Summary Booklet
Flexible Dental Plan

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

Anthem BlueCross BlueShield

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Anthem BlueCross BlueShield
108 Leigus Road,
Wallingford, CT 06492

FLEXIBLE DENTAL PLAN

Issued By:

Anthem Health Plans, Inc. d/b/a
Anthem Blue Cross and Blue Shield
108 Leigus Road
Wallingford, Connecticut 06492

Colchester Board of Education
085512

Important: This is not an insured Benefit Plan. The benefits described in this Summary Booklet or any rider or amendments hereto are funded by the Employer who is responsible for their payment. Anthem BCBS provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

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INTRODUCTION

This Summary Booklet describes generally this Benefit Program, which is funded by the **Colchester Board of Education** 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 Blue Cross and Blue Shield is the trade name of Anthem Insurance Companies, Inc., an independent licensee of the Blue Cross and Blue Shield Association, provides administrative claims payment services only and do not assume any financial risk or obligation with respect to claims.

Anthem BCBS performs various administrative services with 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.

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.

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

Member Services / Customer Service

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

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

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

How to Obtain Language Assistance

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

SCHEDULE OF BENEFITS

FLEXIBLE DENTAL SERVICES

COVERED SERVICE	IN-NETWORK SERVICES
BENEFIT PERIOD	Calendar Year
DEDUCTIBLE	Shared by Category 2
Individual:	$25 per Covered Person per Benefit Period
Family:	Three Individual Deductibles ($75)
COINSURANCE	
Category 1:	Covered at 100%
Category 2:	Covered at 80%
Category 4:	Covered at 60%
MAXIMUM	
Categories 1, and 2:	$2,000 per Covered Person per Benefit Period
Category 4:	$600 per Covered Person per Lifetime
CATEGORY 1	
Initial Oral Exam	1 per Covered Person in 36 Months
Periodic Oral Exam	2 per Covered Person per Benefit Period
Prophylaxis or Periodontal Maintenance Procedure	Combination of 2 per Covered Person per Benefit Period
Topical Application of Fluoride	2 per Covered Person per Benefit Period For Covered Persons Under Age 19
Space Maintainers	2 per Covered Person per Lifetime For Covered Persons Under Age 19
X-rays	
Emergency Treatment	
Periodontal Maintenance	

CATEGORY 2	
Fillings	1 per Covered Person per tooth surface in any consecutive 12-month period
Endodontics	
Reline Dentures	1 per Covered Person in 2 years, not within the first twelve months following placement
Repair Dentures	1 per Covered Person per Benefit Period
Extractions	
Oral Surgery	
Recement Crowns	1 per Covered Person per tooth per year
Recement Bridge	1 per Covered Person per year
Repair Bridge	1 per Covered Person per year
Stainless Steel Crowns (Primary Tooth)	1 per primary tooth in 5 years
Inlays	1 per tooth in 5 years
Onlays	1 per tooth in 5 years
Crowns	1 per tooth in 5 years
Repair Crown	1 per Covered Person per year
Apicoectomy	1 per Covered Person per Lifetime
Hemisection	
Root Canal Retreatment	
CATEGORY 4	
Orthodontics	For Covered Persons Under Age 19
Cephalometric Film	
Ortho Surgery	

PARTICIPATING DENTIST BENEFITS

For the scheduled Covered Services listed above and subject to any applicable Deductibles, Coinsurance or Benefit Maximums, Anthem BCBS will pay on behalf of Employer the lesser of the Dentist's usual charge or the Maximum Allowable Amount as determined by Anthem BCBS.

Except as otherwise specified in this Section, the Dentist will accept the allowance upon which payment is based as payment in full and will make no additional charge to the Covered Person except for any applicable Deductibles, Coinsurance or amounts exceeding Benefit Maximums.

NON - PARTICIPATING DENTIST BENEFITS

For the scheduled Covered Services listed above and subject to any applicable Deductibles, Coinsurance or Benefit Maximums, 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.

DEFINITIONS

ACTIVELY AT WORK: The term Actively At Work means the employee must work at the Employer Group's place of business or at such place(s) as normal business requires. The employee must perform all duties of the job as required of a full-time employee working 20 or more hours per week 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 is the period established in the Benefit Program Section: Acceptance.

