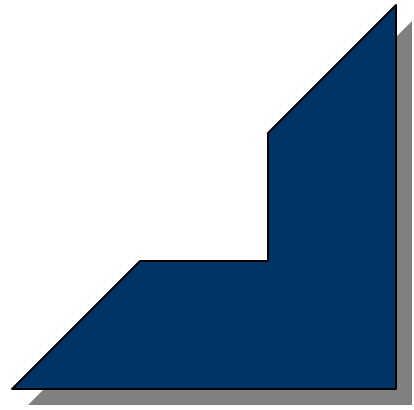
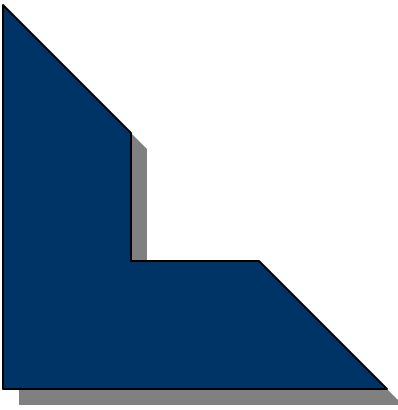


2009 Benefits Book



Introduction

Stamford Public Schools' Benefits Administration Office is pleased to provide you with this reference guide to the comprehensive benefits offered to certified teachers and administrators and school staff - who are members of the Stamford Administrative Unit (SAU), the Stamford Education Association (SEA), the Educational Assistants of Stamford Association (EASA) or the Stamford Board of Education Employees Association – Security Workers and Community Liaison Employees (SCL). Here you will find details about your benefits, when they begin and end, and how to use them during the different stages and events of your life.

If you have any questions that are not answered here, you can call the Benefits Administration Office at 203-977-4196 or 203-977-4773 between 8 a.m. and 4 p.m. Eastern Time, Monday through Friday.

This book is intended to provide a summary of major provisions of certain benefit plans in which you may be eligible to participate as an active employee. Benefits are described as clearly as possible with minimal use of technical words and phrases. However, the individual collective bargaining agreements between the Stamford Board of Education and the Stamford Administrative Unit, the Stamford Education Association, the Educational Assistants of Stamford Association and the Stamford Board of Education Employees Association remain the final authority and, in the event of a conflict with this book or conflict with any oral statement, the terms of these collective bargaining agreements shall govern in all cases. In the event of a conflict between this book and the terms of a master policy contract for a fully-insured benefit, the master policy contract shall govern in all cases.

Within this benefits book, you will find a separate section for each of the following:

- About Your Benefits
- What Happens to Your Benefits When You Have a Qualified Life Event
- Medical
- Prescription Drugs
- Dental
- Flexible Spending Accounts
- Voluntary Life Insurance
- Voluntary Accident Insurance
- Long Term Disability – Benefit for Administrators Only
- Maternal Disability and Childcare Leave
- Administrative Information
- COBRA
- Important Contacts
- HIPAA Privacy Notice

About Your Benefits

Stamford Public Schools (BOE) offers certified teachers, administrators and instructional staff - who are members of the Stamford Administrative Unit (SAU), the Stamford Education Association (SEA), the Educational Assistants of Stamford Association (EASA) or the Stamford Board of Education Employees Association (Security Workers and Community Liaison Employees (SCL) - a comprehensive benefits program that includes medical, dental, prescription drug and life insurance coverage.

Eligibility

Employee

To be eligible for the benefits described in this book, you must be one of the following:

- a full-time and part-time (.50 or more Full Time Equivalent), certified teacher who is a member of the SEA
- a full-time, certified administrator who is a member of the SAU
- a full-time, employee who is a member of the EASA
- a full-time, employee who is a member of the SCL
- full-time discretionary employees

Dependents

You may choose to cover your eligible dependents under the medical, dental, life, and accident insurance plans. Eligible dependents include:

- **Your spouse** is the person to whom you are legally married or legally joined in a Civil Union. Ex-spouses are not eligible for coverage. You must notify the Stamford Public Schools Benefits Administration Office immediately should you and your spouse divorce or if your Civil Union is dissolved.
- **Your unmarried, unemployed children** are:
 - Your natural children*
 - Stepchildren* who live with you
 - Children* you support pursuant to a valid court order
 - A child legally placed for adoption pursuant to a valid adoption agency document, court notice or decree**
 - A legally adopted child pursuant to a valid court notice or decree**
 - A child for whom you have been appointed a legal guardian pursuant to a valid court notice or decree**

*You may cover eligible children up to age 19. Coverage may be extended up to age 25 for children who are full-time students at a recognized college, university or trade school. Coverage may be extended beyond age 25 if your child is unmarried and incapable of self support due to a mental or physical handicap that existed prior to the age of 25, subject to written certification by the benefits administrator of the medical plan. If your child is handicapped, be sure to apply to extend his or her coverage before it would otherwise end.

**The effective date of the coverage will be the placement date as provided in the adoption agency documentation, court decree or notice. If the child needs medical care or prescription drugs prior to the child being enrolled with the medical or prescription drug plan administrator, you are responsible for expenses for such care. You may file a claim for reimbursement of eligible

expenses after the child is enrolled for coverage with the medical or prescription drug plan administrator.

Levels of Coverage

You decide between the following three levels of coverage for your medical, prescription drug and dental benefits:

- You only
- You and one dependent
- You and your family

When Coverage Begins

New Hires

If you are a newly hired employee, as defined in the Eligibility section of this book, and your employment coincides with the start of a school year, your benefits coverage begins on September 1st. If your employment begins after the start of the school year or doesn't coincide with the start of the school year, your benefits begin on the first of the month following your date of hire.

If you are hired as a long-term substitute and you are awaiting certification, your benefits will begin on the first of the month following receipt of your certification. For example, if you are hired on August 28th and your certification is provided to Stamford Public Schools on October 10th, your benefits will begin on November 1st. The beginning of your benefits coverage is not retroactive to your hire date.

Current Employees

The benefit elections you make during the annual open enrollment are effective at the beginning of each program's plan year.

Benefit Plan Years

Medical	July 1 st – June 30 th
Prescription Drugs	July 1 st – June 30 th
Dental	July 1 st – June 30 th
Voluntary Life Insurance	September 1 st – August 31 st
Voluntary Accident Insurance	September 1 st – August 31 st
Flexible Spending Accounts	January 1 st – December 31 st

When Coverage Ends

Termination of Employment Prior to the End of a School Year

- Your medical, prescription drugs and dental coverage end on the last day of the month you terminate your employment.
- Your BOE-provided basic life insurance and basic accident insurance coverage ends on your termination date.
- Your voluntary life insurance coverage ends on the last day of the month you terminate your employment.
- Your voluntary accident insurance coverage ends on the last day of the month you terminate your employment.
- Your participation in the flexible spending accounts ends on your termination date.

Termination of Employment at the End of a School Year

- Your medical, prescription drugs and dental coverage ends on August 31st.
- Your BOE-provided basic life insurance and basic accident insurance coverage end on August 31st.
- Your voluntary life insurance coverage ends on August 31st.
- Your voluntary accident insurance coverage ends on August 31st.
- Your participation in the flexible spending accounts ends on your termination date.

Retirement Prior to the End of a School Year

- As an active employee, your medical, prescription drugs and dental coverage end on the last day of the month you retire. Your coverage as a retiree begins consistent with your retirement with the Connecticut Teachers' Retirement System.
- Your BOE-provided basic life insurance and basic accident insurance coverage end on your retirement date.
- Your voluntary life insurance coverage ends on the last day of the month you retire.
- Your voluntary accident insurance coverage ends on the last day of the month you retire.
- Your participation in the flexible spending accounts ends on your retirement date.

Retirement the End of a School Year

- As an active employee, your medical, prescription drugs and dental coverage end on August 31st. Your coverage as a retiree begins as of September 1st if July 1st is your retirement date with the Connecticut Teachers' Retirement System the Connecticut Teachers' Retirement System.
- Your BOE-provided basic life insurance and basic accident insurance coverage end on August 31st unless you are retiring as an Administrator. If you are an Administrator, your coverage continues in accordance with your collective bargaining agreement.
- Your voluntary life insurance coverage ends on August 31st if your retirement date is July 1st.
- Your voluntary accident insurance coverage ends on August 31st if your retirement date is July 1st.
- Your participation in the flexible spending accounts ends on your retirement date.

Death of Employee or Retiree

- Your medical, prescription drugs and dental coverage end on your date of death. Coverage for your spouse and eligible dependents ends at the end of month during which you die.
- Your BOE-provided basic life insurance (active employees) ends on your date of death.
- Your voluntary life insurance coverage ends on your date of death.
- Your participation in the flexible spending accounts ends on your date of death.

Full-Time to Part-Time Status

Your benefits also end when you go from full-time to part-time status or if you fail to make the required contributions while out on an unpaid leave of absence.

If your health coverage ends, you may be eligible to extend health care coverage for you and your dependents under COBRA. Refer to the COBRA section of this benefits book.

If your life insurance ends, you may convert your life insurance to an individual policy within 31 days. If you die within 31 days of the date your life insurance coverage ends, your beneficiary will be paid the amount in effect before coverage ended. If your dependent dies within 31 days after his or her life insurance ends, you will be paid the amount in effect before coverage ended.

HIPAA Coverage Certificates

When your health coverage ends (for example, if you terminate employment), Anthem will issue you a certificate that will set forth the period your health coverage was in effect. You can use this certificate to reduce pre-existing condition limitations that may apply to you under a later health plan - for example, the plan of a subsequent employer.

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), your period of health coverage under the benefits offered by Stamford Public Schools can reduce the period during which a later plan can exclude coverage for pre-existing conditions, provided you do not have a 63-day break in coverage (not counting waiting periods). Coverage certificates permit you to document your period of coverage under the benefits offered by Stamford Public Schools. You will be sent a certificate of your period of coverage under the benefits offered by Stamford Public Schools after your coverage ends. If you extend your regular coverage under COBRA, you will be sent another certificate after your COBRA coverage ends. If your dependent's coverage ends before yours does and you notify the Benefits Administration Office of this cessation of coverage, a certificate will be issued for your dependent.

Certificates will be sent to your last known address, so be sure to notify Human Capital Development (who will notify the Benefits Administration Office) of any address change. Certificates will be issued as promptly as possible, but allow two months for delivery after coverage ends (or after you provide notice regarding a dependent, if later).

You may request a certificate (or a duplicate certificate) by calling Anthem's Member Services at 800-233-4947.

Cost of Coverage

The cost of your coverage is based upon your employee association's collective bargaining agreement. Pre-tax money is used to pay for medical, prescription drug, dental and flexible spending accounts benefits. You pay for voluntary life and accident insurance coverage with after-tax dollars.

Annual Open Enrollment

The annual open enrollment for medical, dental, voluntary life insurance and voluntary accident insurance benefits occurs at the end of each school year. During this time, you have the chance to review your benefits and make changes that meet your personal needs. You may enroll in, return to, opt out of our plans, and/or add/delete dependents to your benefits coverage. The effective date of your benefit elections is July 1st.

The annual open enrollment for flexible spending accounts occurs each November. You must complete an enrollment form in order to elect to have a flexible spending account for each calendar year. The effective date of your election is January 1st.

An open enrollment memo is sent via email to all employees and to each school's Main Office in May for medical, dental, voluntary life insurance and voluntary accident insurance benefits and in October for flexible spending accounts. This memo provides the open enrollment deadline and steps to enroll. The memo also provides your premium contributions for medical/prescription drugs and dental coverage.

All benefit elections or changes must be submitted to the Benefits Administration Office by the enrollment deadline. If you fail to submit your elections before the annual open enrollment deadline, your existing benefits will continue for the next school year. If you fail to make an election during the annual open enrollment for flexible spending accounts, you will not have a flexible spending account for the next calendar year.

Changing Coverage during the Year

You may make changes to your benefits during the year only if a "Qualified Life Event," as enumerated in IRC Section 125 occurs:

- Marriage or divorce
- Birth or adoption
- Death of your spouse or dependent child
- Dependent child ineligible because of age or ceases to be a full-time student
- Termination or commencement of your spouse's employment
- Change in your or your spouse's job status from full-time to part-time or part-time to full-time
- Taking of an unpaid leave of absence by you or your spouse

You must report the change to the Benefits Administration Office within thirty (30) days of the event. See the **What Happens To Your Benefits When...** section of this book to find out how each benefit is affected by your specific change and what action steps you need to take.

You may also make changes to your benefits during the year if there is a significant change in the cost of the plan, which causes a corresponding increase in your contribution during the plan year or if there is a significant change in your or your spouse's health coverage due to the spouse's employment. **You must report such change to the Benefits Administration Office within thirty (30) days of the change.**

Coordination of Benefits

If you and your covered dependents have medical or dental coverage under more than one group plan, the Stamford Public Schools benefits program has a feature that coordinates benefits to avoid increased costs that result from health care overpayments. Below is a listing of the order of benefit determination rules that you should know.

- Your medical and/or dental benefits plan through Stamford Public Schools is always primary for you.
- If you are covered under your spouse's medical and/or dental benefits plan, that plan is secondary for you.
- If your spouse has coverage through his/her employer, then that benefits plan is primary for your spouse.
- If you cover your spouse, the medical and/or dental plan through Stamford Public Schools is secondary for your spouse.
- If both you and your spouse cover your children, the plan that pays first is determined by the birthday rule, a standard method used in the insurance industry. This means that the plan of the spouse whose birthday falls earlier in the calendar year is primary. (For example, if your birthday is April 1 and your spouse's birthday is October 1, your plan is primary for your children.) If you both have the same birthday, the parent who has been covered longer has the primary plan. Only the month and day of the birthday are considered.
- If you are divorced or separated and a court decree establishes financial responsibility for the health care of a child, the plan of the parent assigned that responsibility will be that child's primary plan. In the absence of a court decree and when not remarried, the plan of the parent with legal custody will be the primary plan. If the parent with legal custody has remarried and the stepparent's plan also covers the child, the plan of the parent with custody will pay first, the plan of the stepparent will pay next, and the plan of the parent without custody will pay last.

When the medical and/or dental benefits plan through Stamford Public Schools is primary, it pays benefits as if it were the only plan. After the medical or dental plan administrator pays benefits, or denies a claim, you may file a claim for any unpaid amounts with your secondary plan.

When the medical and/or dental benefits plan through Stamford Public Schools is secondary, the medical or dental plan administrator determines the benefit that it would pay if it were the only plan (this includes applying the appropriate benefit levels and all other benefit limitations). Then, the benefit amount paid by the primary plan is subtracted. This means that when your medical and/or dental through Stamford Public Schools is secondary, it will pay only the difference, if any, between its usual benefit and the benefit paid by the primary plan. Therefore, coverage through Stamford Public Schools' medical and/or dental benefits plan and another plan may not result in your receiving 100% reimbursement for your medical and dental expenses.

Coordination of Benefits does not apply to the prescription drug program.

What Happens to Your Benefits When You Have a Qualified Life Event

Benefits offered by Stamford Public Schools are intended to support you and your family during the different stages and events of your life. This section gives you the information you need to take full advantage of your benefits when you experience a qualified life event. All changes must be consistent with the qualified life event.

If you experience one of the qualified life events listed in the chart, you must contact the Benefits Administration Office (203-977-4773 or 203-977-4196) within thirty (30) days of the event.

	Medical, Dental and Prescription Drugs	Health Care Flexible Spending Account	Dependent Day Care Flexible Spending Account	Life & Accident Insurance
Marriage	<ul style="list-style-type: none"> ▪ Add spouse and eligible dependent children and change coverage tier to reflect addition of dependents ▪ Cancel your coverage 	<ul style="list-style-type: none"> ▪ Elect, increase, decrease or cancel 	<ul style="list-style-type: none"> ▪ Elect or increase if your marriage creates or increases need for child care ▪ Cancel if your spouse makes an election under his/her employer's plan 	<ul style="list-style-type: none"> ▪ Elect, cancel or change coverage
Divorce	<ul style="list-style-type: none"> ▪ Elect coverage if you lose coverage under your spouse's plan ▪ Cancel spouse's coverage and change coverage tier to reflect cancellation of spouse's coverage 	<ul style="list-style-type: none"> ▪ Elect, increase, decrease or cancel 	<ul style="list-style-type: none"> ▪ Elect or increase election if your divorce creates or increases need for child care ▪ Cancel or decrease election if your divorce negates need for day care 	<ul style="list-style-type: none"> ▪ Elect, cancel or change coverage
Birth or Adoption	<ul style="list-style-type: none"> ▪ Add new dependent to coverage and change coverage tier to reflect addition of dependent(s) 	<ul style="list-style-type: none"> ▪ Elect, increase, decrease or cancel 	<ul style="list-style-type: none"> ▪ Elect or increase election 	<ul style="list-style-type: none"> ▪ Increase or decrease coverage ▪ Elect coverage for new dependent child

If you experience one of the qualified life events listed in the chart, you must contact the Benefits Administration Office (203-977-4773 or 203-977-4196) within thirty (30) days of the event.

	Medical, Dental and Prescription Drugs	Health Care Flexible Spending Account	Dependent Day Care Flexible Spending Account	Life & Accident Insurance
Death of spouse or dependent	<ul style="list-style-type: none"> ▪ Cancel coverage for deceased spouse or dependent and change coverage tier to reflect cancellation of coverage for spouse or dependent 	<ul style="list-style-type: none"> ▪ Elect, increase, decrease or cancel 	<ul style="list-style-type: none"> ▪ Decrease election 	<ul style="list-style-type: none"> ▪ Increase or decrease coverage
Dependent child ceases to be eligible because of age or loss of full-time student status	<ul style="list-style-type: none"> ▪ Cancel coverage for child and change coverage tier to reflect cancellation of dependent child's coverage 	<ul style="list-style-type: none"> ▪ Elect, increase, decrease or cancel 	<ul style="list-style-type: none"> ▪ Decrease election 	<ul style="list-style-type: none"> ▪ No change allowed
Termination of spouse's employment	<ul style="list-style-type: none"> ▪ Add spouse and eligible dependent children coverage and change coverage tier to reflect addition of dependents ▪ Elect coverage if you lose coverage under your spouse's plan 	<ul style="list-style-type: none"> ▪ Elect, increase, decrease or cancel 	<ul style="list-style-type: none"> ▪ Elect if you lose coverage under your spouse's plan 	<ul style="list-style-type: none"> ▪ Increase or decrease coverage
Commencement of spouse's employment	<ul style="list-style-type: none"> ▪ Cancel your coverage if you are added to your spouse's coverage ▪ Cancel you spouse's or dependent's coverage if they are added to your spouse's coverage 	<ul style="list-style-type: none"> ▪ Elect, increase, decrease or cancel 	<ul style="list-style-type: none"> ▪ Elect, increase or cancel election 	<ul style="list-style-type: none"> ▪ Increase or decrease coverage

If you experience one of the qualified life events listed in the chart, you must contact the Benefits Administration Office (203-977-4773 or 203-977-4196) within thirty (30) days of the event.

	Medical, Dental and Prescription Drugs	Health Care Flexible Spending Account	Dependent Day Care Flexible Spending Account	Life & Accident Insurance
Taking an unpaid leave by you or your spouse	<ul style="list-style-type: none"> ▪ Cancel coverage ▪ Retain coverage and pay full premium 	<ul style="list-style-type: none"> ▪ Cancel election 	<ul style="list-style-type: none"> ▪ Cancel election 	<ul style="list-style-type: none"> ▪ Cancel coverage
Return from taking an unpaid leave after 30 days	<ul style="list-style-type: none"> ▪ Elect coverage 	<ul style="list-style-type: none"> ▪ Elect, increase, decrease or cancel 	<ul style="list-style-type: none"> ▪ Elect 	<ul style="list-style-type: none"> ▪ Elect coverage
You or your spouse switches from full-time to part-time or part-time to full-time employment	<ul style="list-style-type: none"> ▪ Elect or cancel coverage 	<ul style="list-style-type: none"> ▪ Elect, increase, decrease or cancel 	<ul style="list-style-type: none"> ▪ Elect 	<ul style="list-style-type: none"> ▪ Elect coverage

Making Benefit Changes

If you experience one of the qualified life events listed in the chart, you must contact the Benefits Administration Office (203-977-4773 or 203-977-4196) within thirty (30) days of the event. If you do not contact the Benefits Administration Office within thirty (30) days of the event, you will not be permitted to make any changes until the next Open Enrollment.

To make changes, you must submit the applicable enrollment form and documentation that verifies the qualified life event. Such documentation includes a birth certificate, court adoption notice, letter from an adoption agency verifying placement, marriage certificate, death certificate and dissolution of marriage decree.

Changes made as a result of a qualified life event are done so without any imposition of pre-existing condition limitations or medical evidence requirements.

Medical

Century Preferred

Century Preferred is a Preferred Provider Organization (PPO) administered by Anthem Blue Cross and Blue Shield (Anthem). This PPO provides service throughout the state of Connecticut. The selection of a primary care Physician (PCP) is not required. However, this is a managed care program which requires that you observe all guidelines and procedures for obtaining Covered Services.

