2014
CONNECTICARE INSURANCE COMPANY, INC.
FLEXPOS

SMALL GROUP CERTIFICATE
OF COVERAGE

ConnectiCare Insurance Company, Inc.
175 Scott Swamp Road
Farmington, Connecticut 06032

WELCOME TO CONNECTICARE!

We are one of the highest rated managed care companies for member satisfaction in the area. We're also accredited by the National Committee for Quality Assurance (NCQA). NCQA is a private organization that inspects managed care companies all across the country with the intent of improving the quality of health care and service delivered to people. NCQA awarded us with an "excellent" rating for our commercial plans.

We want to work with you and your doctors to make sure you and your family make the right choices to maximize the coverage available to you under this Plan.

IMPORTANT

Please read the "Managed Care Rules And Guidelines" section to learn this Plan's rules. Understanding the rules of this Plan will help you maximize your coverage. The "Managed Care Rules And Guidelines" section will explain how this Plan operates and whether your Plan requires you to use Participating Providers, as well as whether you need to obtain a Referral or Pre-Authorization before receiving care. In addition, please read the "Exclusions And Limitations" section to find out what isn't covered under this Plan.

Form: CICI/MI FlexPOS 01 SG (1/2014)

Approved for use beginning 2014

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Take a look at the "Managed Care Rules And Guidelines" section to see if you have to use Participating Providers and the "Pre-Authorization And Pre-Certification (Prior Approval) Addendum" to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

IMPORTANT TELEPHONE NUMBERS AND ADDRESSES

Member Services

ConnectiCare
(860) 674-5757 or 1-800-251-7722

TDD/TYY services
1-800-833-8134

Behavioral Health Program (Mental Health Services)
1-888-946-4658

Pre-Authorization or Pre-Certification

ConnectiCare
1-800-562-6833 Utilization management questions can be asked from 8:00 a.m. to 5:00 p.m. Monday through Friday and after hours, you may leave a voicemail message.

Behavioral Health Program (Mental Health Services)
1-888-946-4658

Radiological Services Program (Outpatient diagnostic x-rays and therapeutic procedures)
1-877-607-2363

Submitting Claims to Us from Non-Participating Providers

ConnectiCare (all claims except Behavioral Health Program)
ConnectiCare Claims
PO Box 546
Farmington, Connecticut 06034-0546

Behavioral Health Program (Mental Health Services)
ConnectiCare Claims
OptumHealth Behavioral Solutions/UBH
PO Box 30757
Salt Lake City, Utah 84130-0757

Questions And Complaints

ConnectiCare (all questions and complaints except Behavioral Health Program)
ConnectiCare Member Services
175 Scott Swamp Road
Farmington, Connecticut 06032 or

www.connecticare.com

Behavioral Health Program (Mental Health Services)
OptumHealth Behavioral Solutions/UBH
Attention: Complaints and Appeals Department
1900 E. Golf Road. Suite 200
Schaumburg, Illinois 60173
Fax 1-800-322-9104

Take a look at the "Managed Care Rules And Guidelines" section to see if you have to use Participating Providers and the "Pre-Authorization And Pre-Certification (Prior Approval) Addendum" to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

INTRODUCTION

ConnectiCare is committed to making this Plan work for you. If you speak a foreign language, translation and interpretation services are available to assist you with understanding this Plan. You may obtain interpreter services for verbal communications with us by calling (860) 674-5757 or 1-800-251-7722.

Hay servicios de traducción y de interpretación disponibles para ayudarlo a entender este Plan. Usted puede obtener el servicio de un intérprete para comunicaciones verbales con nosotros llamando al (860) 674-5757 o al 1-800-251-7722.

Des services de traduction et d'interprétation sont disponibles pour vous aider à comprendre ce Plan. Vous pouvez obtenir des services d'interprétation pour les communications verbales avec nous en composant le (860) 674-5757 ou le 1-800-251-7722.

I servizi di traduzione e interpretariato sono disponibili per assistervi nella comprensione di questo Piano. È possibile ottenere servizi di interpretariato per comunicazioni verbali con noi chiamando l'(860) 674-5757 o l'1-800-251-7722.

Serviços de tradução e interpretação estão disponíveis para auxilia-lo na compreensão deste Plano. Você pode obter serviços de interprete para comunicação conosco, telefonando para (860) 674-5757 ou 1-800-251-7722.

Παρέχονται υπηρεσίες μεταφράσεων και διερμηνείας για να σας βοηθήσουν να κατανοήσετε αυτό το Πρόγραμμα. Μπορείτε να ζητήσετε υπηρεσίες διερμηνείας για την προφορική επικοινωνία μαζί μας καλώντας το (860) 674-5757 ή το 1-800-251-7722.

我们提供翻译及传译服务，助你明白这计划。请致电(860)674-5757 或 1-800-251-7722 查询有关与我们沟通的传译服务详情。

إن خدمة الترجمة الكتابية والشفهية الفورية متوفرة لمساعدتكم في فهم هذه الخطة. يمكنكم الحصول على خدمة الترجمة الشفهية الفورية للتكلم معنا باتصالكم بالرقم ٥٧٥٧-٦٧٤(٨٦٠) أو ٧٢٢٢-٢٥١-٨٠٠-١.

អ្នកអាចទទួលកិច្ចការបកប្រែ ដើម្បីជួយអ្នកឲ្យចាយយល់ពីគំរោងនេះ ។ សម្រាប់ការប្រាស្រ័យទាក់ទងផ្ទាល់និងមាត់ ដោយទូរស័ព្ទមកយើងតាមលេខ (860) 674-5757 ឬក៏តាមលេខ 1-800-251-7722 ។

Ou kapab jwenn sèvis tradiksyon ak entèpretasyon pou ede w konprann Plan sa a. Si w bezwen yon entèprèt pou ede w nan kominikasyon pale, telefone nou nan nimewo (860) 674-5757 oswa 1-800-251-7722.

ມີບໍລິການແປໜັງສືແລະບໍລິການນາຍພາສາໄວ້ ເພື່ອຊ່ວຍທ່ານເຂົ້າໃຈແຜນການນີ້. ທ່ານອາດສາມາດຮັບການບໍລິການນາຍພາສາສຳຫລັບການຕິດຕໍ່ສື່ສານໂດຍຄຳປາກນຳເຮົາໄດ້ ໂດຍໂທໄປຍັງໝາຍເລກ (860) 674-5757 ຫລື 1-800-251-7722.

Для лучшего понимания настоящего Плана, вы можете пользоваться нашими услугами по письменному и устному переводу. Для получения помощи в общении с нами вы можете воспользоваться услугами нашего переводчика если вы позвоните по телефону (860) 674-5757 или 1-800-251-7722.

זמינים לרשותך שירותי תרגום ופרשנות שיעזרו לך בהבנת התוכנית.
באפשרותך להשיג שירותי פרשנות לצורכי תקשורת מילולית איתנו ע"י
חיוג מס' טל' 674-5757 (860) או1-800-251-7722.

Aby ułatwić Państwu zrozumienie Planu, zapewniamy pomoc tłumacza. Pomoc naszego tłumacza ustnego uzyskać można, telefonując na numer (860) 674-5757 lub 1-800-251-7722.

Take a look at the "Managed Care Rules And Guidelines" section to see if you have to use Participating Providers and the "Pre-Authorization And Pre-Certification (Prior Approval) Addendum" to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

MEMBERS' RIGHTS AND RESPONSIBILITIES

YOUR RIGHTS

You have a right to:

- ♥ Receive information about us, our services, our Participating Providers, and **Member's Rights and Responsibilities**.
- ♥ Be treated with respect and recognition of your dignity and right to privacy.
- ♥ Participate with practitioners in decision-making regarding your health care.
- ♥ A candid discussion of appropriate or Medically Necessary treatment options for your condition, regardless of cost or benefit coverage.
- ♥ Refuse treatment and to receive information regarding the consequences of such action.
- ♥ Voice complaints or Appeals/Grievances about us or the care you are provided.
- ♥ Make recommendations regarding our **Member's Rights and Responsibilities** policies.

YOUR RESPONSIBILITIES

You have a responsibility to:

- ♥ Select a Primary Care Provider (PCP).
- ♥ Provide, to the extent possible, information providers need to render care and we need to provide coverage.
- ♥ Follow the plans and instructions for care that you have agreed on with practitioners.
- ♥ Keep scheduled appointments or give sufficient advance notice of cancellation.
- ♥ Pay applicable Copayments, Deductibles or Coinsurance.
- ♥ Follow the rules of this Plan, and assume financial responsibility for not following the rules.
- ♥ Understand your health problems and participate in developing mutually agreed upon treatment goals to the degree possible.
- ♥ Be considerate of our providers, and their staff and property, and respect the rights of other patients.
- ♥ Be considerate of our employees by treating them with respect and dignity.
- ♥ Read this document describing this Plan's benefits and rules.

Take a look at the "Managed Care Rules And Guidelines" section to see if you have to use Participating Providers and the "Pre-Authorization And Pre-Certification (Prior Approval) Addendum" to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

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CERTIFICATE OF COVERAGE

This Certificate Of Coverage is our contract. You and your Eligible Dependents must follow its terms and conditions to obtain benefits for health care services.

Please read your Benefit Summary for details regarding particular features of your Plan, such as Coinsurance, Deductibles, exclusions and limitations.

When we refer to words like "we" or "us," we mean ConnectiCare. When we refer to "you," we mean you, the Subscriber. Words in this document that are in "Upper Case" have special meaning. You can find their meaning in the "Definitions" section.

This document replaces any agreement, contract, policy or program of the same coverage that we may have issued to you prior to the date we issued this document.

CONNECTICARE ID CARD

Always carry your ConnectiCare ID Card and present it whenever you receive services at the doctor's office, in an emergency room or Urgent Care Center, or at any other health care facility. If you receive pharmacy benefits through ConnectiCare, you should use your ID card when you receive prescriptions at Participating Pharmacies.

If you call or write our Member Services Department, give the representative your ID number, so that we can serve you better.

If you lose your ConnectiCare ID card, contact our Member Services Department or visit our web site at www.connecticare.com to request a replacement.

COVERAGE

You are responsible for providing to us information about yourself and your dependents that is complete, accurate and true to the best of your knowledge and belief. Coverage is being provided to you under this Plan on the basis of the information that you have provided to us. In the event that there is a change in the name(s), address, telephone number(s) or email address(es) that you have provided to us, you are responsible for telling us as soon as possible about the change(s).

EFFECTIVE DATE OF COVERAGE

This Plan takes effect for you and your Eligible Dependents on the date detailed in your Employer's eligibility rules.

Coverage For Member Inpatient At The Time Of Coverage

If you or one of your Eligible Dependents are/is sick or injured, and are/is in a Hospital, Hospice, Skilled Nursing Facility, Rehabilitation Facility or Residential Treatment Facility at the time coverage under this Plan begins, this Plan will not cover the costs of that inpatient stay if another insurance company is supposed to pay for those costs.

ELIGIBILITY AND ENROLLMENT

ELIGIBILITY RULES: HMO PLAN

1. You, the Employee, must live or work in the Service Area; must work full-time for your Employer (or part-time, if allowed by your Employer); and must be able to sign up under your Employer's health insurance coverage rules, including having to satisfy any waiting period.

   If you work for an Employer with 50 or fewer employees, and most of them work in Connecticut, you do not have to work in the Service Area to be covered under this Plan.

2. You and your spouse/partner must have a legally valid existing marriage license or valid existing civil union, as applicable, as accepted by the State of Connecticut, and your spouse/partner must live with you or in the Service Area.

3. Your child may be eligible for coverage under this Plan until the end of the last day of this Plan's Contract Year that is after his/her 26th birthday as long as his/her birthday is not the same day as the first day of the Contract Year. If you child's 26th birthday is the first day of this Plan's Contract Year, eligibility for coverage will end on that day.

   The following rules apply to children:

   - **Natural Children**. Your natural children can be covered.
   - **Adopted Children**. Children legally adopted by you can be covered if they meet the rules for natural children once the adoption is final. Before the adoption becomes final, a child can be signed up for coverage when you become legally responsible for at least partial support for the child.
   - **Step-Children**. Your step-children who are the natural or adopted children of your spouse/partner, or children for whom your spouse/partner is appointed legal guardian, can be covered.
   - **Guardianship**. Children for whom you are appointed the legal guardian can be covered.
   - **Handicapped Children**. To continue to be covered beyond the allowable age for dependent children, the child must:
     - Live in the Service Area; and
     - Be unable to support himself/herself by working because of a mental or physical handicap, as certified by the child's physician; and
     - Be dependent on you or your spouse/partner for support and care because he/she has a mental or physical handicap; and
     - Have become handicapped and must have always been handicapped while he/she would have been

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able to be signed up for dependent children coverage if he/she were not disabled.

Proof of the handicap and the child's financial dependence must be given to us within 31 days of the date when the child's coverage would end under another insurer's plan, or when you enrolled under this Plan if the handicap existed before you enrolled for coverage under this Plan. You must give us proof that the child's handicap and financial dependence continue if we ask for such proof. We will not ask for proof more than once a year.

- ♥ **Qualified Medical Child Support Orders**. Special rules apply when a court issues a QMCSO requiring you to provide health insurance for your child. Your Employer decides whether you may sign up the child because of this QMCSO, and we will follow your Employer's decision. We will not require that your child live with you or in the Service Area in order to be covered under this Plan.

4. You and your Eligible Dependents are no longer eligible for coverage if you are away from the Service Area for more than 180 days, even if you still live or work in the Service Area.
5. Plan Benefits for care received outside the Service Area are very limited. Coverage is only for Emergencies and Urgent Care.

ELIGIBILITY RULES: POINT OF SERVICE (POS) PLAN

If you are signed up in one of our POS Plans, you and your Eligible Dependents do not have to live or work in the Service Area to be eligible for coverage.

1. You, the Employee, must work full-time for your Employer (or part-time, if allowed by your Employer); and must be able to sign up under your Employer's health insurance coverage rules, including having to satisfy any waiting period.

   If you work for an Employer with 50 or fewer employees, and most of them work in Connecticut, you do not have to work in the Service area to be covered under this Plan.
2. You and your spouse/partner must have a legally valid existing marriage license or valid existing civil union, as applicable, as accepted by the State of Connecticut and your spouse/partner must live with you.
3. Your child may be eligible for coverage under this Plan until the end of the last day of this Plan's Contract Year that is after his/her 26th birthday as long as his/her birthday is not the same day as the first day of the Contract Year. If your child's 26th birthday is the first day of this Plan's Contract Year, eligibility for coverage will end on that day.

The following rules apply to children:

- ♥ **Natural Children**. Your natural children can be covered.
- ♥ **Adopted Children**. Children legally adopted by you can be covered if they meet the rules for natural children once the adoption is final. Before the adoption becomes final, a child can be signed up for coverage when you become legally responsible for at least partial support for the child.
- ♥ **Step-Children**. Your step-children who are the natural or adopted children of your spouse/partner, or children for whom your spouse/partner is appointed legal guardian, can be covered.
- ♥ **Guardianship**. Children for whom you are appointed the legal guardian can be covered.
- ♥ **Handicapped Children**. To continue to be covered beyond the allowable age for dependent children, the child must:
  - ◆ Be unable to support himself/herself by working because of a mental or physical handicap, as certified by the child's physician; and
  - ◆ Be dependent on you or your spouse/partner for support and care because he/she has a mental or physical handicap; and
  - ◆ Have become handicapped and must have always been handicapped while he/she would have been able to be signed up for dependent children coverage if he/she were not disabled.

  Proof of the handicap and the child's financial dependence must be given to us within 31 days of the date when the child's coverage would end under another insurer's plan, or when you enrolled under this Plan if the handicap existed before you enrolled for coverage under this Plan. You must give us proof that the child's handicap and financial dependence continue if we ask for such proof. We will not ask for proof more than once a year.
- ♥ **Qualified Medical Child Support Orders**. Special rules apply when a court issues a QMCSO requiring you to provide health insurance for your child. Your Employer decides whether you may sign up the child because of this QMCSO, and we will follow your Employer's decision. Your child does not have to live with you or in the Service Area in order to be covered under this Plan.

ADDING DEPENDENTS

HMO Or Point of Service (POS) Plans

Adding a Spouse/Partner. You must add your spouse/partner to a Plan within 31 days of the marriage or civil union to be effective on the date of the marriage or civil union. Otherwise, you must wait until the next Annual Enrollment Period to add your spouse/partner to this Plan.

Take a look at the "Managed Care Rules And Guidelines" section to see if you have to use Participating Providers and the "Pre-Authorization And Pre-Certification (Prior Approval) Addendum" to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

If your marriage or civil union ends, you must tell us immediately, in writing and on a form acceptable to us.

When coverage for your spouse/partner ends under a group Plan, he/she can sign up himself/herself, as well as his/her children, for group coverage continuation as allowed under Connecticut law.

Adding a Child. The newborn natural child of you and your covered spouse/partner receives coverage for the first 61 days after birth. Coverage for the child will end on the day your coverage ends or at the end of this 61-day period, unless you have sent us a notice to sign up the child and paid any additional Premium, if required. If the newborn natural child is not signed up under this Plan within 61 days of the child's birth, any services provided to that child after the 61-day period are not covered, and you must wait until the next Annual Enrollment Period or Special Enrollment Period to sign up the child under this Plan.

If your daughter is covered under this Plan, her newborn child can receive coverage **ONLY** for the first 61 days after the child's birth, unless you or your covered spouse/partner becomes the child's legal guardian and you are signed up under this Plan.

A newly adopted child must be signed up within 61 days of the date of the adoption. We may require health underwriting for a child legally placed for adoption if any Premium and/or completed Enrollment Forms, as required, is/are not received by us within this 61-day period. If the newly adopted child is not signed up within this 61-day period, you must wait until the next Annual Enrollment Period or Special Enrollment Period to sign up the child under this Plan.

A child for whom you or your spouse/partner become(s) the legal guardian must be signed up within 61 days of the date on which you or your spouse/partner become(s) at least partially legally responsible for the adopted child's support and care. If the child is not signed up within this 61-day period, you must wait until the next Annual Enrollment Period or Special Enrollment Period to sign up the child under this Plan.

A step-child must be signed up within 61 days of the date of your marriage to or civil union with the step-child's parent or the date on which you become the legal guardian of the step-child. If the step-child is not signed up within this 61-day period, you must wait until the next Annual Enrollment Period or Special Enrollment Period to sign up the step-child under this Plan.

CHANGES AFFECTING ELIGIBILITY

You must tell us right away about any change that may affect you or your dependents covered under this Plan. Examples of such changes are:

- ♥ Marriage
- ♥ Divorce or end of civil union
- ♥ Birth of your child or of a child of your daughter
- ♥ Dependent child getting coverage as an employee under a group health plan
- ♥ Child reaching maximum age limit for coverage under this Plan
- ♥ Change of home address or of work location
- ♥ Your employment ends or you have a reduction in work hours
- ♥ Loss of eligibility for other reasons specified in this document

Changes should be indicated on an Enrollment Form, which you can obtain from your Employer or at our web site at www.connecticare.com. You should return the Enrollment Form to your Employer, even if what you pay for coverage does not change.

SPECIAL ENROLLMENT PERIOD

End of Other Group Health Insurance Coverage. You may be able to sign up yourself or your dependent(s) for coverage under this Plan if you ask to sign up within 31 days after the date on which your or your dependent's other group health insurance coverage ends.

For you or a dependent to qualify for coverage during this Special Enrollment Period, the other group health insurance coverage must have been lost because COBRA benefits ended, non-COBRA coverage ended due to loss of eligibility for coverage or employer contributions for the coverage ended.

Life Event. You must sign up for coverage under this Plan within 31 days of the Life Event for coverage to become effective. The effective date of coverage depends on the Life Event that triggers this Special Enrollment Period.

