Summary Booklet

for employees of

Town of East Hartford

Vision Plan

INTRODUCTION

This Summary Booklet describes generally this Benefit Program, which is funded by the Town of East Hartford and for which Anthem Blue Cross and Blue Shield performs various administrative services.

This Summary Booklet is a description of the Benefit Program only, it is neither intended to describe any other health benefit plans the Employer Group may offer nor by itself intended to be a summary plan description.

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

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

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

All the defined terms used in this Summary Booklet have the meanings ascribed to them herein without reference to any of the definitions contained in the Administrative Services Only Agreement. The terms of this Summary Booklet shall govern and supersede any previous versions of this Summary Booklet and any outlines or other summaries distributed by the Employer Group or Anthem BCBS with respect to the Benefit Program.

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

None of Anthem BCBS’s employees or the providers with whom it contracts with to make medical management decisions are paid or provided incentives to deny or withhold benefits for services that are

Medically Necessary and are otherwise covered under the Plan. In addition, Anthem BCBS requires certain members of our clinical staff to sign an annual statement. This statement verifies that they are not receiving payments that would either encourage or reward them for denying benefits for services that are Medically Necessary and are otherwise covered under the Plan.

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

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

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

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

TABLE OF CONTENTS

SCHEDULE OF ELIGIBILITY

SUBSCRIBER AND SPOUSE/CIVIL UNION PARTNER ONLY

SCHEDULE OF VISION CARE BENEFITS

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

a. All Covered Services and benefits are subject to the conditions, exclusion, limitations, terms and provisions of this Summary Booklet, including any attachments and riders.

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

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

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

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

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

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

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

VISION EXAMINATION

A complete eye examination with or without refraction and prescription of lenses if needed

With dilation of pupils (cycloplegia) and post-cycloplegic visit, if required	$50.00
Without cycloplegia	$50.00
Maximum: per Covered Person per Calendar Year	$50.00

Prescribed Lenses and Frames - Maximum Allowable Amount for Participating Physicians or Participating Providers

Frames for prescription lenses	$28.00
Prescription lenses:	
Single vision	$33.50
Bifocal	$52.00
Trifocal	$84.00
Contact lenses when used to correct visual acuity to 20/70 or when Medically Necessary	$225.00
Contact lenses when used for any other reason, equivalent to amount payable for single vision lenses	$33.50

NOTE: Pre-existing conditions, if applicable, will not apply to Vision Care benefits.

DEFINITIONS

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

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

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

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

Civil Union: The term Civil Union means a union of two same sex individuals pursuant to Public Act 05-10, An Act Concerning Civil Unions,)the "Act") or any other similarly drafted statutory enactment of a foreign state containing terms and provisions similar in form and substance as those contained in the Act as determined by Anthem BCBS in its sole discretion.

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

Covered Employee: The term Covered Employee means an Eligible Person as defined in the Eligibility Section and in whose name an identification card is issued.

Covered Person: The term Covered Person means either a Covered Employee or a Dependent.

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

a. Medically Necessary or otherwise specifically included as a benefit under this Summary Booklet;
b. Within the scope of the license of the Provider performing the service;
c. Rendered while coverage under this Summary Booklet is in force;
d. Not Experimental or Investigational or otherwise excluded or limited by the Summary Booklet;
e. Authorized in advance by Anthem BCBS if such preauthorization is required under the Summary Booklet.

Creditable Coverage - (Proof of prior coverage): The term Creditable Coverage means health coverage provided through an individual policy, a self-funded or fully insured group health plan offered by a public

or private employer, Medicare, Medical Assistance, General Assistance Medical Care, the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), Federal Employees Health Benefit Plan (FEHBP), Medical Care Program of the Indian Health Service of a tribal organization, a state health benefit risk pool, s State Children's Health Insurance Program (S-CHIP), a qualified Public Health Plan or a Peace Corp health plan.