With Century Preferred, you have the flexibility to determine how you wish to access benefits and obtain Covered Services. There are two levels of coverage under Century Preferred - In-Network and Out-of Network coverage. When you visit an Anthem Century Preferred Provider for Covered Services, you are responsible for the In-Network copays, and any applicable coinsurance. **Your benefits are highest when you visit an Anthem Century Preferred Provider.**

If you visit an Out-of- Network Provider for Covered Services, you are responsible for Out-of-Network copays and any applicable coinsurance. You are also responsible for any charges in excess of the Maximum Allowable Amount (MAA). When establishing the MAA for the Out-of-Network Providers, Anthem considers industry costs, reimbursement and utilization data indices, including geographically based national reimbursement data.

Please see the Schedule of Benefits for the applicable coinsurance for both options. In addition to listing the copays and coinsurance that are your responsibility, this Schedule of Benefits also contains benefit maximums for specific types of coverage.

Century Preferred has a statewide network of Participating Physicians, Providers and Hospitals that you may obtain In-Network services from. For a geographic distribution of these Providers, please refer to the Century Preferred Provider Directory. Or, you may search online for a providing by going to www.anthem.com. Anthem is not responsible for notifying a Physician's patients when the Provider leaves the Participating Provider network. Although the Century Preferred Provider Directory is updated regularly to keep you informed of a Provider's participating/non-participating status; Anthem recommends that you verify with the Provider their participating status prior to incurring services.

Anthem participates in a program called "BlueCard". This program provides you with access to benefits for Covered Services outside of Connecticut. To locate participating Providers throughout the United States please call 1 (800) 810-BLUE.

Schedule of Benefits

Each schedule of benefits provides a summary of:

- what your copay is when you use an in-network provider
- how much you share in the cost of your medical benefits when you use an out-of-network provider
- your out-of-pocket maximum which is the most you will have to pay for covered expenses each year after which the plan pays 100%
- notes on benefits limitations or restrictions

Schedule of benefits can be found online at www.stamfordpublicschools.org. Once on the website, click on Teachers, then Benefits, then Plan Information, then Medical.

Important Definitions

The following definitions relate to your medical coverage and are important to know:

Administrative Services Only Agreement: The term Administrative Services Only Agreement means an administrative agreement between Anthem and Stamford Public Schools establishing administration fees, remittance of paid claims, benefits to be administered, and setting forth Anthem's duties and responsibilities.

Admission: The term Admission means the period from the date you or your covered dependent enters the Hospital, Skilled Nursing Facility, Substance Abuse Treatment Facility, Residential Treatment Facility, Hospice or other Inpatient Facility as an Inpatient until the date of discharge. When counting days of Inpatient services, the date of entry and date of discharge are combined to count together as one day.

Elective Admission: The term Elective Admission means an Inpatient Admission which is Medically Necessary and scheduled in advance where you or your covered dependent do not require immediate medical treatment to prevent death, disability or serious impairment of bodily part or function.

Ambulance Service: The term Ambulance Service means a commercial or municipal Ambulance Service issued a license by the State of Connecticut Office of Emergency Medical Services. If out of state, an Ambulance Service must have equivalent licensure.

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

Appliance(s): The term Appliance(s) means leg, arm, back or neck braces, or artificial legs, arms or eyes, and any prosthesis with supports, including replacement if you or your covered dependent's physical condition changes.

Authorize: The term Authorize (Authorization) means that approval has been obtained from Anthem for the Emergency Admission of you or your covered dependent to a Hospital, Skilled Nursing Facility, Substance Abuse Treatment Facility, Residential Treatment Facility or Hospice, when required under the terms of the benefits offered by Stamford Public Schools.

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.

Birthcenter: The term Birthcenter means a facility separate from a Hospital which provides room, board and Special Services related to the management of normal childbirth. Synonymous terms are Birthing Center and Childbirth Center.

Calendar Year: The term Calendar Year means a period beginning 12:01 a.m. on January 1 and ending midnight on December 31 of the same year.

Cancer Clinical Trial: The term Cancer Clinical Trial means an organized, systematic, scientific study of therapies, tests or other clinical interventions for purposes of treatment or palliation or therapeutic intervention for the prevention of cancer in human being except that a clinical trial for the prevention of cancer is eligible for coverage only if it involves a therapeutic intervention and is a Phase III clinical trial that is conducted at multiple institutions. A Cancer Clinical Trial must be conducted under the auspices of an independent peer-reviewed protocol that has been reviewed and approved by:

- One of the National Institutes of Health; or

- A National Cancer Institute affiliated cooperative group; or
- The federal Food and Drug Administration as part of an investigational new drug or device exemption; or
- The federal Department of Defense or Veterans Affairs.

Case Management: The term Case Management means the process of evaluating and arranging for Medically Necessary treatment for patients, identified through the use of one or more of Anthem's managed care programs.

Chronic Care: The term Chronic Care means a condition that continues and/or recurs over a prolonged period of time. The condition is characterized by either a slow progressive loss of function or a static/stationary loss of function in which little or no measurable objective improvement is made despite therapeutic intervention.

Coinsurance: The term Coinsurance means a fixed percentage you or your covered dependent is required to pay as specified in the Schedule of Benefits.

Concurrent Review: The term Concurrent Review means a process to monitor all Inpatient Admissions to determine its continued Medical Necessity, starting from the assignment of the initial Prior Authorization of days and continuing to the date of discharge.

Copayment: The term Copayment means a fixed amount which you or your covered dependent is required to pay for Covered Services at the time that those services are rendered. Copayments are listed in the Schedule of Benefits.

Cost-Share: The term Cost-Share means the amount which you or your dependent is required to pay for Covered Services. Where applicable, Cost-Shares can be in the form of Copayments, Coinsurance, and/or Deductibles.

Cost-Share Maximum: The term Cost-Share Maximum means the Deductible plus Coinsurance amounts which are paid by you or your covered dependent on a Calendar Year basis.

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

- Medically Necessary or otherwise specifically included as a benefit in this benefits book;
- Within the scope of the license of the Provider performing the service;
- Rendered while coverage as described in this benefits book is in force;
- Not Experimental or Investigational or otherwise excluded or limited as described in this benefits book;
- Authorized in advance by Anthem if such prior authorization is required.

Custodial Care: The term Custodial Care means care primarily for the purpose of assisting you or your covered dependent in the activities of daily living or in meeting personal rather than medical needs, and which is not specific treatment for an illness or injury. It is care which cannot be expected to substantially improve a medical condition and has minimal therapeutic value. Such care includes, but is not limited to:

- assistance with walking, bathing, or dressing;
- transfer or positioning in bed;
- normally self-administered medicine;
- meal preparation;
- feeding by utensil, tube, or gastrostomy;

- oral hygiene;
- ordinary skin and nail care;
- catheter care;
- suctioning;
- using the toilet;
- enemas; and
- preparation of special diets and supervision over medical equipment or exercises; or
- over self-administration of oral medications not requiring constant attention of trained medical personnel.

Care can be custodial whether or not it is recommended or performed by a professional and whether or not it is performed in a facility (e.g. Hospital or Skilled Nursing Facility) or at home.

Date of Placement: The term Date of Placement means the assumption and retention by a person of legal obligation for total or partial support of a child in anticipation of adoption of the child.

Day/Night Visit: The term Day/Night Visit means continuous treatment consisting of not less than 4 hours and not more than 12 hours in any 24 hour period when received in a General or Specialty Hospital or in a Substance Abuse Treatment Facility.

Deductible: The term Deductible means the fixed amount which you or your covered dependent must pay for Covered Services in a Calendar Year prior to the application of Coinsurance when using the Out-of-Network Option.

1. The individual and family Deductible amounts are shown in the Schedule of Benefits
2. The family Deductible amount is met when each of your covered family members meet the individual Deductible amount as specified in the Schedule of Benefits.
3. The family Deductible amount is met when you or one of your covered dependents meet and the other covered family members collectively meet the difference between the individual Deductible and family Deductible amounts, as specified in the Schedule of Benefits.

Durable Medical Equipment: The terms Durable Medical Equipment means equipment which:

1. is designated for repeated use in the Medically Necessary Care, diagnosis or treatment of an illness or injury;
2. improves the function of a malformed body part or prevents or retards further deterioration of you or your covered dependent's medical condition; and
3. is not useful in the absence of injury or illness.

Effective Date: The term Effective Date means the date you and/or your eligible dependents, if any, are accepted by Anthem and eligible to receive benefits for Covered Services under the benefits offered by Stamford Public Schools.

Enrollment Date: The term Enrollment Date means the first day of coverage or, if there is a Waiting Period, the first day of the Waiting Period.

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

- A. Anthem 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

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

Notwithstanding the above, services or supplies will not be considered Experimental 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.

Free Standing Magnetic Resonance Imaging Facility: The term Free Standing Magnetic Resonance Imaging Facility means a facility which needs approval for its magnetic resonance equipment and its services from the State of Connecticut Commission on Hospitals and Health Care. Also, the facility must be accredited as either an Ambulatory Health Care facility by the Joint Commission on Accreditation of Healthcare Organization (JCAHO) or a Magnetic Resonance Imaging Facility by the American College of Radiology (ACR). The term Free-Standing Magnetic Resonance Imaging Facility does not include physician's offices where the primary care is medical services.

Hospice: The term Hospice means a facility, organization or agency certified by Medicare that is primarily engaged in providing pain relief, symptom management and supportive services to terminally ill people and their families.

Hospital: The term Hospital means an institution which provides 24 hour continuous services to confined patients and whose chief function is to provide diagnosis and therapeutic facilities for the surgical and medical diagnosis, treatment or care of injured or sick persons. A professional staff of licensed Physicians and surgeons must provide or supervise the services. The institution must provide General Hospital and major surgical facilities and services or specialty services. The following shall not be considered a Hospital:

- A convalescent or extended care unit within or affiliated with the Hospital;

- A non-Hospital based clinic;
- A nursing, rest or convalescent home, or extended care facility;
- An institution operated mainly for care of the aged;
- A health resort, spa or sanitarium; or
- Any facility not having appropriate state licensure and not accredited as a Hospital by the Joint Commission on the Accreditation of Health Care Organizations (JCAHO), except for a Hospital located outside the United States.

General Hospital: The term General Hospital means a Hospital which is licensed as such by the State of Connecticut and has appropriate accreditation from the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). If out-of-state, a General Hospital must have equivalent licensure and accreditation.

Specialty Hospital: The term Specialty Hospital means a Hospital which is not a General Hospital but which is licensed by the State of Connecticut as a certain type of Specialty Hospital and has appropriate accreditation from the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). If out-of-state, a Specialty Hospital must have equivalent licensure and accreditation.

Participating Hospital: The term Participating Hospital means a Hospital designated and accepted as a Participating Hospital by Anthem to provide Covered Services to you or your covered dependent under the terms of the benefits offered by Stamford Public Schools.

Non-Participating Hospital: The term Non-Participating Hospital means any appropriately licensed Hospital which is not a Participating Hospital under the terms of the benefits offered by Stamford Public Schools.

Identification Card: A card issued by Anthem to you for identification purposes which must be shown by you and your covered dependent to obtain Covered Services.

In-Network Option: The term In-Network Option means that Covered Services are obtained from any Participating Physicians, Participating Hospital or Participating Provider.

Inpatient: The term Inpatient means you or your covered dependent who occupies a bed in a Hospital or other 24 hour care facility, receives board as well as diagnosis, care or treatment and is counted as an Inpatient at the time of a Hospital or 24 hour care facility census.

Inpatient Facility: The term Inpatient Facility means a facility other than a Hospital that provides board as well as diagnosis, care or treatment on a 24 hour basis to patients such as a Skilled Nursing Facility, Hospice, Substance Abuse Treatment Facility, Sub-acute Care Facility and Residential Treatment Facility.

Learning Disability: The term Learning Disability means a disorder in one or more of the basic psychological processes involved in understanding or in using spoken or written language. This may be manifested in disorders of learning, thinking, talking, reading, writing, spelling, arithmetic or social perception.

Licensed Occupational Therapist: The term Licensed Occupational Therapist means a therapist who is licensed by the State of Connecticut. If out of state, a therapist must have equivalent licensure.

Licensed Physical Therapist: The term Licensed Physical Therapist means a therapist who is licensed by the State of Connecticut. If out of state, a therapist must have equivalent licensure.

Licensed Speech Pathologist: The term Licensed Speech Pathologist means a therapist who is licensed by the State of Connecticut to render services referred to by Anthem as Speech Therapy. If out of state, a speech pathologist must have equivalent licensure.

Maintenance Care: The term Maintenance Care means treatment provided for you or your covered dependent's continued well-being by preventing deterioration of a chronic clinical condition; and maintenance of an achieved stationary status which is at a point where little or no measurable objective improvement in musculo-skeletal function can be effectuated despite therapy.

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

1. Participating Physician and Participating Provider: except as otherwise required by law, an amount agreed upon by Anthem and a Participating Physician and Participating Provider as full compensation for Covered Services provided to you or your covered dependent. When applicable, it is you or your covered dependent's obligation to pay Cost-Shares as a component of this Maximum Allowable Amount. The amount Anthem will pay for Covered Services will be the Maximum Allowable Amount or the billed charges, whichever is lower.
2. Non-Participating Physician and Non-Participating Provider: except as otherwise required by law, a reasonable amount as determined by Anthem, after consideration of such industry cost, reimbursement and utilization data and indices, as Anthem deems appropriate in its sole discretion, which is assigned as reimbursement for Covered Services or an amount negotiated with a Non-Participating Physician and Non-Participating Provider for Covered Services. The amount Anthem will pay for Covered Services will be the Maximum Allowable Amount or the billed charges, whichever is lower. It is your obligation to pay Cost-Shares as a component of this Maximum Allowable Amount.
3. Participating Hospital: except as otherwise required by law, an amount which a Participating Hospital accepts as full compensation for Covered Services. When applicable, it is your obligation to pay Cost-Shares as a component of this Maximum Allowable Amount.
4. Non-Participating Hospital: except as otherwise required by law, an amount negotiated with a Non-Participating Hospital for Covered Services provided, or in the absence of a negotiated amount, a Non-Participating Hospital's charge reduced by Cost-Shares for Covered Services. It is your obligation to pay Cost-Shares and amount in excess of this Maximum Allowable Amount.

Please note that the Maximum Allowable Amount may be greater or less than the Participating Physician's, Participating Provider's, Participating Hospital's, Non-Participating Physician's, Non-Participating Provider's or Non-Participating Hospital's billed charges for the Covered Services.

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

Non-Participating Out-of-State Provider Cost Share Calculation

When Covered Services are rendered outside of Connecticut by Non-Participating Physicians, Non-Participating Providers and/or Non-Participating Hospitals, your Cost Share obligation may be calculated based upon one of the following items (note that in the case of items a. and b. the method of Cost-Share calculation must be mandated by the law of the state in which the Covered Person is domiciled pursuant to the exception contained in Ct. General Statute 38a-478j except that in the case of the BlueCard Program, the Cost-Share calculation shall be based on item c.):

- a. The Maximum Allowable Amount; or
- b. Billed charges; or
- c. The Maximum Allowable Amount or billed charges, whichever is lower.

Maximum Allowable Amount: Non-Participating Out-of -State Provider

When Covered Services are rendered outside of Connecticut by Non-Participating Physicians, Non-Participating Providers and/or Non-Participating Hospitals, (whether or not such physicians, providers or hospitals are Host Plan participating physicians, providers or hospitals), the Maximum Allowable Amount shall be determined by that Blue Cross and/or Blue Shield Plan in that area outside of Connecticut.

The Maximum Allowable Amount may be:

1. Under arrangements other than BlueCard, the applicable rate for such services, before deduction of any applicable risk withholds, negotiated with the Provider (Physician, Hospital, other Provider) by that Blue Cross and/or Blue Shield Plan outside of Connecticut which that Blue Cross and/or Blue Shield Plan passes on to Anthem (which may include fee for service rates, per diem rates, scheduled charges, capitated charges, or other pricing mechanisms in that Blue Cross and/or Blue Shield Plan's discretion); or
2. Under BlueCard, the negotiated price, which may be the actual price paid on the claim by the Host Plan to the Provider or may include an estimated price or average discount off of billed charges that factors in settlements, withholds, another contingent payment arrangements and any other non-claims transactions with all of the Host Plan's health care providers or one or more particular providers that the Host Plan passes on to Anthem. Average discounts tend to have a greater range of variability than do estimated prices. Such estimated prices or average discounts may be prospectively adjusted to correct for past over- or underestimation of prices or discounts applicable to BlueCard Program claims. There will be no retrospective adjustment or return of funds to, or request additional payment from, you because the amount paid by you is a final price.

In addition, Anthem will calculate the Cost-Share obligation (i.e., Coinsurance) for the amount for those Covered Services in some cases based on input from the Blue Cross and/or Blue Shield Plan outside the geographic area we serve where the services were rendered.*

Under BlueCard, there may be a small number of states where state law may either specify the basis for the calculation of the Cost-Share obligation for Covered Services that does not reflect the entire savings realized, or expected to be realized on a particular claim, or add a surcharge. The Cost-Share obligation will be based on those statutory provisions, as applicable.

* Applicable to BlueCard and arrangements other than BlueCard.

Medical Emergency: The term Medical Emergency means the onset of a serious illness or injury which requires emergency medical treatment or the onset of symptoms of sufficient severity that a Covered Person reasonably believes that emergency medical treatment is needed.

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

1. Medically appropriate for and consistent with the symptoms and proper diagnosis or treatment of a condition; illness; disease; or injury;
2. Obtained from a Physician and/or duly licensed, certified; or registered Provider;
3. Provided in accordance with applicable medical and/or professional standards;
4. Known to be effective, as proven by scientific evidence, in materially improving health outcomes;

5. The most appropriate supply; setting; or level of service that can safely be provided and which cannot be omitted consistent with recognized professional standards of care (which, in the case of hospitalization, also means that safe and adequate care could not be obtained as an outpatient);
6. Cost-effective compared to alternative interventions; including no intervention. ("Cost-effective" does not mean lowest cost.);
7. Not Experimental or Investigational;
8. Not primarily for you or your covered dependent's convenience; or the Provider;
9. Not otherwise subject to an Exclusion under the benefits offered by Stamford Public Schools.

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

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

Medicare: The term Medicare means Title XVIII of the Social Security Act of 1965, as amended.

Mental Health Care: The term Mental Health Care means services provided to treat a mental disorder as defined in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders". Mental Health Care does not include (1) mental retardation, (2) learning disorders, (3) motor skills disorder, (4) communication disorders, (5) caffeine-related disorders, (6) relational problems, and (7) additional conditions that may be a focus of clinical attention, that are not otherwise defined as mental disorders in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders".

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's designated Subcontractor(s) for the service they perform under the benefits offered by Stamford Public Schools.

Outpatient: The term Outpatient means that you or your covered dependent receive services in a Hospital emergency room, Physician's office, or ambulatory surgical facility and leaves in less than 24 hours.

Partial Hospitalization: The term Partial Hospitalization means continuous treatment in a General Hospital, Specialty Hospital or Residential Treatment Facility consisting of not less than 4 hours and not more than 12 hours in any 24 hour period.

Penalty (Penalties): The term Penalty (Penalties) means that amount that must be paid when Prior Authorization is not obtained; or for a Medical Emergency Admission which is not authorized by Anthem within 2 business days.

Physician: The term Physician means any licensed doctor of medicine (M.D.), osteopathic Physician (D.O.), dentist (D.D.S./D.M.D.), podiatrist (Pod. D/D.S.C./D.P.M.), doctor of chiropractic

(D.C.), naturopath (N.D.), optometrist (O.D.) or psychologist (Ph.D./Ed.D/PsyD.) who is licensed to practice in the state in which services are rendered.

Participating Physician: The term Participating Physician means any appropriately licensed Physician designated and accepted as a Participating Physician by Anthem to provide Covered Services.

Non-Participating Physician: The term Non-Participating Physician means any appropriately licensed Physician who is not a Participating Physician.

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.

Prescription Drug(s): The term Prescription Drug means drugs, biologicals, and compounds which can be dispensed legally only upon written authorization by a Physician, which are required by law to bear the legend "Caution: Federal Law prohibits dispensing without a prescription," and which are listed in one or more of the following publications: United States Pharmacopeia, The National Formulary, or Accepted Dental Remedies.

Prior Authorization (Prior Authorized): The term Prior Authorization means that prior approval has been obtained from Anthem, which enables you or your covered dependent to receive benefits for certain Covered Services.

Proof: The term Proof means any information that may be required by Anthem in order to satisfactorily determine eligibility or compliance with any provision of the benefits offered by Stamford Public Schools.

Prosthetic Device: The term Prosthetic Device means any device which replaces all or part of a body organ (including contiguous tissues), or replaces all or part of the function of a permanently inoperative, absent, or malfunctioning part of the body.

Provider: The term Provider means any appropriately licensed or certified health care professional or facility providing health care services or supplies.