- ♥ **Marriage** - You can sign up for coverage for: you alone; for you and your spouse/civil partner; or for you, your spouse civil partner and any Eligible Dependent(s) acquired through the marriage or civil union. Coverage starts no later than the first day of the first calendar month beginning after the day we receive the completed Enrollment Form.
- ♥ **Birth of a Child** - You can sign up for coverage for: you alone; for you and your spouse/civil partner; for you and the new baby; or for you, your spouse/civil partner and the new baby. Coverage starts the day of the baby's birth.
- ♥ **Adoption/Placement of Adoption of a Child** - You can sign up for coverage for: you alone; for you and your spouse/civil partner; for you and the newly adopted or placed child; or for you, your spouse/civil partner and the newly adopted or placed child. Coverage starts the day of the adoption or placement for adoption of the child.

Take a look at the "Managed Care Rules And Guidelines" section to see if you have to use Participating Providers and the "Pre-Authorization And Pre-Certification (Prior Approval) Addendum" to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

Medicaid or Children's Health Insurance Program (CHIP). If you, your spouse/civil partner or your child(ren) should lose eligibility for coverage under a state Medicaid or Children's Health Insurance Program (CHIP), you may sign up yourself, your spouse/civil partner and your child(ren) in this Plan as long as you ask to sign up within 60 days after the date Medicaid or CHIP coverage ends.

If you, your spouse/civil partner or your child(ren) should become eligible for health plan premium help under a state Medicaid or Children's Health Insurance Program (CHIP) plan, you may sign up yourself, your spouse/civil partner and your child(ren) in this Plan as long as you ask to sign up within 60 days after the day you are eligible for health plan premium help under Medicaid or CHIP.

MANAGED CARE RULES AND GUIDELINES

SELECTION OF A PRIMARY CARE PROVIDER (PCP)

Each Member should pick a PCP for routine physicals and to help when you are ill or need follow-up care after you receive Emergency Services.

Each Member can pick a different PCP.

If a Member does not pick a PCP at enrollment, we will pick one. We will tell you after we make that PCP selection.

A Member can change PCPs at any time by calling or writing our Member Services Department or by visiting us at our web site at www.connecticare.com.

If your current PCP leaves our network or will no longer treat patients at a certain office where you may have received care, we will tell you about that change 30 days before it happens, if possible, or as soon as possible after we become aware of the change. You will then have to pick a new PCP.

WHEN YOU NEED SPECIALIZED CARE

Members **ARE NOT** required to get a pre-approval (referral) to see a specialist.

When you or your Eligible Dependents are seeing a Specialist Physician regularly and that Specialist Physician is no longer participating with us as a part of our network, we will tell you about that change 30 days before it happens, if possible, or as soon as possible after we become aware of the change. Please call your PCP or check our Provider Directory for help in selecting a new Specialist Physician.

SERVICES REQUIRING PRE-AUTHORIZATION OR PRE-CERTIFICATION

The Pre-Authorization Or Pre-Certification Process

When Being Treated By A Participating Provider

Participating Providers or Network Providers must get Pre-Authorization or Pre-Certification of certain services, supplies or drugs when they are treating a Member before the Member gets that service, supply or drug.

When Being Treated By A Non-Participating Provider

If a Member is being treated by a Non-Participating Provider, the Non-Participating Provider will often times send us a request for Pre-Authorization or Pre-Certification for those services, supplies or drugs that need it, **BUT IT IS YOUR RESPONSIBILITY TO MAKE SURE THAT WE HAVE GIVEN PRE-AUTHORIZATION OR PRE-CERTIFICATION BEFORE THE SERVICES HAVE BEEN RENDERED.**

You must call the appropriate telephone number listed in the "Important Telephone Numbers and Addresses" subsection of the "Important Information" section to request Pre-Authorization or Pre-Certification.

You can find the list of Health Services, including prescription drugs that need Pre-Certification or Pre-Authorization at the back of this document.

Changes To The Pre-Authorization Or Pre-Certification Lists

Our Pre-Authorization or Pre-Certification lists may change at any time. Read the member newsletter to learn about the changes. You can also contact our Member Services Department or visit our web site at www.connecticare.com.

When Pre-Authorization Or Pre-Certification Is Denied

No benefits will be provided under this Plan if you or your Eligible Dependents receive services or supplies after Pre-Authorization or Pre-Certification has been denied.

If you fail to comply with the Pre-Authorization or Pre-Certification requirements of this Plan, there will be a Benefit Reduction or, in some cases, a denial of benefits. The only time this won't happen is in those instances where we say it is the responsibility of the Participating Provider or Network Provider to request Pre-Authorization or Pre-Certification. In those instances, benefits will not be reduced or denied if the provider fails to request Pre-Authorization or Pre-Certification.

If you receive an explanation of benefits stating a claim was denied where it was the responsibility of the Participating Provider or Network Provider to request the applicable Pre-Authorization or Pre-Certification (pre-approval), you should contact our Member Services Department, so we can help you resolve the issue.

Benefit Reduction

As mentioned, **when you use Non-Participating Providers to order, arrange, or provide your care, IT IS YOUR RESPONSIBILITY TO OBTAIN PRE-AUTHORIZATION OR PRE-CERTIFICATION** for the services or your benefits will be reduced or denied.

Take a look at the "Managed Care Rules And Guidelines" section to see if you have to use Participating Providers and the "Pre-Authorization And Pre-Certification (Prior Approval) Addendum" to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

Your benefits will be denied if the services you or your Eligible Dependents obtained without Pre-Authorization or Pre-Certification were not Medically Necessary or were not covered by this Plan.

If the services you obtained without the Pre-Authorization or Pre-Certification were Medically Necessary and otherwise covered by this Plan, then your benefits will be reduced as described below. We call this a "Benefit Reduction".

Benefit Reduction Amounts

When a Non-Participating Provider arranges an admission to a Hospital or other facility for you or your Eligible Dependents, or any of the services or supplies listed in the "Services Requiring Pre-Certification Or Pre-Authorization" addendum are rendered by a Non-Participating Provider, coverage for that admission and/or those services or supplies will be reduced as follows if you did not obtain Pre-Certification or Pre-Authorization:

- ♥ The lesser of $500 or 50% of the Maximum Allowable Amount we will pay per admission and/or service or supply, as applicable.

Note: These Benefit Reductions are in addition to the benefits that would normally be paid if proper Pre-Certification or Pre-Authorization was obtained. Benefit Reductions do not apply to Emergency Services.

Benefit Reductions apply to the Out-Of-Network Level Of Benefits. All Benefit Reductions are your financial responsibility.

Benefit Reduction Exception

If you or your Eligible Dependents are admitted to a Participating Hospital or other facility that is a Participating Provider or Network Provider by a doctor that is a Non-Participating Physician, you will not be responsible for the Benefit Reduction if you failed to obtain Pre-Certification for that admission, as long as that admission was Medically Necessary. The Benefit Reductions are in addition to the benefits that would normally be paid if proper Pre-Authorization was obtained. Benefit Reductions do not apply to Emergency Services.

Expedited Review For Pre-Authorization Or Pre-Certification

When a doctor must obtain Pre-Authorization or Pre-Certification for a Hospital stay or for a health care treatment while a Member is sick or injured and in the Hospital, the doctor may request an "Expedited Review" of the doctor's request in the following circumstances.

1. You must already be admitted to a Participating Hospital and your physician must have determined your life will be endangered or that other serious injury or illness could occur if you are discharged from the Hospital or if the treatment in question is delayed.
2. Your attending physician must make a request for an Expedited Review by telephoning the appropriate number designated for Expedited Reviews. If your doctor is unable to make contact by calling that number, he/she may leave a voice-mail message at the designated alternative number(s).
3. If no additional information is required than what your doctor provided with his/her request for the Expedited Review, a decision will be made within three hours from the time the initial request was made. If this three-hour deadline is not met, the Expedited Review request will be deemed approved.
4. If additional information is requested to make a decision that decision will be made within three hours from the time all the necessary additional information was sent to complete the review. If this three-hour deadline is not met, the Expedited Review request will be deemed approved.
5. If the Expedited Review request is approved on the initial telephone call, an authorization number will be given.
6. If the Expedited Review request is not approved, you and your physician will have the Appeal/Grievance process available to you, as described in this document.
7. Your attending physician must provide at least two methods of communication for responding to his/her request.
8. Reviewing staff will be available from 8:00 a.m. to 9:00 p.m. to process Expedited Review requests.
9. The three-hour time period will not apply to Expedited Review requests initiated between 6:00 p.m. and 8:00 a.m.

USING PARTICIPATING PROVIDERS AND NON-PARTICIPATING PROVIDERS

Terms You Should Know:

The **Network Access Area** consists of the geographical area consisting of the State of Connecticut and Hampden, Hampshire, and Franklin counties in Massachusetts.

A **Participating Provider** is a provider or facility who has a contract to provide health care services in the Network Access Area and is listed in our current Provider Directory. Certain other providers or facilities who are contracted with us or our affiliates or subcontractors to provide health care services in areas near the Network Access Area are also Participating Providers.

A **Network Provider** is a provider or facility who has a contract to provide health care services through a designated network vendor outside the Network Access Area.

The In-Network Level Of Benefits

In order to obtain the higher level of benefits available under this Plan, you and your Eligible Dependents need to use the In-Network Level of Benefits option of this Plan.

Here is how you and your Eligible Dependents obtain the In-Network Level Of Benefits.

Take a look at the "Managed Care Rules And Guidelines" section to see if you have to use Participating Providers and the "Pre-Authorization And Pre-Certification (Prior Approval) Addendum" to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

If You Are In The Network Access Area

Using Participating Providers

When a Member uses Participating Providers to order, arrange and provide care when he or she is in the Network Access Area, that Member will be eligible for the higher level of benefits under this Plan. This is called the In-Network Level Of Benefits. The amount of these benefit levels is listed on your Benefit Summary.

To locate a Participating Provider, Members can refer to our Provider Directory, visit us at our web site at www.connecticare.com, or call us.

IMPORTANT: Except in a few VERY LIMITED CIRCUMSTANCES, ALL health care services and supplies must be ordered, rendered and supplied by a Participating Provider when you are in the Network Access Area, or the service or supply will not be covered at the In-Network Level Of Benefits, even if you use a Network Provider or you believe that a Non-Participating Provider is a "better" doctor.

If You Are Out Of The Network Access Area

Using Network Providers

When a Member uses Network Providers when he or she out of the Network Access Area, that Member will also be eligible for a higher level of benefits under this Plan. This is, again, the In-Network Level Of Benefits. The amount of these benefit levels is listed on your Benefit Summary.

To locate a Network Provider, you can refer to the back of your ID Card. Information will be there for you to identify the Network Provider vendor and for instructions on obtaining a list of Network Providers. You can also visit us at our web site at www.connecticare.com, or call us.

Tip: In order to maximize the benefits provided to you under this Plan, think of using Network Providers only if you reside or are traveling are out of the Network Access Area.

Exceptions When You Still Receive The In-Network Level Of Benefits

When a Member obtains care for an Emergency or Urgent Care, he or she always obtains the In-Network Level Of Benefits.

In addition, in very limited circumstances, if we determine Medically Necessary services are not reasonably available from a Participating Provider (or a Network Provider when you are outside of the Network Access Area); you can obtain the In-Network Level Of Benefits for care received from a Non-Participating Provider. But to do that, **you will need written Pre-Authorization BEFORE you obtain the care from the Non-Participating Provider**. Pre-Authorization to obtain care from a Non-Participating Provider at the In-Network Level Of Benefits will be given only if **both** of the following conditions are met:

- ♥ The requesting Participating Provider or Network Provider is in the same specialty as the Non-Participating Provider whose services are requested, **AND**
- ♥ We or, as appropriate, our Delegated Program have determined, at our discretion, Medically Necessary services are not reasonably available from a Participating Provider or a Network Provider.

You, your Participating Provider, or your Network Provider must request Pre-Authorization by calling, faxing, or writing our Clinical Review Department at:

By telephone: (860) 674-5860 or 1-800-562-6833

By facsimile: 1-800-923-2882

Or by writing:

ConnectiCare
Clinical Review Department
175 Scott Swamp Road
Farmington, Connecticut 06032

For mental health or alcohol or substance abuse care, you must call 1-888-946-4658 to request Pre-Authorization before obtaining care.

The Out-Of-Network Level Of Benefits

Members will receive a lower level of benefits when he or she uses the Out-Of-Network Level Of Benefits option.

If You Are In The Network Access Area

Using Non-Participating Providers

When a Member uses Non-Participating Providers to order, arrange and care when he or she is in the Network Access Area, that Member will be eligible for a lower level of benefits under this Plan. This is called the Out-Of-Network Level Of Benefits. The amount of these benefit levels is listed on your Benefit Summary.

IT IS YOUR RESPONSIBILITY to request Pre-Authorization or Pre-Certification before you or your Eligible Dependents obtain care when using Non-Participating Providers. Please refer to the "Services Requiring Pre-Authorization Or Pre-Certification" addendum and "Benefit Reduction" subsection of this section for more details.

Services rendered by a Non-Participating Provider are not covered at the In-Network Level Of Benefits, even if the Member is referred to the Non-Participating Provider by a Participating Provider or a Network Provider.

Using Network Providers, Instead Of A Participating Provider

When a Member uses Network Providers to order, arrange or provide care when he or she is in the Network Access Area, instead of choosing to use Participating Providers, that Member will only be eligible for the lower level of benefits, called the Out-Of-Network Level Of Benefits.

Take a look at the "Managed Care Rules And Guidelines" section to see if you have to use Participating Providers and the "Pre-Authorization And Pre-Certification (Prior Approval) Addendum" to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

Remember: In order to maximize the benefits provided to you and your Eligible Dependents under this Plan, think of using Network Providers only if you reside or are traveling out of the Network Access Area.

If You Are Out Of The Network Access Area

Using Non-Participating Providers

When a Member uses Non-Participating Providers when he or she is out of the Network Access Area, that Member will receive coverage at the Out-Of-Network Level Of Benefits, except in an Emergency and as noted later in this section.

Participating Provider And Network Provider General Rules

Participating Providers and Network Providers generally are doctors, Hospitals, laboratories and other skilled health care professionals and licensed facilities that have agreed to provide Members with professional services and supplies.

A provider's listing in the Provider Directory (in the case of Participating Providers) or on the web site (in the case of Participating Provider and Network Providers) is not a guarantee the provider is still a Participating Provider or Network Provider at the time health care services are rendered.

You should verify a provider is currently a Participating Provider or a Network Provider by calling us.

We have the right to deny authorization for services or supplies rendered by a Non-Participating Provider to be paid at the In-Network Level Of Benefits. In those limited circumstances where authorization of services or supplies by a Non-Participating Provider is to be paid at the In-Network Level Of Benefits, the authorization may impose limits and determine which Non-Participating Provider may be used for the Health Services authorized.

The rate we pay Participating Providers or Network Providers for covered Health Services, before any deduction of any applicable risk withholds, may include:

- ♥ Fee for service, which usually means payment for each particular service;
- ♥ Per diem rates, which usually means payment of daily rates for each inpatient day;
- ♥ Scheduled charges, which usually means payment of a fixed amount for each particular service;
- ♥ Capitated charges, which usually means payment of a fixed amount each month per Member for specific services regardless of the actual number of services provided; or
- ♥ Other pricing mechanisms.

The rate we pay for Non-Participating Provider covered Health Services may vary according to the provider utilized or the services received. Some Non-Participating Providers have agreed to give us a discounted rate through their participation with a provider network management company or through negotiation with either us or a third party vendor. For others, payment may be based on the Non-Participating Provider's billed charges or the amount we would pay a Participating Provider or the Maximum Allowable Amount.

You should also know that Participating Providers or Network Providers are not prohibited from disclosing, to a Member who inquires the method that we use to compensate them.

You may obtain the professional qualifications of Participating Providers or Network Providers by calling the appropriate telephone number listed in the "Important Telephone Numbers And Addresses" subsection of the "Important Information" section or by visiting our web site at www.connecticare.com.

BENEFITS FOR STUDENTS, WHILE TRAVELING AND AFTER HOURS CARE

Coverage is available at the In-Network Level Of Benefits when your children are away at school or your doctor has left for the day.

Students

Coverage is available at the In-Network Level Of Benefits for your Eligible Dependent student while he/she is at school, as long as he or she obtains care from a Network Provider.

In addition, if you obtain Pre-Authorization first, your Eligible Dependent student can still obtain coverage at the In-Network Level Of Benefits if he or she obtains care from a Non-Participating Provider.

In those instances, covered Health Services include:

- ♥ **Allergy shots**

  Your child can arrange to have allergy shots while at school. When a Participating Provider provides the allergy extracts, your child can bring them to a Non-Participating Provider near school who will give the shots.

- ♥ **Emergency Services or Urgent Care**

  Emergency Services or Urgent Care are covered. If your child needs follow up care related to that Emergency or Urgent Care, call us for Pre-Authorization, even if the follow up care is given in the emergency room.

- ♥ **Behavioral Health (Mental Health, alcohol and substance abuse services)**

  Mental health, alcohol and substance abuse services are coordinated by our Behavioral Health Program Delegated Program. If your child needs these services while at school, call our Behavioral Health Program at the telephone number listed on the back of his/her ID card. Representatives are always available to coordinate this care. Our Behavioral Health Program maintains a national network of providers and will try

Take a look at the "Managed Care Rules And Guidelines" section to see if you have to use Participating Providers and the "Pre-Authorization And Pre-Certification (Prior Approval) Addendum" to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

to find a provider in your child's area. Our Behavioral Health Program maintains a national network of providers and will try to find a provider in your child's area. If necessary, it will authorize appropriate care rendered by a Non-Participating Provider.

- **Physical therapy**

  When your child's doctor orders physical therapy treatment as a result of an accident or surgical procedure the therapy is covered.

- **Radiology services**

  Radiology services are covered when your child is at school, including CT scans and MRI/MRA exams. Call us so we can help you coordinate the services.

- **Prescription drugs**

  Prescriptions are covered at Participating Pharmacies throughout the United States. If you have supplemental prescription drug coverage with us, your child needs to present his/her ID card to the pharmacy, along with a prescription, and pay the applicable Cost-Share amount.

While Traveling

While a Member is traveling, coverage is available at the In-Network Level Of Benefits for:

- Emergency Services.
- Urgent Care.

Any continuing treatment of an illness or injury that is provided by Non-Participating Providers and that can be delayed for 24 hours or greater will not be covered at the In-Network Level Of Benefits unless written Pre-Authorization is obtained first.

Other care, such as routine care, prenatal care, preventive care, chemotherapy, home health care services, a medical condition that requires ongoing treatment, routine diagnostic imaging, routine laboratory tests and follow-up visits, is not covered at the In-Network Level Of Benefits when you or your Eligible Dependents are out of the Network Access Area, unless the care is obtained from Network Providers..

After Hours Care

A Member is covered at the In-Network Level Of Benefits for Urgent Care and Emergencies during and after the normal business hours of Participating Providers. If possible, you should call your Primary Care Provider (PCP) in the event you need medical care after hours. PCPs (or covering PCPs) are available 24 hours a day, seven days a week.

If a Member needs mental health, alcohol or substance abuse care after hours, please call the appropriate telephone number listed on the back of your ID card. Representatives are always available to coordinate this care.

COST-SHARES YOU ARE REQUIRED TO PAY

Examples of Cost-Sharing arrangements are "Copayments", "Deductibles" and "Coinsurance".

Review your Benefit Summary for the applicable Cost-Share amounts of this Plan, any maximums this Plan may have, and per calendar year or per Contract Year coverage.

Amount Of In-Network Level Of Benefits

Your Benefit Summary lists the amount of the In-Network Level Of Benefits that you or your Eligible Dependents will receive when Participating Providers (or Network Providers when you are out of the Network Access Area) render Medically Necessary care. In general, you are required to pay a Copayment for the In-Network Level Of Benefits before the In-Network Level Of Benefits is paid, but some benefits require you to pay a Benefit Deductible first.

