Second Level Appeal requests should be mailed to:

Anthem Blue Cross and Blue Shield
Second Level Appeal Panel
370 Bassett Road
P.O. Box 1038
North Haven, Connecticut 06473-4201

A Second Level Appeal review request should include copies of any additional documentation supporting the Second Level Appeal.

A Second Level Appeal determination will be issued in writing within fifteen (15) days from the date the Second Level Appeal request is received. The written determination will be issued within five (5) business days from the date the Appeal decision is made. The written Appeal determination shall state the decision; the specific reason(s) for the decision with a citation to provisions of the Benefit Program on which the decision was based, if applicable; and general information about the next step in the Appeal process.

In the event of an emergency or a life-threatening situation, or when a claim involves urgent care, or when a Covered Person is denied benefits for an otherwise Covered Service on the grounds that it is Experimental and the Covered Person has been diagnosed with a condition that creates a life expectancy of less than two years, an expedited Second Level Appeal review may be requested. A determination will be issued within one (1) business day from the date the expedited appeal request is received.

After the completion of both the First and Second Level Appeal for a utilization review determination, a Covered Person, the provider of record or provider, or the duly authorized representative of a Covered Person of a fully insured health plan or a self-insured governmental health plan which is not subject to ERISA, may seek information (including the application) regarding an external appeal process administered by the Insurance Department by contacting:

State of Connecticut Insurance Departmetn
P.O. Box 816
Hartford, CT 06142-0816

Telephone: (860) 297-3910

Any request for an external appeal regarding an adverse utilization review determination must be received by the Insurance Department within thirty (30) days form the date of the receipt of the final Appeal determination.

Appeal Process for Adverse Non-Utilization Review Determinations

FIRST LEVEL APPEAL

If a non-utilization review determination is not satisfactory, this is considered an adverse determination and a First Level Appeal review of the adverse determination may be requested. The First Level Appeal review request can be initiated orally, electronically or in writing within one hundred eighty (180) days from the date the initial adverse determination is received. Written First Level Appeal review requests should be mailed to:

Appeals- First Level Appeal Review
Health Management Systems, Inc.
555 Middle Creek Parkway
Colorado Springs, CO. 80921-3634

A First Level Appeal review request should include copies of any additional documentation supporting the First Level Appeal.

A First Level Appeal determination will be issued in writing within thirty (30) days of receipt of the First Level Appeal. The written determination will be issued within five (5) business days from the date the Appeal decision is made. The written Appeal determination shall state the decision; the specific reason(s) for the decision with a citation to provisions of the Benefit Program on which the decision was based, if applicable; and general information about the next step in the Appeal process.

SECOND LEVEL APPEAL

If the First Level Appeal determination is not satisfactory, a Second Level Appeal review may be requested. At this time, an in-person presentation, telephonic conference, or conference via other form of acceptable technology may be requested and should be noted with the Second Level Appeal request, if desired.

The Second Level Appeal review request can be initiated orally, electronically or in writing to the Second Level Appeal Panel. The Second Level Appeal review request must be received within ten (10) days from the date the First Level Appeal determination is received. If the Second Level Appeal request is received more than ten (10) days from the date that the First Level Appeal determination is received, the time period in excess of that ten days will be considered a request for an extension by the Covered Person. Such extension shall be granted for a period of up to sixty (60) days from the date that the First Level Appeal determination is received. Written Second Level Appeal requests should be mailed to:

Anthem Blue Cross and Blue Shield
Second Level Appeal Review
370 Bassett Road
P.O. Box 1038
North Haven, CT 06473-4201

A Second Level Appeal review request should include copies of any additional documentation supporting the Second Level Appeal.

A Second Level Appeal determination will be issued in writing within twenty (20) days from the date the Second Level Appeal request is received. The written Appeal determination will be issued within five (5) business days from the date the Appeal decision is made. The written Appeal determination will state the decision; the specific reason(s) for the decision with reference to the Benefit Program provisions on which the decision is based, if applicable; and general information about the next step in the Appeal process.

The First and Second Levels of Appeal for an adverse non-utilization review determination will not take longer than sixty (60) days from Anthem Blue Cross and Blue Shield's receipt of the First Level Appeal review request as prescribed by state law, unless an extension as described above has been granted.

OTHER COVERED PERSON RIGHTS

- The Covered Person is entitled to receive upon request and free of charge, reasonable access to, and copies of, any documents, records, and other information relevant to the Covered Person's claim for benefits.

- If an internal rule, guideline, protocol, or other similar criterion is relied upon in making the adverse benefit determination, the specific rule, guideline protocol or other similar criterion will be provided to the Covered Person free of charge upon request.

- If the adverse benefit determination is based on a Medical Necessity, or experimental treatment, or other similar exclusion or limit, an explanation of the scientific or clinical judgement for the determination applying the terms of the health benefit plan to the Covered Person's medical circumstances will be provided free of charge upon request.

- If a consultant's advice was obtained in connection with a Covered Person's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination, the consultant will be identified upon request.