BENEFIT PROGRAM: The term Benefit Program means the program of Dental Care benefits administered by Anthem BCBS on behalf of the Employer, identified on the cover page of this Summary Booklet and described herein.

CALENDAR YEAR: The term Calendar Year means a year beginning on January 1 and ending on December 31 of the same year. The first Calendar Year will begin on the 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 (COST SHARING): The term Cost Share means the amount which the Covered Person is required to pay for Covered Services. Where applicable, Cost Shares can be in the form of 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: 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.

DEDUCTIBLE: The term Deductible means that portion of the charges for Covered Services incurred in a Calendar Year which is the Covered Person's responsibility to pay.

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

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

3. Documents issued by and/or 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.

LATE ENROLLEE: The term Late Enrollee means an eligible employee and/or Dependent who requests health insurance following the open enrollment period effective date, if applicable, or more than 31 days after the employee's and/or Dependent's earliest opportunity to enroll for coverage under any health insurance plan sponsored by the Employer. The term open enrollment period means the period of time during which an employer group allows employees to select group health coverage.

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

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

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

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

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

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

ORTHODONTICS: The term Orthodontics means any medical service or supply; or dental service or supply furnished to prevent or to diagnose or to correct a misalignment: of the teeth; the bite; or of the jaw or jaw joint relationship whether or not for the purpose of relieving pain.

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

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.

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 Person is unable to perform the duties of any occupation for which the Covered Person is suited by reason of education, training or experience.

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

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

TREATMENT PLAN: The term Treatment Plan means a written report showing the diagnosis and recommended treatment of any dental disease, defect or injury prepared for a 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

Eligible Person

An Eligible Person is:

1. a current employee who is employed full time, defined as working at least 20 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 of eligibility for benefits for Covered Services is to be effective, or

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

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

4. a retiree of the 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.

Eligible Dependent

An Eligible Dependent is:

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

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

3. the unmarried, under age 25, Dependent child for whom the 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.

6. Qualified Medical Child Support Orders (QMCSO) - A Dependent child may become eligible for benefits for Covered Services as a consequence of a domestic relations order issued by a state court to a divorced parent who is a 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.

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 be considered Late Enrollee.

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

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

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

   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.

   c. Newborn children of the Eligible Person or lawful spouse are initially eligible as of the moment of 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.

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

   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 warrants 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 warranties. 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.

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 Eligible Person is not Actively at Work on the date upon which coverage would otherwise become effective for the Eligible Person, the Effective Date of coverage for that Eligible 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.

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 Schedule 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.

Dental Provision Descriptions

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.

Deductible: The term Deductible means that portion of the charges for Covered Services incurred in a Calendar Year which is the Covered Person's responsibility to pay. There is a separate Deductible for each Covered Person.

The family Deductible applies to any Covered Services incurred in a Calendar Year by any Covered Persons collectively and applied against the separate individual Deductibles. When the separate individual Deductibles equal the family Deductible amount, all Covered Persons will be considered to have met their separate individual Deductibles for the rest of that Calendar Year.

The Covered Person is guaranteed the Maximum Allowable Amount when Covered Services are rendered by a Participating Dentist, subject to any applicable Cost Share.
Benefit maximums are shown on the Schedule of Benefits.

Before starting a course of treatment, a Dentist may submit a Treatment Plan if the anticipated Covered Services in a course of treatment will exceed $200. Anthem BCBS will make a pre-determination and estimate the benefits. The Covered Person and Dentist will be told what the estimated benefit is before treatment starts.

1. Subject to the applicable Deductible and Coinsurance amounts, the maximum amount of benefits payable for each Covered Person in a Calendar Year is shown in the Schedule of Benefits. However, in computing the maximum amount of benefits payable, any benefits paid under the Dental – Orthodontics Amendment or Dental – Orthodontic Services and Temporomandibular Joint Dysfunction Amendment will be excluded.
2. The Flexible Dental Benefits listed in the Schedule of Benefits are subject to the following qualifications:

Diagnostic and Preventative

Initial Oral Evaluation, 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.