Take a look at your Benefit Summary for Cost-Share amount details.

Amount Of Out-Of-Network Level Of Benefits

Your Benefit Summary lists the amount of the Out-Of-Network Level Of Benefits that you and your Eligible Dependents will receive when Non-Participating Providers render Medically Necessary care (or you obtain covered Health Services from Network Providers while you are in the Network Access Area). In general, the Out-Of-Network Level Of Benefits is equal to the Coinsurance percentage listed on your Benefit Summary multiplied by the Maximum Allowable Amount after the applicable Deductible has been met.

Any amount charged by provider exceeding the amount of the Out-Of-Network Level Of Benefits is your financial responsibility.

Take a look at your Benefit Summary for Cost-Share amount details.

Deductibles

A Deductible is the total amount that each Member must pay during the year for certain benefits under a plan before we will begin paying for those benefits.

Your Benefit Summary describes the Deductibles that apply to your Plan.

Plan Deductibles

In-Network Level Of Benefits Plan Deductible

This Plan may require that you meet an In-Network Level Of Benefits Plan Deductible for most covered Health Services that are rendered by Participating Providers (or by Network Providers when you are out of the Network Access Area) before we will begin paying our portion of those benefits. After the Plan Deductible is met, benefits will be paid subject to the Member's payment of either a Copayment amount or Coinsurance amount.

Take a look at the "Managed Care Rules And Guidelines" section to see if you have to use Participating Providers and the "Pre-Authorization And Pre-Certification (Prior Approval) Addendum" to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

NOTE: The In-Network Level Of Benefits Plan Deductible DOES NOT apply to certain covered Health Services. However, those services that are exempt from the In-Network Level Of Benefits Plan Deductible may be subject to a Copayment or Coinsurance amount. To find out the covered Health Services that the In-Network Level Of Benefits Plan Deductible DOES NOT apply to and all the Cost-Share amounts of this Plan, please refer to your Benefit Summary.

Out-Of-Network Level Of Benefits Plan Deductible

This Plan may require that you meet an Out-Of-Network Level Of Benefits Plan Deductible for most covered Health Services when they are rendered by Non-Participating Providers (or by Network Providers when you are in the Network Access Area) before we will begin paying our portion of covered Health Services. After the Plan Deductible is met, benefits will be paid subject to the Member's payment of a Coinsurance amount.

Please refer to your Benefit Summary to see the amount of the Plan Deductibles that you are required to pay in this Plan.

Combination In-Network and Out-Of-Network Level Of Benefits Plan Deductible

Some Plan options have a combination In-Network and Out-Of-Network Level Of Benefits Plan Deductible. If your Plan has a combination In-Network and Out-Of-Network Level Of Benefits Plan Deductible it means there is a combined Plan Deductible amount a Member must pay for all covered Health Services (from any providers) during the year before we will begin paying for benefits at the applicable In-Network Level Of Benefits or Out-Of-Network Level Of Benefits throughout the remainder of that year.

The combination In-Network and Out-Of-Network Level Of Benefits Plan Deductible can be met for you or your family as described in the "How Plan Deductibles Are Met" provisions of this subsection or by combining the amounts you pay in either case. In-Network Level Of Benefit Plan Deductible amounts and Out-Of-Network Level Of Benefit Plan Deductible amounts **DO** accrue toward meeting the combined In-Network and Out-Of-Network Level Of Benefits Plan Deductible.

After the combination In-Network and Out-Of-Network Level Of Benefit Plan Deductible is met, benefits will be paid subject to the Member's payment of the applicable In-Network or Out-Of-Network Level Of Benefits Cost-Share amount.

Please refer to your Benefit Summary to see if this option applies to your Plan and to see the amount of the combination In-Network and Out-Of-Network Level Of Benefits Plan Deductible and the applicable In-Network and Out-Of-Network Level Of Benefits Cost-Share amounts you must pay after that Plan Deductible is met.

How Plan Deductibles Are Met

The In-Network Level Of Benefits Plan Deductible amount is met by combining the total Plan Deductible amounts the Member has paid during the year for services rendered by Participating Providers (or by Network Providers when you are out of the Network Access Area).

The Out-Of-Network Level-Of-Benefits Plan Deductible amount is determined by combining the total Plan Deductible amounts the Member has paid during the year for services rendered by Non-Participating Providers (or by Network Providers when you are in the Network Access Area).

In-Network Level Of Benefits Plan Deductible amounts do not accrue toward the Out-Of-Network Level Of Benefits Plan Deductible and vice versa.

The applicable individual (when you are the only Member covered under your Plan) In-Network Level Of Benefits Plan Deductible and the Out-Of-Network Level Of Benefits Plan Deductible are considered to be met for a Member if the applicable Plan Deductibles are met by the amounts paid for that Member for Health Services covered by each Plan Deductible.

The applicable family (when you and one other person are covered under your Plan) In-Network Level Of Benefits Plan Deductible and the family (two Member) Out-Of-Network Level Of Benefits Plan Deductible are met for each Member when each Member separately meets the applicable individual Plan Deductible amount specified on your Benefit Summary.

An applicable family (when you and at least two other persons are covered under your Plan) In-Network Level Of Benefits Plan Deductible and the family (three or more Members) Out-Of-Network Level Of Benefits Plan Deductible are met by **combining the total expenses for Health Services incurred by each family member**, whereby no one family member incurs more than the applicable individual Member Plan Deductible amount, up to the applicable family Plan Deductible amount as specified on your Benefit Summary.

Amounts paid by Members as their Coinsurance responsibility, or because charges exceed the Maximum Allowable Amount, or due to a Benefit Reduction, or for services that are not covered by this Plan do not count towards meeting any Deductible.

The Plan Deductibles generally apply to all covered Health Services, except those that have their own Benefit Deductibles.

Benefit Deductible

This Plan may have a specific Benefit Deductible that applies separately to certain benefits. For example, there may be a Benefit Deductible for your prescription drug program (if that prescription drug program has been selected as part of this Plan). When this Plan does have a prescription drug

Benefit Deductible, that Benefit Deductible must be individually met by you or your Eligible Dependents each year before we will begin paying for those prescription drug benefits. Anything paid by Members for prescription drugs under this Benefit Deductible does not count towards meeting any Plan Deductible amounts.

Combined In-Network Ambulatory Services (Outpatient) And Inpatient Hospitalization Services Benefit Deductible Calculation

If this Plan has a combined ambulatory services (outpatient) and inpatient Hospitalization services Benefit Deductible, the individual Benefit Deductible amount (when you are the only Member covered under your Plan) is met when you meet the individual Benefit Deductible amount specified on your Benefit Summary.

The family Benefit Deductible amount (when you and one other person are covered under your Plan) is met for **EACH** Member when each Member separately meets the individual Benefit Deductible amount specified on your Benefit Summary.

The family Benefit Deductible amount (when you and at least two other persons are covered under your Plan) is met by **combining the total amounts each family member paid** for Health Services, so that no one person paid more than the individual Member Benefit Deductible amount, up to the family Benefit Deductible amount as specified on your Benefit Summary.

This combined ambulatory services (outpatient) and inpatient Hospitalization services Benefit Deductible does not apply to Partial Hospitalizations or Intensive Outpatient services.

This combined ambulatory services (outpatient) and inpatient Hospitalization services Benefit Deductible **DOES NOT** need to be met before we will begin paying for any other benefits that may have their own separate benefit Deductible.

Deductible and Coinsurance amounts paid for covered Health Services when your Plan has a combined in-network ambulatory services (outpatient) and inpatient Hospitalization services Benefit Deductible are based on the lower of the provider's billed charges for the covered Health Services or our contracted rate.

More About Deductibles

Any Copayment or Coinsurance amounts paid, if any, **DO NOT** count towards meeting any of this Plan's Benefit Deductibles or the Plan Deductibles.

In addition, amounts you pay because charges exceed the Maximum Allowable Amount, due to a Benefit Reduction, or for services that are not covered by this Plan do not count towards meeting the Benefit Deductible or the Plan Deductibles.

Plan Deductibles **DO NOT** need to be met for services that have their own Benefit Deductible before we will begin paying for those benefits. **However, Plan Deductibles DO need to be met for ALL other covered Health Services before we will begin paying our share.**

90-Day Lookback Period

This 90-day lookback period **DOES NOT** count if your Plan's benefits are determined on a Contract Year.

In certain circumstances, medical expenses the Member paid for under the Employer's prior plan will count towards meeting this Plan's Deductibles. This credit will count towards expenses the Member paid when benefit periods for the other insurance plan and this Plan are the same or overlapping and the expenses actually happened and went towards the deductibles of the Employer's prior insurance plan during the 90 days before he/she signed up for this Plan. The following rules apply to get this credit:

- The expenses must have happened while the Member was covered by the Employer's prior insurance plan;
- The amounts he/she paid must have been counted towards the deductibles in the Employer's prior insurance plan;
- The amounts he/she paid must have been for benefits that this Plan would have covered if it had been in effect on the date he/she paid for those expenses while insured under the other plan;
- The amounts he/she paid must be for the same kind of services that would have counted towards this Plan's Deductibles if this Plan had been in effect at the time he/she paid for those services;
- The Member was not eligible for benefits because his/her previous plan had an extension of benefits rule; and
- The Member gives us an explanation of benefits ("EOB") from the other insurance plan, or other proof that he/she paid for the medical expenses under the Employer's prior insurance plan.

Copayments

A Copayment is an In-Network Level Of Benefits Cost-Share arrangement in which a Member pays a specific charge directly to a provider for a covered Health Service **EVERY TIME** the service is supplied.

Claims for services come to us from doctors and other providers of health care with various billing codes on them. Those codes determine how we will pay for covered Health Services by identifying the service that is provided and where. The Copayment amount a Member is required to pay depends on that information. So, if you get a bill with a doctor's office visit Copayment on it, even though you may have received the services at some place other than a doctor's office, you will be required to pay the doctor's office visit Copayment.

Take a look at the "Managed Care Rules And Guidelines" section to see if you have to use Participating Providers and the "Pre-Authorization And Pre-Certification (Prior Approval) Addendum" to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

Copayments for inpatient admissions vary by Plan. Your Benefit Summary will describe your inpatient Copayment, if any.

There are no Copayments for the following services, when no other services are provided:

- ♥ Pre-natal visits after the initial visit for routine care until the baby is born
- ♥ Immunizations
- ♥ Mammography (when noted on your Benefit Summary)

A Member does not have to pay Emergency room Copayments if the Member:

- ♥ Is admitted directly to the Hospital from the emergency room, or
- ♥ Was treated at an Urgent Care Center and told by the treating provider that he/she should go immediately to an emergency room (ER) because the ER was better equipped to handle his/her medical problem.

Coinsurance

Coinsurance is the Member's share of a percentage of the cost of covered Health Services after any applicable Deductible is met.

When Coinsurance applies as a result of the In-Network Level Of Benefits, except as otherwise required by law, the Coinsurance amount will be calculated based on the lesser of:

- ♥ The physician's or provider's charges for a Health Service at the time it is provided; or
- ♥ The contracted rate with the physician or provider for the Health Service.

When Coinsurance applies as a result of the Out-Of-Network Level Of Benefits, except as otherwise required by law, the Coinsurance amount will be calculated based on the Maximum Allowable Amount.

A charge by a physician or provider for a Health Service eligible for the Out-Of-Network Level Of Benefits that is in excess of the Maximum Allowable Amount is not considered Coinsurance and shall be your financial responsibility.

Review your Benefit Summary for Coinsurance amount details.

More Information About Deductibles And Coinsurance

Deductible and Coinsurance amounts paid for covered Health Services under this Plan's In-Network Level Of Benefits Plan Deductible are based on the lower of the provider's billed charges for the covered Health Services or our contracted rate.

Maximums

Benefit Maximums

Some benefits may have a benefit maximum. When a benefit does have a maximum, the benefit maximum applies to the total benefit covered, whether you receive the benefit at the In-Network Level Of Benefits or Out-Of-Network Level Of Benefits. Benefit maximums are listed on your Benefit Summary.

Coinsurance Maximum

Your Plan may have an In-Network Level Of Benefits Coinsurance Maximum, an Out-Of-Network Level Of Benefits Coinsurance Maximum, or a combination In-Network and Out-Of-Network Level Of Benefits Coinsurance Maximum.

Take a look at your Benefit Summary to see if your Plan has a Coinsurance Maximum.

In-Network Level Of Benefits Coinsurance Maximum

If this Plan has an In-Network Level Of Benefits Coinsurance Maximum, that Coinsurance Maximum includes all Coinsurance amounts paid by the Member in a year for benefits paid at the In-Network Level Of Benefits (paid to Participating Providers), including certain prescription drug programs (if one of our prescription drug programs has been selected as part of this Plan).

When the In-Network Level Of Benefits Coinsurance Maximum is met in a year, the In-Network Level Of Benefits Coinsurance no longer applies for the remainder of the year. However Members are still required to pay any other applicable Cost-Share amounts.

The In-Network Level Of Benefits Coinsurance Maximum is met for a Member if his/her individual In-Network Level Of Benefits Coinsurance Maximum is met by the Coinsurance amounts paid by that Member for services paid to Participating Providers.

The family In-Network Level Of Benefits Coinsurance Maximum is met by the total In-Network Level Of Benefits Coinsurance amounts paid by that Member and all of the members in the family who are covered by the Plan for services paid to Participating Providers, where no one member exceeds the individual amount for services paid to Participating Providers.

Even when the In-Network Level Of Benefits Coinsurance Maximum is met, Members are still responsible for other applicable Cost-Share amounts.

Your Benefit Summary describes any Coinsurance Maximum.

Out-Of-Network Level Of Benefits Coinsurance Maximum

If this Plan has an Out-Of-Network Level Of Benefits Coinsurance Maximum, that Coinsurance Maximum includes all Coinsurance amounts paid by the Member in a year for benefits paid at the Out-Of-Network Level Of Benefits (paid

Take a look at the "Managed Care Rules And Guidelines" section to see if you have to use Participating Providers and the "Pre-Authorization And Pre-Certification (Prior Approval) Addendum" to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

to Non-Participating Providers), including certain prescription drug programs (if one of our prescription drug programs has been selected as part of this Plan).

When the Out-Of-Network Level Of Benefits Coinsurance Maximum is met in a year, the Out-Of-Network Level Of Benefits Coinsurance no longer applies for the remainder of the year. However Members are still required to pay any other applicable Cost-Share amounts.

The Out-Of-Network Level Of Benefits Coinsurance Maximum is met for a Member if his/her individual Out-Of-Network Level Of Benefits Coinsurance Maximum is met by the Coinsurance amounts paid by that Member for services paid to Non-Participating Providers.

The family Out-Of-Network Level Of Benefits Coinsurance Maximum is met by the total Coinsurance amounts paid by that Member and all of the members in the family who are covered by the Plan for services paid to Participating Providers, where no one member exceeds the individual amount for services paid to Non-Participating Providers.

Even when the Out-Of-Network Level Of Benefits Coinsurance Maximum is met, Members are still responsible for other applicable Cost-Share amounts, as well as those amounts for covered Out-Of-Network Level Of Benefits in excess of the Maximum Allowable Amount.

Coinsurance Maximum amounts do not include:

- ♥ Charges by a provider in excess of the Maximum Allowable Amount,
- ♥ Amounts paid by Members as Benefit Reductions, and
- ♥ Deductibles or any Copayments.

Your Benefit Summary describes any Coinsurance Maximum.

Combination In-Network And Out-Of-Network Level Of Benefits Coinsurance Maximum

If this Plan has a combination In-Network And Out-Of-Network Level Of Benefits Coinsurance Maximum, that Coinsurance Maximum includes all Coinsurance amounts paid by the Member in a year for benefits paid to Participating Providers, , Network Providers, and Non-Participating Providers, including certain prescription drug programs (if one of our prescription drug programs has been selected as part of this Plan).

When the combination In-Network And Out-Of-Network Level Of Benefits Coinsurance Maximum is met in a year, the Coinsurance no longer applies for the remainder of the year. However Members are still required to pay any other applicable Cost-Share amounts.

The combination In-Network And Out-Of-Network Level Of Benefits Coinsurance Maximum is met for a Member if his/her individual combination In-Network And Out-Of-Network Level Of Benefits Coinsurance Maximum is met by the Coinsurance amounts paid by that Member for services paid to Participating Providers and to Non-Participating Providers.

The family combination In-Network And Out-Of-Network Level Of Benefits Coinsurance Maximum is met by the total Coinsurance amounts paid by that Member and all of the members in the family who are covered by the Plan for services paid to Participating Providers and to Non-Participating Providers, where no one member exceeds the individual amount for services paid to Participating Providers and to Non-Participating Providers.

Even when the combination In-Network And Out-Of-Network Level Of Benefits Coinsurance Maximum is met, Members are still responsible for other applicable Cost-Share amounts, as well as those amounts for covered Out-Of-Network Level Of Benefits in excess of the Maximum Allowable Amount.

Coinsurance Maximum amounts do not include:

- ♥ Charges by a provider in excess of the Maximum Allowable Amount,
- ♥ Amounts paid by Members as Benefit Reductions, and
- ♥ Deductibles or any Copayments.

Your Benefit Summary describes any Coinsurance Maximum.

Cost-Share Maximums

Your Plan may have an In-Network Level Of Benefits Cost-Share Maximum, an Out-Of-Network Level Of Benefits Cost-Share Maximum, or a combination In-Network and Out-Of-Network Level Of Benefits Cost-Share Maximum.

Take a look at your Benefit Summary to see if your Plan has a Cost-Share Maximum.

In-Network Level Of Benefits Cost-Share Maximum

If this Plan has an In-Network Level Of Benefits Cost-Share Maximum, that Cost-Share Maximum includes all Copayment and Coinsurance amounts paid by the Member in a year for benefits paid to Participating Providers, including certain prescription drug programs (if one of our prescription drug programs has been selected as part of this Plan). It **DOES NOT** include any Deductible amounts the Plan may have.

When the In-Network Level Of Benefits Cost-Share Maximum is met in a year, the In-Network Level Of Benefits Copayment and Coinsurance no longer apply for the remainder of the year. However Members are still required to pay any Deductible amounts.

The In-Network Level Of Benefits Cost-Share Maximum is met for a Member if his/her individual Copayment and Coinsurance amounts paid to Participating Providers adds up to the per member In-Network Level Of Benefits Cost-Share Maximum.

The family In-Network Level Of Benefits Cost-Share

Maximum is met by the total Copayment and Coinsurance amounts paid by a Member and all of the members in the family who are covered by the Plan to Participating Providers adds up to the per family In-Network Level Of Benefits Cost-Share Maximum, where no one member exceeds the individual amount for services paid to Participating Providers.

Even when the Cost-Share Maximum is met, Members are still responsible for other applicable Deductible amounts.

Your Benefit Summary describes any Cost-Share Maximum.

Out-Of-Network Level Of Benefits Cost-Share Maximum

If this Plan has an Out-Of-Network Level Of Benefits Cost-Share Maximum, that Cost-Share Maximum includes all Copayment and Coinsurance amounts paid by the Member in a year for benefits paid to Non-Participating Providers, including certain prescription drug programs (if one of our prescription drug programs has been selected as part of this Plan). It **DOES NOT** include any Deductible amounts the Plan may have.

When the Out-Of-Network Level Of Benefits Cost-Share Maximum is met in a year, the Out-Of-Network Level Of Benefits Copayment and Coinsurance no longer apply for the remainder of the year. However Members are still required to pay any Deductible amounts.

The Out-Of-Network Level Of Benefits Cost-Share Maximum is met for a Member if his/her individual Out-Of-Network Level Of Benefits Copayment and Coinsurance amounts paid to Non-Participating Providers adds up to the per member Out-Of-Network Level Of Benefits Cost-Share Maximum.