Dependent: The term Dependent means an Eligible Spouse of a Covered Employee or a party to a Civil Union as specified in the Schedule of Eligibility.

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

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

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 BCBS determines in its sole discretion to be Experimental or Investigational.

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

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

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

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

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

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

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

B. Any service not deemed Experimental or Investigational based on the criteria in subsection A. may still be deemed to be Experimental or Investigational by Anthem BCBS. In determining whether a

service is Experimental or Investigational, Anthem BCBS will consider the information described in subsection C. and assess the following:

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

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

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

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

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

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

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

3. Documents issued by and/or 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 BCBS 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.

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

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

1. Participating Physicians and Participating Providers: Except as otherwise provided by law, an amount agreed upon by Anthem BCBS and a Participating Physician and Participating Provider as full compensation for Covered Services provided to a Covered Person. When applicable, it is the Covered Person's obligation to pay Cost-Shares as a component of this Maximum Allowable Amount. The amount Anthem BCBS will pay on behalf of Employer for Covered Services will be the Maximum Allowable Amount or the billed charges, whichever is lower.

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

   It is the Covered Person's obligation to pay Cost-Shares as a component of this Maximum Allowable Amount and amounts in excess of the Maximum Allowable Amount.

3. Participating Hospital: Except as otherwise required by law, an amount which a Participating Hospital accepts as full compensation for Covered Services provided to a Covered Person. When applicable, it is the Covered Person's obligation to pay Cost-Shares as a component of this Maximum Allowable Amount.

4. Non-Participating Hospital: Except as otherwise required by law, an amount negotiated with a Non-Participating Hospital for Covered Services provided to a Covered Person, or in the absence of a negotiated amount, a Non-Participating Hospital's charge reduced by Cost-Shares for the Covered Services. It is the Covered Person's obligation to pay Cost-Shares and amounts 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 Service.

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

5. When Covered Services are rendered outside of Connecticut by Non-Participating Physicians, Non-Participating Providers and/or Non-Participating Hospitals, the Covered Person's Cost-Share obligations may be calculated based upon one of the following (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.

   When Covered Services are rendered outside of Connecticut to a Covered Person by a Physician, Provider or Hospital participating in the BlueCard Program, the Maximum Allowable Amount shall be determined by the Blue Cross and/or Blue Shield Plan in that area outside of Connecticut.

   The Maximum Allowable Amount may be:

   1. 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 BCBS (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. The negotiated price, which can include an estimated price or average discount off charges that factors in settlements or other non-claims transactions for all providers (physicians, hospitals, other providers) or for a specific group of providers (physicians, hospitals, other providers) that the Blue Cross and/or Blue Shield Plan passes on to Anthem BCBS. Such estimated prices or average discounts may be prospectively adjusted to correct for over or underestimation of prices or discounts applicable to BlueCard Program claims. There will be no retrospective adjustment or return of funds to the Covered Person.

In addition, that Blue Cross and/or Blue Shield Plan will be calculating the Cost-Share obligation (i.e. Coinsurance) amount for those Covered Services.

   There may be a small number of states where state law may 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. The Cost-Share obligation will be based on those statutory provisions, as applicable.

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

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

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

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

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

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

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

7. Not Experimental or Investigational;

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

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

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

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

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

Physician, Doctor: The term Physician or Doctor 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./Psy.D.) who is licensed to practice in the state in which services are rendered. For the purpose of C.G.S. 38a-526, the term Physician, Doctor will also include: licensed physician assistant, certified nurse practitioner, certified psychiatric - mental health clinical nurse specialist or certified nurse midwife.

1. Participating Physician: The term Participating Physician means any appropriately licensed Physician designated and accepted as a Participating Physician by Anthem BCBS to provide Covered Services to Covered Persons under the terms of the Description of Benefits.

2. Non-Participating Physician: The term Non-Participating Physician means any appropriately licensed Physician who is not a Participating Physician under the terms of the Description of Benefits.

