

# 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](http://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](http://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 more of the following criteria apply when the service is rendered with respect to the use for which benefits are sought.

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

1. Cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (“FDA”) or any other state or federal regulatory agency and such final approval has not been granted; or
  2. Has been determined by the FDA to be contraindicated for the specific use; or
  3. Is provided as part of a clinical research protocol or clinical trial or is provided in any other manner that is intended to evaluate the safety, toxicity or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply; or
  4. Is subject to review and approval of an Institutional Review Board (“IRB”) or other body serving a similar function; or
  5. Is provided pursuant to informed consent documents that describe the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply as Experimental or Investigational or otherwise indicate that the safety, toxicity or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply is under evaluation.
- B. Any service not deemed Experimental or Investigational based on the criteria in subsection A. may still be deemed to be Experimental or Investigational by Anthem. 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 cartilage hair hypoplasia, Diamond Blackfan syndrome, Thalassemia, Sickle cell anemia, Primary thrombocytopathy including Glanzmann's syndrome, Gaucher disease, Mucopolysaccharidoses and lipidoses to include Hurler's syndrome, Sanfilippo's syndrome, Maroteaux-Lamy syndrome, Morquio's syndrome, Hunter's syndrome, and metachromatic leukodystrophy
  - All other uses of Allogeneic or Syngeneic Bone Marrow Transplants or other forms of stem cell rescue and stem cell infusion (with or without high dose chemotherapy or radiation) are not covered.
- ▲ 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 an 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](http://www.anthem.com)
- [www.stamfordpublicshools.org](http://www.stamfordpublicshools.org)

### Where do I send a medical claim form?

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