The family In-Network Level Of Benefits Cost-Share Maximum is met by the total Copayment and Coinsurance amounts paid by a Member and all of the members in the family who are covered by the Plan to Non-Participating Providers adds up to the per family Out-Of-Network Level Of Benefits Cost-Share Maximum, where no one member exceeds the individual amount for services paid to Non-Participating Providers.

Even when the Out-Of-Network Level Of Benefits Cost-Share Maximum is met, Members are still responsible for other applicable Deductible amounts, as well as those amounts for covered Out-Of-Network Level Of Benefits in excess of the Maximum Allowable Amount.

Cost-Share Maximum amounts do not include:

- ♥ Charges by a provider in excess of the Maximum Allowable Amount,
- ♥ Amounts paid by Members as Benefit Reductions, and
- ♥ Deductibles.

Your Benefit Summary describes any Cost-Share Maximum.

Combination In-Network And Out-Of-Network Level Of Benefits Cost-Share Maximum

If this Plan has a combination In-Network and Out-Of-Network Level Of Benefits Cost-Share Maximum, that Cost-Share Maximum includes all Copayment and Coinsurance amounts paid by the Member in a year for benefits paid to Participating Providers, Network Providers, and Non-Participating Providers, including certain prescription drug programs (if one of our prescription drug programs has been selected as part of this Plan). It **DOES NOT** include any Deductible amounts the Plan may have.

When the combination In-Network and Out-Of-Network Level Of Benefits Cost-Share Maximum is met in a year, Copayment and Coinsurance no longer apply for the remainder of the year. However Members are still required to pay any Deductible amounts.

The combination In-Network and Out-Of-Network Level Of Benefits Cost-Share Maximum is met for a Member if his/her individual Copayment and Coinsurance amounts paid to Participating Providers and to Non-Participating Providers adds up to the per member combination In-Network and Out-Of-Network Level Of Benefits Cost-Share Maximum.

The family combination In-Network and Out-Of-Network Level Of Benefits Cost-Share Maximum is met by the total Copayment and Coinsurance amounts paid by a Member and all of the members in the family who are covered by the Plan to Participating Providers and to Non-Participating Providers adds up to the per family combination In-Network and Out-Of-Network Level Of Benefits Cost-Share Maximum, where no one member exceeds the individual amount for services paid to Participating Providers and Non-Participating Providers.

Even when the combination In-Network and Out-Of-Network Level Of Benefits Cost-Share Maximum is met, Members are still responsible for other applicable Deductible amounts, as well as those amounts for covered Out-Of-Network Level Of Benefits in excess of the Maximum Allowable Amount.

Cost-Share Maximum amounts do not include:

- ♥ Charges by a provider in excess of the Maximum Allowable Amount,
- ♥ Amounts paid by Members as Benefit Reductions, and
- ♥ Deductibles.

Your Benefit Summary describes any Cost-Share Maximum.

Out-Of-Pocket Maximum

This Plan may have an Out-Of-Pocket Maximum.

The Out-Of-Pocket Maximum amount and the Cost-Share categories that add up to meet your Out-Of-Pocket Maximum are listed on your Benefit Summary.

In-Network Level Of Benefits Out-Of-Pocket Maximum

The In-Network Level Of Benefits Out-Of-Pocket Maximum is the Member's maximum payment liability per year for services (**including prescription drug coverage**) covered at the In-Network Level Of Benefits. You need to add the Out-Of-Pocket Maximum on your medical Benefit Summary with the Out-Of-Pocket Maximum on your prescription drug Benefit Summary to determine the total Out-Of-Pocket Maximum on your Plan.

The In-Network Level Of Benefits Out-Of-Pocket Maximum is met for a Member if his or her individual In-Network Level Of Benefits Out-Of-Pocket Maximum is met by the eligible amounts paid by that Member for services paid at the In-Network Level Of Benefits or if the family In-Network Level Of Benefits Out-Of-Pocket Maximum is met by the total eligible amounts paid by that Member and all of the members in his or her family who are covered by the Plan for services paid at the In-Network Level Of Benefits.

When the In-Network Level Of Benefits Out-Of-Pocket Maximum is met, the In-Network Level Of Benefits will be paid at 100% of the contracted rate with physicians or providers for remainder of the year.

The following amounts you pay **DO NOT** count towards this Plan's In-Network Level Of Benefits Out-Of-Pocket Maximum:

- ♥ Amounts a Member pays toward any non-covered Health Services, or
- ♥ Amounts a Member pays toward any Out-Of-Network Level Of Benefits, or
- ♥ Charges by a provider in excess of the Maximum Allowable Amount.

Your Benefit Summary describes any Out-Of-Pocket Maximum.

Out-Of-Network Level Of Benefits Out-Of-Pocket Maximum

The Out-Of-Network Level Of Benefits Out-Of-Pocket Maximum is the Member's maximum payment liability per year for services (**including prescription drug coverage**) covered at the Out-Of-Network Level Of Benefits. You need to add the Out-Of-Pocket Maximum on your medical Benefit Summary with the Out-Of-Pocket Maximum on your prescription drug Benefit Summary to determine the total Out-Of-Pocket Maximum on your Plan.

The Out-Of-Network Level Of Benefits Out-Of-Pocket Maximum is met for a Member if his or her individual Out-Of-Network Level Of Benefits Out-Of-Pocket Maximum is met by the eligible amounts paid by that Member for services paid at the Out-Of-Network Level Of Benefits or if the family Out-Of-Network Level Of Benefits Out-Of-Pocket Maximum is met by the total eligible amounts paid by that Member and all of the members in his or her family who are covered by the Plan for services paid at the Out-Of-Network Level Of Benefits.

When the Out-Of-Network Level Of Benefits Out-Of-Pocket Maximum is met, the Out-Of-Network Level Of Benefits will be paid at 100% of the Maximum Allowable Amount for the remainder of the year.

The following amounts you pay **DO NOT** count towards this Plan's Out-Of-Network Level Of Benefits Out-Of-Pocket Maximum:

- ♥ Amounts a Member pays toward any non-covered Health Services, or
- ♥ Amounts a Member pays toward any In-Network Level Of Benefits, or
- ♥ Charges by a provider in excess of the Maximum Allowable Amount.

Your Benefit Summary describes any Out-Of-Pocket Maximum.

Combination In-Network and Out-Of-Network Level Of Benefits Out-Of-Pocket Maximum

The combination In-Network Level Of Benefits and Out-Of-Network Level Of Benefits Out-Of-Pocket Maximum is the Member's maximum payment liability per year for covered Health Services from Participating Providers, Network Providers, and/or Non-Participating Providers (**including prescription drug coverage**). You need to add the Out-Of-Pocket Maximum on your medical Benefit Summary with the Out-Of-Pocket Maximum on your prescription drug Benefit Summary to determine the total combination In-Network Level Of Benefits and Out-Of-Network Level Of Benefits Out-Of-Pocket Maximum on your Plan.

1. If you have individual coverage under this Plan (when you are the only Member covered under your Plan), your Out-Of-Pocket Maximum for your covered Health Services (**including prescription drug coverage**) is the amount specified for individual in your Benefit Summary.
2. If you have family coverage under this Plan (for yourself and any other Eligible Dependents), the Out-Of-Pocket Maximum for all of the covered Health Services (**including prescription drug coverage**) is the total amount specified for family in your Benefit Summary without regard to which family member uses the benefits.

When the combination In-Network and Out-Of-Network Level Of Benefits Out-Of-Pocket Maximum is met, the In-Network Level Of Benefits will be paid at 100% of the contracted rate with physicians or providers for the remainder of that year and the Out-Of-Network Level of Benefits will be paid at 100% of the Maximum Allowable Amount for the remainder of the year.

The following amounts you pay **DO NOT** count towards this Plan's combined In-Network and Out-Of-Network

Level Of Benefits Out-Of-Pocket Maximum:

- ♥ Amounts a Member pays toward any non-covered Health Services, or
- ♥ Charges by a provider in excess of the Maximum Allowable Amount.

Your Benefit Summary describes any Out-Of-Pocket Maximum.

MEDICAL NECESSITY AND APPROPRIATE SETTING FOR CARE

"Medically Necessary" means those Health Services that a health care practitioner, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

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

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

"Medically Necessary" health care services are those Health Services that are required diagnostic or therapeutic treatments for an illness or injury.

Health care treatments, medications and supplies that are not Medically Necessary are not covered under this Plan. We determine if a treatment, medication or supply is Medically Necessary. These determinations are made through various Utilization Management processes, including pre service review, concurrent review, post service review, discharge planning and Case Management.

A health care practitioner determines medical care, but coverage for that care under this Plan is subject to Medical Necessity as determined by us. We use input from physicians, including specialists, to approve, and in some cases develop, our Medical Necessity protocols.

Case Managers help to arrange and coordinate Medically Necessary care. At our discretion, development of alternative individual plans may include coverage of otherwise non-covered services or supplies.

UTILIZATION MANAGEMENT

Utilization Management decisions are made using medical protocols developed from national standards with local physician input. We do not reward practitioners or other individuals conducting utilization review for issuing denials of coverage for health care treatments, medications or supplies. We do not provide financial incentives to encourage Utilization Management decision-makers to deny coverage for Medically Necessary care.

QUALITY ASSURANCE

The goal of the Quality Improvement (QI) Program is to establish processes that lead to continuous improvement of the care and services provided to our Members. The QI Program helps us to better serve Members, Employers and Participating Providers. Through the QI Program we:

- ♥ Systematically monitor, evaluate and suggest improvements for both the process of care and the outcome of care delivered to Members.
- ♥ Identify and implement opportunities for improvement in the quality of care and services delivered to Members, both administrative and clinical, including behavioral health.
- ♥ Evaluate and improve Members' access to and satisfaction with clinical and administrative services.
- ♥ Facilitate Members' access to appropriate medical care.
- ♥ Encourage Members to become more knowledgeable, active participants in their own medical and preventative care by implementing initiatives that focus on member education and health management wellness programs.
- ♥ Carry out systematic data collection related to plan and practitioner performance and communicate, in the aggregate, these data and their interpretation to internal and peer review committees for analysis and action.
- ♥ Monitor whether the care and service provided meets or exceeds established local, state, and national managed care standards.
- ♥ Develop innovative approaches to facilitating the delivery of care to diverse populations.

The scope of activities within the QI Program focuses on facilitating: quality of care and services, continuity and coordination of care, chronic care management, credentialing, behavioral health, Member safety, utilization management, Member and physician satisfaction, accessibility, availability, delegation, Member complaints and Appeals, cultural diversity, wellness and prevention, pharmacy management, and Member decision support tools.

Take a look at the "Managed Care Rules And Guidelines" section to see if you have to use Participating Providers and the "Pre-Authorization And Pre-Certification (Prior Approval) Addendum" to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

NEW TREATMENTS

New Treatments are new supplies, services, devices, procedures or medications, or new uses of existing supplies, services, devices, procedures or medications, for which we have not yet made a coverage policy.

When we receive a request for coverage for a New Treatment, we review the New Treatment to determine whether it should be covered under this Plan.

Generally, New Treatments, other than drugs with FDA approval for the use for which they are prescribed, are not covered. However, during our review phase of a New Treatment, we may, in some limited circumstances and in our discretion, cover a New Treatment for Members in the same or similar circumstances before our determination is made. Once we complete our review, if we determine the New Treatment should be covered, those New Treatments rendered **AFTER** our determination will be covered. There will be no retroactive coverage of a New Treatment.

If we determine the New Treatment should not be covered by this Plan, then the New Treatment will continue to be excluded.

In the case where a New Treatment is a prescription drug with FDA approval for the use for which it is being prescribed, the medication will be covered at the highest tier Copayment level until our Pharmacy and Therapeutics (P&T) Committee has had an opportunity to review it, unless it is in a class of medication that is specifically excluded as described in the "Exclusions And Limitations" section or in our **Prescription Drug Rider**, if applicable.

A New Treatment may also require Pre-Authorization. When the P&T Committee does its review, it will decide if the medication will remain at the highest tier cost share level or be switched to a lower tier cost share level, and also whether the medication will have Pre-Authorization requirements or dosage limits placed on it. When you receive a medication that is a New Treatment, the conditions under which you can receive the medication might change after the P&T Committee completes its review.

To obtain information about whether a procedure, medication, service, device or supply is a New Treatment, or if a New Treatment requires Pre-Authorization, or to obtain information about whether we have made our determination with respect to a New Treatment, you should contact our Member Services Department.

EXPERIMENTAL OR INVESTIGATIONAL

A service, supply, device, procedure or medication (collectively called "Treatment") will, in our sole discretion, be considered Experimental Or Investigational if any of the following conditions are present:

1. The prescribed Treatment is available only through participation in a program designated as a clinical trial, whether a federal Food and Drug Administration (FDA) Phase I or Phase II clinical trial, or an FDA Phase III experimental research clinical trial or a corresponding trial sponsored by the National Cancer Institute, or another type of clinical trial; or
2. A written informed consent form or protocols for the Treatment disclosing the experimental or investigational nature of the Treatment being studied has been reviewed and/or has been approved or is required by the treating facility's Institutional Review Board, or other body serving a similar function or if federal law requires such review and approval; or
3. The prescribed Treatment is subject to FDA approval and has not received FDA approval for any diagnosis or condition.

If a Treatment has multiple features and one or more of its essential features are Experimental Or Investigational based on the above criteria, then the Treatment as a whole will be considered to be Experimental Or Investigational and not covered.

We will monitor the status of an Experimental Or Investigational Treatment and may decide that a Treatment, which at one time was considered Experimental Or Investigational, may later be a covered Health Service under this Plan. No Treatment that is or has been determined by us, in our sole discretion, to be Experimental Or Investigational, will be considered as a covered Health Service under this Plan until such time as, in our sole discretion, the Treatment is deemed by us to be no longer Experimental Or Investigational and we have determined that it is Medically Necessary in treating or diagnosing an illness or injury.

Coverage for a Treatment will not be denied as Experimental Or Investigational if a Treatment has successfully completed a Phase III clinical trial of the FDA for the condition being treated or for the diagnosis for which it is prescribed.

INSUFFICIENT EVIDENCE OF THERAPEUTIC VALUE

Any service, supply, device, procedure or medication (collectively called "Treatment") for which there is Insufficient Evidence Of Therapeutic Value for the use for which it is being prescribed is not covered. There is insufficient evidence of therapeutic value when we determine, in our sole discretion, that either:

1. There is not enough evidence to prove that the Treatment directly results in the restoration of health or function for the use for which it is being prescribed, whether or not alternative Treatments are available; or
2. There is not enough evidence to prove that the Treatment results in outcomes superior to those achieved with reasonable alternative Treatments which are less intensive or invasive, or which cost less and are at least equally effective for the use for which it is being prescribed.

There may be Insufficient Evidence Of Therapeutic Value

Take a look at the "Managed Care Rules And Guidelines" section to see if you have to use Participating Providers and the "Pre-Authorization And Pre-Certification (Prior Approval) Addendum" to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

for a Treatment even when it has been approved by a regulatory body or recommended by a health care practitioner.

We will monitor the status of a Treatment for which there is Insufficient Evidence Of Therapeutic Value and may decide that a Treatment for which at one time there was Insufficient Evidence Of Therapeutic Value may later be a covered Health Service under this Plan. Coverage will not become effective until we have made a determination that there is sufficient evidence of therapeutic value for the Treatment and we have decided to make the Treatment a covered Health Service. All Treatment with sufficient evidence of therapeutic value must also be Medically Necessary to treat or diagnose illness or injury in order to be covered.

DELEGATED PROGRAMS

We may use outside companies to manage and administer certain categories of benefits or services provided under this Plan. These outside companies make decisions and act on our behalf.

Delegated Programs may be added or removed from this Plan at any time at our discretion.

BENEFITS

Benefits for Medically Necessary Health Services provided under this Plan are subject to all the rules of this document.

Please review your Benefit Summary for the amounts you have to pay (Copayment, Deductible, Coinsurance amounts), and the benefit maximums of this Plan.

PREVENTIVE AND WELLNESS CARE

Some Participating Provider preventive and wellness services, as defined by the United States Preventive Service Task Force and as listed in your Benefit Summary, are exempt from all Member Cost Shares (Deductible, Copayment and Coinsurance) under the federal Patient Protection and Affordable Care Act (PPACA). These services are identified by the specific coding your Participating Provider submits to ConnectiCare. The service coding must match ConnectiCare's coding list to be exempt from all Cost Sharing under PPACA.

PREVENTIVE SERVICES

The following **preventive services are covered when provided in the doctor's office**:

Routine Medical Exams And Preventive Care

Infant/Pediatric (Under Age 19)

Members under age 19 have coverage for the following routine exams and preventive care.

Preventive Care Medical Services

Office visits for infant/pediatric preventive care services (routine exams and preventive care) are **covered**.

Routine Eye Care

Routine eye care, including refraction (a test to determine whether you are near-sighted or far-sighted) for Members under age 19 is **covered up to the benefit maximum, as shown on your Benefit Summary**.

Adult (Age 19 And Over)

Members age 19 and over have coverage for the following routine exams and preventive care.

Preventive Care Medical Services

Office visits for adult preventive care services (routine exams and preventive care) are **covered**.

Routine Eye Care

Routine eye care for Members over age 19 is **covered up to the maximum benefit, as shown on your Benefit Summary**.

Gynecological Preventive Exam Office Services

Office visits for gynecological preventive exam office services (routine exams and preventive care) are **covered**.

The Member's doctor decides the number of times she should get periodic health evaluations and checkups.

Preventive Exams And Preventive Care Limitations

Unless specified in this "Routine Medical Exams And Preventive Care" subsection, not covered under this subsection are charges for:

- Services which are covered to any extent under any other part of this Certificate Of Coverage;
- Services which are for diagnosis or treatment of a suspected or identified illness or injury;
- Exams given during your inpatient stay for medical care;
- Services not given by a physician or under his or her direction; and
- Psychiatric, psychological, personality or emotional testing or exams.

Take a look at the "Managed Care Rules And Guidelines" section to see if you have to use Participating Providers and the "Pre-Authorization And Pre-Certification (Prior Approval) Addendum" to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

Pediatric Dental Care (Under Age 19)

IMPORTANT: If you opt to receive Dental Services that are not covered benefits under this Plan, a Participating Provider, including a Dentist may charge you his or her usual and customary rate for such services or procedures. Prior to providing you with Dental Services that are not covered benefits, the dental provider should provide you with a treatment plan that includes each anticipated service or procedure to be provided and the estimated cost of each such service or procedure.

Whenever covered Dental Services are expected to exceed $250, or whenever services such as orthodontics, dentures, crowns, periodontics or bridgework are to be done, you may ask your Dentist to submit a request for predetermination of covered benefits. This step protects you and your Dentist, since it advises you both in advance as to what portion of your dental treatment costs may be paid by us, as long as you are still eligible for benefits. This is a very common procedure and your Dentist will be pleased to complete the reporting form. You need not do anything more at that time.

Medically Necessary pediatric dental care is **covered** as follows:

Diagnostic Services

Oral examinations and diagnostic casts.

X-Rays

Full mouth x-ray series, periapical x-rays, bitewing x-rays, panoramic x-rays.

Preventive

Prophylaxis, fluoride applications, and space maintainers.

Restorative

Treatment of tooth decay include the use of amalgam and/or composite restorations (fillings).

Restorative-Crowns

The use of stainless steel, gold, semiprecious, or non-precious metals to restore a tooth or teeth which cannot be restored with amalgam or composite restorations.

Endodontics

Treatment of the diseases of the nerve of the tooth include pulp capping, pulpotomy, root canal, apexification and apicoectomy.

Periodontics

Treatment of the supporting tissues of the teeth, gums, and underlying bone, with either surgical or non-surgical procedures (where applicable) include gingivectomy or gingivoplasty.

Prosthetics-Removable

Replacement of missing teeth by the use of a removable appliance include full and cast or acrylic partial dentures.