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

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

1. 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 BCBS to provide Covered Services to Covered Persons under the terms of the Benefit Program.

2. 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 under the terms of the Benefit Program.

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

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

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

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

ELIGIBILITY

A. ELIGIBLE PERSON An Eligible Person is:

1. a current employee who is employed full time, defined as working at least 35 hours a week on a regularly scheduled basis (unless otherwise mutually agreed upon by Anthem BCBS and the Employer) and who is Actively At Work on the date eligibility for benefits for Covered Services is to be effective, or

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

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

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

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

B. ELIGIBLE DEPENDENT An Eligible Dependent is the lawful spouse of the Eligible Person under a legally valid, existing marriage or a person who has established a Civil Union with the Eligible Person (pursuant to Public Act No. 05-10) and who is deemed eligible under the Benefit Program..

C. INITIAL DATE OF ELIGIBILITY AND EFFECTIVE DATE

1. If an annual open enrollment period is mutually agreed to by Anthem BCBS and the Employer, applications from Eligible Persons and their dependent shall be effective as of the Benefit Program renewal date provided such applications are submitted and accepted by Anthem BCBS in advance of the renewal date. Applications received or accepted after the renewal date shall be considered Late Enrollee.

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

   The initial date of eligibility of newly Eligible Persons and newly Eligible Dependent are as follows:

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

Applications received and accepted by Anthem BCBS prior to the 20th of the month shall be effective the first of the following month. Applications received and accepted by Anthem BCBS between the 21st and the 31st of the month shall be effective the first of the second following month.

(b) New spouses and parties to a Civil Union are initially eligible the first of the month following the date of the marriage of the new spouse to the Eligible Person or the first of the month following the date of the Civil Union.

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

3. A Late Enrollee is an eligible employee or Dependent of an eligible employee who requests coverage more than 31 days after the employee's earliest opportunity to enroll for coverage as determined under applicable eligibility rules, or after the employer group's open enrollment period, unless otherwise agreed upon by Anthem BCBS and the employer group. An eligible employee and/or Dependent shall not be considered a Late Enrollee if a request for membership is made and one of the following conditions is satisfied:

   (a) Coverage was not elected when the employee and/or Dependent was first eligible under this Benefit Program solely because another group health insurance Plan provided coverage for the eligible employee and/or Dependent and coverage is lost under that Plan due to employment termination, death of a spouse or party to a Civil Union, divorce or due to that Plan's involuntary termination or cancellation by its carrier for reasons other than non-payment of premium, and the employee and/or Dependent enrolls under this Benefit Program within 31 days after loss of membership under the other Plan; or

   (b) The eligible employee and/or Dependent is employed by an employer which offers multiple health program options and the employee and/or Dependent elects a different program option during an open enrollment period; or

   (c) A court has ordered coverage be provided for a spouse or party to a Civil Union under the employer group's health care benefits Plan and a request for enrollment is made within 31 days after issuance of such court order; or

   (d) The request for enrollment is made within 31 days after the marriage of the Covered Person

   Proof of such marriage or court order must be provided to Anthem BCBS.

4. The Effective Date of eligibility for benefits for Covered Services for applicants accepted by Anthem BCBS between the 1st and 20th of the current month shall be the first of the next month. The Effective Date of eligibility for benefits for Covered Services for applicants accepted by Anthem BCBS between the 21st and the 31st of the current month shall be the first of the second following month.

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

D. ELIGIBILITY REQUIREMENTS

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

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

3. C.G.S. Section 38a-541 requires that when both the Eligible Person and spouse or party to a Civil Union are employed by the same employer and by reason of employment both participate in the group insurance plan, the benefits described in this Description of Benefits will be available to each spouse or party to the Civil Union, both as a dependent and as an employee. In no event shall benefits provided under this Benefit Program exceed 100% of charges for covered expenses or services.

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

5. Anthem BCBS has the right to terminate this Benefit Program pursuant to Section: General Provisions, Subsection D. 1. if the Employer at any time does not meet the Eligibility Requirements specified in paragraph D.1. above.