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

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.

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

Space Maintainers - Anthem BCBS will provide benefits on behalf of Employer for devices to preserve space due to premature loss of primary teeth, but not for interceptive orthodontic devices. Anthem BCBS will provide benefits on behalf of Employer for up to two devices per Covered Person per lifetime for Covered Persons under Age 19.

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 scheduled or routine 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).

Restorative

Fillings - Anthem BCBS will provide benefits on behalf of Employer as follows:

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

Stainless Steel Crowns (Primary tooth) - Anthem BCBS will provide benefits on behalf of Employer for stainless steel crowns placed on primary teeth once every 5 years.

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.

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 has coverage for prosthodontics.

Endodontics

Endodontic, 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.

Oral Surgery

Oral Surgery - Anthem BCBS will provide benefits on behalf of Employer for treatment of fractures and dislocations, diagnosis and treatment of cyst and abscess, surgical extractions and impactions.

Prosthodontics

Prosthetic Services consisting of: Dentures, full and partial; Bridges, fixed (including bridge abutments and pontics) and removable; and addition of teeth to partial dentures to replace extracted teeth are subject to the following:

- Anthem BCBS will provide benefits on behalf of Employer for standard procedures for prosthetic services, as determined by Anthem BCBS.
- For fixed bridges (including bridge abutments and pontics): Anthem BCBS will provide benefits on behalf of Employer for the replacement of missing teeth and for one tooth on either side or two teeth on one side of the replacement.
- Anthem BCBS will not provide benefits on behalf of Employer for a denture or bridge replacement which is provided less than five years following a placement or replacement which was covered under this Summary Booklet.
- Anthem BCBS will not provide benefits on behalf of Employer for crowns splinted together for any reason including periodontal stabilization.

Prosthetic Services include the following:

- First installation of removable dentures to replace one or more natural teeth extracted while the Covered Person was covered. This includes adjustments for the 6 month period following the date they were installed.
- Replacement of an existing removable denture or fixed bridgework by a new denture, or the adding of teeth to a partial removable denture.
- First installation of fixed bridgework to replace one or more natural teeth extracted which the Covered Person is covered. This includes inlays and crowns as abutments.
- Replacement of an existing removable denture or fixed bridgework by new fixed bridgework, or the adding of teeth to existing fixed bridgework.
- Inlays, onlays, gold fillings and crowns, including precision attachments for dentures.

Prosthesis Replacement Rule: Certain replacements or additions to existing dentures or bridgework will be covered under this Policy. But Proof satisfactory to Anthem BCBS must be given that:

- The replacement or addition of teeth is required to replace teeth extracted after the present denture or bridgework was installed. The person must have been covered when the tooth was extracted.
- The present denture or bridgework cannot be made serviceable. Also, it must be at least 5 years old.
- The present denture is an immediate temporary one to replace one or more natural teeth extracted while the person is covered and cannot be made permanent. Replacement by a permanent denture is needed. It takes place within 12 months from the date the immediate temporary one was first installed.

Prosthetic Services include:

- Crowns
- Inlays/Onlays (specialized metal fillings)
- Temporary Crown on Fractured Tooth

Individual Crowns, Inlays and Onlays - Anthem BCBS will provide benefits on behalf of Employer for these procedures only when amalgam or synthetic fillings would not be satisfactory for the retention of the tooth, as determined by Anthem BCBS. 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 Summary Booklet. Anthem BCBS will not provide benefits on behalf of Employer 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. Benefits for posts and cores will be provided only when benefits are available for the corresponding crowns.

Orthodontics

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

Anthem BCBS will provide benefits on behalf of Employer for orthodontic services for handicapping malocclusion, consisting of the installation of orthodontic appliances and orthodontic treatments concerned with the reduction or elimination of an existing malocclusion through the correction of malposed teeth.

The maximum amount payable for Covered Services is the amount shown on the Schedule of Benefits.

Benefits will be paid in installments over the period of active treatment (not including retention). If coverage becomes effective after treatment begins or is terminated before treatment ends, benefits will be reduced proportionately for the period of time this coverage is in effect. Anthem BCBS will determine the payment formula and prorate the benefits for the appropriate length of active treatment.