Prosthetics Adjustment

Repair or modification of existing removable and/or fixed appliances so that they can continue to be serviceable include adjustments, repairs, rebasing and relining.

Prosthetics Fixed

The use of gold, semiprecious, or precious metal to replace a missing tooth or teeth, which cannot otherwise be replaced with a removable appliance include fixed partial denture pontics and crowns.

Dental Implants

A device specifically designed to be placed surgically within or on the mandibular or maxillary bone as a means of providing for dental replacement are NOT covered.

Extractions

The extraction, either simple or surgical, of either a single tooth or multiple teeth, the shaping of bone ridges, the removal of a tooth end abscess, etc. are included.

Bony Impactions

The surgical removal of teeth partially or fully covered by bone are included.

Orthodontics

The straightening of teeth for dental health reasons are included.

General Services

Benefits for other adjunctive general services as described in the American Dental Association (ADA) Code on Dental Procedures and Nomenclature (CDT Code)™ , which are not included in the specific categories listed above, include (where applicable) general anesthesia, IV sedation, and behavior management.

Pediatric Dental Care Exclusions And Limitations

There is no coverage for Dental Services, including, but not limited to the following:

- ♥ Any service, procedure, or treatment modality not specifically listed in this "Pediatric Dental Care (Under Age 19)" subsection
- ♥ For adults (Members over age 19)
- ♥ Dental treatments, medications and supplies that are not Medically Necessary
- ♥ Experimental Or Investigational procedures.

  Procedures to alter vertical dimension (bite height based on the resting jaw position) including but not limited to, occlusal (bite) guards and periodontal splinting appliances (appliances used to splint or

Take a look at the "Managed Care Rules And Guidelines" section to see if you have to use Participating Providers and the "Pre-Authorization And Pre-Certification (Prior Approval) Addendum" to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

adhere multiple teeth together), and restorations (filings, crowns, bridges, etc.)

- ♥ Space maintainers for dependent children age ten or over
- ♥ Services or supplies rendered or furnished in connection with any duplicate prosthesis or any other duplicate appliance
- ♥ Restorations which are not of any dental health benefit, but primarily Cosmetic Treatment in nature, including, but not limited to laminate veneers

  Payment of the applicable Cost-Share of this Plan's Maximum Allowable Amount for the alternate service, if any, will be made toward such treatment and the balance of the cost remains the responsibility of the Member
- ♥ Personalized, elaborate, or precision attachment dentures or bridges, or specialized techniques, including the use of fixed bridgework, where a conventional clasp designed removable partial denture would restore the arch

  Payment of the applicable Cost-Share of this Plan's Maximum Allowable Amount for the alternate service, if any, will be made toward such treatment and the balance of the cost remains the responsibility of the Member
- ♥ General anesthesia, except for the following reasons:
  - ◆ Removal of one or more impacted teeth;
  - ◆ Removal of four or more erupted teeth;
  - ◆ Treatment of a physically or mentally impaired person;
  - ◆ Treatment of a child under age 11; and
  - ◆ Treatment of a Member who has a medical problem, when the attending physician requests in writing that the treating Dentist administer general anesthesia. This request must accompany the dental claim form.
- ♥ Duplicate charges
- ♥ Services incurred prior to the effective date of coverage
- ♥ Services incurred after cancellation of coverage, or losses of eligibility
- ♥ Services incurred in excess of any Contract Year maximum
- ♥ Services or supplies that are not Medically Necessary according to accepted standards of dental practice
- ♥ Services that are incomplete
- ♥ Orthodontic services for persons age 19 or over, when orthodontics is a covered Dental Service
- ♥ Sealants on teeth other than the first and second permanent molars, or applications applied more frequently than every thirty-six months or a service provided outside of ages five through fourteen
- ♥ Services such as trauma which are customarily provided under medical-surgical coverage
- ♥ More than two oral examinations of any type in any consecutive 12-month period
- ♥ More than two prophylaxes in any consecutive 12-month period
- ♥ More than one full mouth x-ray series in any period of 36 consecutive months
- ♥ More than one bitewing x-ray series in any consecutive 12-month period
- ♥ Adjustments or repairs to dentures performed within six months of the installation of the denture
- ♥ Services or supplies in connection with periodontal splinting (adhering multiple teeth together)
- ♥ Implants and Implantology services, including implant bodies, abutments, attachments and implant supported prosthesis (such as crowns, dentures, pontics, or bridgework)
- ♥ Expenses incurred for the replacement of an existing denture which is or can be made satisfactory
- ♥ Additional expenses incurred for a temporary denture.
- ♥ Expenses incurred for the replacement of a denture, crown, or bridge for which benefits were previously paid, if such replacement occurs within five years from the date of the previous benefit
- ♥ Training in plaque control or oral hygiene, or for dietary instruction
- ♥ Completion of reporting forms
- ♥ Charges for missed appointments
- ♥ Charges for services and supplies which are not necessary for treatment of the injury or disease, or are not recommended and approved by the attending Dentist, or charges which are not reasonable
- ♥ Scaling and root planing which is not followed, where indicated, by definitive pocket elimination procedures. In the absence of continuing periodontal therapy, scaling and root planning will be considered a prophylaxis and subject to the limitations of that procedure
- ♥ Periodontal surgery procedures more than once per quadrant in any period of 36 consecutive months
- ♥ More than one periodontal scaling and root planning per quadrant in any consecutive 36 month period
- ♥ More than two periodontal maintenance procedures in any consecutive 12-month period, as well as periodontal therapy, periodontal maintenance procedures in the absence of benefited comprehensive

Take a look at the "Managed Care Rules And Guidelines" section to see if you have to use Participating Providers and the "Pre-Authorization And Pre-Certification (Prior Approval) Addendum" to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

- ♥ Services for any condition covered by worker's compensation law or by any other similar legislation
- ♥ Services to correct or in conjunction with treatment of congenital malformations (e.g. congenitally missing teeth, supernumerary teeth, enamel and dental dysplasia, etc.), developmental malformation of teeth, or the restoration of teeth missing prior to the effective date of coverage
- ♥ Claims submitted more than 11 months (335 days) following the date of service

Other Preventive Services

Blood Lead Screening Exams And Risk Assessments

If the Member's Primary Care Provider decides that blood lead screenings and risk assessments are needed, they are **covered** as follows.

Lead Screening Exams

- ♥ At least annually for a child from 9- 35 months of age.
- ♥ For a child 3-6 years of age who has not been previously screened or is at risk.

Risk Assessments:

- ♥ For lead poisoning at least annually for a child 3-6 years of age.
- ♥ At any time in accordance with state guidelines for a child age 36 months or younger.

Cervical Cancer Screening (Pap Tests)

Cervical cancer screenings (pap tests) for female Members are **covered**.

The Member's doctor decides the number of times she should get cervical cancer screenings.

Colorectal Cancer Screenings

Colorectal cancer screenings, using fecal occult blood testing, sigmoidoscopy, colonoscopy, or radiological imaging, are **covered** in accordance with the recommendations established by the American Cancer Society.

- ♥ If the screening is coded as preventive, a Member can get one screening per year.
- ♥ If the screening is not preventive, the Member's doctor decides the number of times he/she should get colorectal cancer screenings.

You may have to pay a Cost-Share for these screenings. The amount depends on where the procedure is received and your Plan. For example, if you have a procedure done at a doctor's office, you may be required to pay an office services Copayment, but if you get the service on an outpatient basis, either in a Hospital or in an ambulatory surgery facility, you may be required to pay an ambulatory services Cost-Share amount.

This Plan will not require the Member to pay:

- ♥ A Deductible amount for a procedure that his/her doctor initially performs as a screening colonoscopy or a screening sigmoidoscopy in accordance with the American Cancer Society recommendations, or
- ♥ Any Cost-Share amount for repeat colonoscopies ordered by a doctor in a benefit year, unless the Member is enrolled in one of our HSA-compatible high deductible health plans (HDHPs).

Hearing Screenings

Hearing screenings are **covered**:

- ♥ As a part of a physical examination if a Member is under age 19.

  Some Plans cover screenings up to a different age. If your Plan covers screenings up to a different age, the hearing screenings benefit and corresponding age will be listed on your Benefit Summary.

- ♥ If Medically Necessary to evaluate the sudden onset of severe symptoms of an injury or illness. No coverage is available if the Member is already diagnosed with a permanent hearing loss.

Immunizations

Immunizations (vaccine and injection of vaccine) are **covered.**

The following immunizations are **NOT** covered:

- ♥ Immunizations a Member gets only because someone else says he/she needs them (for example, to get a job or to go to camp).
- ♥ Immunizations received for travel.
- ♥ Immunizations and vaccinations for cholera, plague or yellow fever.
- ♥ Routine immunizations received at an Urgent Care Center.
- ♥ Vaccinations an employer is legally required to provide because of an employment risk.

Mammogram Screenings

Mammogram screenings are **covered**.

The following suggests how often mammogram screenings should be obtained, but the Member's doctor decides the number of times a Member should get mammogram screenings.

Mammogram Screenings	
Ages 35 to 39:	**One baseline screening**
Age 40 and over:	**One screening mammogram per year**

In addition to the mammogram screenings noted above, comprehensive ultrasound screening of an entire breast or breasts is also **covered**.

Take a look at the "Managed Care Rules And Guidelines" section to see if you have to use Participating Providers and the "Pre-Authorization And Pre-Certification (Prior Approval) Addendum" to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

Ultrasound screening of an entire breast or breasts is **covered**, if:

- ♥ A mammogram demonstrates heterogeneous or dense breast tissue based on the Breast Imaging Reporting and Data System established by the American College of Radiology; or
- ♥ A woman is believed to be at increased risk for breast cancer due to family history or prior personal history of breast cancer, positive genetic testing or other indications as determined by her physician or advanced practice registered nurse.

Magnetic resonance imaging (MRI) of an entire breast or breasts is **covered** in accordance with guidelines established by the American Cancer Society.

Some types of breast cancer screenings (e.g., when a Member has or is thought to have a clinical genetic disorder) require Pre-Authorization.

Please refer to your Benefit Summary to see if a non-routine ultrasound screening or MRI counts toward your Plan Deductible.

Newborn Care

Newborn children are **covered for the first 61 days following birth**.

Continued coverage for a newborn child requires the newborn to be signed up in this Plan within 61 days of his/her birth for coverage to continue past this initial 61 days. There is no coverage after 61 days for a newborn who doesn't qualify as your dependent child.

Prostate Screening

Laboratory and diagnostic tests to screen for prostate cancer are **covered** for a Member who:

- ♥ Is at least 50 years old; or
- ♥ Is any age and is also symptomatic; or
- ♥ Is any age and has a biological father or brother who has been diagnosed with prostate cancer.

In addition, treatment for prostate cancer will also be **covered** in accordance with national guidelines established by the National Comprehensive Cancer Network, the American Cancer Society or the American Society of Clinical Oncology.

OUTPATIENT SERVICES

This Plan **covers** Medically Necessary services provided in the doctor's office, including consultations. It also **covers** Medically Necessary services in the Member's home to treat an illness or injury.

Allergy Testing

Allergy testing with allergenic extract (or RAST allergen specific testing) is typically **covered after the applicable Cost-Share up to the benefit maximum as shown on your Benefit Summary.** In addition, allergy testing for medicine, biological or venom sensitivity is typically **covered after the applicable Cost-Share up to the benefit maximum as shown on your Benefit Summary**.

Benefit maximums apply to the total allergy testing benefits, whether at the In-Network Level Of Benefits or at the Out-Of-Network Level Of Benefits.

Chiropractic Services

Medically Necessary short-term chiropractic services include office visits and manipulation. These services are **covered after the applicable Cost-Share up to the benefit maximum as shown on your Benefit Summary** if they are expected to return function to the same level the Member had before he/she became injured or ill.

There is no coverage for chiropractic therapy that is long term or maintenance in nature.

Gynecological Office Services

Gynecological services in a doctor's office are **covered.**

Laboratory Services

Outpatient laboratory services, including services a Member receives in a Hospital or laboratory facility, are **covered**. You should use laboratories that are Participating Providers to reduce your out of pocket expenses.

Some laboratory services require Pre-Authorization to be **covered**.

Maternity Care Office Services

Maternity services (pre-natal and post-partum) in a doctor's office are **covered.** There may be a Cost-Share that the Member will have to pay for care related to pregnancy for each visit, even after the initial pre-natal office visit. The Cost-Share amount depends on where the services are received.

Outpatient Habilitative Therapy And Rehabilitative Therapy, Including Physical, Occupational and Speech Therapy

Medically Necessary short-term outpatient habilitative therapy and rehabilitative therapy (including those services a Member receives at a day program facility or in an office) is **covered after the applicable Cost-Share amount up to the combined outpatient habilitative and rehabilitative therapy, including physical, occupational and speech therapy benefit maximum, as shown on your Benefit Summary.**

If you are age 65 or older and your Benefit Summary includes prevention and wellness services as defined by the United States Preventive Service Task Force, the following provision applies to you.

If this Plan has a benefit maximum (as shown on your Benefit Summary), that maximum does not apply to physical therapy. However, if you receive physical therapy as described, it will count towards meeting the benefit maximum.

Physical, occupational, and speech therapy coverage is **covered** as follows:

- ♥ The services must be ordered by a physician; and
- ♥ The services are limited to short-term physical, occupational and speech therapy

Services are no longer covered once therapeutic goals have been met or when a home exercise program is appropriate to achieve further gains.

Physical therapy for the treatment of temporomandibular joint (TMJ) dysfunction is **covered** as follows:

- ♥ Post-operative physical therapy for surgery is covered when the TMJ surgery is covered under this Plan; and
- ♥ Pre-Authorization is required as part of the surgical procedure; and
- ♥ Physical therapy must be provided during the 90-day period beginning on the date of the covered TMJ surgery.

There is no coverage for physical, occupational and speech therapy that is long term or maintenance in nature.

Primary Care Provider Office Services

When a Member has an injury or illness that does not require a special doctor to treat it and the care can be obtained in a Primary Care Provider's office, the services are **covered** subject to the Primary Care Provider Office Services Cost-Share amount.

Radiological Services

Outpatient diagnostic x-rays and therapeutic procedures may be **covered**. We may use an outside company to manage and administer this program.

The services performed in a Hospital or radiological facility are **covered after the applicable Cost-Share amount.** The Cost-Share amount depends on where the Member receives the services.

Some radiology services require Pre-Authorization to be covered. Covered radiology services are:

- ♥ Computerized Axial Tomography (CAT)
- ♥ Magnetic Resonance Imaging (MRI)
- ♥ Positron Emission Tomography (PET)
- ♥ Nuclear cardiology
- ♥ Bone densitometry scans
- ♥ Ultrasound and
- ♥ X-rays (e.g., chest x-rays)

Specialist Office Services

When a Member has an injury or illness that requires a special doctor to treat it and the care can be obtained in a Specialty Physician's office, the services are **covered** subject to the Specialist Office Services Cost-Share amount.

EMERGENT/URGENT CARE

Ambulance/Medical Transport Services

Emergency Services

Emergency land or air ambulance/medical transport services are **covered** only for Medically Necessary Emergency transportation if the Member requires Emergency Services and the Member's medical condition prevents the Member from getting to a health care facility safely by any other means, as determined by us.

Non-Emergency Services

Non-Emergency land or air ambulance/medical transport services for non-routine care visits will be **covered** only when Medically Necessary and with Pre-Authorization if the Member's medical condition prevents safe transport to a health care facility by any other means.

Ambulance/medical transportation services will also be **covered**, if the Member is in-patient at an acute care facility and needs air transportation to another acute care facility because Medically Necessary services to help the Member are not available in the facility where the Member is confined.

There is no coverage for ambulance services that are non-Emergency medical transport services to and from a provider's office for routine care or if the transport services are for a Member's convenience.

Emergency Services

Emergency Services provided both within and outside of the Service Area are **covered at the In-Network Level Of Benefits for Cost-Sharing**, whether a Member receives Emergency Services from a Participating Provider or Non-Participating Provider. You may be responsible to pay a bill submitted to you by Non-Participating Providers for their charges over and above the amount paid by us.

In the event of an Emergency, the Member should get medical assistance as soon as possible. In an Emergency 911 should be called and/or the Member should get care from:

- ♥ The closest emergency room; or
- ♥ A Participating Hospital emergency room.

If possible, you or your representative should contact your Primary Care Provider (PCP) **or, for mental health care or alcohol and substance abuse Emergencies, your practitioner or our Behavioral**

Take a look at the "Managed Care Rules And Guidelines" section to see if you have to use Participating Providers and the "Pre-Authorization And Pre-Certification (Prior Approval) Addendum" to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

Health Program prior to obtaining care, so your PCP, your practitioner or our Behavioral Health Program can be involved in the management of your health care.

Determination of whether a condition is an Emergency rests with us.

Urgent Care/Walk-In

Urgent Care

Urgent Care is **covered after the Cost-Share amount as shown on your Benefit Summary**. The following rules apply to the use of an Urgent Care Center:

- Use an Urgent Care Center only when your doctor is unable to provide or arrange for the treatment of an illness or injury.
- If you want the follow up care to be covered at the highest level of benefits that this Plan offers, then you must use a Participating Provider.

  Continuing care and follow-up care in an Urgent Care Center are not covered, even if the center is a Participating Provider. However, the removal of stitches is covered, if the same Urgent Care Center used to obtain the stitches is used to take them out.

There is no coverage for routine physical exams or immunizations at an Urgent Care Center.

Walk-In Care

Walk-in care is **covered after the Cost-Share amount as shown on your Benefit Summary**. The following rules apply to the use of a Walk-In Care Clinic:

- Use a Walk-In Care Clinic only when your doctor is unable to provide or arrange for the treatment of common ailments like:
  - Colds, flu symptoms, sore throat, cough or upper respiratory symptoms,
  - Ear or sinus pain,
  - Minor cuts, bruises, or scrapes
  - Rash, hives, stings and bites,
  - Sprains

NOTE: The use of a Walk-In Care Clinic is usually less expensive than the use of an Urgent Care Center.

There is no coverage for routine physical exams, immunizations or follow-up care at a Walk-In Care Clinic.

AMBULATORY SERVICES (OUTPATIENT)

Medically Necessary ambulatory services (outpatient) are **covered.** Ambulatory services include procedures performed by a doctor on an outpatient basis, whether in a Hospital, at a Hospital Outpatient Surgical Facility, at an Ambulatory Surgery Center, or at a birthing center.

There may be a Cost-Share that you will have to pay for Medically Necessary ambulatory surgery or certain radiological diagnostic procedures.

Some of these services require Pre-Authorization from us.

INPATIENT SERVICES

Hospital Services

Pre-Certification Rules For Non-Emergencies

All non-Emergency Inpatient admissions must be Pre-Certified at least five business days before the Member is admitted.

Special Pre-Authorization rules apply to transplant services. Pre-Authorization must be obtained ten business days before any evaluative transplant services are performed.

General Hospitalizations

Medically Necessary inpatient Hospital services generally performed and usually provided by acute care general Hospitals with Pre-Certification from us are **covered.**

Examples of covered inpatient Hospital Health Services are:

- Administration of whole blood, blood plasma and derivatives
- Anesthesia and oxygen services
- Autologous blood transfusions (self-donated blood)
- Doctor services
- Drugs and biologicals
- Intensive care unit and related services
- Laboratory, x-ray and other diagnostic tests
- Nursing care
- Operating room and related facilities
- Room and board in a semi-private room
- Therapy: cardiac rehabilitation, inhalation, occupational, physical, pulmonary, radiation and speech.

Dental Anesthesia

Medically Necessary anesthesia, nursing and related Hospital services for the treatment of dental conditions are **covered** when:

- The services, supplies or medicines are Medically Necessary as determined by the Member's dentist or oral surgeon and his/her Primary Care Provider (PCP); and
- The treatment is Pre-Authorized; and
- A licensed dentist and a doctor specializing in primary care decide the Member has a complicated dental condition that requires treatment be done in a Hospital; or

  A licensed doctor specializing in primary care decides

the Member has a developmental disability that puts the Member at serious risk.