VISION CARE BENEFITS

Subject to the Exclusions, Conditions and Limitations, and Schedules of Eligibility and Benefits of this Description of Benefits, a Covered Person is entitled to benefits for Covered Services as described in this Vision Care Benefits Section for Medically Necessary Care when prescribed or ordered by a Physician.

A. DEFINITIONS

In addition to the defined terms listed in the Definitions Section of this Description of Benefits, the following also apply to this Vision Care Benefits Section:

Full Payment: The term Full Payment means that feature which provides payment of the Maximum Allowable Amount on behalf of Employer for Covered Services performed by a Participating Physician or a Participating Provider.

B. COVERED VISION CARE SERVICES

1. Vision Examination

Benefits for Covered Services will be made for Eye Examinations and Optical Services as follows:

A complete eye examination with or without refraction and prescription of lenses if needed. Includes initiation of indicated diagnostic and treatment programs and verification of lenses if prescribed:

With dilation of pupils (cycloplegia)
and post-cycloplegic visit if required. . . . . .See Schedule of Benefits

Without cycloplegia. . . . . .See Schedule of Benefits

Maximum: per Covered Person per Calendar Year . . . . . .See Schedule of Benefits

The Covered Person is guaranteed the Full Payment benefits of this Vision Examination Section only when the services are rendered by a Participating Physician or a Participating Provider.

2. Prescribed Lenses and Frames

Lenses and frames, consisting of lenses (including contact lenses subject to the Limitations set forth below), frames and services needed to effectuate use, such as: facial measurements, assistance in selection of frames, acquiring proper lenses and frames, fitting and adjustment and aftercare for verification of fitting and lens adjustment, and for maintenance of comfort and efficiency.

Frames for prescription lenses. . . . . .See Schedule of Benefits

Limited to one set per Covered Person per Calendar Year

Prescription lenses of a quality that will conform with standard Z 80 of the American National Standards Institute (per pair).

Limited to one pair per Covered Person per Calendar Year

Single vision. . . . . .See Schedule of Benefits
Bifocal . . . . . .See Schedule of Benefits
Trifocal. . . . . .See Schedule of Benefits
Contact (including fitting, training and life-time warranty).
See Exclusions, Conditions and Limitations. . . . . .See Schedule of Benefits

C. EXCLUSIONS, CONDITIONS AND LIMITATIONS

1. No benefits on behalf of Employer will be provided for:

   a. Services, frames, and lenses required by the employer as a condition of employment or provided through a medical department, clinic, or other similar service provided or maintained by the employer, or provided under any other group coverage furnished by or arranged through any employer;

   b. Contact lenses for cosmetic, convenience or any other purpose except to correct visual acuity to 20/70 in the better eye when eyeglass lenses will not achieve this 20/70 correction or when the Medical Necessity is determined by Anthem BCBS on behalf of Employer;

   c. Sunglasses, tinted glasses or industrial safety glasses unless they are prescription lenses obtained at the option of the Covered Person within the benefits otherwise provided; or

   d. Services rendered after the date the Covered Person ceases to be covered under this Benefit Program except for lenses and frames ordered prior to such termination and delivered within 31 days from such date.

2. The benefits of this section are not payable for any service covered for the Covered Person under the Medical/Surgical Section of this Description of Benefits or Amendment.

EXCLUSIONS, CONDITIONS AND LIMITATIONS

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

B. Except as specifically provided in this Description of Benefits, no benefits will be provided under the Benefit Program for the following:

1. Duplicate Coverage and Other Third Party Liability

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

b. No-Fault: No benefits will be provided for services paid, payable or required to be provided as Basic Reparations Benefits under C.G.S. Section 38a-365(a) or similar benefits under any other No-Fault Automobile Insurance Law.

c. An uninsured motorist will be considered to be self-insured. Anthem BCBS will not be required to extend benefits on behalf of Employer which are required to be provided under any No-Fault Automobile Insurance Law.