Participating Provider: The term Participating Provider means any appropriately licensed or certified health care professional or facility designated and accepted as a Participating Provider by Anthem to provide Covered Services.

Non-Participating Provider: The term Non-Participating Provider means any appropriately licensed or certified health care professional or facility which is not a Participating Provider.

Residential Treatment Facility: The term Residential Treatment Facility means a treatment center for children and adolescents which provides residential care and treatment for emotionally disturbed individuals, is licensed by the Department of Children and Families (DCF), and is accredited by the Council on Accreditation or The Joint Commission on the Accreditation of Health Care Organizations as a Residential Treatment Facility.

Routine Patient Care Cost: The term Routine Patient Care Costs means: Costs for Medically Necessary health care services that are incurred as a result of treatment for purposes of a Cancer Clinical Trial that would otherwise be covered if such services were not rendered in conjunction with a Cancer Clinical Trial. Such services shall include those rendered by a Physician, diagnostic or laboratory tests, hospitalization or other services provided during the

course of treatment in Cancer Clinical Trial and coverage for Routine Patient Care Costs incurred for off-label drug prescriptions.

Routine Patient Care Costs shall not include:

1. the cost of an investigational new drug or device that has not been approved for market for any indication by the federal Food and Drug Administration;
2. the cost of a non health care service that may be required as a result of the treatment being provided for the purposes of the Cancer Clinical Trial;
3. facility, ancillary, professional services and drug costs that are paid for by grants or funding for the Cancer Clinical Trial;
4. costs of services that (A) are inconsistent with widely accepted and established regional or national standards of care for a particular diagnosis, or (B) are performed specifically to meet the requirements of the Cancer Clinical Trial;
5. costs that would not be covered under this Plan for non-investigational treatments, including items excluded from coverage under the Plan; and
6. transportation, lodging, food or any other expenses associated with travel to or from a facility providing the Cancer Clinical Trial, for the patient or any family member or companion.

Skilled Nursing Facility: The term Skilled Nursing Facility means any institution that:

1. accepts and charges for patients on an Inpatient basis;
2. is primarily engaged in providing skilled nursing care, rehabilitative and related services to patients requiring medical and skilled nursing care;
3. is under the supervision of a licensed Physician;
4. provides 24 hour a day nursing service under the supervision of a registered nurse; and
5. is not a place primarily for the treatment of nervous-mental disorders, pulmonary tuberculosis, a place of rest, Custodial Care or acute Inpatient level of care.

Special Services: The term Special Services means services and supplies, rendered by a health care facility in relation to the illness or injury during an Inpatient stay.

Specialized Formula: The term Specialized Formula means a nutritional formula for children up to age eight that is exempt from the general requirements for nutritional labeling under the statutory and regulatory guidelines of the Federal Food and Drug Administration and is intended for use solely under medical supervision in the dietary management of specific diseases.

Subacute Care Facility: The term Subacute Care Facility means a facility that is generally engaged in providing subacute care services, is licensed by the State of Connecticut as a chronic and convalescent nursing home and has appropriate accreditation from the Joint Commission on Accreditation of Health Care Organizations (JCAHO).

Subcontractor: The term Subcontractor means an entity with which Anthem 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's behalf.

Substance Abuse Care: The term Substance Abuse Care means services to treat alcoholism or drug dependency.

Substance Abuse Treatment Facility: The term Substance Abuse Treatment Facility means a facility which is established primarily to provide 24 hour Inpatient treatment of substance abuse and licensed for such care by the State of Connecticut Department of Public Health and Addiction Services.

Totally Disabled: The term Totally Disabled means the inability to perform the duties of any occupation for which you are suited by reason of education, training or experience because of an injury or disease. A covered dependent shall be 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 will determine disability status under the terms of the benefits offered by Stamford Public School. Proof of continued disability must be provided if Anthem requests it.

Urgent Care: The term Urgent Care means care for an illness or injury which is not a Medical Emergency but requires immediate medical attention.

Urgent Care Facility: The term Urgent Care Facility means a Participating Provider from whom Urgent Care services may be obtained when a Participating Physician or covering Physician is not available.

Waiting Period: The term Waiting Period means the period of time which must pass before the first day of coverage under the Benefit Program.

Well Newborn: The term Well Newborn means an infant who:

1. weighs more than 5 pounds; or
2. in the opinion of the attending Physician, does not have any disease, illness, injury or congenital anomaly requiring immediate medical attention during the Hospital stay in which the birth occurred; or
3. is not born of a mother with metabolic, endocrine or other disorders or predisposing factors which are known to cause problems in the care of the infant during the neonatal period.

Managed Care Guidelines

Your medical benefits program requires you to follow certain policies or guidelines and limitations, including, but not limited to: Anthem Medical Policy; Prior Authorization; Concurrent Review; and Case Management. If you fail to follow the any of the required Managed Care Guidelines, there will be a reduction in or denial of benefits.

Anthem Medical Policy

Anthem Medical Policy reflects the standards of practice and medical interventions identified as reflecting appropriate medical practice. The purpose of the Anthem Medical Policy is to assist Anthem in the determination of Medical Necessity. However, the benefits, exclusions and limitations take precedence over Anthem Medical Policy. Medical technology is constantly changing and Anthem reserves the right to review and update the Anthem Medical Policy periodically.

Prior Authorization

Prior Authorization of certain services is required so that Anthem can review the service to verify that it is medically necessary and that the treatment provided is the proper level of care. It is your responsibility to contact Anthem to determine which services require Prior Authorization. Services that typically require Prior Authorization include:

- hospital admissions/inpatient facility admissions or admission to a partial hospitalization or day/night program.

- certain prosthetic devices and durable medical
- human organ and tissue transplants
- mental health care and substance abuse care
- high cost diagnostic services such as MRIs, PET scans and CAT scans

Elective Admissions

You must call Anthem (at the number located on the back of your ID card) when the admission is scheduled. This call must be made no later than one business day prior to the elective admission day. If you don't obtain the appropriate Prior Authorization, benefits will be reduced and no benefits will be payable for physician inpatient medical care visits or hospital room and board charges.

Medical Emergency Admissions

You or a representative must notify Anthem within 2 business days of an inpatient admission due to a medical emergency. If you are admitted due to a medical emergency and Anthem is not notified within 2 business days, benefits for you shall only be provided if your condition at the time of diagnosis, care or treatment is confirmed to have been a medical emergency.

Concurrent Review

The availability of inpatient benefits for you will be subject to Concurrent Review. Based on the results of the Concurrent Review, Anthem will determine that:

- There will be additional inpatient days Prior Authorized; or
- There will be a change in the services, supplies, treatment or setting; or
- There will be no additional Inpatient days authorized as of a specific date.

If continued hospitalization can no longer be authorized beyond a specific date, Anthem will assist you, your physician and hospital to coordinate continued care, where appropriate. No benefits will be provided for inpatient care billed by the hospital and the admitting physician after the specific date indicated in the Anthem authorization notice.

Case Management

Anthem may at its discretion, provide benefits supplemental to those Covered Services provided under this plan as a part of Case Management. Case Management is a program tailored to you. Anthem's case managers work collaboratively with you, your family and providers to coordinate your health care benefits. In certain extraordinary circumstances involving intensive Case Management, Anthem on behalf of Stamford Public Schools, may provide benefits for care that is not listed as a Covered Service. Anthem, on behalf of Stamford Public Schools, may also extend Covered Services beyond the contractual benefits limits of this plan. Anthem, on behalf of Stamford Public Schools, will make its decisions regarding Case Management on a case-by-case basis.

If Anthem denies, reduces or terminates benefits at any time during the review process, you, your representative, hospital, skilled nursing facility, substance abuse treatment facility, residential treatment facility, hospice or other inpatient facility or physician may request an Appeal review. See the Administrative Information section of this benefits book for further information regarding the Appeal process.

Covered Services

Covered services are health care services you receive that are eligible for benefits under your medical benefits plan, subject to deductibles, copays, and other plan conditions, exclusions and limitations. Your medical benefits plan shall provide benefits for the Covered Services described in this section when performed by a Participating Physician, Participating Provider, Participating Hospital, or Non-Participating Physician, Non-Participating Provider or Non-Participating Hospital, and subject to the Managed Benefits Section of this benefits book.

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

- a. To receive maximum benefits for Covered Services, you must follow the terms of this benefits book, including, obtaining any required Prior Authorization.
- b. Benefits for Covered Services are based on the Maximum Allowable Amount for such service.
- c. 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 cannot prohibit non-network Providers from billing you for the difference in the non-network Provider's charge and the Maximum Allowable Amount.
- d. 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.
- e. Anthem bases its decisions about referrals, Prior Authorization, Medical Necessity, experimental services and new technology on medical policy developed by Anthem. Anthem 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.
- f. This plan does not cover any service or supply not specifically listed as a Covered Service in this benefits book.

Acupuncture Services

The plan covers acupuncture services when used as a form of anesthesia; or for the relief of pain; to ease the symptoms of substance abuse; or to treat a range of disorders other than pain. Acupuncture services must be rendered by a licensed Physician; or an acupuncturist certified by the American Association of Acupuncture and Oriental Medicine who is practicing with the scope of both his certification and the laws of the area where treatment is given.

Ambulance/Medically Necessary Transportation Services

The plan covers the following:

- medically necessary medical transportation services
- ambulance services when your condition at the time of the treatment is confirmed to have been a medical emergency.
- medical transportation services when medically necessary, from a hospital or provider where you are inpatient to a participating hospital or participating provider
- medical transportation services provided through the home health agency in conjunction with the home health care services as follows:
 - from a hospital or provider to your home after discharge
 - to and from a hospital or provider for treatment
 - from your home to a hospital or provider, if readmission is necessary

Chiropractic Services

The plan covers chiropractic care (including the initial exam) performed by a licensed chiropractor for diagnosis and treatment for a misalignment or dislocation of the spine (including any strained muscle or related ligament).

Diabetes Services and Supplies

The plan covers diabetic equipment, drugs and supplies. The plan also covers outpatient diabetes self-management training if prescribed by a licensed health care professional and performed by a certified, licensed or registered health care professional trained in diabetes care and operating within the scope of their licensure. Benefits are provided for 10 hours of initial training, 4 hours of additional training because of changes in the individual's condition and four hours of training required by new developments in the treatment of diabetes.

Diagnostic Services

The plan covers the following:

- diagnostic x-ray or imaging studies
- Magnetic Resonance Imaging (MRI)
- laboratory and pathology tests
- electronic diagnostic medical procedures
- outpatient polysomnography
- laboratory and diagnostic tests including PSA tests to screen for prostate cancer
- CAT Scan
- colorectal cancer screening, including, but not limited to: an annual fecal occult blood test and colonoscopy, flexible sigmoidoscopy or radiologic imaging.

Durable Medical Equipment, Prosthetic Devices, Supplies & Appliances

Certain Durable Medical equipment may not require Prior Authorization. Remember to contact Member Services at 1-800-233-4947 before you obtain any such equipment to determine if Prior Authorization is required.

The plan covers the following:

- durable medical equipment which improves the function of a malformed body part, or prevents or retards further deterioration of your medical condition
- prosthetic devices, when prescribed, whether surgically implanted or worn as an anatomic supplement and subject to the following: repair, replacement, fitting, and adjustments are covered when made necessary by normal wear and tear or by body growth or change
- non-dental prosthetic devices, including maxillo-facial prosthetic devices used to replace anatomic structures removed during treatment of head or neck tumors, and additional appliances essential for the support of such prosthetic devices - in cases of a tumor of the oral cavity
- appliances such as a leg, arm, back or neck brace or artificial legs, arms or eyes or any prosthesis with supports, including replacement if your physical condition changes
- ostomy bags, catheters and supplies required for their use, and any other medically necessary ostomy-related appliances including; but not limited to: collection devices; irrigation equipment and supplies; and skin barriers and protectors
- external breast prosthesis following mastectomy for malignancy or other disease of breast tissue
- hearing aid coverage available for children twelve years of age or younger
- wigs if prescribed by a licensed oncologist for a patient who suffers hair loss as a result of chemotherapy

- hypodermic needles or syringes prescribed by a licensed practitioner for the purpose of administering medications for medical conditions, provided such medications are covered under this plan

Hearing Benefits

The plan covers hearing examinations including screening to determine the medical necessity for hearing correction when performed by a certified otolaryngologist or a legally qualified audiologist holding a Certificate of Clinical Competence in Audiology from the American Speech and Hearing Association in the absence of any applicable licensing requirements.

Home Health Care

Through the use of an authorized home health care agency, you may be able to shorten your hospital stay and speed your recovery in your own home. The plan covers home health care services after an admission, commencing within 7 days after discharge from the hospital. Home health care services must be rendered for treatment of the same illness or injury for which you were hospitalized. Covered services include:

- occupational, speech and respiratory therapy
- medical and surgical supplies and prescribed durable medical equipment
- prescription drugs dispensed from a retail pharmacy
- oxygen and its administration
- home health aide services consisting primarily of patient care of a medical or therapeutic nature
- laboratory services
- dietary services
- transportation to and from a hospital for treatment, re-admission or discharge by the most safe and cost-effective means available

The plan covers the following services in lieu of an admission:

- terminal illnesses upon diagnosis by a physician
- skilled nursing care by a Registered Nurse (R.N.) or a Licensed Practical Nurse (L.P.N.) under the supervision of a R.N. when the services of a R.N. are not available
- skilled, progressive and rehabilitative services of a licensed physical therapist

Benefits rendered by a home health aide are provided for up to 4 hours per day for non-terminally ill Covered Person and 8 hours per day for a terminally ill Covered Person.

Expenses for the following services are **not covered**:

- meals, personal comfort items and housekeeping services
- nursing services provided in the home by a relative, even if a registered nurse or a licensed practical nurse

Hospice Care

Hospice care refers to the medical, psychological, and nursing care provided to terminally ill patients with a life expectancy of six months or less. It allows someone to leave a hospital for a more comfortable setting. **With Prior Authorization**, the plan covers the following services:

- inpatient hospice services in a hospice, hospice unit in a hospital or skilled nursing facility
- part-time intermittent nursing care by a registered nurse or licensed practical nurse and services of a home health aide for patient care up to 8 hours
- psychological and dietary counseling

- consultation or case management services by a physician
- physical and/or occupational therapy
- medical supplies, drugs and medicines prescribed by a physician.
- medical social services under the direction of a physician up to the greater of \$420 or 6 visits
- hospice services in the home from a home health care agency
- part-time or intermittent services of a home health aide for patient care up to 8 hours per day

Expenses for the following services are **not covered**:

- bereavement counseling
- pastoral counseling
- financial or legal counseling
- custodial care

Hospital Services - Inpatient

The plan covers room and board for a semi-private hospital room. If a private room is used, the plan shall only cover services up to the cost of the semi-private room rate, unless Anthem determines that a private room is medically necessary.

Following a mastectomy, the plan will provide coverage at least 48 hours after a mastectomy or lymph node dissection unless otherwise agreed upon by you and your physician.

Covered hospital services and supplies include:

- use of an operating, delivery and treatment room, and equipment (including intensive care)
- prescribed drugs
- administration of blood and blood processing
- anesthesia, anesthesia supplies and services
- medical and surgical dressing, supplies, casts and splints
- diagnostic services
- rehabilitative and restorative physical therapy and occupational therapy and speech therapy for treatment expected to result in the reasonable improvement of your condition
- radiation therapy
- chemotherapy for treatment of cancer
- laboratory tests
- X-ray or imaging studies
- pre-admission testing
- tests and studies required in connection with a scheduled admission for surgery
- services for hemodialysis or peritoneal dialysis for chronic renal disease, including equipment, training and medical supplies until you are eligible for the Medicare End Stage Renal Disease program
- services associated with accidental consumption or ingestion of a controlled drug or other substance
- anesthesia, nursing and related hospital charges for inpatient dental services
- one day dental services if deemed medically necessary by the treating dentist or oral surgeon and you physician in accordance **with Prior Authorization** requirements and (1) you have been determined by a licensed dentist in conjunction with a licensed physician to have a dental condition of sufficient complexity that it requires inpatient services, or (2) you have a developmental disability, as determined by a licensed physician, that places you at serious risk

If you are admitted as an inpatient as a result of outpatient surgery, you must notify Anthem within 2 business days of the admission. Please refer to the Managed Care Guidelines section of this benefits book for information on how to notify Anthem of your admission.

Pre-admission testing must be rendered to you as an outpatient prior to your scheduled hospital admission and not repeated upon admission for surgery. You will be responsible for the charges for pre-admission testing if you cancel or postpone your scheduled admission.

Expenses for the following services are **not covered**:

- private duty nursing services during an inpatient hospital admission

Hospital Services - Outpatient

Covered outpatient hospital services and supplies include:

- use of an operating, delivery and treatment room, and equipment
- prescribed drugs
- administration of blood and blood processing
- anesthesia, anesthesia supplies and services
- medical and surgical dressing, supplies, casts and splints
- diagnostic services
- rehabilitative and restorative physical therapy and occupational therapy and speech therapy for treatment expected to result in the reasonable improvement of your condition
- radiation therapy
- chemotherapy for treatment of cancer
- laboratory tests, X-ray andr imaging studies
- pre-admission testing
- tests and studies required in connection with a scheduled admission for surgery
- services for hemodialysis or peritoneal dialysis for chronic renal disease, including equipment, training and medical supplies until you are eligible for the Medicare End Stage Renal Disease program
- services associated with accidental consumption or ingestion of a controlled drug or other substance
- outpatient hospital dental services

Human Organ and Tissue Transplant Services

With Prior Authorization, the plan covers directly related services of the following:

- Heart
- Lung
- Heart-lung
- Pancreas
- Liver (adult or child)
- Kidney
- Bone marrow
- Peripheral Stem Cell procedures when performed in conjunction with the administration of high dose chemotherapy

In addition, the plan also covers without Prior Authorization for the following services provided in connection with human organ and tissue transplant services:

- Blood transfusion
- Cornea transplant
- Bone and cartilage grafting
- Skin grafting

With Prior Authorization, the following hospital services are covered:

- room and board for a semi-private room (If a private room is used, the plan will only cover services up to the cost of the semi-private room rate unless Anthem determines that a private room is medically necessary.)

- services and supplies furnished by the hospital
- care provided in a special care unit which concentrates all facilities, equipment, and supportive services necessary to provide an intensive level of care for critically ill patients
- use of operating and treatment rooms
- diagnostic services, which includes a referral for evaluation
- rehabilitative and restorative physical therapy services
- hospital supplies: prescribed drugs; whole blood, administration of blood, and blood processing; anesthesia, anesthesia supplies and services; medical and surgical dressings and supplies.

With Prior Authorization, the following surgical services in connection with covered human organ and tissue transplants are covered:

- surgery, including diagnostic services directly associated with a surgery (separate payment will not be made for pre-operative and post-operative services, or for more than one surgical procedure performed at one operative session)
- services of a physician who actively assists the operating surgeon in the performance of such surgery
- administration of anesthesia ordered by the attending physician and rendered by a physician or other provider other than the surgeon or assistant at surgery

With Prior Authorization, the following services in connection with covered human organ and tissue transplants are covered:

- inpatient medical care visits
- intensive medical care rendered to you when your condition requires a physician's constant attendance and treatment for a prolonged period of time
- medical care rendered concurrently with surgery during your hospital stay by a physician other than the operating surgeon for treatment of a medical condition separate from the condition for which the surgery was performed.
- medical care by two or more physicians rendered concurrently during your hospital stay when the nature or severity your condition requires the skills of separate physicians
- consultation services rendered by another physician at the request of the attending physician, other than staff consultations which are required by hospital rules and regulations
- home, office and other outpatient medical care visits for your examination and treatment
- diagnostic services, which includes a referral for evaluation

The plan covers rehabilitative and restorative therapy services:

- **with Prior Authorization**, services provided in a skilled nursing facility which are neither custodial in nature nor for your convenience or the physician, and only until you have reached the maximum level of recovery possible for the particular condition and no longer requires skilled nursing care or definitive treatment other than routine supportive care
- home health care to you if you are homebound and when prescribed by your attending physician in lieu of hospitalization and arranged prior to discharge from the hospital
- medically necessary immunosuppressant drugs prescribed in connection with covered human organ and tissue transplants and which, under Federal law, may only be dispensed by written prescription and which are approved for general use by the Food and Drug Administration
- benefits for transportation and lodging for the transplant recipient and companion(s) limited to a maximum of \$10,000 per transplant
- transportation costs incurred for travel to and from the site of surgery for a transplant recipient and one other individual accompanying the patient, or if the transplant recipient is a minor child, transportation costs for two other individuals accompanying the patient
- reasonable and necessary lodging and meal expenses, not to exceed \$150 total per day (\$200 total if two companions are accompanying a minor child), are payable for the individual accompanying the patient

- lodging for the transplant recipient while receiving medically necessary post-operative outpatient care at the hospital

The plan covers the following services when provided in connection with covered human organ and tissue transplants:

- transportation of the surgical harvesting team and donor organ or tissue; and
- evaluation and surgical removal of the donor organ or tissue and related supplies

If a human organ or tissue transplant is provided from a donor to a transplant recipient, the following apply:

- When both the recipient and the donor are individuals covered under the plan, each is entitled to the services specified in this section of the benefits book.
- When only the recipient is covered under the plan, both the donor and the recipient are entitled to the following:
 - The donor benefits are limited to only those not provided or available to the donor from any other source. This includes, but is not limited to, other insurance coverage, grants, foundations, government programs, etc.;
 - Benefits provided to the donor will be charged against the recipient's coverage under the plan.