Medically Necessary anesthesia for the treatment of dental conditions may also be covered in an outpatient setting as long as all three above conditions are met.

Outpatient facility and anesthesia charges are **covered** if the Member needs to have dental services performed in an outpatient facility because the Member has a serious medical condition that requires close monitoring or treatment during the procedure, and when Pre-Authorized by us. In this situation, we do not pay for what the provider charges during the procedure (usually called "professional fees").

Mastectomy Services

Health Services for a mastectomy or lymph node dissection are **covered**.

- If the Member is admitted to a Hospital, we will cover a minimum of a 48-hour length of stay following the mastectomy or lymph node dissection. We will cover a longer stay if the Member's doctor recommends it.
- If medically appropriate, and if the Member and his/her attending doctor approve, the Member may choose a shorter Hospital length of stay or have the services performed in an outpatient facility.

Maternity Services

Inpatient Services

Any Member who is admitted to a Hospital to have her baby will be covered for a minimum of a 48-hour length of stay for a vaginal delivery and a minimum of a 96-hour length of stay for a caesarean delivery.

The time periods begin at the time the baby is delivered.

Post-Discharge Benefits

If the Member and her newborn baby stay in the Hospital for the 48 or 96-hour period, the following post-discharge home health services will be **covered**:

- Vaginal Delivery (48-Hour Length of Stay):

  One skilled nursing visit by a maternal child health nurse from a Home Health Agency (requires Pre-Authorization from us).

  Comprehensive lactation visits at home up to two months after the delivery.

- Caesarean Delivery (96-Hour Length of Stay):

  Comprehensive lactation visits at home up to two months after the delivery.

Optional Early Discharge Programs

If medically appropriate, and if the Member and her attending doctor both approve, a Member may choose a shorter Hospital length of stay. In these situations, the following home health services will be **covered**:

- Vaginal Delivery with Less than 48-Hour Length of Stay; or Caesarean Delivery with Less than 96-Hour Length of Stay:

  Two skilled nursing visits by a maternal child health nurse from a Home Health Agency within two weeks of the delivery (requires Pre-Authorization from us).

  Comprehensive lactation visits at home up to two months after the delivery.

Testing for Bone Marrow

Expenses arising from human leukocyte antigen testing (also known as histocompatibility locus antigen testing) for A, B or DR antigens for use in bone marrow transplantation are **covered after the applicable Cost-Share** when the testing is performed in a facility both accredited by the American Society for Histocompatibility and Immunogenetics and certified under the Clinical Laboratory Improvement Act of 1967.

The Cost-Share for the testing depends on who ordered the procedures and where the procedures are provided, and shall not be more than 20% of the cost of such testing per year, unless the Member is enrolled in one of our HSA-compatible high deductible health plans (HDHPs).

Coverage for the testing is limited as follows:

- To a Member who, at the time of the testing, completed and signed an informed consent form that also authorizes the results of the test to be used for participation in the National Marrow Donor Program.
- One testing per Member per lifetime.

Solid Organ Transplants And Bone Marrow Transplants

Medically Necessary transplants are **covered after the applicable Cost-Share amount**. The Cost-Share amount depends on where the procedures are rendered.

The following organ transplants are **covered**:

- Bone marrow
- Cornea
- Heart
- Heart-lung
- Intestinal
- Kidney
- Liver
- Lung
- Pancreas
- Pancreas-kidney

Bone marrow procedures such as autologous or allogeneic transplants, or peripheral stem cell rescue, or any procedure similar to these, are considered "organ transplants" under this Plan and are subject to its provisions.

Take a look at the "Managed Care Rules And Guidelines" section to see if you have to use Participating Providers and the "Pre-Authorization And Pre-Certification (Prior Approval) Addendum" to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

Transplant Pre-Authorization Rules

Except for cornea transplants, all requests for transplants and related services require Pre-Authorization at the time of diagnosis. **Pre-Authorization must be obtained at least ten business days before any evaluative services have been received.**

If Pre-Authorization has not been obtained, payment for the transplant and related services, as well as for medical diagnosis and evaluation, will be reduced or denied as described in this document.

A Member may use any provider for transplants. However, to obtain the In-Network Level Of Benefits, you must use Participating Providers. By using Participating Providers, you reduce your out-of-pocket expenses.

Donor Benefits

Medically Necessary expenses of organ donation, including Medically Necessary services and tests to determine if the organ or the bone marrow/stem cell type is a suitable match, are **covered after the applicable Cost-Share amount**. The Cost-Share amount depends on where the procedures are received.

Donor coverage is only available if the transplant recipient is our Member and Pre-Authorization for evaluation has been obtained.

Transportation, Lodging And Meal Expenses For Transplants

Expenses for transportation, lodging and meals for the Member receiving the transplant and for one companion of the Member are **covered** as described below**.**

The transplant facility must be located outside of Connecticut and Massachusetts and be more than 50 miles from where the Member receiving the transplant lives for this reimbursement to apply.

- Expenses may be submitted beginning with the date the transplant evaluation began through 90 days after the transplant was received.
- Transportation costs for travel to and from a transplant facility for the Member receiving the transplant and one companion are **covered**.

  If air transportation is chosen, coverage includes round trip coach class air fare for the Member receiving the transplant and one companion **up to two round trips per person**.

  If a personal car is used, mileage will be paid based on the federal Internal Revenue Code mileage reimbursement rate at the time the travel was taken **for a maximum of two round trips to and from where the Member receiving the transplant lives to the transplant facility**.
- Lodging expenses for up to ten nights for the Member receiving the transplant and one companion are **covered up to the standard average room rate in the city where the transplant is performed**.
- Meal expenses (excluding alcoholic beverages) for the Member receiving the transplant and one companion are **covered up to two meals per day for a maximum of ten days.**

In order for us to approve payment, transportation, lodging and meal receipts must be sent to us at the appropriate address listed in the information you will receive from us.

There is no coverage for the following expenses:

- Any expenses for anyone other than the Member receiving the transplant and one companion.
- Any expenses other than the transportation, lodging and meals described in this provision.
- Expenses over those described above.
- Local transportation costs while at the transplant facility.
- Rental car costs.

Skilled Nursing And Rehabilitation Facilities

Medically Necessary skilled nursing care is **covered up to the benefit maximum as shown in your Benefit Summary** if such care is provided:

- At a Skilled Nursing Facility,
- At an acute Rehabilitation Facility, or
- On a specialized inpatient rehabilitation floor in an acute care Hospital.

The following limitations and conditions apply to the Skilled Nursing Facility/Rehabilitation Facility benefits:

- In order to be covered, the skilled nursing care must be for intense rehabilitation or sub-acute medical services, or a substitution for inpatient Hospitalization.
- The care must be ordered by a doctor. The doctor's order must specify the skills of qualified health professionals such as registered nurses, physical therapists, occupational therapists, or speech pathologists, required for the Member's care in the facility.

  Admissions and continued stay requests will be reviewed by us by using nationally recognized measures to determine if the skilled nursing care will result in significant functional gain or improvement to the Member's medical condition.
- The services in the Skilled Nursing Facility/Rehabilitation Facility must be provided directly by, or under the supervision of, a skilled health professional, and
- Admission must be Pre-Certified by us.

Take a look at the "Managed Care Rules And Guidelines" section to see if you have to use Participating Providers and the "Pre-Authorization And Pre-Certification (Prior Approval) Addendum" to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

BEHAVIORAL HEALTH (MENTAL HEALTH SERVICES)

Coverage for behavioral health (mental health services) under this Plan is administered under our Behavioral Health Program. Decisions regarding mental health coverage are made by licensed mental health professionals.

Inpatient Mental Health Services

Medically Necessary inpatient mental Health Services, as defined in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders," received in an acute care Hospital or a Residential Treatment Facility, are **covered** just as they would be for any other illness or injury as described in the "Hospital Services" section.

Inpatient Alcohol And Substance Abuse Services

Medically Necessary inpatient services, supplies and medicine in connection with medical complications of alcoholism, such as cirrhosis of the liver, gastrointestinal bleeding, pneumonia and delirium tremens, as defined in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders", are **covered** just as they would be for any other illness or injury as described in the "Hospital Services" section. Benefits also include coverage for Medically Necessary inpatient services, supplies and medicine to treat substance abuse.

Outpatient Mental Health And Alcohol And Substance Abuse Treatment

Medically Necessary outpatient services for the diagnosis and treatment of mental illnesses, as defined in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders", are **covered** just as they would be for any other illness or injury as described in the "Outpatient Services" section. Benefits also include coverage for treatment for alcohol and substance abuse. The services must be provided by a licensed mental health provider.

Pre-Authorization is required for some outpatient treatment for mental health and alcohol and substance abuse services, including office visits, subsequent to an evaluation. Please refer to the "Pre-Authorization And Pre-Certification (Prior Approval) Addendum" to find out what services require Pre-Authorizations.

There is no coverage for behavioral health conditions with the following diagnoses:

- Caffeine-related disorders
- Communication disorders
- Learning disorders
- Mental retardation
- Motor skills disorders
- Relational disorders
- Sexual deviation, or
- Other conditions not defined as mental disorders in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders."

OTHER SERVICES

Home Health Services

Medically Necessary home health services must be provided by a Home Health Agency and Pre-Authorized. Home health services are **covered up to the benefit maximum as shown on the Benefit Summary**, if:

- We determine that Hospitalization or admission to a Skilled Nursing Facility would otherwise be required; or,
- The Member is diagnosed as terminally ill and his/her life expectancy is six months or less; or
- A plan of home health care is ordered by a physician and approved by us.

  The home health services must be medical and therapeutic health services provided in the Member's home, including:

  - Nursing care by a registered nurse or licensed practical nurse;
  - Social services by a Masters-prepared social worker provided to, or on behalf of, a terminally ill Member;
  - Physical, occupational or speech therapy;
  - Hospice care for a terminally ill patient (i.e., having a life expectancy of six months or less); or
  - Certain medical supplies, medications and laboratory services.

There is no coverage for:

- Custodial Care
- Convalescent care
- Domiciliary care
- Rest home care, or
- Home health aide care that is not patient care of a medical or therapeutic nature.

The benefit maximum does not apply to Hospice care.

Disposable Medical Supplies And Durable Medical Equipment (DME), Including Prosthetics

Disposable Medical Supplies

Some, but not all, disposable medical supplies, which are used with covered durable medical equipment or covered medical treatment received in the home, are **covered after**

the applicable Cost-Share as shown on your Benefit Summary.

The following limitations and conditions apply:

- Disposable medical supplies must be ordered by a physician.

  Note: Having a doctor's order is not a guarantee that the disposable supplies are covered.

- Disposable medical may be obtained from either a Participating Provider or a Non-Participating Provider by presenting the physician's order to the vendor.
- Disposable medical supplies will also be covered if they are dispensed in:
  - A physician's office as part of the physician services; or
  - An emergency room as part of Emergency Services; or
  - An Urgent Care Center as part of Urgent Care.

  In these cases, the disposable medical supplies will be covered as part of the Disposable Medical Supplies, Emergency Room or Walk-In/Urgent Care Centers benefit, as applicable.
- We have the right to change the list of covered disposable medical supplies from time to time.

Durable Medical Equipment (DME), Including Prosthetics

Durable Medical Equipment (DME) including prosthetics, consists of non-disposable equipment which is primarily used to serve a medical purpose that is generally not useful to a person in the absence of illness or injury and is appropriate for use in the home. DME is **covered after the applicable Cost-Share as shown on the Benefit Summary**.

The following limitations and conditions apply:

- DME must be ordered by a physician.

  Note: Having a doctor's order is not a guarantee that the DME is covered.
- The equipment must be provided by a DME Participating Provider in order for the DME to be covered at the highest level of benefits.
- If a Participating Provider does not carry the covered DME, the DME may be purchased at a Non-Participating Provider as long the DME is prescribed by a doctor and Pre-Authorized by us.
- Some DME requires Pre-Authorization before it will be covered. The DME that requires Pre-Authorization is listed in the "Services Requiring Pre-Authorization Or Pre-Certification" section.
- DME may be authorized for rental or purchase based on the expected length of medical need and the cost/benefit of a purchase or rental. We will decide whether DME is to be rented or purchased. If a rental item is converted to a purchase, the Coinsurance the Member pays for the purchase will be based on only the balance remaining to be paid in order to purchase the equipment.
- DME will be covered without Pre-Authorization if it is dispensed in:
  - A physician's office as part of physician services;
  - An emergency room as part of Emergency Services; or
  - An Urgent Care Center as part of Urgent Care.

  In these cases, DME will be covered as part of the DME, Emergency Room or Walk-In/Urgent Care Centers benefit, as applicable.
- Hearing aids for a Member age 12 and under are **covered** up to one hearing aid **every 24 months**.
- A wig prescribed by an oncologist for a Member suffering hair loss as a result of chemotherapy or radiation therapy is **covered without Pre-Authorization up to one wig per year**.
- To be covered, DME must not duplicate the function of any previously obtained equipment.

Ostomy Supplies And Equipment

Medically Necessary disposable medical supplies and DME for ostomy care following surgery are **covered after the applicable Cost-Share as shown on the Benefit Summary**.

Examples of covered ostomy supplies and equipment are: collection devices, irrigation equipment and supplies, skin barriers and skin protectors.

Ostomy Supplies, Limitations And Conditions

The following limitations and conditions apply to the ostomy supplies and equipment benefit:

- Ostomy supplies and equipment must be prescribed or ordered by a doctor as a result of surgery.
- Ostomy supplies or equipment ordered by a doctor may be obtained from either a Participating Provider or a Non-Participating Provider. To obtain the supply or equipment, the Member must present the prescription or doctor's order to the provider that is selling the supply or equipment.
- Ostomy supplies or equipment will also be covered as part of the Outpatient Services, Emergency Room or Walk-In/Urgent Care Centers benefit if dispensed in:
  - A doctor's office as part of doctor services,
  - An emergency room as part of Emergency Services, or
  - An Urgent Care Center as part of Urgent Care.

  In the cases listed immediately above, the ostomy

supplies and equipment will be covered as part of the Outpatient Services, Emergency Room or Walk-In/Urgent Care Centers benefit, as an applicable benefit.

ADDITIONAL SERVICES

Autism Services

Medically Necessary diagnosis and treatment of Autism Spectrum Disorders (ASDs), identified and ordered in a treatment plan developed by a licensed doctor, psychologist or clinical social worker pursuant to a comprehensive evaluation are **covered**:

- Behavioral Therapy for children up until their 15th birthday, when provided or supervised by a behavioral analyst who is certified by the Behavioral Analyst Certification Board, or by a licensed doctor, or by a licensed psychologist are **covered** as follows:
  - 210 hours per year – Child 0 to 9 years
  - 145 hours per year – Child 9 to 13 years
  - 105 hours per year – Child 13 to 15 years
- Direct psychiatric or psychological services and consultations provided by a licensed psychiatrist or by a psychologist.
- Occupational, physical and speech/language therapy provided by a licensed therapist.

  This occupational, physical and speech/language therapy benefit is not subject to any benefit maximum for outpatient rehabilitative therapy listed on your Benefit Summary.
- Prescription drugs when prescribed by a physician, by a doctor's assistant or by an advanced practice registered nurse for the treatment of symptoms and comorbidities of ASD, as **covered** as described in the "Prescription Drug" subsection of the "Benefits" section.

There is no coverage for special education and related services, except as described above.

Birth To Three Program (Early Intervention Services)

Early intervention services consist of care as part of an Individualized Family Service Plan as prescribed by State law and are **covered** for a Member from his/her birth until his/her third birthday.

For children with Autism Spectrum Disorders (ASDs) who are receiving early intervention services, the benefit maximum payable under the birth to three early intervention benefit shall be 210 hours per Member per year with a combined benefit of 630 hours per Member over the three year early intervention period. The amount of coverage provided in the "Autism Services" section does not increase over the amounts already provided: any coverage provided for Autism Spectrum Disorders through an early intervention Individualized Family Service Plan is credited toward the coverage amounts described in the "Autism Services" section.

The Cost-Share amount depends on where the procedures are rendered and will only apply if the Member is enrolled in one of our HSA-compatible high deductible health plans (HDHPs).

Any benefit amount paid for early intervention services does not:

- Count towards any benefit maximums this Plan may have, except as permitted under applicable law, or
- Negatively affect the eligibility of coverage under this Plan to the child, the child's parent or the child's family members who are Members under this Plan, or
- Constitute a reason for us to rescind or cancel the Member's coverage under this Plan.

Cardiac Rehabilitation

Cardiac rehabilitation is **covered after the applicable Cost-Share amount described in your Benefit Summary.**

Phase I cardiac rehabilitation is **covered**.

Medically Necessary Phase II cardiac rehabilitation is **covered** if it is ordered by a doctor and received in a structured setting.

Coverage for Phase III cardiac rehabilitation is only available for Members who meet the rules for enrollment in our HeartCare health management program and when the rehabilitation program is approved by us. See the "Health Management Programs" section.

Phase IV Cardiac rehabilitation is **not covered**.

Casts And Dressing Application

Application of casts and dressings is **covered after the applicable Cost-Share amount**. The Cost-Share amount depends on where the services are provided.

Clinical Trials

Certain routine care for a Member who is a patient in a disabling or Life-Threatening chronic diseases clinical trial, such as for cancer, is **covered** just as routine care would be covered under this Plan if the Member were not involved in a disabling or Life-Threatening chronic diseases clinical trial. All of the terms and conditions of this document apply.

For the purposes of this clinical trials benefit, **Life-Threatening means** any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

In order for the Member to be eligible for coverage, the trial must be Pre-Authorized and must take place under an independent peer-reviewed protocol approved or funded by:

- One of the National Institutes of Health,

- ♥ The Centers for Disease Control and Prevention,
- ♥ The Agency for Health Care Research and Quality,
- ♥ The Centers for Medicare & Medicaid Services,
- ♥ A National Cancer Institute affiliated cooperative group or the federal Department of Defense, Department of Energy, or Department of Veterans Affairs,
- ♥ The federal Food and Drug Administration (FDA) as part of an investigational new medication or device application or exemption

Coverage includes Health Services at Non-Participating Providers, if the treatment is not available at Participating Providers and is not paid for by the clinical trial sponsor. Payments made to Non-Participating Providers for clinical trials will be made at no greater cost to the Member than if the treatment were provided at Participating Providers.

The Connecticut Insurance Department has issued a standardized form that must be used when a Member asks us to cover routine care costs in a clinical trial.

Denials are subject to the State of Connecticut utilization review external Appeal/Grievance program.

We may require the following in order for a Member to be considered for coverage:

- ♥ Evidence that the Member meets all of the selection criteria for the trial;
- ♥ Evidence that the Member has given appropriate informed consent to the trial;
- ♥ Copies of any medical records, rules, test results or other clinical information used to enroll the Member in the trial;
- ♥ A summary of how the expected routine care costs would exceed the costs for standard treatment;
- ♥ Information about any items or services (including routine care) that may be paid for by another entity, including the name of the company paying for the trial; and/or
- ♥ Any other information we may reasonably need to review the request.