Other Provisions

1. If during the course of treatment, a case is transferred from one Dentist to another Dentist, or if more than one Dentist renders services for one procedure, Anthem BCBS will provide benefits on behalf of Employer only in 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).

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 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:

Duplicate Coverage and Other Third Party Liability:

1. 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.

2. 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.

3. 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.

4. 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.

5. 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.

6. 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 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); Remove if TMJ is covered;
3. Orthognathic surgery;
4. Use of any Experimental or Investigational diagnosis, treatment, procedure, facility, equipment, drugs, drug usage, devices or supplies. Any service associated with or as follow-up to any of the above is not a Covered Service;
5. Replacement of Prosthetic Devices due to loss or theft;
6. Application of sealants, regardless of reason;
7. General anesthesia (deep sedation) and intravenous sedation;
8. Any hospital or inpatient facility fee resulting from services performed in a hospital or inpatient facility;
9. Cosmetic surgery or services performed solely to improve appearance and not designed to restore body function or to correct deformity resulting from the treatment of malignancy or physical trauma;
10. Any services for or related to a self-inflicted injury;
11. Any services for or related to an injury or condition for which benefits exist under Worker's Compensation or occupational disease;
12. Any services for or related to a dental treatment which is provided by a federal or state agency;
13. Benefits for services resulting from war or any act of war, whether declared or undeclared, or while in the armed forces of any country;
14. Benefits for services which are covered under Medicare or the Social Security Act;
15. Any service or supply performed without functional or pathological need;
16. Myofunctional therapy;
17. Removal of third molar (wisdom teeth) where there is no evidence of disease;
18. Any supplies intended for home use (e.g. toothbrush, dental floss, mouthwash, irrigators);
19. Any services received from a dental or medical department maintained by an employer, a mutual benefit association, labor union, trustee or other similar person or group;
20. Any services for which the Covered Person incurs no Dentist’s charge 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. Temporary crowns, except as provided in the Dental Benefits;
26. Services, as determined by Anthem BCBS on behalf of Employer, that are rendered in a manner contrary to normal 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 and build-ups 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/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 Summary Booklet.

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 Summary Booklet, Anthem BCBS will not provide benefits on behalf of 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

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 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:

    a. other than a Dependent.

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

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

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

d. 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.

e. 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" (known as the non-complying Plan) 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. If the non-complying Plan does not provide the information needed by this Plan to determine its benefits within a reasonable time after it is requested to do so, this Plan shall assume that the benefits of the non-complying Plan are identical to its own, and shall pay its benefits accordingly. However, this Plan must adjust any payments it makes based on such assumption whenever information becomes available as to the actual benefits of the non-complying Plan.

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 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 Employer under this Benefit Program.

Right of Recovery

1. Whenever Anthem BCBS has made payments on behalf of 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

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

2. No person other than a Covered Person is entitled to receive benefits under this Summary Booklet. 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 Cover 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.

3. Benefits for Covered Services specified in this Summary Booklet 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

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 Of 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 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.
- 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 payment 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 the 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 such a 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 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 judgment 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.

GRIEVANCE REVIEW PROCESS

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

Rights Available to Members

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

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

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

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

Other Helpful Resources

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

Consumer Affairs Division of the Connecticut Insurance Department

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

Connecticut Office of the Health Care Advocate

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

If You Have a Complaint or An Appeal

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

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

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

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

To file a grievance, you, your doctor, or any person you choose (your authorized representative) can request a grievance in writing or by calling Member Services/ Customer Service at the phone number on your Identification Card. Your grievance should be sent to the following address:

For Dental Issues:
Anthem Blue Cross and Blue Shield
Attn: Grievance Department
P.O. Box 1122
Minneapolis, Minnesota
53400-0551

How are Grievances Handled?

If your grievance is based on medical necessity, the appropriate clinical peer will review it. A clinical peer is a doctor or other health care professional who holds a non-restricted license in a state of the United States and in the same or similar specialty as typically manages the medical condition, procedure or treatment under review. All relevant information given to us by you or on your behalf will be reviewed regardless of whether it was considered at the time the initial decision was made.