When the recipient is uninsured and the donor is covered under the plan this plan will only provide benefits related to the procurement of the organ up to the maximum stated in this section of the benefits book.

No benefits will be provided for procurement of a donor organ or organ tissue which is not used in a transplant procedure which is a Covered Service, unless the transplant is cancelled due to the medical condition or death of the person covered under the plan and the organ cannot be transplanted to another person. No benefits will be provided for procurement of a donor organ or organ tissue which has been sold rather than donated.

These Covered Services: including Hospital, surgical, medical, storage and transportation costs will be subject to a maximum of \$15,000 per transplant.

Expenses for the following services are **not covered**:

- benefits for services if the person covered under the plan is not a suitable candidate as determined by the hospital designated and approved by Anthem to provide such services
- benefits for services for donor searches or tissue matching, or personal living expenses related to donor searches or tissue matching, for the recipient or donor, or their respective family or friends
- any human organ and tissue transplant service that is determined to be experimental or investigational is not a Covered Service.
- benefits for transportation and lodging for the transplant recipient and companion(s), when the human organ or tissue transplant is provided in a hospital or other facility not designated and approved by Anthem.

Mastectomy Treatments

In accordance with the Women's Health and Cancer Rights Act, the plan covers reconstructive surgery and services after a mastectomy including:

- breast reconstruction (for the breast that required the mastectomy)
- reconstruction of the other breast (to produce a symmetrical appearance)
- prostheses
- treatment of physical complications at all states of mastectomy

Maternity/Family Planning Services

The plan covers the following services:

- obstetrical care or pregnancy, delivery, prenatal and postpartum care
- care related to complications of pregnancy including surgery and interruptions of pregnancy
- hospital services including room and board
- abortions and miscarriages

Birthcenter services are available only when the provider has a participating agreement with Anthem.

Inpatient care for you and your newborn will be provided for a minimum of 48 hours following a vaginal delivery, and for a minimum of 96 hours following a cesarean delivery, unless otherwise agreed upon by you and your physician. If you and your physician agree to an earlier discharge time, benefits for Covered Services shall be provided for a follow-up home visit within 48 hours of discharge and an additional follow-up visit within 7 days. The time period shall commence at the time of your delivery.

The plan covers medically necessary infertility services including: the diagnosis and treatment of infertility, ovulation induction, intrauterine insemination, in-vitro fertilization (IVF), uterine embryo lavage, embryo transfer, gamete intra-fallopian transfer (GIFT), zygote intra-fallopian transfer (ZIFT) and low tubal ovum transfer.

Mental Health and Substance Abuse Care

With Prior Authorization, the plan covers the following services:

- outpatient treatment for mental health care and substance abuse care
- inpatient hospital services in a hospital or residential treatment center facility for mental health care
- inpatient rehabilitation treatment for substance abuse care in a hospital or substance abuse treatment facility
- partial hospitalization sessions and day/night visits

Outpatient care for mental illness includes services rendered in the following locations: a non-profit community mental health center, a non-profit licensed adult mental health center, a non-profit licensed adult psychiatric clinic operated by an accredited hospital or in a residential treatment facility when provided by or under the supervision of a physician practicing as a psychiatrist, licensed psychologist, certified independent social worker, certified marriage and family therapist or a licensed or certified alcohol and drug counselor; or appropriately licensed professional counselor.

Outpatient care for mental illness includes services by a person with a master's degree in social work when such person renders service in a child guidance clinic or in a residential treatment facility under the supervision of a physician practicing as a psychiatrist, licensed psychologist, certified independent social worker, certified marriage and family therapist or a licensed or certified alcohol and drug counselor or appropriately licensed professional counselor.

Benefits for confinement in a residential treatment facility shall be provided only in the following situations:

- you have a serious mental illness which substantially impairs your thought, perception of reality, emotional process, or judgment or grossly impairs behavior as manifested by recent disturbed behavior
- you have been confined in a hospital for such illness for a period of at least three days
- immediately preceding such confinement in a residential treatment facility; and

- such illness would otherwise necessitate continued confinement in a hospital if such care and treatment were not available through a residential treatment facility; and an individual treatment plan must be prescribed by a physician with certain specific attainable goals and objectives appropriate to both the patient and the treatment modality of the program.

Oral Surgery

The plan covers the following services:

- an initial visit for the prompt immediate repair of trauma, due to an accident or injury, to the jaw, natural teeth, cheeks, lips, tongue and/or the roof of the mouth. Benefits available for services provided during the initial visit, include but are not limited to the following:
 - evaluation
 - radiology to evaluate extent of injury
 - treatment of the wound; tooth fracture or evulsion
- oral surgical services for treatment of lesions, tumors and cysts on or in the mouth . Oral surgery services for treatment related to tumors of the oral cavity, treatment of fractures of the jaw and/or facial bones, and dislocation of the jaw
- wisdom teeth extractions of impacted, partially erupted or completed erupted teeth
- dental anesthesia only when used in conjunction with removal of impacted wisdom teeth

Expenses for the following services are **not covered**:

- in the case of injury to the oral cavity, non-covered prosthetic devices include, but are not limited to, plates, bridges, dentures or caps/crowns
- injury to teeth or soft tissue as a result of chewing or biting shall not be considered an accidental injury

Other Provisions

The plan covers the following services:

- Services from birth to age three for early intervention Covered Services for your covered dependent
- Blood and blood plasma
- Amino acid modified preparations and low protein modified food products for the treatment of inherited metabolic diseases
- Specialized formulas when such specialized formulas are Medically Necessary for the treatment of a disease or condition and are administered under the direction of a Physician **and** when Prior Authorization is obtained.
- Outpatient self-management training for the treatment of diabetes including medical nutrition therapy if prescribed by a licensed health care professional and performed by a certified, licensed or registered health care professional trained in diabetes care and operating within the scope of their licensure. Benefits are provided for 10 hours of initial training, 4 hours of additional training because of changes in the individual's condition and four hours of training required by new developments in the treatment of diabetes.
- Intravenous and oral antibiotic therapy for the treatment of Lyme Disease. Coverage is provided for up to 30 days of intravenous antibiotic therapy, or 60 days of oral antibiotic therapy, or both, for the treatment of Lyme Disease. Further treatment is covered if recommended by a board-certified rheumatologist, infectious disease specialist or neurologist
- Routine patient Care Costs in connection with Cancer Clinical Trial. A Cancer Clinical Trial must be conducted under the auspices of an independent peer-reviewed protocol that has been reviewed and approved by: one of the National Institutes of Health; or a National Cancer Institute affiliated cooperative group; or the federal Food and Drug Administration as part of an investigational new drug or device exemption; or the federal Department of Defense or Veterans Affairs.

Physician Medical/Surgical Services

The plan covers the following services:

- Medical services for the treatment of an illness or injury.
- Medical office visits, specialist consultations, injections and home visits by a Physician.
- Chiropractic services, evaluation and treatment.
- Allergy testing.
- Inpatient Hospital/Inpatient Facility visits during a covered Admission.
- Acute Psychiatric Care while an Inpatient at a Hospital or Inpatient Facility. 1 session per Inpatient day.
- Inpatient consultations by other than the attending Physician. 2 per 30 day period.
- Coverage for Medically Necessary orthodontic processes and appliances for the treatment of craniofacial disorders for individuals eighteen years of age or younger if such processes and appliances are prescribed by a craniofacial team recognized by the American Cleft Palate-Craniofacial Association.

The plan covers the following surgical procedures:

- When multiple or bilateral surgical procedures are performed at the same operative session, benefits are provided at 100% of the Maximum Allowable Amount of the procedure with the highest reimbursement. Benefits for additional surgical procedures are provided at 50% of the Maximum Allowable amount of the specific procedure.
- For breast implants which were surgically implanted as a result of a mastectomy, benefits for Covered Services for the Medically Necessary removal of such implants due to a medical complication of a mastectomy will be covered the same as any other illness or injury. As to all other breast implants, benefits for Covered Services for the Medically Necessary removal of any breast implant without regard to the reason for implantation, at least \$1,000 per covered individual per Calendar Year will be provided.
- Surgical assistant services.
- Services of only one Physician in a given specialty if the surgery reasonably could be expected to be performed by one Physician.
- Services of surgical assistants are payable as a surgery benefit based on approved surgical assistant procedures when a Hospital or ambulatory surgical facility does not provide surgical assistants through a residential or surgical assistant program.

Breast Reconstruction Surgery Benefits and the Women's Health and Cancer Rights Act of 1998:

If you are receiving covered benefits for a mastectomy, you should know that the Women's Health and Cancer Rights Act of 1998 provides for:

- reconstruction of the breast(s) on which a covered mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- prostheses and treatment of physical complications related to all stages of a covered mastectomy, including lymphedema (swelling). Prior authorization is not applicable to such prostheses.

The manner in which services are provided is between you and your physician. Coverage is subject to all of the terms and conditions stated in this benefits book, including any applicable deductible, co-payment and coinsurance. Contact Anthem's Member Services at 800-233-4947 for additional information.

Covered Services do not include:

- Initial medical care for scheduled Admissions for surgery. This means the first non-surgical services rendered as an Inpatient by the attending Physician.

- Separate charges for pre and post-operative care.

Private Duty Nursing

The plan covers private duty nursing services subject to the plan's calendar year maximum as shown in the Schedule of Benefits.

Expenses for the following services are **not covered**:

- private duty nursing care services for your convenience or while you are an inpatient in a hospital or skilled nursing facility
- care primarily to provide room and board (with or without routine nursing care), training in personal hygiene, and other forms of self-care

Skilled Nursing Facilities

With Prior Authorization, the plan covers:

- skilled nursing care
- rehabilitative and related services
- semiprivate room and board

Room and board charges exceeding the skilled nursing facility's most common semi-private rate shall be excluded from coverage.

Therapy Services

The plan covers:

- outpatient physical, occupational and chiropractic therapy
- speech therapy when prescribed by a physician (M.D.) and provided by a licensed speech pathologist
- outpatient cardiac rehabilitation therapy
- radiation therapy
- chemotherapy for the treatment of cancer
- electroshock therapy
- kidney dialysis in a hospital or free-standing dialysis center

The plan also covers outpatient hospital or home infusion therapy regimens, supplies, solutions, pharmaceuticals and nursing under the following conditions:

- a plan of care for such services is prescribed in writing by a physician (M.D.)
- plan of care is reviewed and recertified by the physician (M.D.)
- Infusion therapy is limited to:
 - chemotherapy (including gamma globulin)
 - intravenous antibiotic therapy
 - total parenteral nutrition
 - enteral therapy when nutrients are only available by a physician's prescription
 - intravenous pain management
 - blood derivatives

Urgent Care

The plan covers Urgent Care services received at a designated Urgent Care Facility or provided by a Participating Physician. Urgent Care Services are only available in Connecticut. Urgent Care services will be covered only if signs and symptoms at the time of treatment are such that Urgent Care services are Medically Necessary as determined by Anthem.

Exclusions and Limitations

In addition to the other limitations, conditions and exclusions indicated elsewhere in this benefits book, the plan does not cover expenses related to the services, supplies, conditions or situations listed in this section except when approved by Anthem as part of Case Management. These items and services are not covered even if you receive them from your provider or according to your provider's referral.

The following list of exclusions is not a complete list of all services, supplies, conditions or situations that are not Covered Services. If a service is not covered, then all services performed in conjunction with that service are not covered. Anthem is the final authority for determining if services or supplies are medically necessary.

- ▲ Benefits for services which are not:
 - specifically described in this benefits book
 - rendered or ordered by a physician
 - within the scope of the physician's, provider's or hospital's licensure
 - medically necessary care for the proper diagnosis and treatment of your condition
- ▲ Benefits may be reduced or denied subject to the Managed Benefits – Managed Care Guidelines. Any reduced or denied benefits paid by you do not apply toward the Cost Share Maximums shown in the Schedule of Benefits
- ▲ Any reduction in benefits, including but not limited to Penalties, imposed by another Plan, which are similar to those stated in the Managed Benefits – Managed Care Guidelines, are not reimbursable as a Covered Service
- ▲ Benefits for services rendered before the effective date of your coverage under this plan
- ▲ Benefits for services rendered after the plan has been rescinded, suspended, cancelled, interrupted or terminated
- ▲ Care for conditions which are required by State or Local law to be treated in a public facility.
- ▲ Services and care in a Veteran's Hospital or any Federal Hospital, except as may be otherwise required by law
- ▲ Services covered in whole or in part by public or private grants
- ▲ Services required by third parties, including but not limited to: school, employment, summer camp and premarital physicals and related tests
- ▲ Studies related to pregnancy except for significant medical reasons
- ▲ Simplified or self-administered tests and multiphasic screening
- ▲ Cosmetic surgery or services 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
- ▲ Dental diagnosis, care, treatment, x-rays, or appliances, for any of the diseases or lesions of the oral cavity, its contents or contiguous structures, the extraction of teeth, the correction of malpositions of the teeth and jaw, or for pain, deformity, deficiency, injury or physical condition of teeth, unless otherwise provided for under the plan
- ▲ Surgical and non-surgical examination, diagnosis, including invasive (internal) and non-invasive (external) procedures and tests, and all services related to diagnosis and treatment, both medical and surgical, of temporomandibular joint dysfunction or syndrome also called myofascial pain dysfunction or craniomandibular pain syndrome. This exclusion includes but is not limited to the following: contrast and non-contrast imaging, arthroscopic and open surgical procedures, physical therapy, and appliance therapy such as occlusal appliances (splints) or adjustments
- ▲ Routine foot care in the absence of systemic or vascular disease affecting the foot, including hygienic care, treatment of corns or calluses, services performed in conjunction with fitting of supportive or comfort devices for the foot or other foot care
- ▲ Services for custodial care, chronic care and/or maintenance care
- ▲ Prenatal medical conferences with a pediatrician regarding an unborn child unless the visit is the result of a medical referral

- ▲ Charges for room and board after a leave of absence from the hospital, substance abuse treatment facility or other inpatient facility
- ▲ Evaluation, treatment, procedures and prescription drugs related to and performance of sex-change operations including follow-up treatment, care and counseling
- ▲ Vaccines other than routine immunizations or those needed for travel
- ▲ Services, medical supplies or supplies not specifically listed as Covered Services. These include but are not limited to educational therapy, marital counseling, sex therapy, weight control programs, nutritional programs and exercise programs
- ▲ Experimental or investigational treatment, procedure, facility, equipment, drugs, devices or supplies. Any services associated with or as follow-up to any of the above is not a Covered Service.
- ▲ Any treatment, procedure, facility, equipment, drug, device or supply which requires Federal or other governmental agency approval not granted at the time services are rendered. Any service associated with, or as follow-up to, any of the above is not a Covered Service.
- ▲ Any services by a physician or provider to himself or herself or for services rendered to his or her parent, spouse, children, grandchildren or any other immediate family member or relation even if a participating physician or participating provider
- ▲ Services which you or Anthem is not legally required to pay
- ▲ Wigs, except as noted in the Covered Services section.
- ▲ Inpatient services which can be properly rendered as outpatient services.
- ▲ Disease contracted or injuries resulting from war
- ▲ Charges after the provider's or hospital's regular discharge hour on the day indicated for your discharge by your physician
- ▲ Charges in excess of the Maximum Allowable Amount
- ▲ Eyeglasses and contact lenses
- ▲ Supervisory care by a physician for you if you are mentally or physically disabled and if you are not under specific medical, surgical or psychiatric treatment to reduce the disability to the extent necessary to enable you to live outside an institution providing medical care; or when despite such treatment, there is no reasonable likelihood that the disability will be so reduced
- ▲ Travel, whether or not recommended by a physician
- ▲ Certain pulmonary function tests which in the opinion of Anthem do not meet the definition of a covered diagnostic laboratory test
- ▲ Services or procedures rendered without regard for specific clinical indications, routinely for groups or individuals or which are performed solely for research purposes
- ▲ Services or procedures which have become obsolete or are no longer medically justified as determined by appropriate medical specialties
- ▲ Radiation therapy as a treatment for acne vulgaris
- ▲ Services rendered by a physician in the employ of a Home (e.g. Skilled Nursing Facility) do not qualify as Home & Office Care.
- ▲ Allogeneic or Syngeneic Bone Marrow Transplant or other forms of stem cell rescue and stem cell infusion (with or without high dose chemotherapy and/or radiation) are those with a donor other than the patient. They are not covered except in the following cases:
 - When at least five out of six histocompatibility complex antigens match between the patient and the donor.
 - The mixed leukocyte culture is non-reactive.
 - One of the following conditions is being treated: Severe aplastic anemia, Acute nonlymphocytic leukemia in first or subsequent remission or early first relapse, Myelodysplastic syndrome, Secondary acute nonlymphocytic leukemia as initial therapy, Acute lymphocytic leukemia in second or subsequent remission, Acute lymphocytic leukemia in first remission, Chronic myelogenous leukemia in chronic and accelerate phase, Non-Hodgkin's lymphoma, high grade, in first or subsequent remission, Hodgkin's lymphoma low grade, which has undergone conversion to high grade, Neuroblastoma, stage 3 or relapsed stage 4, Ewing's sarcoma, Severe combined immunodeficiency syndrome, Wiskott-Aldrich syndrome, Osteopetrosis, infantile malignant, Chediak-Higashi syndrome, Congenital life-threatening neutrophil disorders to include Kostmann's syndrome, chronic granulomatous disease, and

- All other uses of Allogeneic or Syngeneic Bone Marrow Transplants or other forms of stem cell rescue and stem cell infusion (with or without high dose chemotherapy or radiation) are not covered.
- ▲ Autologous Bone Marrow Transplantation or other forms of stem cell rescue and stem cell infusion (in which the patient is the donor) with high dose chemotherapy or radiation are not covered except for the following:
 - Non-Hodgkin's lymphoma, high grade, first or subsequent remission. No morphological evidence of bone marrow involvement should be evident.
 - Hodgkin's disease as defined above with an absence of bone marrow involvement.
 - Acute nonlymphocytic leukemia in second remission, in which no HLA matched donor exists or an allogeneic transplant is inappropriate.
 - Acute lymphocytic leukemia in second remission, in which no HLA matched donor exists or an allogeneic transplant is inappropriate.
 - Retinoblastoma, adjuvant setting after successful induction (consolidation).
 - Neuroblastoma, adjuvant setting after successful induction (consolidation).

Autologous Bone Marrow Transplants or other forms of stem cell rescue and stem cell infusion (with high dose chemotherapy and/or radiation), for all other cases are not covered.
- ▲ Drugs or medications, legend and over-the-counter, prescribed for use as an outpatient except as otherwise stated in this benefits book. Refer to Prescription Drug section of this Benefits Book.

Filing a Claim Form

Will I need to submit a medical claim form?

- Yes, if you use a out-of-network medical provider.
- No, if you use an in-network medical provider or hospital and show your medical ID card.

What's the deadline for submitting a medical claim form?

- The deadline for filing a claim is two years from the date you received the service.

Where can I get information on the status of a medical claim?

- 800-233-4947
- www.anthem.com
- www.stamfordpublicschools.org

Where do I send a medical claim form?

Anthem Blue Cross and Blue Shield
 P.O. Box 533
 North Haven CT 06473-0533

Prescription Drugs

The prescription drug benefit, offered through Stamford Public Schools and administered by Medco, provides coverage for employees and family members enrolled in the medical plan administered by Anthem Blue Cross Blue Shield. Employees and family members enrolled in the medical plan administered by Aetna have their own prescription drug coverage through Aetna.

This section of the Benefits Book provides coverage information for the benefit administered by Medco.

Medco offers the following ways to get your prescriptions filled:

- **At a retail pharmacy** - you can purchase up to a 30-day supply of prescription drugs at a discounted price when you use your prescription benefit card. And, you do not have to file a claim form. You simply pay your copay based on your union's collective bargaining agreement.
- **Medco by Mail** - if you take maintenance medication (that is, prescriptions that require over 2 refills), Medco by Mail saves you money and a few trips to the pharmacy by sending a three-month supply to your home.

Retail Pharmacy

At a retail pharmacy, the pharmacist will dispense your medication for up to a 30-day supply. Your copay will be consistent with the medication that is actually dispensed. For example, if your prescription states that a brand-name drug is to be dispensed, you will pay the applicable brand-name copay for the drug that you receive even if a generic drug is available.

Medco by Mail

Through Medco by Mail, mail order pharmacies will dispense your medication for up to a 90-day supply and you pay just one mail-order copay. To maximize your savings, ask your physician to write your prescription for a 90-day supply with refills when appropriate. You'll be charged the mail-order copay regardless of the day's supply written on the prescription. Please be sure that your physician writes your prescription for a 90-day supply and not a 30-day supply with three refills.