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

C. Services Specifically Excluded: Anthem BCBS will provide on behalf of Employer only the benefits which are described in this Description of Benefits. Examples of benefits which are not provided under the Benefit Program include:

1. Charges in excess of the Maximum Allowable Amount.

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

E. No benefits will be provided for any charges for services rendered by a Physician or other Provider to himself or herself or for services rendered to his or her immediate family including parents, spouse and children.

F. No benefits will be provided for services and supplies which are experimental or investigational. Such services or supplies shall include but not be limited to any diagnosis, treatment, procedure, facility, equipment, drugs, drug usage, devices or supplies which are determined in the sole discretion of consultant(s) designated by Anthem BCBS to be experimental or investigational.

G. No benefits will be provided for services and supplies (meaning any treatment, procedure, facility, equipment, drugs, drug usage, devices, or supplies) requiring federal or other governmental agency approval not granted at the time services were rendered.

I. No benefits will be provided for services or procedures which have become obsolete or are no longer medically justified as determined by appropriate medical specialties.

OTHER PROVISIONS

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

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

COORDINATION OF BENEFITS

We consider this Plan primary in all circumstances.

A. RIGHT OF RECOVERY

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

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

GENERAL PROVISIONS

A. BENEFITS TO WHICH COVERED PERSONS ARE ENTITLED

1. Anthem BCBS's sole obligation is to administer on behalf of Employer the benefits specified herein.

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

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

B. RECORDS OF COVERED PERSON ELIGIBILITY AND CHANGES IN COVERED PERSON ELIGIBILITY

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

C. TERMINATION OF COVERED PERSON'S COVERAGE UNDER THE BENEFIT PROGRAM

1. A Dependent spouse will cease to be covered under the Benefit Program upon the first day of the month following a divorce or annulment, except as provided in the Conversion Section.

2. A Dependent party to a Civil Union will cease to be covered under the Benefit Program upon the first day of the month following the dissolution of the Civil Union.

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

4. During the first 2 years following the effective date of this Benefit Program, Anthem BCBS on behalf of the Employer may rescind the Benefit Program, if the Covered Person has provided the Employer or Anthem BCBS with false or misleading data about eligibility, insurability or health status and Anthem BCBS decides material falsification exists.

D. NOTICE OF CLAIM

1. Anthem BCBS will not be obligated to process on behalf of Employer any claim for benefits for Covered Services under the Benefit Program unless proper notice is furnished to Anthem BCBS that Covered Services have been rendered to a Covered Person. Written notice must be given within 60 days after completion of the Covered Services. The notice must include the data necessary for Anthem BCBS to determine benefits. An expense will be considered incurred on the date the service or supply was received.

2. Failure to give notice to Anthem BCBS within the time specified will not reduce any benefit if it is shown that the notice was given as soon as reasonably possible, but in no event will Anthem BCBS be required to accept notice more than two years after Covered Services are received.

E. INFORMATION PRACTICES NOTICE

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

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

F. LIMITATION OF ACTIONS

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

G. PAYMENT OF BENEFITS

1. Anthem BCBS is authorized to make payments on behalf of Employer directly to Physicians, Providers or Hospitals furnishing Covered Services for which benefits are provided under the Benefit Program. However, except as otherwise provided for in any participating agreement, Anthem BCBS reserves the right to make payments on behalf of Employer directly to either the Covered Person or the Covered Employee at Anthem BCBS's discretion.

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

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

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

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

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

6. Whenever Anthem BCBS has made payments for Covered Services on behalf of the Employer either in error or in excess of the Maximum Allowable Amount of payment necessary to satisfy the provisions of the Benefit Program, irrespective of to whom paid, Anthem BCBS has the right on the behalf of the Employer to recover these payments from one or more of the following:

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

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

H. CLAIM DENIALS

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

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

a. whether an internal rule, guideline, protocol or other criterion was relied upon in making the claim decision and that this information is available to the Covered Person upon request and at no charge;
b. that an explanation of the scientific or clinical judgement for a decision based on Medical Necessity, Experimental or Investigational treatment or similar limitation is available to the Covered Person upon request and at no charge.