There is no coverage for the following:

- ♥ Costs of Experimental Or Investigational medicines or devices that are not exempt from new medicine or device application by the Food and Drug Administration
- ♥ Costs for non-Health Services
- ♥ Costs that would not be covered by this Plan for a non-Experimental Or Investigational treatment
- ♥ Facility, ancillary, professional services and medicine costs paid for by grants or funding for the trial
- ♥ Routine costs that are:
  - ◆ Experimental Or Investigational,
  - ◆ Obtained by a Non-Participating Provider, unless you are enrolled in one of our **POS Plans** or you are enrolled in one of our **HMO Plans** and the clinical trial is not available through a Participating Provider,
  - ◆ Provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the Member, or
  - ◆ Services that are clearly inconsistent with widely accepted and established standards of care for a particular diagnosis
- ♥ Transportation, lodging, food or other travel expenses for the Member or any family member or companion of the Member

Corneal Pachymetry

Medically Necessary corneal pachymetry (measurement of the thickness of the cornea) is **covered after the applicable Cost-Share amount**. The Cost-Share amount depends on where the test is rendered. Coverage is available for one complete test per lifetime without Pre-Authorization. However, repeat corneal pachymetry tests require Pre-Authorization.

Craniofacial Disorders

Medically Necessary orthodontic treatment and appliances for the treatment of craniofacial disorders are **covered** for Members age 18 and younger, if the treatment and appliances are prescribed by a craniofacial team recognized by the American Cleft Palate-Craniofacial Association and if Pre-Authorized by us. The Cost-Share amount depends on where the services are provided.

Diabetes Services

All Medically Necessary laboratory and diagnostic tests for diabetes and all Medically Necessary services, supplies, equipment and prescription drugs when ordered by a doctor for the treatment of diabetes (including treatment for routine foot care) are **covered**. The Cost-Share amount depends on where the services are provided.

Education

Outpatient self-management training for the treatment of diabetes, if the training is prescribed by a licensed health care professional, is **covered**. The training must be provided by a certified, registered or licensed health care professional trained in the care and management of diabetes. The Cost-Share amount depends on where the training is provided.

Benefits cover:

- ♥ Up to ten hours of initial training for a Member who is first diagnosed with diabetes for the care and management of diabetes, including counseling in nutrition and proper use of equipment and supplies for the treatment of diabetes; and

- ♥ Up to four hours for Medically Necessary training and education as a result of an additional diagnosis by a doctor of a major change in the Member's symptoms or condition that requires a change of his/her program of self-management of diabetes; and
- ♥ Up to four hours for Medically Necessary training and education as a result of new techniques and treatment for diabetes.

Prescription Drugs And Supplies

If a Member obtains prescription drugs and supplies for the treatment of diabetes, the rules described in the "Prescription Drug" subsection of the "Benefits" section, including its Cost-Share provisions apply.

If a Member obtains these same supplies for the treatment of diabetes from a supplier that is not a Participating Pharmacy, the supplies are covered as described in the "Disposable Medical Supplies" section.

Prescription drugs administered by a needle, which are not obtained from a doctor or from a Home Health Agency, are **covered** as described in the "Prescription Drug" subsection of the "Benefits" section.

Drug Ingestion Treatment (Accidental)

Medically Necessary services needed to treat the accidental ingestion or consumption of a controlled drug are **covered**. The Cost-Share amount depends on where the services are provided.

Drug Therapy (Outpatient/Home)

Medically Necessary Drug Therapy is **covered after the applicable Cost-Share amount**. The Cost-Share amount depends on where the Drug Therapy is rendered.

Some Drug Therapy requires Pre-Authorization.

Drug Therapy services include all drugs administered by a licensed provider in an outpatient Hospital facility, an infusion center or the Member's home.

Eye Care

Diseases And Abnormal Conditions Of The Eye

Medically Necessary medical and surgical diagnosis and treatment of diseases or other abnormal conditions of the eye and structures next to the eye are **covered after the applicable Cost-Share amount**. This coverage includes annual retinal eye exams for Members with an existing condition of the eye, such as glaucoma or diabetic retinopathy. The Cost-Share amount depends on where the services are received.

Eyeglasses And Contact Lenses

Prescription lenses, frames, and prescription contact lenses for Members under age 19 are **covered up to the maximum benefit, as shown on your Benefit Summary**, as follows:

- ♥ One pair of eyeglasses (lenses and frames) per year; or
- ♥ Contact lenses which include one fitting and set of lenses per year.

There is no coverage for adults (Members over age 19) eyeglasses and contact lenses.

Genetic Testing

Certain genetic testing is **covered after the applicable Cost-Share amount** when a Member has or is thought to have a clinical genetic condition and when the genetic testing is Pre-Authorized. The Cost-Share amount depends on where the tests are provided.

Coverage will be available only:

1. When the Member has obtained genetic counseling and
2. An appropriate evaluation has been performed consisting of:
   - ♥ A complete history,
   - ♥ A physical examination,
   - ♥ Conventional diagnostic studies and
   - ♥ Pedigree analysis
3. When a diagnosis cannot be made using routine diagnostic testing and there remains the possibility of a genetic condition that will affect the Member's health, and,
4. When the result of the genetic testing will directly impact the Member's treatment

Only the following genetic tests will be covered.

Unless otherwise noted, genetic testing for any of these conditions requires Pre-Authorization.

1. Genetic screening tests recommended by the American Congress of Obstetricians and Gynecologists (ACOG) or the American College of Medical Genetics (ACMG);
2. Cancer genetic testing recommended by either the National Comprehensive Cancer Network or the American Society of Clinical Oncologists;
3. Genetic testing to guide medication therapy for the treatment of lymphoma, leukemia, and inflammatory bowel disease;
4. Prenatal genetic testing associated with chorionic villus sampling and/or amniocentesis and consistent with standard of care;
5. One of the following genetic conditions:
   - ♥ CADASIL
   - ♥ Colorectal Cancer Susceptibility
   - ♥ Cystic Fibrosis - **Pre-Authorization not required**
   - ♥ Factor V Leiden - **Pre-Authorization not required**
   - ♥ Fragile X - **Pre-Authorization not required**
   - ♥ Hemoglobinopathies

Take a look at the "Managed Care Rules And Guidelines" section to see if you have to use Participating Providers and the "Pre-Authorization And Pre-Certification (Prior Approval) Addendum" to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

- ♥ Hereditary Breast and Ovarian Cancer Syndrome (BRCA)
- ♥ Hereditary Hemochromatosis - **Pre-Authorization not required**
- ♥ Hypertrophic Cardiomyopathy
- ♥ Long QT Syndrome
- ♥ Medullary thyroid cancer and multiple endocrine neoplasia type 2, MEN2 (RET)
- ♥ Prothrombin - **Pre-Authorization not required**
- ♥ Retinoblastoma

In addition to these genetic testing services, some pre-implantation genetic testing in the setting of in-vitro fertilization (IVF), gamete intra-fallopian transfer (GIFT), zygote intra-fallopian transfer (ZIFT) and low tubal ovum transfer procedures are **covered**. Please see the "Infertility Services" subsection for more information.

There is no coverage for:

- ♥ All other genetic testing services, as well as genetic testing panels not endorsed by ACOG or ACMG
- ♥ Genetic testing kits available either direct to the consumer or via a physician prescription
- ♥ Genetic testing only for the benefit of another family member
- ♥ Whole genome or whole exome genetic testing

Hospice Care

Medically Necessary Hospice care is **covered** if the Member has a life expectancy of six months or less and if the care is Pre-Authorized or Pre-Certified by us. The Member's doctor must contact us to arrange Hospice care. Hospice care does not apply to any specific benefit maximums your Plan may have.

Hospital Care

Visits a doctor makes to examine or treat a Member who is hospitalized are **covered**.

Infertility Services

Benefits

The following Medically Necessary diagnostic and testing procedures and therapy needed to treat diagnosed Infertility are **covered at the applicable Cost-Share amounts as shown on your Benefit Summary, up to the limits described below,** if Pre-Authorized by us for a Member up to his/her 40th birthday:

- ♥ Ovulation induction (to a maximum of four cycles no matter what the reasons are for the ovulation induction).
- ♥ Intrauterine insemination (to a maximum of three cycles per recipient, no matter the source, where one cycle equals one intrauterine insemination (IUI) within a 30 day period).
- ♥ Uterine embryo lavage, in-vitro fertilization (IVF), gamete intra-fallopian transfer (GIFT), zygote intra-fallopian transfer (ZIFT) or low tubal ovum transfer, including the use of gonadotropins and other medicines designed to stimulate ovulation (to a maximum of two cycles **combined for all procedures**, with not more than two embryo implantations per cycle). These cycles are only covered when the Member has been unable to conceive or produce conception or sustain a successful pregnancy through the less expensive and medically appropriate treatments covered by this Plan.

  A particular Infertility treatment or procedure does not have to be tried first if the Member's treating Board Eligible or Board Certified Reproductive Endocrinologist certifies that the treatment or procedure is unlikely to be successful.
- ♥ Pre-implantation genetic testing only when Medically Necessary and Pre-Authorized, as part of a Pre-Authorized IVF, GIFT, ZIFT or low tubal ovum transfer procedure, if embryos are at risk for known genetic mutations. Pre-implantation genetic testing to determine the gender of an embryo is covered only when there is a documented risk of an x-linked disorder.
- ♥ Prescription drugs (medicines) to treat Infertility when Pre-Authorized.

  These drugs or medications are only covered for the gender indicated by the federal Food and Drug Administration (FDA) and are **covered** as described in the "Prescription Drug" subsection of the "Benefits" section

Rules

In order to obtain benefits for Infertility the following rules apply:

1. For certain Infertility services, a Member must be treated by a board eligible or board certified reproductive endocrinologist at a facility that meets the standards and rules of the American Society of Reproductive Medicine or the Society of Reproductive Endocrinology and Infertility after the Member has obtained an evaluation from his/her OB-GYN or Primary Care Provider (PCP).

   If you are enrolled in either our **HMO Personal Care Plan** or our **POS Personal Care Plan** (a plan that requires Referrals), then services will not be covered unless you obtain a Referral from your OB-GYN or PCP to the board eligible or board certified reproductive endocrinologist.
2. All services must be provided by the providers noted above in order to be covered. If you are enrolled in one of our **HMO Plans** (a plan that requires you use

Participating Providers), then you must use Participating Providers for coverage.

In addition, oral medicines needed to treat Infertility must be prescribed by your OB-GYN to be covered.

There is no coverage for:

- Cryopreservation (freezing) or banking of eggs, embryos, or sperm.
- Genetic analysis and testing, except as described above or in the "Genetic Testing" section, including:
  - All other genetic testing services, as well as genetic testing panels not endorsed by ACOG or ACMG
  - Genetic testing kits available either direct to the consumer or via a physician prescription
  - Genetic testing only for the benefit of another family member
  - Whole genome or whole exome genetic testing
- Medicines for sexual dysfunction, unless your Plan includes our **Supplemental Sexual Dysfunction Prescription Drug Rider**.
- Recruitment, selection and screening and any other expenses of donors (donors of eggs, embryos or sperm).
- Reversal of surgical sterilization.
- Surrogacy and all charges associated with surrogacy such as prescription drugs or egg harvesting, fertilization or implantation.

There may be instances where Infertility benefits will not be covered where the Employer is a "religious employer" as defined in 26 USC 3121 or a church-affiliated organization. Check your Benefit Summary.

Lyme Disease Services

Medically Necessary treatment of Lyme Disease is **covered** as follows:

- Up to a maximum of 30 days of intravenous antibiotic therapy or 60 days of oral antibiotic therapy, or both; and
- Further antibiotic treatment if it is recommended by a board certified rheumatologist, by an infectious disease specialist, or by a neurologist.

Antibiotic drugs are covered under the rules as described in the "Prescription Drug" subsection of the "Benefits" section, subject to the Cost-Shares in your Benefit Summary.

Neuropsychological Testing

Medically Necessary psychological, neuropsychological or neurobehavioral testing is **covered** only when performed by an appropriately licensed neurologist, by a psychologist or by a psychiatrist. Pre-Authorization is required, **EXCEPT** for neuropsychological testing ordered by a doctor to determine the extent of any cognitive or developmental delays due to chemotherapy or radiation treatment in a child diagnosed with cancer.

Nutritional Counseling

Coverage for nutritional counseling services is limited to **two visits per Member per year**. Nutritional counseling must be for illnesses requiring therapeutic dietary monitoring, including the diagnosis of obesity. In addition, the services must be prescribed by a licensed health care professional and provided by a certified, registered or licensed health care professional.

Nutritional Supplements And Food Products

Enteral Or Intravenous Nutritional Therapy

Medically Necessary enteral (tube feeding) or intravenous nutritional products are **covered** when ordered by a doctor, if they are needed for a medical illness or injury, are to be used for the total caloric needs of the Member and are Pre-Authorized.

Oral nutritional products (except for Modified Food Products For Inherited Metabolic Diseases and Other Specialized Formulas) that are specially changed to allow them to be taken through an irregular gastrointestinal tract are **covered** when:

- They are ordered by a doctor;
- They are needed due to a gastrointestinal illness or injury preventing them from being taken normally;
- They are to be used for the total caloric needs of a Member; and
- They are Pre-Authorized.

Modified Food Products For Inherited Metabolic Diseases

Medically Necessary modified food products (low protein) and amino acid modified preparations are **covered** for the treatment of the following inherited metabolic diseases:

- Biotinidase deficiency
- Congenital adrenal hyperplasia
- Cystic fibrosis
- Galactosemia
- Homocystinuria
- Hypothyroidism
- Inborn errors of metabolism, as described by the Department of Public Health
- Maple syrup urine disease
- Phenylketonuria (for which newborn screening is required)
- Sickle cell disease

To be covered, the modified food products (low protein) and amino acid preparations must be ordered for the therapeutic

treatment of one of the inherited metabolic diseases noted above by a doctor and administered under his/her direction.

Benefits will be paid at 100% for these modified food products, even if this Plan requires you to meet a Deductible before benefits will be paid and you have not yet met that Deductible amount. If you are enrolled in one of our **HMO or POS High Deductible Health Plans (HDHP)**, this benefit is subject to your Deductible before benefits will be covered at 100%.

Other Specialized Formulas

Specialized formulas are **covered** if Pre-Authorized for a Member up to his/her twelfth birthday when the formula does not have to be part of the general nutritional labeling requirements of the federal Food and Drug Administration and its intended use is solely for the dietary management of specific diseases or conditions. The formula must be Medically Necessary, ordered by a doctor and administered under his/her direction.

Benefits will be paid at 100% for these other specialized formulas, even if your Plan requires you to meet a Deductible before benefits will be paid and you have not yet met that Deductible amount. If you are enrolled in one of our **HMO or POS High Deductible Health Plans (HDHP)**, this benefit is subject to your Deductible before benefits will be covered at 100%.

Except as noted above, no other nutritional supplements, food supplements, infant formulas, enteral nutritional therapies or specialized formula are covered.

Pain Management Services

Medically Necessary pain management services provided by a doctor (including evaluation and therapy) for short or long term pain conditions are **covered after the applicable Cost-Share amount**. The Cost-Share amount depends on where the services are provided.

Prescription Contraception

Prescription contraception methods approved by the federal drug administration (FDA) are **covered at no Cost-Share when they are obtained at a Participating Pharmacy**.

Benefits include to following:

- ♥ Cervical caps
- ♥ Diaphragms
- ♥ Intrauterine Devices (IUDs)
- ♥ Oral contraceptives

NOTE: Prescription contraception methods are NOT covered, if specified on your Benefit Summary.

Renal Dialysis

Medically Necessary renal dialysis for the treatment of kidney disease is **covered**.

If a Member is signed up in one of our **HMO Plans** and will be out of the Services Area for one week or more, renal dialysis for the treatment of kidney disease will be **covered up to six renal dialysis treatments per year** if Pre-Authorized and if the treatment is provided to the Member by a Non-Participating Provider.

Sleep Studies

Medically Necessary sleep studies are **covered after the applicable Cost-Share amount**. The Cost-Share amount depends on where the services are provided. Coverage is available for **one complete study per lifetime** when provided by a sleep facility or out-of-center sleep organization that is accredited by the American Academy of Sleep Medicine (AASM) under the supervision of a board-eligible or board-certified practitioner of Sleep Medicine. A complete sleep study may include more than one session.

Surgery And Other Care Related To Surgery

Medically Necessary surgery provided by a doctor is **covered after the applicable Cost-Share amount**. The Cost-Share amount depends on where the services are provided. Some surgical procedures require Pre-Authorization. The surgical procedures that require Pre-Authorization are listed in the "Services Requiring Pre-Authorization Or Pre-Certification" section.

Anesthesia Services

Anesthesia services as part of a covered inpatient or outpatient surgical procedure provided by a doctor are **covered**.

Breast Implants

The surgical removal of any breast implant which was implanted on or before July 1, 1994, no matter what the purpose of the implantation, is **covered** if the services are provided by a doctor. The surgical implantation of a prosthetic device required in connection with the surgical removal of a breast due to a tumor is **covered**.

Oral Surgery Services

Medically Necessary oral surgical services for the treatment of tumors, cysts, injuries of the facial bones and for the treatment of fractures and dislocations involving the face and jaw, including temporomandibular joint (TMJ) dysfunction surgery (for demonstrable joint disease only) or temporomandibular disease (TMD) syndrome, provided by a doctor are **covered**. Oral surgery requires Pre-Authorization.

There is no coverage for non-surgical treatment of temporomandibular joint (TMJ) dysfunction or temporomandibular disease (TMD) syndrome, including but not limited to appliances, behavior modification, physiotherapy and prosthodontic therapy.

Reconstructive Surgery

The following reconstructive surgery provided by a doctor and when Pre-Authorized is **covered**:

- ♥ Procedures to correct a serious disfigurement or

deformity resulting from:

- Illness or injury,
- Surgical removal of tumor, or
- Treatment of leukemia.

♥ Medically Necessary reconstructive surgery for the correction of a congenital anomaly restoring physical or mechanical use to that part of the Member's body.

Other reconstructive surgery for the correction of congenital malformation is excluded. See the "Exclusions And Limitations" section.

♥ Medically Necessary breast reconstructive surgery on each breast on which a mastectomy has been performed and on a non-diseased breast (in conjunction with reconstruction after mastectomy) to produce a symmetrical appearance.

Sterilization

Sterilization services provided by a doctor are **covered after the applicable Cost-Share amount**. The Cost-Share amount depends on where the procedures are provided.

Termination Of Pregnancy

Services for elective and non-elective termination of pregnancy are **covered after the applicable Cost-Share, as shown on your Benefit Summary, up to three terminations of pregnancy per lifetime**. The Cost-Share amount depends on where the procedures are provided.

Wound Care Supplies

Medically Necessary wound care supplies (including wound vacs) are covered when:

♥ Prescribed by a physician

♥ Supplied by a participating health care provider or Home Care Agency

♥ Pre-Authorized by us, and

♥ Provided in conjunction with authorized home care services

If wound care supplies are **not** being provided in conjunction with authorized home care services then the applicable Cost-Share amount will apply. Refer to the "Disposable Medical Supplies" section.

Wound Care Supplies for Epidermolysis Bullosa

Medically necessary wound care supplies administered under the direction of a physician for the treatment of epidermolysis bullosa are **covered** with Pre-Authorization. Supplies will be **covered after the applicable Cost-Share amount**. The Cost-Share amount depends on where the supplies are obtained.

Discount Arrangements And Health Management Programs

Discount Arrangements

Discount arrangements are not insurance. We may arrange for discounts with certain service providers to promote wellness or health activities. These third party service providers are independent contractors that are solely responsible to you for the provision of any goods or services. Some of these providers may compensate us for making these discounts available, but we do not pay these providers for goods or services. We reserve the right to modify or discontinue such arrangements at any time. There are no benefits payable to Members. These arrangements are voluntary and do not affect the covered benefits available under this Plan.

Health Management Programs

Health management programs are set up to help Members manage their long term health conditions.

Members in this Plan may be eligible to enroll in one or more of our health management programs. In addition, Members may be contacted and managed by our High Risk Member Outreach Program.

Depending on the programs that are available at the time, a Member may receive the following items or services as value added services or covered benefits:

♥ Educational mailings or visits

♥ Nicotine replacement therapy (NRT)

♥ Pillboxes

♥ Special medical equipment such as a blood pressure monitor/cuff, a peak flow meter, a glucose monitor or a scale to assist during convalescence or to monitor a special medical condition)

When these items are covered benefits, they will not be subject to standard claim processing and Cost-Sharing rules.