Preferred Medications

There is a list, or formulary, of commonly prescribed FDA approved generic and brand name medications that are preferred by your prescription drug plan. You don't have to use the drugs on the formulary, but you'll pay less when you do.

Medco's formulary is created with the help of an independent Pharmacy & Therapeutics committee made up of physicians and pharmacists. On a regular basis, the committee reviews the formulary to ensure that it contains a variety of drugs to treat a variety of medical conditions and that the drugs are safe and clinically effective. Since new drugs become available every year and the uses of existing drugs change often, the formulary may change - but not more than quarterly. For an updated complete list of preferred drugs, contact Medco at www.medco.com or at 800-711-0917.

Drugs not found on the formulary are considered Non-Preferred Brand Name Drugs.

Medication and Supplies Not Covered

Medication and supplies not covered include:

- Certain injectable medications - **Call Member Services to confirm which medications are not covered.**
- Antiobesity medications
- Smoking deterrents
- Fertility medications
- Dental fluoride products
- Growth hormones
- Retin-A age 36 and older
- All other vitamins
- Ostomy supplies
- Mifeprex
- Therapeutic devices or appliances
- Drugs whose sole purpose is to promote or stimulate hair growth or for cosmetic purposes only
- Allergy Serums
- Biologicals, Immunization agents or Vaccines including Rhogam
- Blood or blood plasma products
- Drugs labeled "Caution-limited by Federal law to investigational use", or experimental drugs, even though a charge is made to the individual.
- Medication for which the cost is recoverable under any Workers' Compensation or Occupational Disease Law or any State or Governmental Agency, or medication furnished by any other Drug or Medical Service for which no charge is made to the member.
- Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed hospital, rest home, sanitarium, extended care facility, skilled nursing facility, convalescent hospital, nursing home or similar institution which operates on its premises or allows to be operated on its premises, a facility for dispensing pharmaceuticals.
- Any prescription refilled in excess of the number of refills specified by the physician, or any refill dispensed after one year from the physician's original order.
- Charges for the administration or injection of any drug.

Filing a Claim Form

Will I need to submit a prescription drug claim form?

- Yes, if you use a non-network pharmacy
- No, if you use a network pharmacy and show your prescription benefit card
- No, if you use Medco by Mail (you'll pay your portion by check or credit card)

What's the deadline for submitting a prescription drug claim form?

- The deadline for filing a claim is one year from the date you fill the prescription.

Where can I get information on the status of a prescription drug claim?

- www.medco.com
- 800-711-0917

Where do I send a prescription drug claim form?

Medco
P.O. Box 2187
Lee's Summit, MO 64063-2187

Dental

With the CIGNA Dental PPO Plan (DPPO), you have two options to access dental care. Visit a participating or nonparticipating dentist. The choice is yours. Simply select a provider of your choice. You do not need to select a primary care dentist. You do not need a referral to seek care from a participating network specialist. And, you do not need an ID card to access dental care

Visit a Participating Dentist

You can obtain dental care from any participating general dentist or specialist in the DPPO Network. When you do, you will enjoy lower out-of-pocket costs for covered services. CIGNA Dental will pay the provider based upon a negotiated, discounted fee and consistent with the coinsurance levels provided in the following Benefits Summary. Your participating dentist will submit claims for you.

Visit a Nonparticipating Dentist

If you choose to obtain care from a dentist that does not participate in the DPPO network, your out-of-pocket expenses will generally be higher because the dentist has not agreed to negotiated rates with CIGNA Dental. CIGNA Dental will pay the provider based on a percentage of reasonable and customary (R&C) charges. That means the dentist may balance bill you for the difference between the payment they receive from CIGNA Dental and their usual fees.

Locating a Participating DPPO Provider

To locate an in-network, participating dentist or specialist, visit www.cigna.com or myCIGNA.com. Or, call 1.800.CIGNA24 (1.800.244.6224) to use CIGNA Dental's automated Dental Office Locator.

What's Covered

DPPO offers coverage for a wide range of services at a cost savings. Your coverage includes:

- Preventive care (cleanings, x-rays, and more).
- Basic care (fillings, basic restorative work).
- Major services (bridges, crowns, root canals and more).
- Orthodontic coverage for dependent children up to age 19.

See Benefits Summary for more information.

Benefit Summary

	In-Network		Out-of-Network	
Calendar Year Maximum	\$1,500		\$1,500	
Annual Deductible*				
Individual	\$50 per person		\$50 per person	
Family	\$100 per family		\$100 per family	
Reimbursement Levels**	Based on Reduced Contracted Fees		90th percentile of Reasonable and Customary Allowances	
	Plan Pays	You Pay	Plan Pays	You Pay
Preventive & Diagnostic Care Exams (3 per Calendar Year) Cleanings (3 Routine per Calendar Year or 2 Periodontal per Calendar Year) Full Mouth X-rays (1 complete set every 3 Calendar Years) Bitewing X-rays (2 per Calendar Year) Panoramic X-ray (1 every 3 Calendar Years) Periapical X-rays Fluoride Application (1 per Calendar Year for persons under 19) Sealants (Limited to posterior tooth/1 treatment per tooth every 3 Calendar Years) Space Maintainers (Limited to nonorthodontic treatment) Emergency Care to Relieve Pain Histopathologic Exams	100%	No Charge	100%	No Charge
Basic Restorative Care Fillings Root Canal Therapy/Endodontics Osseous Surgery Periodontal Scaling and Root Planing Denture Adjustments and Repairs Oral Surgery – Simple Extractions Oral Surgery – all except simple extractions Anesthetics Surgical Extractions of Impacted Teeth Repairs to Bridges, Crowns and Inlays	80%*	20%*	80%*	20%*
Major Restorative Care Crowns (Replacement every 5 Calendar Years) Dentures (Replacement every 5 Calendar Years) Bridges (Replacement every 5 Calendar Years) Inlays/Onlays (Replacement every 5 Calendar Years) Prosthesis Over Implant (1 per 84 consecutive months is unserviceable and cannot be repaired.)	60%*	40%*	60%*	40%*
Orthodontia Dependent children to age 19 Lifetime Maximum	60%* \$750	40%* \$750	60%* \$750	40%* \$750

All deductibles, plan maximums, and service specific maximums (dollar and occurrence) cross accumulate between in and out of network.

Missing Tooth Limitation – Teeth missing prior to coverage under the CIGNA Dental PPO plan are not covered until insured for 24 months; thereafter, considered a Class III expense.

Pretreatment review is available on a voluntary basis when extensive dental work in excess of \$200 is proposed.

* Subject to annual deductible

**For services provided by a CIGNA Dental PPO network dentist, CIGNA Dental will reimburse the dentist according to a Contracted Fee Schedule. For services provided by an out-of-network dentist, CIGNA Dental will reimburse according to Reasonable and Customary Allowances but the dentist may balance bill up to their usual fees.

What's Not Covered

Covered expenses will not include, and no payment will be made for, expenses incurred for:

- Wisdom teeth extractions;
- Services performed solely for cosmetic reasons;
- Replacement of a lost or stolen appliance;
- Replacement of a bridge, crown or denture within five years after the date it was originally installed unless: (a) such replacement is made necessary by the placement of an original opposing full denture or the necessary extraction of natural teeth; or (b) the bridge, crown or denture, while in the mouth, has been damaged beyond repair as a result of an injury received while a person is insured for these benefits;
- Any replacement of a bridge, crown or denture which is or can be made useable according to common dental standards;
- Procedures, appliances or restorations (except full dentures) whose main purpose is to (a) change vertical dimension; (b) diagnose or treat conditions or dysfunction of the temporomandibular joint; (c) stabilize periodontally involved teeth; or (d) restore occlusion;
- Porcelain or acrylic veneers of crowns or pontics on or replacing the upper and lower first, second or third molars;
- Bite registrations; precision or semi-precision attachments; or splinting;
- A surgical implant of any type;
- Instruction for plaque control, oral hygiene and diet;
- Dental services that do not meet common dental standards;
- Services that are deemed to be medical services;
- Services and supplies received from a hospital;
- Services for which benefits are not payable according to the "General Limitations" section.
- In addition, these benefits will be reduced so that the total payment will not be more than 100% of the charge made for the dental service if benefits are provided for that service under this plan and any medical expense plan or prepaid treatment program sponsored or made available by you or Stamford Public Schools

General Limitations

No payment will be made for expenses incurred for you or any one of your dependents:

- For or in connection with an injury arising out of, or in the course of, any employment for wage or profit;
- For or in connection with a sickness which is covered under any workers' compensation or similar law;
- For charges made by a hospital owned or operated by or which provides care or performs services for the United States Government, if such charges are directly related to a military service connected condition;
- To the extent that payment is unlawful where the person resides when the expenses are incurred;
- For charges which the person is not legally required to pay;
- To the extent that they are more than either the applicable Contracted Fee, applicable Reasonable or Customary Charges or applicable Scheduled Amount;
- For charges for unnecessary care, treatment or surgery;
- To the extent that you or any of your dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid; or
- For or in connection with experimental procedures or treatment methods not approved by the American Dental Association or the appropriate dental specialty society.

No payment will be made for expenses incurred by you or any one of your dependents to the extent that benefits are paid or payable for those expenses under the mandatory part of any auto insurance policy written to comply with a “no-fault ” insurance law or an uninsured motorist insurance law. Connecticut General Life Insurance Company will take into account any adjustment option chosen under such part by you or any one of your dependents.

Using Your Dental Benefits

Whether you choose to visit a participating dental provider or not, the CIGNA DPPO Plan covers eligible dental expenses after you meet any applicable deductibles (a dollar amount you must pay before coverage begins). Once any deductibles are met, you will pay a coinsurance (a percentage of dentist’s contracted charges) at the time of service. Be sure to refer to the Benefits Summary to determine the coinsurance percentage you must pay for the type of dental care you are undergoing.

When you visit your dental provider, be sure to bring a claim form with you. The claim form, which is available online at www.stamfordpublicschools.org, has the group number and the claim mailing address. **An ID card is not provided since you don’t need an ID card to access dental care.**

If your dental treatment is expected to be \$200 or more, you may want to have your benefits determined before you are treated. You can find out what a treatment will cost prior to treatment by asking your dentist for a predetermination of benefits. Your dentist can request an explanation of benefits that shows what would be covered and how much you would have to pay. You can then discuss your plans for treatment and payment as a well-informed patient.

Filing a Claim Form

Will I need to submit a dental claim form?

- Yes, if you use a nonparticipating dental provider.
- No, if you use a participating dental provider. You will bring you claim form to the provider and the provider will submit it to CIGNA Dental.

What's the deadline for submitting a dental claim form?

- The deadline for filing a claim is one year from the date you received the service.

Where can I get information on the status of a dental claim?

- www.cigna.com or mycigna.com
- 800-244-6224

Where do I send a dental claim form?

CIGNA Dental Claims
PO Box 188037
Chattanooga, TN 37422-8037

Flexible Spending Accounts

Flexible Spending Accounts (FSA) allow you to pay for eligible out-of-pocket health and dependent care expenses with before-tax dollars. You set aside pre-determined, pre-tax dollars through payroll deduction, and then use them to pay for eligible medical, dental and pharmacy expenses.

Health Care

The Health Care FSA is used for health care expenses not covered by a medical plan, such as copayments, coinsurance, deductibles or certain vision, hearing or orthodontic care costs.

Dependent Day Care

The Dependent Day Care FSA is used for non-medical day care expenses for children ages 12 and under, or disabled dependents that satisfy the definition of a "Qualifying Relative" under federal tax law. Dependent day care expenses are reimbursable as long as the provider is not your spouse, another dependent, or your child if age 19 or younger.

How the Flexible Spending Accounts Work

- You estimate costs for all out-of-pocket medical and dependent day care expenses for the calendar year – January through December. Estimate carefully because any remaining funds are forfeited.
- You decide if you want to elect to participate in the Health Care Account, the Dependent Day Care Account or both.
- You decide how much to contribute. The maximum election is \$3,000 per calendar year for the Health Care account and \$5,000 per calendar year for the Dependent Day Care account.
- You submit a completed Enrollment Form to the Benefits Administration Office during the annual open enrollment (which occurs typically in November of each year) or within 30 days of a qualified life event.
- Payroll will deduct your annual election from 21 paychecks beginning each January.
- Your tax-free paycheck deductions will be credited to your account administered by CIGNA HealthCare.
- You pay expenses and submit claims to CIGNA HealthCare for reimbursement.

Flexible Spending Account Rules

Flexible Spending Accounts are allowed by Section 125 of the Internal Revenue Code and certain restrictions apply.

- You cannot change your annual election amount once you've elected it. The amount of pretax dollars you choose remains in effect for the entire calendar year. You can adjust your election only if you have a change in family status, such as the addition or loss of a dependent, or a

change in marital status. **You must make any changes within 30 days of the change in family status.**

- The Health Care FSA and Dependent Day Care FSA are separate. Funds may not be transferred between the two, nor can health care expenses be reimbursed from a Dependent Day Care FSA, or dependent day care expenses from a Health Care FSA.
- If you don't use it, you lose it: the IRS requires that you forfeit any unused account balances remaining at the end of the year. You cannot carry funds over to the next year.
- Expenses reimbursed from Health and/or Dependent Day Care FSA cannot be claimed as deductions or credits on income tax returns.
- You cannot withdraw funds from your accounts. You may not be reimbursed without an eligible claim.
- If contributions to your account are stopped, you can only be reimbursed for expenses incurred before the contributions were stopped.

Health Care Expenses

The following health care expenses **may be eligible** for reimbursement:

- Unreimbursed medical, prescription drug, dental and vision expenses, including deductibles and copays;
- Acupuncture performed by a licensed practitioner;
- Payment to a treatment center for alcoholism or drug dependency;
- Oral contraceptives;
- Syringes, needles or other medical supplies;
- Orthodontia and non-cosmetic dental expenses;
- Psychotherapy by a licensed practitioner;
- Chiropractic services;
- Speech and physical therapy by a licensed practitioner;
- Hospice care;
- Crutches and wheelchairs;
- Over-the-counter drugs, including pain relievers, antacids, allergy and cold medications that are for your personal use (or that of your dependents) and are used to alleviate or treat personal injuries or sickness;
- Nursing home care for treatment of illness or injury;
- Prosthetic and orthopedic devices;
- Contact lenses and equipment required for use (i.e., saline solution);

- Vitamin expenses if accompanied by a doctor's letter of medical necessity.

The following health care expenses **are not eligible** for reimbursement:

- Expenses incurred before your date of participation in the Health Care Reserve Account;
- Any expenses incurred after you stop making contributions;
- Expenses reimbursed through any other policy, plan or program;
- Expenses claimed as a deduction or credit on your federal income tax return;
- Cosmetic surgery (unless medically necessary);
- Tooth-whitening procedures;
- Fees for marriage or family counseling that does not involve therapeutic treatment;
- Custodial care;
- Funeral and burial expenses;
- Weight-loss classes or programs, unless prescribed by a doctor for a specific health condition;
- Maternity clothes, diaper services, etc;
- Vitamins or food supplements taken for general health purposes;
- Cosmetics, toiletries, etc;
- Prescription drugs used for cosmetic purposes
- Health care insurance premiums, including long-term care insurance;
- COBRA premiums;
- Hair transplant or removal;
- Expenses merely beneficial to health, such as vacations or fitness programs

Dependent Day Care Expenses

The following dependent day care expenses **may be eligible** for reimbursement:

- Expenses for a day care center or preschool. The facility must be licensed under state or local law if it cares for seven or more children.
- Expenses for an unlicensed day care center that cares for six or fewer children.
- Expenses at an adult day care facility (but not expenses for overnight, nursing home facilities).

- The cost of day care and housekeeping services in your home for your child or other qualifying individual.
- The cost of meals, lunches and snacks, supplied by a day care provider (not the cost of meals while on field trips and outings or those meals included as part of the cost of such trips).

The following dependent day care expenses **are not eligible** for reimbursement:

- Day care for a child age 13 or older.
- Overnight summer camp (cannot prorate for the day portion).
- Kindergarten or school tuition for a child age 5 and older.
- Expenses for any care provided to a qualifying dependent by another dependent or child under age 19.
- Housekeeping expenses not related to dependent day care.
- The expenses for which you claim a dependent day care tax credit on your federal income tax return.
- The registration fees paid for day care, summer camp, kindergarten, preschool, etc. The only exception is day camp or registration fees applied toward the first payable bill. These are eligible once the initial bill has been paid and the service has been provided.
- The cost of meals while on field trips and outings or those meals included as part of the cost of such trips.
- Expenses for a day care center, summer day camp or preschool while you have time off for the summer.

Filing a Claim Form

Will I need to submit a claim form for reimbursement?

- Yes.

What information must I submit with my claim form?

- You must submit documentation such as invoices, explanation of benefits from your medical plan, cancelled checks (for dependent care only), receipts, etc. that show the following:
 - Patient's/Dependent's Name
 - Description of Service
 - Date Service Was Provided
 - Charges

If a copy of a cancelled check is submitted as documentation for dependent care, a copy of both sides of the check is necessary.

The amount of expenses you want reimbursed should be circled on the documentation.

What's the deadline for submitting a claim form for reimbursement?

- All claims, for expenses incurred between January 1st and December 31st, must be postmarked by March 31st of the following year.

Where can I get information on the status of a claim?

- 800-292-5108

Where do I send a claim form?

Dependent Care Claims

Cigna HealthCare FSA Claims
P.O. Box 5200
Scranton, PA 18505-5200

Health Care Claims

Cigna HealthCare Choice Fund
P.O. Box 182223
Chattanooga TN 37422-7233

Estimating your Health Care Expenses

This is only a partial list of the expenses eligible for reimbursement under the Health Care Flexible Spending Account. For a more detailed list of eligible expenses, see Internal Revenue Service Publication #502.

	Your Annual Cost
Medical Expenses	
Medical plan deductible, copayments or coinsurance	
Out-of-pocket expenses for psychiatric therapy and counseling	
Out-of-pocket expenses for treatment for alcohol or substance abuse	
Medical expenses not covered by the BOE's Plan	
Prescription Drug Expenses	
Retail pharmacy coinsurance or copayments	
Mail-order pharmacy copayments	
Over-the-Counter Medicines and Products	
To treat injuries or illnesses, including: <ul style="list-style-type: none"> Allergy medicines (including Claritin) Antacids, anti-nausea and antidiarrheal medication Antibiotic ointment for cuts and scrapes First-aid supplies and bandages Cold medicine, cough syrup, cough drops Pain relievers (e.g., Tylenol®, Advil®, aspirin and Aleve) Smoking cessation products 	
Dental Expenses	
Dental plan coinsurance	
Dental expenses above the annual maximum (including orthodontia)	
Dental expenses not covered by the BOE's Plan	
Vision Expenses	
Glasses and Contact Lenses	
Laser eye surgery	
Vision expenses not covered by the BOE's benefits	
Total:	

Voluntary Life Insurance

In addition to the basic life insurance provided to you by the Stamford Board of Education (refer to the collective bargaining agreement between the Stamford Board of Education and your employee association), you also have the opportunity to purchase affordable term life insurance through the Reliance Standard Life Insurance Company (Reliance).

Life Insurance Options

For You

You may purchase voluntary life insurance in increments of \$10,000, from \$10,000 to a maximum of \$500,000. Your insurance amount reduces to 60% at age 75 and to 35% at age 80. Refer to your Certificate of Insurance for the full scale of age reductions. See **New Hires** and **Current Employee** sections below for more information regarding coverage amounts that require proof of good health.

For Your Spouse

You may purchase voluntary life insurance in multiples of \$10,000, from \$10,000 to a maximum of \$500,000 for your spouse if your spouse is under age 70. Spouse coverage terminates at age 75. The benefit amount for your spouse does not have to be the same as yours. And, you don't have to purchase coverage for yourself to purchase coverage for your spouse.

See **New Hires** and **Current Employee** sections below for more information regarding coverage amounts that require proof of good health.

For Your Dependent Children

You may purchase voluntary life insurance for your dependent child or children age 14 days up to age 20 or 25 if your child is a full-time student. Children must be unmarried and financially dependent on you for support.

The benefit amount is \$10,000 for children age 6 months or more. Coverage includes a \$1,000 benefit for children age 14 days to 6 months. Newborn children automatically become insured at 14 days of age if you insure other dependent children. Only one insured spouse may cover eligible children. **You or your spouse must be insured for children to be insured.**

New Hires

As a new hire, you may elect to purchase voluntary life insurance for during your first 31 days of employment.

For You

- If you are under age 60, you are eligible for coverage up to \$180,000 without proof of good health. Amounts over \$180,000 require proof of good health.
- If you are over age 60 but under age 70, you are eligible for coverage up to \$10,000 without proof of good health. Amounts over \$10,000 require proof of good health.
- If you are age 70 or older, all amounts of coverage require proof of good health.