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

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

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

Standard (Non-urgent) Grievance

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

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

Urgent (Expedited) Grievances

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

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

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

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

GET HELP IN YOUR LANGUAGE

Curious to know what all this says? We would be too. Here's the English version

This notice has important information about your application or benefits. Look for important dates. You might need to take action by certain dates to keep your benefits or manage costs. You have the right to get this information and help in your language for free. Call the Member Services number on your ID card for help. (TTY/TDD: 711)

Spanish

Este aviso contiene información importante acerca de su solicitud o sus beneficios. Busque fechas importantes. Podría ser necesario que actúe para ciertas fechas, a fin de mantener sus beneficios o administrar sus costos. Tiene el derecho de obtener esta información y ayuda en su idioma en forma gratuita. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación para obtener ayuda. (TTY/TDD: 711)

Albanian

Ky njoftim përmban informacion të rëndësishëm rreth aplikimit ose përfitimeve tuaja. Shihni datat kryesore. Mund t'ju nevojitet të veproni brenda afateve të caktuara për të vazhduar të përfitoni ose për të menaxhuar kostot. Keni të drejtën të merrni falas ndihmë dhe informacion në gjuhën tuaj. Për ndihmë, telefononi numrin e shërbimeve për anëtarët, të shënuar në kartën tuaj ID. (TTY/TDD: 711)

Arabic

يحتوي هذا الإشعار على معلومات مهمة حول طلبك أو المزايا المقدمة لك. احرص على تتبع المواعيد المهمة. قد تحتاج إلى اتخاذ إجراء قبل مواعيد محددة للاحتفاظ بالمزايا أو لإدارة التكلفة. يحق لك الحصول على هذه المعلومات والمساعدة بلغتك مجانًا. يُرجى الاتصال برقم خدمات الأعضاء الموجود على بطاقة التعريف الخاصة بك للمساعدة (TTY/TDD:711).

Chinese

本通知有與您的申請或利益相關的重要資訊。請留意重要日期。您可能需要在特定日期前採取行動以維護您的利益或管理費用。您有權使用您的語言免費獲得該資訊和協助。請撥打您的 ID 卡上的成員服務號碼尋求協助。(TTY/TDD: 711)

French

Cette notice contient des informations importantes sur votre demande ou votre couverture. Vous y trouverez également des dates à ne pas manquer. Il se peut que vous deviez respecter certains délais pour conserver votre couverture santé ou vos remboursements. Vous avez le droit d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour cela, veuillez appeler le numéro des Services destinés aux membres qui figure sur votre carte d'identification. (TTY/TDD: 711)

Greek

Αυτή η ειδοποίηση περιέχει σημαντικές πληροφορίες για την εφαρμογή σας ή τις παροχές σας. Αναζητήστε τις σημαντικές ημερομηνίες. Ενδέχεται να χρειαστεί να κάνετε κάποιες ενέργειες μέχρι συγκεκριμένες ημερομηνίες, ώστε να διατηρήσετε τις παροχές σας ή να διαχειριστείτε το κόστος. Έχετε το δικαίωμα να λάβετε αυτές τις πληροφορίες και αυτήν τη βοήθεια στη γλώσσα σας δωρεάν. Καλέστε τον αριθμό του Τμήματος Υπηρεσιών Μέλους (Member Services) που αναγράφεται στην ταυτότητά σας (ID card) για βοήθεια. (TTY/TDD: 711)

Haitian

Avi sa a gen enfòmasyon enpòtan sou aplikasyon ou an oswa avantaj ou yo. Veye dat enpòtan yo. Ou ka bezwen pran aksyon avan sèten dat pou kenbe avantaj ou yo oswa jere depans ou yo. Ou gen dwa pou resevwa enfòmasyon sa a ak asistans nan lang ou pou gratis. Rele nimewo Manm Sèvis la ki sou kat idantifikasyon ou a pou jwenn èd. (TTY/TDD: 711)