I. COVERED PERSON/PHYSICIAN/PROVIDER/HOSPITAL RELATIONSHIP

1. The choice of a Physician, Provider or Hospital is solely the Covered Person's.

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

3. The use or non-use of an adjective such as "Participating" or "Non-Participating" in modifying the term Physician, Provider or Hospital is not a statement as to the ability of the Physician, Provider or Hospital.

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

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

J. AGENCY RELATIONSHIPS

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

K. COVERED PERSON APPEAL PROCESS

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

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

This Appeal process applies to any adverse non-utilization review determination (which is considered an adverse post-service claim determination) under this Benefit Program. Non-utilization review determinations concern issues relating to the Covered Person's Benefit Program, such as eligibility for benefits, coverage of claims or claims processing.

Appeal Process for Adverse Non-Utilization Review Determinations

FIRST LEVEL APPEAL

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

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

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

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

SECOND LEVEL APPEAL

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

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

Written Second Level Appeal requests should be mailed to:

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

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

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

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

Other Covered Person Rights

- The Covered Person is entitled to receive upon request and free of charge, reasonable access to, and copies of, any documents, records, and other information relevant to the member's claim for benefits.
- If an internal rule, guideline, protocol, or other similar criterion is relied upon in making the adverse benefit determination, the specific rule, guideline protocol or other similar criterion will be provided to the Covered Person free of charge upon request.
- If the adverse benefit determination is based on a Medical Necessity, or experimental treatment, or other similar exclusion or limit, an explanation of the scientific or clinical judgement for the determination applying the terms of the health benefit plan to the Covered Person's medical circumstances will be provided free of charge upon request.
- If a consultant's advice was obtained in connection with a Covered Person's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination, the consultant will be identified upon request.

Authority for Discretionary Decisions

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

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

L. CONTINUATION OPTIONS

Continuation options will be provided under each of the following circumstances for the period indicated or until the Covered Person becomes eligible for other group insurance, except as otherwise stated in this Section.

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

1. Covered Persons in groups subject to the Consolidated Omnibus Budget Reconciliation Act of 1985, P.L. 99-272(COBRA) may continue membership in this Benefit Program to the extent permitted by law. The Employer is responsible for notifying the Covered Person regarding whether the Employer or Anthem BCBS will be administering the program.
   a. Continuation of coverage for up to 36 months shall be available for an enrolled Dependent following:

      (i) The death of the Covered Person;

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

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

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

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

      (ii) The Covered Person's voluntary resignation;

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

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

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

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

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

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

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

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

CONTINUATION OF COVERAGE DUE TO MILITARY SERVICE

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

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

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

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

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

CONVERSION

Conversion coverage for a vision plan is not available after the termination of this Vision Benefit Program.

M. CERTIFICATES OF CREDITABLE COVERAGE

Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), a certificate of creditable coverage must be issued to a Covered Person and his or her covered Dependent who terminate from this Benefit Program. The information included on the certificate of creditable coverage will include the names of any Covered Persons terminating, the date coverage under this Benefit Program ended, and the type of coverage provided under this Benefit Program. This certificate of creditable coverage will provide a subsequent insurer or group plan with information regarding previous coverage to assist it in determining any Pre-Existing Condition exclusion period or Affiliation Period. This certificate of creditable coverage should be presented by the Covered Person to his or her next employer group and/or when applying for subsequent group health insurance. A certificate of creditable coverage will be issued to terminating Covered Persons 14 days after the date Anthem BCBS is notified of his or her termination. In addition, a terminated Covered Person may request an additional copy of the Certificate of Creditable Coverage by contacting Member Services.