For Your Spouse

- If your spouse is under age 60, your spouse is eligible for coverage up to \$50,000 without proof of good health. An amount of \$50,000 requires you to apply for at least \$50,000 for yourself. Amounts over \$50,000 require proof of good health.
- If your spouse is over age 60, all amounts of coverage require proof of good health.

Current Employees

If you elect to purchase voluntary life insurance more than 30 days after your date of hire, except during each year's open enrollment, you will be considered a late entrant and your insurance elections will be subject to medical underwriting by Reliance.

Annual Open Enrollment

The annual open enrollment for voluntary life insurance occurs annually at the end of each school year. The effective date of your benefit election is September 1st. During the annual open enrollment, you have the chance to apply for voluntary life insurance to meet your personal needs.

For You

- If you are under age 60, you may apply for an increase of \$10,000 without proof of good health. If you are over age 60, proof of good health is required for any amount of coverage.

For Your Spouse

- If you elect to purchase coverage for your spouse, proof of good health will be required for all amounts of coverage.

Changing Coverage during the Year

In addition to making changes during each year's Open Enrollment, you may apply for or make changes in your Voluntary Life Insurance coverage during the year if a "Qualified Life Event," as enumerated in IRC Section 125 occurs:

- Marriage or divorce
- Birth or adoption of first dependent child
- Death of your spouse or dependent child
- Termination or commencement of your spouse's employment
- Change in your or your spouse's job status from full-time to part-time or part-time to full-time

Coverage amount rules that apply to you as a new hire also apply when you experience a Qualified Life Event.

Certificate of Insurance

Once Reliance processes your application, it will issue a Certificate of Insurance showing the insurance effective date. The effective date is subject to eligibility requirements and satisfaction of any service waiting period. The effective date may be deferred for an employee not actively at work and for enrolled dependents confined in a hospital or at home.

Your Certificate of Insurance also provides complete details of your Voluntary Life Insurance coverage, including any requirements necessary to receive a benefit or exercise an option, and any specific benefit/option limitations and/or exclusions. Below is a brief summary of plan features that are included in the Certificate.

Living Benefit / Accelerated Death Benefit

An insured may be able to receive a portion of his/her life insurance benefit if he/she becomes terminally ill (as defined in the Certificate).

Waiver of Premium

Premiums may be waived if you should become totally disabled (as defined in the Certificate).

Conversion and Portability of Coverage

When your coverage ends or is reduced, you may convert all or part of your life insurance and your dependent's life insurance to an individual policy consistent with the terms of the master policy contract. Or you may choose to continue your voluntary life insurance under another group policy with Reliance (where portability is permitted by law). Your request for portability will be considered if you have not submitted an application to convert your coverage to an individual policy.

For either conversion or portability, you must submit an application and pay the first premium to Reliance within 31 days of the date the group coverage ends. The policy becomes effective at the end of the 31-day period. The maximum amount of coverage that may be converted or portable is based on the reason group coverage ends, the amount of coverage the individual has before it ends, whether the individual will become eligible for any other group coverage within 31 days of the date your group coverage ends, and state regulations. The maximum amount of coverage that may be portable is subject to state regulations.

To request an application for portability or conversion, contact the Benefits Administration Office.

Suicide Exclusion

Death by suicide is not covered during the first two years an insured's insurance is in force. Reliance will return the premiums paid for the coverage.

Limitation on Amount of Insurance

Neither you nor your spouse may hold more than a total of \$500,000 of group term life insurance with Reliance under the Stamford Public Schools Master Group Policy. Insurance over that amount will be void and the premium refunded.

Beneficiaries

The beneficiary you name for Basic Life Insurance will be your beneficiary for your Voluntary Life Insurance coverage unless you choose someone else. You may change or add beneficiaries at any time by completing a beneficiary form found online at www.stamfordpublicschools.org. Once at the site, click on Teachers, then Benefits, then Life Insurance Beneficiary Forms. You are automatically the beneficiary for any life or accident coverage you elect for your spouse and child(ren).

If you have not named a beneficiary, or your beneficiary does not survive you (or, in the case of dependent life, you do not survive your dependents), your benefits will be paid to the first survivor among:

- Your spouse, in full;
- Your child(ren), in equal shares (natural children, legally adopted children, and stepchildren who reside with you);
- Your parents, in equal shares;
- Your brothers and sisters, in equal shares;

If you do not have any living beneficiary or immediate relatives, your benefits will be paid to your estate.

Applying for Benefits

As soon as reasonably possible, a beneficiary must contact the Benefits Administration Office by calling 203-977-4196.

Voluntary Accident Insurance

In addition to the basic accident insurance provided to you by the Stamford Board of Education (refer to the collective bargaining agreement between the Stamford Board of Education and your employee association), you also have the opportunity to purchase affordable group accident insurance through the Reliance Standard Life Insurance Company (Reliance).

Accident Insurance Options

For You

You may purchase voluntary accident insurance in increments of \$10,000, from \$10,000 to a maximum of \$500,000, subject to ten times your earnings for amounts over \$150,000. Your insurance amount reduces to 50% of your pre-age 75 amount at age 75 and further reduces to 25% of your pre-age 75 amount at age 80.

For Your Dependents

You may purchase voluntary accident insurance for your dependents as follows:

- 50% of your Principal Sum For Spouse **with no** Dependent Child(ren) being covered
- 40% of your Principal Sum For Spouse **with** Dependent Child(ren) being covered
- 10% of your Principal Sum Each Dependent Child
- 15% of your Principal Sum Each Dependent Child if no Spouse

Annual Open Enrollment

Open enrollment for voluntary accident insurance occurs annually at the end of each school year. The effective date of your benefit election is September 1st. During the annual open enrollment, you have the chance to apply for voluntary accident insurance to meet your personal needs.

Changing Coverage during the Year

In addition to making changes during each year's open enrollment, you may apply for or make changes in your voluntary accident insurance coverage during the year if a "Qualified Life Event," as enumerated in IRC Section 125 occurs:

- Marriage or divorce
- Birth or adoption of first dependent child
- Death of your spouse or dependent child
- Termination or commencement of your spouse's employment
- Change in your or your spouse's job status from full-time to part-time or part-time to full-time

Coverage amount rules that apply to you as a new hire also apply when you experience a Qualified Life Event.

Beneficiaries

The beneficiary you name for basic accident insurance will be your beneficiary for your voluntary accident insurance coverage unless you choose someone else. You may change or add beneficiaries at any time by completing a beneficiary form. You are automatically the beneficiary for any accident coverage you elect for your spouse and child(ren).

If you have not named a beneficiary, or your beneficiary does not survive you (or, in the case of dependent life, you do not survive your dependents), your benefits will be paid to the first survivor among:

- Your spouse, in full;
- Your child(ren), in equal shares (natural children, legally adopted children, and stepchildren who reside with you);
- Your parents, in equal shares;
- Your brothers and sisters, in equal shares;

If you do not have any living beneficiary or immediate relatives, your benefits will be paid to your estate.

Certificate of Insurance

You will receive a Certificate of Insurance. Your Certificate of Insurance provides complete details of your voluntary accident insurance coverage, including any requirements necessary to receive a benefit or exercise an option, and any specific benefit/option limitations and/or exclusions. Below is a brief summary of plan features that are included in the Certificate.

What's Covered

The following chart shows how much you will be paid if a death or injury occurs within 365 days of an accident:

If you suffer a loss of...	Percent of Your Benefit Amount
Life	100%
Speech and hearing (both ears)	100%
Speech or hearing (both ears)	50%
Both hands or both feet or sight in both eyes	100%
Two or more of the following: hand, foot or eye	100%
One hand and one foot	100%
One hand or one foot or one eye	50%
Thumb and index finger of same hand	25%

Conversion and Portability of Coverage

When your coverage ends or is reduced, you may convert all or part of your voluntary accident insurance to an individual policy. You must submit an application and pay the first premium to Reliance within 31 days of the date the group coverage ends. The policy becomes effective at the end of the 31-day period. The converted policy's Principal Sum will be the lower of your existing coverage or \$250,000.

To request an application for conversion, contact the Benefits Administration Office.

Exposure Benefit

If you suffer a loss due to exposure, the loss will be covered as if it were due to an injury, provided the loss results directly and independently of all other causes from accidental exposure to the elements.

Disappearance Benefit

If the vehicle in which you are riding is involved in a covered accident and disappears as a result, it will be presumed that loss of life occurred and the full benefit amount will be payable one year after the accident if the body has not been found.

Education Benefit

If coverage for your spouse or dependent children is in effect and you die in a covered accident, Reliance will pay an amount equal to the actual tuition charges incurred for a period of up to 4 consecutive academic years. The amount payable per dependent child cannot exceed an academic year maximum of \$5,000 and an overall maximum of 5% of your coverage amount. The amount payable for your spouse cannot exceed \$3,000 annually. Reliance must receive proof that your child was enrolled as a full-time student at an accredited college, university, or vocational school above the 12th grade level or is at the 12th grade level and within one year after the date of your death enrolls as a full-time student. Reliance must receive proof that your spouse was enrolled in an accredited school, or within 30 months after the date of your death, your spouse enrolls in an accredited school.

Seatbelt Benefit

If a loss results from a covered accident that occurs while riding or driving in a private passenger car equipped with seatbelts that are in use and properly fastened at the time of the accident, an additional benefit of up to 10% of the coverage amount will be payable, to a maximum of \$25,000.

Airbag Benefit

If a loss results from a covered accident that occurs while riding or driving in a private passenger car and your seat was protected by an airbag at the time of the accident, an additional benefit of 5% will be payable, to a maximum of \$25,000. Your seatbelt must have also been properly fastened.

Exclusions

The voluntary accident insurance does not cover any loss:

- to which sickness, disease, or myocardial infarction, including medical or surgical treatment thereof, is a contributing factor; or
- caused by suicide, or intentionally self-inflicted injuries; or
- caused by or resulting from war or any act of war, declared or undeclared; or
- caused by an accident that occurs while in the armed forces of any country, except as shown under the Reserve-National Guard Benefit (any premium paid to Reliance for any period not covered by this Policy while the Insured is in such service will be returned pro rata); or

- caused by or resulting from riding in, getting into or out of any aircraft, unless:
 - you are a passenger (not a pilot or crew member) in a tested and approved civilian aircraft being operated as passenger transport in compliance with the then current rules of the authority having jurisdiction over its operation; and
 - the aircraft is not owned, leased or operated by or on behalf of you, or any other employer of yours, unless a specific written agreement has been obtained from Reliance; or
- sustained during your commission or attempted commission of an assault or felony; or
- to which your acute or chronic alcoholic intoxication is a contributing factor. The term intoxication means the state of being poisoned or inebriated due to the ingestion of excessive alcohol; or
- caused by your voluntary use of any controlled substance, as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as now or hereafter amended, unless as prescribed for you by your physician.

Applying for Benefits

You or your beneficiary must apply for benefits within 31 days of a death or injury, or as soon as reasonably possible. Proof of the loss is required within 90 days of the date it occurs, if reasonably possible. Reliance has the right to make an autopsy in case of death, unless the law forbids it. Reliance will pay for the cost of both the examination and the autopsy.

Claims for benefits must be submitted by mailing a completed claim form along with any requested information to:

Reliance Standard Life Insurance Company
Claims Department
P.O. Box 8330
Philadelphia, PA 19101-8330
800-644-1103

Long Term Disability – Administrators Only

A Long Term Disability benefit is provided to all administrators of Stamford Public Schools at no cost to the employee. The benefit, administered by The Paul Revere Life Insurance Company (Paul Revere), is intended to be a source of income replacement if you become totally disabled while insured due to injury or illness. Below is an overview of the major provisions of the long term disability benefit. However, the official agreement between Stamford Public Schools and The Paul Revere Life Insurance Company remains the final authority on all benefits provisions.

Amount of Disability Benefit

Paul Revere pays a monthly benefit equal to 66 2/3% of your basic monthly earnings. The minimum benefit is 15% of your basic monthly earnings up to a maximum of \$100. The maximum benefit is \$5,000 per month.

Maximum Benefit Period

If your disability begins before you reach age 60, the benefit continues until you reach age 65. If your disability begins after you attain age 60, but before you attain age 65, the benefit is limited to 48 months or to age 65, whichever is greater. If your disability begins after you attain age 65, but before age 69, the benefit is limited to 30 months, but not beyond your attain age 70. If your disability begins after you attain age 69, the benefit is limited to 12 months.

Reduction of Disability Benefits

While you are disabled, you may be eligible for benefits from other income sources. If so, Paul Revere will reduce your benefit by the amount of such other benefits paid or payable. However, if you receive an increase in the benefit you receive from the other source Paul Revere will not reduce your monthly benefit further as a result of the increase.

Listed below are other income sources which will reduce your benefit:

- Unemployment compensation, Workers' Compensation benefits, Social Security disability, or retirement benefits for you and your family, and other legislated benefits for disability, retirement, or unemployment
- Insurance or other recoveries relating to your disability (whether or not for lost earnings)
- Disability, retirement, and unemployment benefits provided by a plan sponsored by another employer or under other group coverage
- Pension or similar benefits from the Teachers Retirement Board's pension plan
- Payments from your auto insurance

Limitations

Benefits are not paid for any disability that results from:

- War (declared or undeclared), insurrection, rebellion, or participation in a riot or civil commotion
- A self-inflicted injury that is not accidental while sane or insane
- A criminal act or occupation which you commit or attempt to commit
- Loss of a professional or occupational license or certification (which, by itself, does not constitute a disability)

- A pre-existing condition unless you have been insured for a period of 12 consecutive months

Applying for Benefits

To receive a benefit, a disability claim must be submitted to Paul Revere within 20 days of the first date for which you claim benefits. Claim forms can be obtained by contacting the Benefits Administration Office at 203-977-4773 or 203-977-4196.

Maternal Disability and Childcare Leave

Stamford Public Schools' Maternal Disability and Childcare Leave Policy is intended to meet the requirements of the state and federal Family and Medical Leave Acts ("FMLA"), under which eligible employees are entitled to unpaid leave for qualifying reasons.

Maternal Disability

You are entitled to all job-related benefits (sick leave, continuation of your health benefits, pension contributions and retirement credit) for any period of time that your physician certifies that you are unable to perform the duties of your job because of your pregnancy.

Childcare Leave

A leave may be granted to tenured staff upon the birth or adoption of a child. If your spouse is also employed by Stamford Public Schools, a childcare leave will only be granted to one spouse at a time.

Requesting a Leave

If the need for a leave is foreseeable based on an expected birth or placement of a child, you must contact the Human Capital Development Office by calling 203-977-5903. You must also provide a written notice of your intention to take a leave to the Human Capital Development Office at least thirty (30) days before the commencement of a leave. In all other cases, including FMLA leave taken on an emergency basis, you must provide such written notice as soon as possible. Notice may not be provided after the leave has ended.

Upon receiving your request for a leave, the Human Capital Development Office will send you a kit that will include the following:

- Response to Request for Family or Medical Leave (FMLA)
- Certification of Physician or Practitioner – to certify disability
- Medical Examiner's Certification – for return to work
- Stamford Public Schools' Maternal Disability and Childcare Leave Policy

All forms must be completed in their entirety and returned to Human Capital Development Office.

Duration of a Leave

For maternal disability leaves, the duration of your leave will be based on your physician's written statement regarding your ability to resume the duties of your job.

For childcare leaves, your leave will normally be for one year's duration plus any fraction of a school year. A request can be made for a one-year extension. The maximum length of a childcare leave is two full years plus any fraction. You must provide a written request to return to your job or to extend a childcare leave to the Human Capital Development Office at least sixty (60) days prior to the termination of your leave. Failure to do so will be considered an automatic resignation.

Returning From a Leave

You must inform the Human Capital Development Office of your intent to return to work. If your intent is to return to work at the start of a new school year, you must contact the Human Capital Development Office by February 1st.

Continuing Your Benefits during Your Leave

Your medical, dental, prescription drug, basic life insurance, basic accident insurance, voluntary life insurance, voluntary accident insurance benefits continue for the duration of your maternal disability or childcare leave. Participation in the flexible spending accounts and contributions to your tax sheltered annuity continue as long as you are on a paid maternal disability or childcare leave. Participation in the flexible spending accounts and contributions to your tax sheltered annuity terminate upon the commencement of your unpaid maternal disability or childcare leave.

Paying for Your Benefits during Your Leave

Benefit contributions will continue to be deducted from your pay for the duration of your paid maternal disability or childcare leave.

Since benefit contributions are not deducted from your pay while you are on an unpaid maternal disability or childcare leave, you will be responsible for making the appropriate contribution. While on an unpaid maternal disability or childcare leave, your benefits contribution is equal to the amount that would have been deducted from your pay if you were on a paid maternal disability or childcare leave.

The exact amount of your benefits contribution will be stated in the Response to Request for Family or Medical Leave notice provided to you by the Human Capital Development Office. Payment of your benefits contribution must be submitted to the Benefits Administration Office within thirty (30) days of the date of the Response to Request for Family or Medical Leave notice. Acceptable forms of payment are a check or money order made payable to Stamford Board of Education.

Upon your return to work, Payroll will resume deducting your benefits contributions from your pay. If your leave was taken based upon the birth or adoption of a child and you have elected to add your child to your benefits, your contributions will be adjusted after you return to work.

Administrative Information

This section contains information on the administration and funding for your plans, as well as your rights as a plan participant. While you may not need this information for day-to-day participation in your benefit plans, you should read through this section. It is important for you to understand your rights, the procedures you need to follow and the appropriate contacts you may need in certain situations.

Participation in any of the benefit plans sponsored by Stamford Public Schools should not be viewed as a contract of employment.

Employer Name, Address and Identification Number

Stamford Public Schools sponsors the plans described in this book. The federal employer identification number assigned for Stamford Public Schools is #06-6001536.

Stamford Public Schools
Benefits Administration Office
P.O. Box 9310
Stamford CT 06904
203-977-4196 or 203-977-4773

Plan Administrator

The plan administrator is Stamford Public Schools. Administration of all the plans described in this book is the responsibility of the plan administrator. The plan administrator may be contacted by phone, in person or in writing at the following address:

Stamford Public Schools
Benefits Administration Office
P.O. Box 9310
Stamford CT 06904
203-977-4196 or 203-977-4773

Employee Association Agreements

The eligibility of employees represented by an employee association for the benefits described in this book is subject to negotiation between Stamford Public Schools and the applicable union.

Plan Funding

The benefit plans are funded in different ways, depending upon the type of plan, as described below. Stamford Public Schools and participating employees make contributions to the benefit plans. Employee contributions are determined by the collective bargaining agreement between Stamford Public Schools and the applicable union. Employee contributions for medical, dental and prescription drug coverage and flexible spending accounts are intended to be made on a pre-tax basis in accordance with section 125 of the Internal Revenue Code.

Stamford Public Schools-Funded Plans

Medical, dental and prescription drug benefits are paid from the general assets of Stamford Public Schools and are not pre-funded or insured. Third party administrators administer the benefits. The name and address of each administrator are listed below. Each benefits administrator has the discretionary authority to determine all benefits in accordance with this benefits book and applicable union collective bargaining agreements. The administrative services provided by the benefits administrator include claims processing and payment.

Medical

Anthem Blue Cross and Blue Shield
370 Bassett Road
North Haven CT 06473
800-233-4947

Prescription Drugs

Medco Health
100 Parsons Pond Drive
Franklin Lakes NJ 07417
800-711-0917

Dental

CIGNA HealthCare
900 Cottage Grove Road
Hartford CT 06152
800-244-6224

The above listed administrators are authorized to make payments on behalf of Stamford Public Schools directly to Physicians, Providers or Hospitals furnishing Covered Services for which benefits are provided under the benefits offered by Stamford Public Schools. However, except as otherwise provided for in any Physician, Provider or Hospital agreement, Anthem reserves the right to make payments on behalf of Stamford Public Schools directly to you or your covered dependent at Anthem's discretion. In the absence of a participating agreement, and one parent or custodian who has custody of a minor dependent child, Anthem will make payments on behalf of Stamford Public Schools to that custodial parent or custodian.

Once Covered Services are rendered by a Physician, Provider or Hospital, Anthem will reject a request not to pay the claims submitted by the Physician, Provider or Hospital. Anthem will have no liability to any person because of its rejection of the request.

You must advise the Physician, Provider or Hospital that you or your dependent is covered under the benefits offered by Stamford Public Schools when arrangements for services are made or as soon as reasonably possible thereafter.

Anthem will not routinely issue a benefit payment on behalf of Stamford Public Schools of less than \$1.00 except upon a written request from you or your covered dependent.

Claims for benefits for Covered Services will be processed within thirty (30) days of the date the claim is received by Anthem. 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 will send a written notice of the reason(s) for the delay.