Hindi

इस सूचना में आपके आवेदन या लाभों के बारे में महत्वपूर्ण जानकारी है। महत्वपूर्ण तिथियाँ देखें। अपने लाभ बनाए रखने या लागत का प्रबंध करने के लिए, आपको निश्चित तिथियों तक कार्रवाई करने की ज़रूरत हो सकती है। आपके पास यह जानकारी और मदद अपनी भाषा में मुफ़्त में प्राप्त करने का अधिकार है। मदद के लिए अपने ID कार्ड पर सदस्य सेवाएँ नंबर पर कॉल करें। (TTY/TDD: 711)

Italian

Il presente avviso contiene informazioni importanti relative alla domanda da lei presentata o ai benefici a lei riservati. Consulti le date importanti riportate. Per continuare a usufruire dei benefici o ricevere assistenza per il pagamento delle spese, potrebbe dover eseguire determinate azioni entro scadenze specifiche. Ha il diritto di ricevere queste informazioni ed eventuale assistenza nella sua lingua senza alcun costo aggiuntivo. Per assistenza, chiami il numero dedicato ai Servizi per i membri riportato sul suo libretto. (TTY/TDD: 711)

Korean

이 공지사항에는 귀하의 신청서 또는 혜택에 대한 중요한 정보가 있습니다. 중요 날짜를 살펴 보십시오. 혜택을 유지하거나 비용을 관리하기 위해 특정 마감일까지 조치를 취해야 할 수 있습니다. 귀하에게는 무료로 이 정보를 얻고 귀하의 언어로 도움을 받을 권리가 있습니다. 도움을 얻으려면 귀하의 ID 카드에 있는 회원 서비스 번호로 전화하십시오. (TTY/TDD: 711)

Polish

Niniejsze powiadomienie zawiera istotne informacje dotyczące wniosku lub świadczeń. Zwróć uwagę na ważne daty. Zachowanie świadczeń lub zarządzanie kosztami może wymagać podjęcia dodatkowych działań w konkretnych terminach. Masz prawo do bezpłatnego otrzymania stosownych informacji oraz uzyskania pomocy w swoim języku. W tym celu skontaktuj się z Działem Obsługi Klienta pod numerem telefonu podanym na karcie identyfikacyjnej. (TTY/TDD: 711)

Portuguese-Europe

Este aviso contém informações importantes sobre a sua candidatura ou benefícios. Preste atenção a datas importantes. Poderá ser necessário agir até determinadas datas para manter os seus benefícios ou gerir os custos. Tem o direito de receber gratuitamente estas informações e ajuda no seu idioma. Ligue para o número dos Serviços para Membros indicado no seu cartão de identificação para obter ajuda. (TTY/TDD: 711)

Russian

Настоящее уведомление содержит важную информацию о вашем заявлении или выплатах. Обратите внимание на контрольные даты. Для сохранения права на получение выплат или помощи с расходами от вас может потребоваться выполнение определенных действий в указанные сроки. Вы имеете право получить данную информацию и помощь на вашем языке бесплатно. Для получения помощи звоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте.
(TTY/TDD: 711)

Tagalog

May mahalagang impormasyon ang abisong ito tungkol sa inyong aplikasyon o mga benepisyo. Tukuyin ang mahahalagang petsa. Maaaring may kailangan kayong gawin sa ilang partikular na petsa upang mapanatili ang inyong mga benepisyo o mapamahalaan ang mga gastos. May karapatan kayong makuha ang impormasyon at tulong na ito sa ginagamit ninyong wika nang walang bayad. Tumawag sa numero ng Member Services na nasa inyong ID card para sa tulong. (TTY/TDD: 711)

Vietnamese

Thông báo này có thông tin quan trọng về đơn đang ký hoặc quyền lợi bảo hiểm của quý vị. Hãy tìm các ngày quan trọng. Quý vị có thể cần phải có hành động trước những ngày nhất định để duy trì quyền lợi bảo hiểm hoặc quản lý chi phí của mình. Quý vị có quyền nhận miễn phí thông tin này và sự trợ giúp bằng ngôn ngữ của quý vị. Hãy gọi cho Dịch Vụ Thành Viên trên thẻ ID của quý vị để được giúp đỡ. (TTY/TDD: 711)

IT'S IMPORTANT WE TREAT YOU FAIRLY

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1-800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.