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

When Anthem has made payments for Covered Services either in error or in excess of the maximum amount of payment necessary to satisfy the provisions of the benefits offered by Stamford Public Schools, Anthem has the right to recover these payments from one or more of the following as may be appropriate. Anthem will not attempt to recover from you or a Provider, overpayments not made to or held by you or a Provider. Overpayments may be recovered from:

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

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

Under BlueCard, recoveries made from a Blue Cross and/or Blue Shield plan in the BlueCard program or from participating providers of a Blue Cross and/or Blue Shield plan in the BlueCard program can arise in several ways, including, but not limited to, anti-fraud and abuse audits, Provider/Hospital audits, credit balance audits, utilization review refunds, and unsolicited refunds. In some cases, the Blue Cross and/or Blue Shield plan will engage third parties to assist in discovery or collection of recovery amounts. The fees of such a third party are netted against the recovery. Recovery amounts, net of fees, if any, will be applied in accordance with applicable BlueCard policies, which generally require correction on a claim-by-claim or prospective basis.

Insured Plans

The following benefits are insured by a third party:

- Medical benefits under Aetna
- The basic and voluntary life and accident insurance coverage
- Long term disability coverage for Administrators

The name and address of each insurer is listed below. The administrative services provided by the insurer include claims processing and payment. The master contract for coverage specifies the time and the circumstances under which the insurer is to pay for benefits. For example, the insurer would not have to pay claims incurred after the contract is terminated. The insurer has the discretionary authority to determine all benefits according to the terms of the official policy documents and applicable union collective bargaining agreements.

Medical

Aetna Inc.
151 Farmington Avenue
Hartford CT 06156
888-287-4295

Life & Accident Insurance

Reliance Standard Life Insurance Company
P.O. Box 7818
Philadelphia PA 19101
800-644-1103

Long Term Disability Plan (for Administrators Only)

The Paul Revere Life Insurance Company
18 Chestnut Street
Worcester MA 01608-1528
800-799-4455

Flexible Spending Accounts

The flexible spending accounts are administered by CIGNA HealthCare. Under the tax laws, participating employee contributions are treated as Stamford Public Schools contributions for the employees' benefit and are intended to be non-taxable to the participating employees when used for eligible expenses.

CIGNA HealthCare has the discretionary authority to determine all benefits in accordance with IRS regulations that govern flexible spending accounts. Stamford Public Schools sets up a reserve on its books for the amount directed to the participating employee's flexible spending account. Stamford Public Schools acknowledges its obligation to make payments due and the participating employee has all the rights of a general creditor.

Claiming Health Benefits

Usually, claims for benefits will be made by your providers. However, occasionally you may be required to file a formal claim for benefits. The procedures for filing a formal claim for benefits are set forth below. For purposes of these procedures, in the case of insured programs "benefits administrator" means the insurer or its delegates. In the case of programs that are not insured, "benefits administrator" means the plan administrator or its delegate. See the previous Plan Funding section to determine if a program is insured.

Stamford Public Schools, as plan administrator, or its delegate, has the exclusive discretionary authority to construe and to decide all questions of eligibility for benefits and to determine the amount of such benefits, and its decisions on such matters are final and conclusive. As the plan administrator, Stamford Public Schools has periodically exercised its authority to delegate discretionary authority in contracts, letters and various plan documents, e.g., to the various claims or contract administrators and insurers.

Filing a Medical, Dental or Prescription Drug Claim – Post-Service

If you use a medical provider that is in Anthem Blue Cross and Blue Shield's Century Preferred network or a pharmacy in Medco's network and you use the applicable ID card, then you don't need to file a claim. If you don't use your ID card, you must submit a claim to the applicable benefits administrator. You will also need to submit a claim to CIGNA Dental whenever you obtain dental care.

To make a claim for benefits, you must submit a claim form to the benefits administrator at the address shown earlier in the Medical and Prescription Drugs sections. You will receive a written notice from the benefits administrator or its delegate regarding your claim within 30 days of its receipt by the benefits administrator. If an extension of time to process your claim is required because of reasons beyond the control of the benefits administrator, you will receive written notice of the need for an extension before the end of the 30-day period, explaining the reasons for the delay. The extension period will be 15 days from the end of the initial period. If the reason for the extension is due to your failure to provide necessary information, the determination period will be tolled from the date the benefits administrator gives you notice that additional information is necessary until the earlier of the date you respond to the request for additional information or 45 days from the date you receive the request. You must provide any additional information needed to process your claim within 45 days of receiving the request for additional information. If you don't provide the needed information within the 45-day period, your claim will be denied if there is insufficient information to decide the claim. A denial notice will explain the reason for the denial, refer to the part of the plan on which the denial is based, and provide the claim appeal procedure.

If your health benefits are provided through an HMO, contact the HMO for information on how to file a claim for benefits.

Appealing a Denied Post-Service Medical, Dental or Prescription Drug Claim

If the benefits administrator denies all or part of your claim, you or your beneficiary will be notified in writing. Claim denials include denials for pre-certification requests (see next section). This notice will include:

- Specific reasons why the claim was denied and reference to the specific plan provision(s) on which the denial is based;
- Description of any additional information needed to perfect the claim, and an explanation of why such information is necessary;
- A statement of any internal rule, protocol, or guideline if relied upon to make the denial;
- If a denial is based on medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination or a statement that you may receive such explanation free of charge upon request; and
- An explanation of how to appeal for reconsideration of the benefits administrator's decision.

If you disagree with the benefits administrator's decision, you must submit your written appeal to the benefits administrator within 180 days after you receive the claim denial. After the benefits administrator receives your written request appealing the initial determination, a full and fair review of your claim will be conducted. You will be notified in writing of a decision within 30 days, after the benefits administrator receives your written request for review.

If you are not satisfied with the first level appeal decision, you may request a second level appeal. Your second level appeal request must be submitted to the benefits administrator within 60 days of your receipt of the first level appeal decision. A second level appeal will be conducted and you will be notified of the decision within 30 days from receipt of a request for review of the first level appeal decision. If your second level appeal is denied, or if you do not receive a response within 30 days, you have exhausted the plan's appeals process. If your denied claim is through an HMO, the HMO will tell you how to appeal it.

Also available to you are services through the State of Connecticut's Office of the Healthcare Advocate. More information about how the State of Connecticut's Office of the Healthcare Advocate may assist you with appeal/grievance procedures may be obtained online at www.ct.gov/oha or by calling 866-HMO-4446.

Prior Authorization

Claims for prior authorization under the medical plans administered by Anthem BCBS are also subject to the claims and appeals process. You must call Anthem BCBS' Member Services at 1-800-233-4947 to request prior authorization for certain medical services or treatments. You must also call Anthem BCBS' Member Services to request prior authorization for mental health and/or substance abuse services or treatments.

Non-Urgent Care

You will receive a written notice from the benefits administrator regarding your prior authorization within 15 days of its receipt by the benefits administrator. If an extension of time to process your

claim is required because of reasons beyond the control of the benefits administrator, you will receive written notice of the need for an extension before the end of the 15-day period, explaining the reasons for the delay. The extension period will be 15 days from the end of the initial period. If the reason for the extension is due to your failure to provide necessary information, the determination period will be tolled from the date the benefits administrator gives you notice that additional information is necessary until the earlier of the date you respond to the request for additional information or 45 days from the date you receive the request. You must provide any additional information needed to process your prior authorization within 45 days of receiving the request for additional information. If you don't provide the needed information within the 45-day period, your claim will be denied if there is insufficient information to decide the claim. A denial notice will explain the reason for the denial, and provide the claim appeal procedure.

Urgent care

You will receive notice of the benefit determination as soon as possible, taking into account the seriousness of your condition, but in any event within 72 hours after the benefits administrator receives your prior authorization request. If your prior authorization was properly filed and denied, a written denial notice will be provided to you within three days.

If your prior authorization request is filed improperly, the benefits administrator will notify you of the improper filing and how to correct it within 24 hours after the prior authorization request was received. If additional information is needed to process the prior authorization, the benefits administrator will notify you of the information needed within 24 hours after the prior authorization request was received. You will then have 48 hours to provide the requested information.

You will be notified of a determination no later than 48 hours after the earlier of:

- The benefits administrator is in receipt of the requested information; or
- The end of the 48-hour period within which you were to provide the additional information, if the information is not received within that time.
- A denial notice will explain the reason for denial, and provide the appeal procedures.

Concurrent Care

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments and you request to extend the treatment in an urgent care circumstance, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. The benefits administrator will make a determination on your request for the extended treatment within 24 hours from receipt of your request. If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an urgent care claim and decided according to the timeframes described above.

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new prior authorization and decided according to non-urgent care or urgent care timeframes, whichever applies.

Appealing a Denied Prior Authorization

If the benefits administrator denies all or part of your request for prior authorization, you or your beneficiary will be notified in writing. This notice will include:

- Specific reasons why the prior authorization was denied and reference to the specific plan provision(s) on which the denial was based;
- Description of any additional information needed to perfect the claim, and an explanation of why such information is necessary;

- A statement of any internal rule, protocol, or guideline if relied upon to make the denial;
- If a denial is based on medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination or a statement that you may receive such explanation free of charge upon request; and
- An explanation of how to appeal for reconsideration of the benefits administrator's decision.

Non-Urgent Care

If you disagree with the benefits administrator's decision, you must submit your written appeal to the benefits administrator within 180 days after you receive the denial. After the benefits administrator receives your written request appealing the initial determination, a full and fair review of the denial will be conducted. You will be notified in writing of a decision within 15 days after the benefits administrator receives your written request for review.

If you are not satisfied with the first level appeal decision, you may request a second level appeal. Your second level appeal request must be submitted to the benefits administrator within 60 days of your receipt of the first level appeal decision. A second level appeal will be conducted and you will be notified of the decision within 15 days from receipt of a request for review. If your second level appeal is denied or if you do not receive a response within 15 days, you have exhausted the plan's appeals process.

Urgent care

The appeal does not need to be submitted in writing. You or your physician should call the benefits administrator as soon as possible. The benefits administrator will provide you with a written determination within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.

Filing a Flexible Spending Account Claim

You must submit a claim for all medical, dental, prescription drug and dependent care expenses. To make a claim for benefits, you must file a written claim with CIGNA HealthCare, the benefits administrator, using the claim form found online at www.stamfordpublicschools.org.

You will receive a written notice from the benefits administrator or its delegate regarding your claim within 30 days of its receipt by the benefits administrator. If an extension of time to process your claim is required because of reasons beyond the control of the benefits administrator, you will receive written notice of the need for an extension before the end of the 30-day period, explaining the reasons for the delay. The extension period will be 15 days from the end of the initial period. If the reason for the extension is due to your failure to provide necessary information, the determination period will be tolled from the date the benefits administrator gives you notice that additional information is necessary until the earlier of the date you respond to the request for additional information or 45 days from the date you receive the request. You must provide any additional information needed to process your claim within 45 days of receiving the request for additional information. If you don't provide the needed information within the 45-day period, your claim will be denied if there is insufficient information to decide the claim. A denial notice will explain the reason for the denial, refer to the part of the plan on which the denial is based, and provide the claim appeal procedure.

Appealing a Denied Flexible Spending Account Claim

If the benefits administrator denies all or part of your claim, you or your beneficiary will be notified in writing. This notice will include:

- Specific reasons why the claim was denied and reference to the specific plan provision(s) on which the denial is based;
- Description of any additional information needed to perfect the claim, and an explanation of why such information is necessary;
- A statement of any internal rule, protocol, or guideline if relied upon to make the denial; and
- An explanation of how to appeal for reconsideration of the benefits administrator's decision.

If you disagree with the benefits administrator's decision, you must submit your written appeal to the benefits administrator within 180 days after you receive the claim denial. After the benefits administrator receives your written request appealing the initial determination, a full and fair review of your claim will be conducted. You will be notified in writing of a decision within 30 days, after the benefits administrator receives your written request for review.

If you are not satisfied with the first level appeal decision, you must request a second level appeal. Your second level appeal request must be submitted to the benefits administrator within 60 days of your receipt of the first level appeal decision. A second level appeal will be conducted and you will be notified of the decision within 30 days from receipt of a request for review of the first level appeal decision. If your second level appeal is denied, or if you do not receive a response within 30 days, you have exhausted the plan's appeals process.

Filing a Disability Claim – Administrators Only

To make a claim for disability benefits, you must file a claim with The Paul Revere Life Insurance Company, the benefits administrator.

You will receive a written notice from the benefits administrator or its delegate regarding your claim within 45 days of its receipt by the benefits administrator. If an extension of time is required to process your claim, you will receive written notice of the need for an extension before the end of the 45-day period, explaining the reasons for the delay. The 45-day response period may be extended by two additional 30-day periods (with prior notice) for a total of 105 days. If the reason for the extension is your failure to provide necessary information to decide the claim, the determination period will be tolled from the date notice of insufficiency is given, until you respond to the notice. You will have 45 days within which to provide the specified information.

Appealing a Denied Disability Claim

If the benefits administrator denies all or part of your claim, you will be notified in writing. This notice will include:

- Specific reasons why the claim was denied;
- Specific references to applicable provisions of the plan document or other relevant records or papers, and information regarding where you may see them;
- A description of any additional material or information necessary for you to complete your claim and an explanation of why such material or information is necessary;
- Any guidelines that were relied upon in issuing the denial or a statement that such guidelines will be provided to you free of charge upon request; and
- Information as to the steps to be taken if you wish to appeal the determination, including your right to submit written comments and have them considered, and your right to review (or request at no charge) relevant documents and other information.

If you disagree with the benefits administrator's decision, you have 180 days to request a review. Your appeal must be submitted in writing within 180 days after the benefits administrator's initial notice of adverse benefit determination, or else you will lose the right to appeal your denial. Your

written appeal should state the reasons that you feel your claim should not have been denied. It should include any additional facts and/or documents you feel support your claim. You may also ask additional questions and make written comments, and you may review (on request at no charge) documents and other information relevant to your appeal.

The benefits administrator will review and decide your appeal within a reasonable time not longer than 45 days after it is submitted and will notify you of the decision in writing. If the benefits administrator determines that an extension to process the appeal is necessary due to special circumstances, the benefits administrator can extend the 45-day response period for up to 45 days by notifying you, prior to the termination of the initial 45-day period, of the circumstances requiring the extension and the date by which it expects to render a decision. If the reason for the extension is your failure to provide necessary information, the determination period shall be tolled until the earlier of the date you respond to the request for additional information or 45 days from the date you receive the request. If you don't provide the needed information within the 45-day period, your claim will be denied if there is insufficient information to decide the appeal.

The individual who decides your appeal will not be the same individual who decided your initial claim denial and will not be that individual's subordinate. In the case of an appeal involving medical judgment, the benefits administrator will secure independent medical or other advice and require such other evidence, as it deems necessary to decide your appeal, except that any medical expert consulted in connection with your appeal will be different from any expert consulted in connection with your initial claim. If the decision on appeal affirms the initial denial of your claim, you will be furnished with a notice of adverse determination on review setting forth:

- Specific reasons for the denial;
- Specific plan provisions on which the decision is based;
- If the benefits administrator relied on an "internal rule, guideline, protocol, or other similar criterion" in making the decision, a description of the specific rule, guideline, protocol, or other similar criterion, or a statement that such a rule, guideline, protocol or similar criterion was relied on and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request; and

Any claim that is subsequently reviewed by any entity other than the benefits administrator shall be conditioned on you having fully exhausted the rights and procedures described above and shall be reviewed solely on the basis of the information before the benefits administrator.

Filing a Life Insurance and/or an Accidental Death & Dismemberment Claim

To make a claim for life insurance and/or accidental death & dismemberment (AD&D) benefits you will need to the Benefits Administration Office (203-977-4196 or 203-977-4773) as soon as is reasonably possible after the accident and/or death of the insured. After receiving a claim form from the Benefits Administration Office, you must return the completed claim form with the required proof to the Benefits Administration Office. The Benefits Administration Office will verify your insurance coverage and send the claim form and proof to The Reliance Standard Life Insurance Company (Reliance). When Reliance receives the claim form and proof, they will review the claim, and process it for approval (processing time 4-6 weeks). Upon a successful approval, Reliance will pay benefits subject to the terms and provisions of Stamford Public School's Group Policy.

Life and/or AD&D Claims Appeal Process

Initial Determination

After Reliance receives your claim, it will review your claim and notify you of its decision to approve or deny your claim. Such notification will be provided to you within a reasonable period, not to exceed 90 days from the date Reliance received your claim, unless Reliance notifies you within that period that there are special circumstances requiring an extension of time of up to 90 additional days.

If Reliance denies your claim in whole or in part, the notification of the claims decision will state the reason why your claim was denied and reference the specific Policy provision(s) on which the denial is based. If the claim is denied because Reliance did not receive sufficient information, the claims decision will describe the additional information needed and explain why such information is needed. The notification will also include a description of the Policy review procedures and time limits, including a statement of how to appeal the determination.

Appealing the Initial Determination

In the event a claim has been denied in whole or in part, you or, if applicable, your beneficiary can request a review of your claim by Reliance. This request for review must be sent in writing to The Reliance Standard Life Insurance Company within 60 days after you or, if applicable, your beneficiary received notice of denial of the claim. If you do not file an appeal within the 60-day period, you will be deemed to have waived any right to appeal the denial of the claim. When requesting a review, please state the reason you or, if applicable, your beneficiary believes the claim was improperly denied and submit in writing any written comments, documents, records or other information you or, if applicable, your beneficiary deems appropriate. Upon your written request, Reliance will provide you free of charge with copies of relevant documents, records and other information.

Reliance will re-evaluate all the information, will conduct a full and fair review of the claim, and you or, if applicable, your beneficiary will be notified of the decision. Such notification will be provided within a reasonable period not to exceed 60 days from the date Reliance received your request for review, unless Reliance notifies you within that period that there are special circumstances requiring an extension of time of up to 60 additional days.

If Reliance denies the claim on appeal, it will send you a final written decision that states the reason(s) why the claim you appealed is being denied, references any specific Policy provision(s) on which the denial is based, any voluntary appeal procedures offered by the Policy. Upon written request, Reliance will provide you free of charge with copies of documents, records and other information relevant to your claim.

Reimbursing the Plan

If you or one of your dependents suffers a loss or injury caused by the actions or omissions of a third party, that third party may be responsible for paying your medical and dental expenses.

For example, if you are injured in a car accident, the person who caused the accident is the "third party," and may be responsible for paying for your injury-related expenses.

You will be required to provide information concerning any claim or lawsuit you or your dependents may have against a third party for injury caused by that party. You may be asked to

sign a repayment agreement as a condition for receiving benefits under the plan. If the agreement is not signed or you fail to cooperate with the benefits administrator, you will lose your medical benefits related to the accident.

If you decide to sue the person who caused the accident, you must inform the Benefits Administration Office.

If you receive any type of payment, reimbursement or legal recovery from the third party or an insurer, you are obligated to reimburse the plan for any expenses which the plan paid to you and/or your dependent(s) and for any related legal and collection costs the plan incurred.

In the above example, if the plan paid for the medical expenses which you incurred as a result of the accident, and you later received money from the person who caused the accident, you must pay back the plan from the money paid by the person who caused the accident.

Your obligation to reimburse the plan exists for any legal recovery that relates to an injury or illness covered by your benefits (including any amounts used to pay your legal fees), **even if you recover less than initially claimed (or less than your full loss) and even if the legal recovery is designated as not for medical expenses.**

Right of Subrogation

The plan's right to receive any payment, reimbursement or recovery discussed above supercedes and has priority over your or your dependent's right to receive any payment, reimbursement or recovery. The plan expressly rejects and overrides any default rule that the plan does not have a right of subrogation until you or your dependent have been fully compensated.

Limitations on Actions

You cannot bring any legal action against Stamford Public Schools or any claims administrator to recover reimbursement until you have properly submitted a request for reimbursement as described in this section and all required reviews of your claim have been completed. If you want to bring a legal action against Stamford Public Schools or any claims administrator, you must do so within three years from the expiration of the time period in which a request for reimbursement must be submitted or you lose any rights to bring such an action against Stamford Public Schools or any claims administrator. You cannot bring any legal action against Stamford Public Schools or any claims administrator for any reason unless you first complete all the steps in the appeal process described in this section. After completing that process, if you want to bring a legal action against Stamford Public Schools or any claims administrator you must do so within three years of the date you are notified of our final decision on your appeal. Otherwise, you lose any rights to bring such an action against Stamford Public Schools or any claims administrator.

Qualified Medical Child Support Orders

A "Qualified Medical Child Support Order" (QMCSO) is a medical child support order creating or recognizing your child's right to receive coverage under a medical plan established and maintained by Stamford Public Schools. Orders, which need to be qualified, should be sent to the Benefits Administration Office. Payments for coverage required by a QMCSO will generally be deducted from your pay.

Information about Taxes

The plans described in this book provide benefits to eligible employees in accordance with federal law and governing documents. It is intended that the value of welfare plan coverage generally be non-taxable for federal income tax purposes where permissible under the tax code. Stamford Public Schools does not guarantee the tax consequences of plan participation and no one at Stamford Public Schools is authorized to give you tax advice. You are urged to consult with a tax advisor if you have any questions or concerns about your individual situation.

Your Rights under COBRA

The health care program gives you and your dependents the option to extend your health care coverage in certain instances when coverage under the program would otherwise end. This is called COBRA coverage. A federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), created the right to COBRA continuation coverage.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of medical, prescription drug, dental and health care flexible spending account coverage when such coverage would otherwise end because of a life event known as a “qualifying event.”

What is a Qualifying Event under COBRA?

Qualifying events include:

- Employee loses coverage because of reduced work hours
- Employee retires or terminates for any reason (except gross misconduct)
- Employee or dependent is disabled (as defined by Title II or XVI of the Social Security Act) during the first 60 days of COBRA coverage, and provides notice within 60 days of determination, but no later than the end of the initial 18-month period
- Employee dies
- Employee and spouse are divorced or legally separated
- Employee enrolls in Medicare within 18 months before a qualifying event that is a termination of employment or reduction of hours
- Child no longer qualifies as dependent

Who is a Qualified Beneficiary?

After a qualifying event, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” You, your spouse, and your dependent children could become qualified beneficiaries if medical, prescription drug, dental and health care flexible spending account coverage is lost because of the qualifying event.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;

- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child."

When Is COBRA Coverage Available?

COBRA continuation coverage will be offered to qualified beneficiaries only after the Stamford Public Schools Benefits Administration Office has been notified that a qualifying event has occurred. When coverage has been lost due to the end of employment, a reduction of hours of employment or the death of the employee, Human Capital Development will notify the Benefits Administration Office.

What Is Your Responsibility?

You and your dependents are responsible for notifying the Benefits Administration Office to request COBRA materials in the event of:

- Divorce or legal separation of the active employee and spouse
- A dependent child's loss of eligibility for coverage as a dependent child

You must notify the Benefits Administration Office within 60 days of the divorce or legal separation. You must notify the Benefits Administration Office within 30 days of a dependent child's loss of eligibility for coverage as a dependent child.

How Is COBRA Provided?

Once the Stamford Public Schools Benefits Administration Office receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

Coverage Details

If COBRA is elected, your medical, prescription drug, dental and Health Care Flexible Spending Account coverage previously in effect will generally be continued. You will be given the opportunity to make a new election during annual enrollment or when you have a change in status. Any newly eligible dependents you may have may be enrolled under the same rules that apply to active employees.

If elected, contributions to the Health Care Flexible Spending Account continue only through the end of the plan year of the qualifying event, at which point you may no longer contribute.

You or your eligible dependents have 60 days from the later of the COBRA election notice date or the date of loss of coverage to elect continued participation under COBRA. Once you make your election, you will have 45 days to pay the initial premium payment. COBRA coverage will be effective the day after the change in status.

How long will COBRA Continuation Coverage last?

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement.

For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

Under what circumstances is continuation coverage terminated before the end of the maximum period?

Continuation coverage will be terminated before the end of the maximum period if:

- Stamford Public Schools no longer provides group health coverage to any of its employees.
- Any required premium is not paid; your coverage will not be terminated for non-payment of premiums until you have been contacted by the Stamford Public Schools Benefits Administration Office.
- A qualified beneficiary becomes covered, after electing continuation coverage, under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary.
- A qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation coverage.

Continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

How can you extend the length of COBRA continuation coverage?

If you elect continuation coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs and the initial coverage period is less than 36 months. You must notify the Stamford Public Schools Benefits

Administration Office of a disability or a second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Stamford Public Schools Benefits Administration Office in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Stamford Public Schools Benefits Administration Office. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

How can you elect COBRA continuation coverage?

To elect continuation coverage, you must complete the Election Form and submit it to the Stamford Public Schools Benefits Administration Office within 60 days of the loss of your coverage.

How much does COBRA continuation coverage cost?

Each qualified beneficiary must pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent of the cost to the group health plan (including both Stamford Public Schools and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage. The required payment for each continuation coverage period is provided in the Election Form.

When and how must payment for COBRA continuation coverage be made?

First payment for continuation coverage

If you elect continuation coverage, you do not have to send any payment with the Election Form. After the Stamford Public Schools Benefits Administration Office has received your Election Form, you will receive a COBRA Premium Notice with instructions regarding your first payment. You must make your first payment for continuation coverage not later than 45 days after the date of your election. (This is the date the Election Notice is post-marked, if mailed.) If you do not

make your first payment for continuation coverage in full not later than 45 days after the date of your election, you will lose all continuation coverage rights under the Plan. You are responsible for making sure that the amount of your first payment is correct.

Monthly Premium payments for continuation coverage

After you make your first payment for continuation coverage, you will be required to make monthly premium payments for each subsequent coverage period. The amount due for each coverage period for each qualified beneficiary is shown in your COBRA Premium Notice. The monthly premium payments can be made on a monthly basis. Under the Plan, each of these monthly payments for continuation coverage is due on the 1st day of each month for that coverage period. If you make a monthly payment on or before the first day of the coverage period to which it applies, your coverage under the Plan will continue for that coverage period without any break.

All monthly premium payments for continuation coverage should be made payable to the Stamford Board of Education and sent to: Stamford Public Schools, Benefits Administration Office, P.O. Box 9310, Stamford CT 06904.

For more information, contact the Stamford Public Schools, Benefits Administration Office at 203-977-4773 or 203-977-4196.

Important Contacts

Benefit	Contact	When to Contact
Medical - including Mental Health	Anthem BlueCross BlueShield 1-800-233-4947 www.anthem.com	<ul style="list-style-type: none"> ▪ To locate a network doctor or hospital ▪ To check on the status of claims ▪ To verify coverage
Prescription Drugs	Medco Health 1-800-711-0917 www.medco.com	<ul style="list-style-type: none"> ▪ To locate network pharmacies ▪ To fill or refill a prescription for maintenance drugs ▪ To check on the status of claims
Dental	CIGNA Dental 1-800-244-6224 www.mycigna.com	<ul style="list-style-type: none"> ▪ To pre-certify dental treatment plan ▪ To locate a network provider ▪ For information about your coverage ▪ To check on the status of a claim
Flexible Spending Accounts	CIGNA HealthCare 1-800-292-5108 www.cigna.com/healthcare	<ul style="list-style-type: none"> ▪ To get your account balance ▪ To find out if an expense is covered ▪ To check on the status of a reimbursement
COBRA Continuation	Benefits Administration Office Benefits Assistant – 203-977-4773 Benefits Manager – 203-977-4196	<ul style="list-style-type: none"> ▪ To get information on continuing benefits through COBRA ▪ For questions about COBRA bills
Retirement Benefit – Administrators & Teachers	State of Connecticut – Teachers' Retirement Board 1-800-504-1102 1-860-241-8413 www.state.ct.us/trb	<ul style="list-style-type: none"> ▪ To obtain a copy of an Annual Statement of Benefits ▪ To confirm credited service ▪ To obtain a pension benefits estimate ▪ For questions about the retirement application process
Retirement Benefit – Educational Assistants & Security Personnel	City of Stamford Human Resources Department 203-977-4038 203-977-4074	<ul style="list-style-type: none"> ▪ For questions about the retirement

HIPAA Privacy Notice

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes numerous requirements on employer health plans concerning the use and disclosure of individual health information. This information, known as protected health information, includes virtually all individually identifiable health information held by the Plan — whether received in writing, in an electronic medium, or as an oral communication. This notice describes the privacy practices of the following plans: Medical, Prescription Drugs, Dental and Flexible Spending Accounts

The plans covered by this notice may share health information with each other to carry out Treatment, Payment, or Health Care Operations. These plans are collectively referred to as the Plan in this notice, unless specified otherwise.

The Plan's duties regarding health information about you

The Plan is required by law to maintain the privacy of your health information and to provide you with this notice of the Plan's legal duties and privacy practices with respect to your health information. If you participate in an insured plan option, you will receive a notice directly from the Insurer. It's important to note that these rules apply to the Plan, not Stamford Public Schools as an employer — that's the way the HIPAA rules work. Different policies may apply to other Stamford Public Schools programs or to data unrelated to the health plan.

How the Plan may use or disclose your health information

The privacy rules generally allow the use and disclosure of your health information without your permission (known as an authorization) for purposes of health care Treatment, Payment activities, and Health Care Operations. Here are some examples of what that might entail:

- **Treatment** includes providing, coordinating, or managing health care by one (1) or more health care providers or doctors. Treatment can also include coordination or management of care between a provider and a third party, and consultation and referrals between providers. *For example, the Plan may share health information about you with physicians who are treating you.*
- **Payment** includes activities by this Plan, other plans, or providers to obtain premiums, make coverage determinations and provide reimbursement for health care. This can include eligibility determinations, reviewing services for medical necessity or appropriateness, utilization management activities, claims management, and billing; as well as "behind the scenes" plan functions such as risk adjustment, collection, or reinsurance. *For example, the Plan may share information about your coverage or the expenses you have incurred with another health plan in order to coordinate payment of benefits.*
- **Health care operations** means that the Plan may use and disclose your health information to enable the Plan to operate or to operate more efficiently. This includes: conducting quality assessment and improvement activities, determining employee contributions, conducting or arranging for medical review, legal services, and audit services, disease management, case management, planning and development and general Plan administrative activities. *For example, the Plan may use your claims information to refer you to a disease management program, project future benefit costs, review the effectiveness of wellness programs, or audit the accuracy of its claims processing functions.*

The amount of health information used or disclosed will be limited to the "Minimum Necessary" for these purposes, as defined under the HIPAA rules. The Plan may also contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you, or to send you a reminder for important services such as mammograms or prostate cancer screenings..

How the Plan may share your health information with Stamford Public Schools

The Plan, or its health insurer, may disclose your health information without your written authorization to Stamford Public Schools for plan administration purposes. Stamford Public Schools may need your health information to administer benefits under the Plan. Stamford Public Schools agrees not to use or disclose your health information other than as permitted or required by the Plan documents and by law. Designated Human Capital Development and Benefits staffs are the only Stamford Public Schools employees who will have access to your health information for plan administration functions.

Here's how additional information may be shared between the Plan and Stamford Public Schools, as allowed under the HIPAA rules:

- The Plan, or its Insurer, may disclose "summary health information" to Stamford Public Schools if requested, for purposes of obtaining premium bids to provide coverage under the Plan, or for modifying, amending, or terminating the Plan. Summary health information is information that summarizes Participants' claims information, but from which names and other identifying information has been removed.
- The Plan, or its Insurer, may disclose to Stamford Public Schools information on whether an individual is participating in the Plan, or has enrolled or disenrolled in an insurance option offered by the Plan.
- In addition, you should know that Stamford Public Schools cannot and will not use health information obtained from the Plan for any employment-related actions. However, health information collected by Stamford Public Schools from other sources, for example under the Family and Medical Leave Act, Americans with Disabilities Act, or workers' compensation is not protected under HIPAA (although this type of information may be protected under other federal or state laws).

Other allowable uses or disclosures of your health information

Third party "business associates" that perform various services for the Plan also may have access to your health information. However, the Plan's business associates have agreed to safeguard your health information in accordance with HIPAA.

In certain cases, your health information can be disclosed without authorization to a family member, close friend, or other person you identify who is involved in your care or payment for your care. Information describing your location, general condition, or death may be provided to a similar person (or to a public or private entity authorized to assist in disaster relief efforts). You will generally be given the chance to agree or object to these disclosures (although exceptions may be made, for example if you're not present or if you're incapacitated). In addition, your health information may be disclosed without authorization to your legal representative.

The Plan is also allowed to use or disclose your health information without your written authorization for the following activities:

Necessary to prevent serious threat to health or safety	Disclosures made in the good-faith belief that releasing your health information is necessary to prevent or lessen a serious and imminent threat to public or personal health or safety, if made to someone reasonably able to prevent or lessen the threat (including disclosures to the target of the threat); includes disclosures to assist law enforcement officials in identifying or apprehending an individual because the individual has made a statement admitting participation in a violent crime that the Plan reasonably believes may have caused serious physical harm to a victim, or where it appears the individual has escaped from prison or from lawful custody
Public health activities	Disclosures authorized by law to persons who may be at risk of contracting or spreading a disease or condition; disclosures to public health authorities to prevent or control disease or report child abuse or neglect; and disclosures to the Food and Drug Administration to collect or report adverse events or product defects
Victims of abuse, neglect, or domestic violence	Disclosures to government authorities, including social services or protective services agencies authorized by law to receive reports of abuse, neglect, or domestic violence, as required by law or if you agree or the Plan believes that disclosure is necessary to prevent serious harm to you or potential victims (you'll be notified of the Plan's disclosure if informing you won't put you at further risk)
Judicial and administrative proceedings	Disclosures in response to a court or administrative order, subpoena, discovery request, or other lawful process (the Plan may be required to notify you of the request, or receive satisfactory assurance from the party seeking your health information that efforts were made to notify you or to obtain a qualified protective order concerning the information)
Law enforcement purposes	Disclosures to law enforcement officials required by law or pursuant to legal process, or to identify a suspect, fugitive, witness, or missing person; disclosures about a crime victim if you agree or if disclosure is necessary for immediate law enforcement activity; disclosure about a death that may have resulted from criminal conduct; and disclosure to provide evidence of criminal conduct on the Plan's premises
Decedents	Disclosures to a coroner or medical examiner to identify the deceased or determine cause of death; and to funeral directors to carry out their duties
Organ, eye, or tissue donation	Disclosures to organ procurement organizations or other entities to facilitate organ, eye, or tissue donation and transplantation after death
Research purposes	Disclosures of the information during a research project, subject to approval by institutional or private privacy review boards, and subject to certain assurances and representations by researchers regarding necessity of using your health information and treatment
Health oversight activities	Disclosures to health agencies for activities authorized by law (audits, inspections, investigations, or licensing actions) for oversight of the health care system, government benefits programs for which health information is relevant to beneficiary eligibility, and compliance with regulatory programs or civil rights laws
Specialized	Disclosures about individuals who are Armed Forces personnel or foreign military personnel under appropriate military command; disclosures to

government functions	authorized federal officials for national security or intelligence activities; and disclosures to correctional facilities or custodial law enforcement officials about inmates
HHS investigations	Disclosures of your health information to the Department of Health and Human Services (HHS) to investigate or determine the Plan's compliance with the HIPAA privacy rule

Except as described in this notice, other uses and disclosures will be made only with your written authorization. You may revoke your authorization as allowed under the HIPAA rules. However, you can't revoke your authorization if the Plan has taken action relying on it. In other words, you cannot revoke your authorization with respect to disclosures the Plan has already made.

Your individual rights

You have the following rights with respect to your health information the Plan maintains. These rights are subject to certain limitations, as discussed below. This section of the notice describes how you may exercise each individual right.

Right to request restrictions on certain uses and disclosures of your health information and the Plan's right to refuse

You have the right to ask the Plan to restrict the use and disclosure of your health information for Treatment, Payment, or Health Care Operations, except for uses or disclosures required by law. You have the right to ask the Plan to restrict the use and disclosure of your health information to family members, close friends, or other persons you identify as being involved in your care or payment for your care. You also have the right to ask the Plan to restrict use and disclosure of health information to notify those persons of your location, general condition, or death — or to coordinate those efforts with entities assisting in disaster relief efforts. If you want to exercise this right, your request to the Plan must be in writing. Contact the Benefits Administration Office at 203-977-4196 or go to www.stamfordpublicschools.org. Once at the site, click on Teachers, then Benefits, then HIPAA to obtain a request form.

The Plan is not required to agree to a requested restriction. And if the Plan does agree, a restriction may later be terminated by your written request, by agreement between you and the Plan (including an oral agreement), or unilaterally by the Plan for health information created or received after you're notified that the Plan has removed the restrictions. The Plan may also disclose health information about you if you need emergency treatment, even if the Plan has agreed to a restriction.

Right to receive confidential communications of your health information

If you think that disclosure of your health information by the usual means could endanger you in some way, the Plan will accommodate reasonable requests to receive communications of health information from the Plan by alternative means or at alternative locations.

If you want to exercise this right, your request to the Plan must be in writing, and you must include a statement that says that disclosure of all or part of the information could endanger you. Contact the Benefits Administration Office at 203-977-4196 or go to www.stamfordpublicschools.org. Once at the site, click on Teachers, then Benefits, then HIPAA to obtain a request form.

Right to inspect and copy your health information

With certain exceptions, you have the right to inspect or obtain a copy of your health information in a "Designated Record Set." This may include medical and billing records maintained for a health care provider; enrollment, payment, claims adjudication, and case or medical management record systems maintained by a plan; or a group of records the Plan uses to make decisions about individuals. However, you do not have a right to inspect or obtain copies of psychotherapy notes or information compiled for civil, criminal, or administrative proceedings. In addition, the Plan may deny your right to access, although in certain circumstances you may request a review of the denial.

If you want to exercise this right, your request to the Plan must be in writing. Contact the Benefits Administration Office at 203-977-4196 or go to www.stamfordpublicschools.org. Once at the site, click on Teachers, then Benefits, then HIPAA to obtain a request form. Within 30 days of receipt of your request (60 days if the health information is not accessible onsite), the Plan will provide you with:

- The access or copies you requested;
- A written denial that explains why your request was denied and any rights you may have to have the denial reviewed or file a complaint; or
- A written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request.

The Plan may provide you with a summary or explanation of the information instead of access to or copies of your health information, if you agree in advance and pay any applicable fees. The Plan may also charge reasonable fees for copies or postage.

If the Plan doesn't maintain the health information but knows where it is maintained, you will be informed of where to direct your request.

Right to amend your health information that is inaccurate or incomplete

With certain exceptions, you have a right to request that the Plan amend your health information in a Designated Record Set. The Plan may deny your request for a number of reasons. For example, your request may be denied if the health information is accurate and complete, was not created by the Plan (unless the person or entity that created the information is no longer available), is not part of the Designated Record Set, or is not available for inspection (e.g., psychotherapy notes or information compiled for civil, criminal, or administrative proceedings).

If you want to exercise this right, your request to the Plan must be in writing, and you must include a statement to support the requested amendment. Contact the Benefits Administration Office at 203-977-4196 or go to www.stamfordpublicschools.org. Once at the site, click on Teachers, then Benefits, then HIPAA to obtain a request form. Within 60 days of receipt of your request, the Plan will:

- Make the amendment as requested;
- Provide a written denial that explains why your request was denied and any rights you may have to disagree or file a complaint; or
- Provide a written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request.

Right to receive an accounting of disclosures of your health information

You have the right to a list of certain disclosures the Plan has made of your health information. This is often referred to as an "accounting of disclosures." You generally may receive an accounting of disclosures if the disclosure is required by law, in connection with public health activities, or in similar situations listed in the table earlier in this notice, unless otherwise indicated below.

You may receive information on disclosures of your health information going back for six (6) years from the date of your request, but not earlier than April 14, 2003 (the general date that the HIPAA privacy rules became effective). You do not have a right to receive an accounting of any disclosures made:

- For Treatment, Payment, or Health Care Operations;
- To you about your own health information;
- Incidental to other permitted or required disclosures;
- Where authorization was provided;
- To family members or friends involved in your care (where disclosure is permitted without authorization);
- For national security or intelligence purposes or to correctional institutions or law enforcement officials in certain circumstances; or
- As part of a "limited data set" (health information that excludes certain identifying information).

In addition, your right to an accounting of disclosures to a health oversight agency or law enforcement official may be suspended at the request of the agency or official.

If you want to exercise this right, your request to the Plan must be in writing. Contact the Benefits Administration Office at 203-977-4196 or go to www.stamfordpublicschools.org. Once at the site, click on Teachers, then Benefits, then HIPAA to obtain a request form. Within 60 days of the request, the Plan will provide you with the list of disclosures or a written statement that the time period for providing this list will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request. You may make one (1) request in any 12-month period at no cost to you, but the Plan may charge a fee for subsequent requests. You'll be notified of the fee in advance and have the opportunity to change or revoke your request.

Right to obtain a paper copy of this notice from the Plan upon request

You have the right to obtain a paper copy of this Privacy Notice upon request. Even individuals who agreed to receive this notice electronically may request a paper copy at any time.

Exercise Your Rights

Generally Stamford Public Schools maintains limited PHI. Most of your PHI is held by the Plan's benefits administrators. So, to exercise your rights under HIPAA, you should first contact the appropriate benefits administrator. See the Important Contacts section for a directory of contact information. For PHI that is maintained by Stamford Public Schools, contact the Benefits Administration Office at 203-977-4196.

Changes to the information in this notice

The Plan must abide by the terms of the Privacy Notice currently in effect. This notice took effect on April 14, 2003. However, the Plan reserves the right to change the terms of its privacy policies as described in this notice at any time, and to make new provisions effective for all health information that the Plan maintains. This includes health information that was previously created or received, not just health information created or received after the policy is changed. If changes are made to the Plan's privacy policies described in this notice, you will be provided with a revised Privacy Notice mailed to your home.

Complaints

If you believe your privacy rights have been violated, you may complain to the Plan and to the Secretary of Health and Human Services. You won't be retaliated against for filing a complaint. To file a complaint, send your complaint to:

Benefits Manager
Stamford Public Schools
Benefits Administration Office
P.O. Box 9310
Stamford CT 06904

Contact

For more information on the Plan's privacy policies or to exercise your rights under HIPAA, contact the Benefits Administration Office at 203-977-4196.