If you are enrolled in one of our HSA-compatible high deductible health plans (HDHP), the health management program items or services that are covered benefits are subject to the Plan Deductible. However, those items or services may not be subject to the other Cost Share amounts that do apply after the Plan Deductible is satisfied.

You can call our Member Services Department to find out more about our current health management programs.

PRESCRIPTION DRUGS

Benefits

NOTE: Under federal law, we will permit certain medications, certain over-the-counter (OTC) contraceptives and vitamins, as defined by the United States Preventive Service Task Force, to be exempt from Member Cost-Shares (Deductible, Copayment and Coinsurance). As a result, there may be times when you will not be required to pay the applicable Cost-Shares you usually pay for covered medications under your Plan.

Subject to all of the provisions of this member document, including the guidelines, and exclusions and limitations, benefits consist of the following prescription drugs, medications, and supplies.

- ♥ All federal Food and Drug Administration (FDA) approved prescription drugs.

NOTE: Prescription Infertility medications are NOT covered under this Plan if specified on your Benefit Summary.

- ♥ All prescription contraceptive methods approved by the federal FDA, including:
  - ◆ Cervical caps
  - ◆ Diaphragms
  - ◆ Intrauterine Devices (IUDs)
  - ◆ Oral contraceptives

NOTE: Prescription contraception is NOT covered under this Plan if specified on your Benefit Summary.

- ♥ For the treatment of Lyme Disease: up to 30 days of intravenous antibiotic therapy or up to 60 days of oral antibiotic therapy, or both, and further antibiotic treatment if recommended by a board certified rheumatologist specialist, infectious disease specialist or neurologist.
- ♥ Injectable drugs, provided that they are obtained at a pharmacy and all of the other rules of this subsection are followed.

NOTE: Orally administered anticancer drugs shall be covered no less favorably than the intravenous administration of injectable anticancer drugs are, where consistent with applicable federal law.

- ♥ Insulin and the following equipment and supplies:
  - ◆ Acetone/ketone testing agents
  - ◆ Blood and urine glucose testing agents
  - ◆ Injectable syringes and needles
  - ◆ Lancets

To be covered, prescription drugs must:

- ♥ Be Medically Necessary;
- ♥ Be marketed in the United States at the time of purchase; and
- ♥ In most cases, bear the label: "Caution: Federal law prohibits dispensing without prescription." (Please see the "Over-The-Counter (OTC) Medications" subsection to find out when OTC medications are covered.)

Additional Benefits

Over-The-Counter (OTC) Medications

Certain over-the-counter (OTC) medications are **covered**, subject to terms and conditions of this member document and the following:

1. The OTC medication must be an OTC medication that we will cover. The OTC medications that we will cover are listed in this subsection.
2. You must obtain a prescription for the OTC medication from your doctor.
3. The OTC medication must be filled at a Participating Pharmacy by the pharmacist; otherwise it will not be covered.
4. When such OTC medications are covered, they will be covered as described in the "Tiered Cost-Share Program" provisions of the "Prescription Drug Programs" subsection of this section and at the applicable Cost-Share amount found on your Benefit Summary.

The Cost-Share amounts you are required to pay for prescriptions are found on your Benefit Summary.

The following OTC medications are covered

Cetirizine OTC
Fexofenadine OTC
Ketotifen ophthalmic
Loratadine OTC
Omeprazole OTC
Prevacid 24

This list may change at any time. When the list does change, you will be notified in our member newsletter. You should call our Member Services Department at the telephone number listed in the "Important Telephone Numbers And Addresses" section (or visit us at our web site at www.connecticare.com) to find out if an OTC medication may be covered under this member document. We have the right to change the drugs on the list in our discretion.

Specialty Drugs

Specialty drugs are those prescription drugs that are not needed immediately to treat a sudden medical condition, and that require:

- ♥ A higher level of pharmacy expertise,
- ♥ Increased patient knowledge to administer, and
- ♥ Special handling,

Take a look at the "Managed Care Rules And Guidelines" section to see if you have to use Participating Providers and the "Pre-Authorization And Pre-Certification (Prior Approval) Addendum" to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

In addition, specialty drugs are not typically stocked in a retail pharmacy.

Certain specialty prescription drugs require Pre-Authorization. You can find out the specialty drugs that require Pre-Authorization by calling our Member Services Department at the telephone number listed in the "Important Telephone Numbers And Addresses" section or visiting us at our web site at www.connecticare.com.

Specialty drugs that require Pre-Authorization should be filled through specialty pharmacies that are Participating Pharmacies, unless you qualify for an exception. If you believe you should be eligible for an exception, your provider must complete a specialty pharmacy exception form and then send it to us via fax at (860) 674-2851 or via regular mail at the following address:

ConnectiCare Pharmacy Services
175 Scott Swamp Road
Farmington, CT 06032-3124

If you need a copy of the specialty pharmacy exception form, it can be obtained by calling our Member Services Department at the telephone number listed in the "Important Telephone Numbers And Addresses" section or by visiting us at our web site at www.connecticare.com.

If an exception to this policy is granted by us, that exception will only be for a defined period of time, usually six months to one year. At the end of that exception period of time, your provider is required to request the exception again for you to continue receiving that specialty drug. If we deny the request, we will reply to you and your provider, in writing, why the exception request was not approved.

If you are out of a specialty drug or if the specialty drug ordered by a Participating Provider does not arrive in time, we will authorize the specialty drug for up to a 30-day supply, so you can obtain the needed medication at a Participating Pharmacy near you and you will not be required to pay any additional amounts above the normal Cost-Share amounts of this Plan.

When you or your provider contacts us for Pre-Authorization of the drug, you or your provider will be notified of the number to call to contact the specialty pharmacy if Pre-Authorization is granted. Specialty prescription drugs, when Pre-Authorized by us, will be dispensed for a maximum of 30-day supply per fill. You may also obtain the contact information for the specialty pharmacy by calling our Member Services Department directly at the telephone number listed in the "Important Telephone Numbers And Addresses" section. The drugs will be shipped to your doctor's office, your home, or other location based on the type of drug or treatment. Specialized counseling and education is available to you from the specialty pharmacies regarding proper administration, storage, dosage, drug interactions, and side effects of these specialty drugs.

You can find the list of specialty drugs that need Pre-Authorization at the back of this document.

Updates to the list of specialty drugs requiring Pre-Authorization are also published from time to time in our member newsletter. You should call our Member Services Department at the telephone number listed in the "Important Telephone Numbers And Addresses" section (or visit us at our web site at www.connecticare.com) to find out if a specialty drug requires Pre-Authorization. We have the right to change the specialty drugs on the list in our discretion.

Guidelines

In addition, to be covered, all prescription drugs and supplies must meet the following rules and guidelines.

When you bring your prescription to the pharmacy to be filled, that submission of the prescription to the pharmacy does not represent a "claim" for coverage under this Plan. Requests for coverage or Pre-Authorization must be made directly to us to be considered a claim under the Plan.

Certain Prescription Drugs/Supplies Require Pre-Authorization

Certain prescription drugs and supplies require Pre-Authorization from us before they will be covered. In addition, any drug that is newly available to the market will also require Pre-Authorization until such time that we re-publish our list of drugs that require Pre-Authorization. You can find the list of prescription drugs that need Pre-Authorization at the back of this document.

Updates to the list of drugs or supplies requiring Pre-Authorization are also published from time to time in our member newsletter. You should call our Member Services Department at the telephone number listed in the "Important Telephone Numbers And Addresses" section (or visit us at our web site at www.connecticare.com) to find out if a prescription drug or supply requires Pre-Authorization. We have the right to change the drugs or supplies on the list in our discretion.

When A Participating Provider Writes A Prescription

When a Participating Provider writes the prescription for the drug or supply, it is the responsibility of the Participating Provider to obtain the Pre-Authorization, but you should check with your health care practitioner to make sure he or she has obtained Pre-Authorization **BEFORE** you go to the pharmacy.

When a prescription drug or supply requiring Pre-Authorization is not Pre-Authorized, it will be rejected by the pharmacy.

If the prescription drug or supply is filled, benefits available under this Plan will not be reduced or denied if the Participating Provider fails to request Pre-Authorization. However, when you submit that claim for reimbursement,

Take a look at the "Managed Care Rules And Guidelines" section to see if you have to use Participating Providers and the "Pre-Authorization And Pre-Certification (Prior Approval) Addendum" to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

we will review it for Medical Necessity. If we determine that the prescription drug or supply was not Medically Necessary, re-fills of that prescription drug or supply will not be covered.

When A Non-Participating Provider Writes A Prescription

It is your responsibility to obtain Pre-Authorization from us if a Non-Participating Provider writes your prescription.

When a prescription drug or supply requiring Pre-Authorization is not Pre-Authorized, it will be rejected by the pharmacy. If the prescription drug or supply is filled and you submit a claim to us for reimbursement, you should request your Non-Participating Provider to ask us for Pre-Authorization. When that occurs we will review the claim for Medical Necessity. If we determine that the prescription drug or supply was Medically Necessary and Pre-Authorization is then granted, we will reimburse you for the prescription drug or supply, which may be subject to the Benefit Reduction provisions described in the "Managed Care Rules And Guidelines" section of the member document. If we determine that the prescription drug or supply was not Medically Necessary, that prescription drug or supply will not be covered.

When Pre-Authorization is obtained, it is your responsibility to make sure the authorization is still applicable when you go to the pharmacy to have your prescription filled. If the authorization was for a time period that expired you will have to pay for the prescription. If the authorization was for an amount of drugs that is less than your prescription, your prescription will be filled at the amount of drugs that was Pre-Authorized.

Always Use Your ID Card

You and your covered dependents are required to use the ConnectiCare ID card when obtaining a prescription drug or covered supply. In the event you do not use your ID card, you will be charged the discount lost because the prescription drug or covered supply was processed without the ID card, in addition to any Cost-Share amount or other charge due under this Plan.

Participating Pharmacy Network

Under this Plan, you are free to use either Participating Pharmacies or Non-Participating Pharmacies to obtain covered prescription drugs, medications, and supplies; however you will pay different levels of Cost-Shares (Copayments, Coinsurance, and/or Deductibles) depending on the pharmacy that dispenses the covered prescription drugs, medications, and supplies.

This table highlights the way the Participating Pharmacies network works and the costs you will have. Your Benefit Summary will tell you the Cost-Share amount you are required to pay.

If You Use A	You Have
Participating Pharmacy	Lower Member Cost
Non-Participating Pharmacy	Highest Member Cost

Using A Participating Pharmacy

When you and your Eligible Dependents use a Participating Pharmacy, the out-of-pocket Cost-Share amount you pay is lower than what you would have pay if you were to use a Non-Participating Pharmacy.

To reduce your out-of-pocket costs, use a Participating Pharmacy.

To locate a Participating Pharmacy, you can refer to our Provider Directory, visit us at our web site at www.connecticare.com, or call us.

Using A Non-Participating Pharmacy

When you use a Non-Participating Pharmacy for prescriptions, you and your Eligible Dependents will still have coverage, but the out-of-pocket costs will be higher than they would be if you were to use a Participating Pharmacy.

Your Benefit Summary will tell you Cost-Share amount you are required to pay.

Prescription Drug Programs

The following provisions may apply to our Prescription Drug Programs. To determine which programs apply to your Plan, consult your Benefit Summary.

Generic Substitution Program

1. Most plans have the "Generic Substitution Program." To determine whether your Plan uses this program, consult your Benefit Summary. This program applies to prescriptions filled at Participating Pharmacies (retail or specialty pharmacies) and our designated mail order vendor.
2. In most plans, when you obtain certain Brand Name Drugs Or Supplies for which there is a Generic Equivalent, you must pay the applicable Cost-Share amount for the corresponding Generic Drug Or Supply in addition to the difference in price between the Generic Equivalent drug or supply and the Brand Name Drug Or Supply that you obtained.

   In some plans, the Cost-Share amount for a Brand Name Drug Or Supply is the same as the Cost-Share amount for a Generic Drug Or Supply.
3. If your physician prescribes the Brand Name Drug Or Supply for which there is a Generic Equivalent required to be substituted, the Participating Pharmacy will automatically switch the prescription to the Generic Equivalent drug or supply that is comparable to the Brand Name Drug Or Supply that was prescribed for you, unless your physician has written on the prescription that there should be no substitution or unless you request the Brand Name Drug Or Supply.

Take a look at the "Managed Care Rules And Guidelines" section to see if you have to use Participating Providers and the "Pre-Authorization And Pre-Certification (Prior Approval) Addendum" to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

Participating Pharmacies have information about Brand Name Drugs Or Supplies with Generic Equivalents that are required to be substituted. You should call our Member Services Department at the telephone number listed in the "Important Telephone Numbers And Addresses" section (or visit us at our web site at www.connecticare.com) to find out if a drug or supply is covered. We have the right to change the drugs or supplies that are required to be substituted in our discretion.

Pay The Difference Waiver

Some plans have the Pay The Difference Waiver as part of the Generic Substitution Program. To determine whether your Plan uses this waiver, consult your Benefit Summary.

When this waiver applies, in most plans we will cover the Brand Name Drug Or Supply at the applicable Cost-Share amount, when your physician requests the Brand Name Drug Or Supply on the prescription, without you having to pay the difference in price between the Brand Name Drug Or Supply and the Generic Equivalent drug or supply.

Tiered Cost-Share Program

1. Most plans have the "Tiered Cost-Share Program." To determine whether your Plan uses this program, consult your Benefit Summary. This program applies to prescriptions filled at Participating Pharmacies (retail pharmacies), our designated mail order vendor, or specialty pharmacies, as well as those OTC medications covered under this Plan (please refer to the "Over-The-Counter (OTC) Medications" subsection).
2. Under this program covered prescription drugs (including certain OTC medications) and supplies are put into categories (i.e., "tiers") to designate how they are to be covered and the Member's Cost-Share. The placement of a drug or supply into one of the tiers is determined by the ConnectiCare Pharmacy Services Department and approved by the ConnectiCare Pharmacy & Therapeutics Committee based on the drug's or supply's clinical effectiveness and cost, not on whether it is a Generic Drug Or Supply or Brand Name Drug Or Supply.

   The Cost-Share amount for a drug that is designated on the first tier is generally the lowest amount you will pay for a prescription. Conversely, if a drug or supply is put into a higher tier designation, you will generally have to pay more for that prescription. If a covered drug is in a higher tier designation, that doesn't mean it's not a good drug or that you shouldn't get it. It just means that you will have to pay more for it. If your Plan has a prescription drug Benefit Deductible this may not always be the case for particular prescriptions.

   In some plans, the Cost-Share amount from tier to tier is the same as the Cost-Share amount for another tier designation.

   In some plans with this program, you must pay a higher amount in addition to the Cost-Share amount, when you obtain a Brand Name Drug Or Supply when there is a Generic Equivalent.

We have the right to change the drugs (including certain OTC medications) or supplies in each tier in our discretion, even in the middle of the year. You should call our Member Services Department at the telephone number listed in the "Important Telephone Numbers And Addresses" section (or visit us at our web site at www.connecticare.com) to find out which tier (if any) a prescription drug or supply is in.

Mandatory Drug Substitution Program

1. Most plans have the "Mandatory Drug Substitution Program." To determine whether your Plan uses this program, consult your Benefit Summary. This program applies to prescriptions filled at Participating Pharmacies (retail pharmacies) and our designated mail order vendor.
2. Prescription drugs that are on our "Mandatory Drug Substitution" list are not covered, except as described below. Instead, another drug that has the same active ingredient as the excluded drug, but which is made by a different manufacturer or sold by a different distributor, will be covered. (The inactive ingredients may differ in the drugs. Active ingredients are those ingredients with a therapeutic effect. Inactive ingredients are those ingredients with no therapeutic effect.)
3. If your physician prescribes the excluded drug that is on the "Mandatory Drug Substitution" list, the Participating Pharmacy will switch the prescription or call your physician to receive authorization, if needed, to make the change to the covered drug from the excluded drug that was prescribed for you.
4. In certain cases, this Plan will cover the excluded drug on the "Mandatory Drug Substitution" list if we determine, in our discretion that, because of your or your covered dependent's adverse reaction to the covered drug or the covered drug's ineffectiveness for the Member, the excluded drug is Medically Necessary. We will make this determination based on clinical evidence presented by your physician to us.
5. We will also cover excluded drugs which are added to the "Mandatory Drug Substitution" list, if the following conditions are met:

   - ♥ You were obtaining, through your coverage under the Plan, the excluded drug for the treatment of a chronic illness prior to it being added to the "Mandatory Drug Substitution" list; and
   - ♥ Your doctor provides to us a written statement that the excluded drug is Medically Necessary and includes the reasons why the excluded drug is more medically beneficial in treating your chronic illness than the drugs that are covered under the Plan.

The drugs on the "Mandatory Drug Substitution" list are published from time to time in our member newsletter. You should call our Member Services

Department at the telephone number listed in the "Important Telephone Numbers And Addresses" section (or visit us at our web site at www.connecticare.com) to find out if a prescription drug is on this list. We have the right to change the drugs on this list in our discretion.

Mandatory Drug Limitations Program

For some drugs, we will cover only a limited number of dosages per prescription and/or time period for the drug. These are drugs where we have determined, in our discretion, that the number of dosages available for the drug should be limited in accordance with the proper medical use of the drug. We will make these determinations based on the drug manufacturer's suggestions, federal FDA guidelines and medical literature, with input from physicians.

In certain cases, this Plan will cover additional units above the limited number of dosages per prescription and/or time period for the drug if we determine, in our discretion, that, because of your or your covered dependent's condition, these additional units are Medically Necessary. We will make this determination based on clinical evidence presented by your physician to us. When this occurs, you may be required to pay the applicable Cost-Share amount.

In addition, we reserve the right to designate that certain prescriptions be filled or refilled for no more than a 30-day supply at a time, regardless of whether your Benefit Summary has a fill or refill limit. When coverage is limited to a 30-day supply at a time for a drug, you will not be able to purchase that drug through our Voluntary Mail Order Program.

Voluntary Mail Order Program

1. Some plans have the "Voluntary Mail Order Program." To determine whether your Plan uses this program, consult your Benefit Summary.
2. Under the Voluntary Mail Order Program, you and your covered dependents may fill your prescriptions at our designated mail order vendor.
3. You and your covered dependents may obtain up to a 90 or 100-day supply of prescription drugs or covered supplies through our designated mail order vendor. Please refer to your Benefit Summary to see the day supply limit and Cost-Share amounts for your Plan.
4. If your Plan requires a Deductible, you must make payment arrangements with the Voluntary Mail Order Program vendor to fill prescriptions by mail when your Deductible has not yet been satisfied. The telephone number to call for assistance is 1-800-369-0675.
5. To obtain these benefits, your physician must prescribe the 90 or 100-day supply of the prescription drugs or covered supplies. Detailed information about how to use the mail order program is provided to you in a separate flyer.
6. If you have a prescription that for any reason cannot be filled by our designated mail order vendor and you need to use a retail pharmacy to fill it instead, the retail pharmacy Cost-Share amount found on your Benefit Summary applies.

We have the right to change or limit the drugs eligible for dispensing through this program in our discretion, even in the middle of the year. You should call our Member Services Department at the telephone number listed in the "Important Telephone Numbers And Addresses" section to receive a list of drugs or drug classes ineligible for dispensing through this program.

Clinically Equivalent Alternative Drugs Or Supplies Program

1. Some Plans have the "Clinically Equivalent Alternative Drug Or Supplies Program." This program applies to prescriptions filled at retail or specialty pharmacies and our designated mail order vendor.
2. The Clinically Equivalent Alternative Drugs Or Supplies Program includes a limited list of drugs and supplies that are covered under this Plan that have been reviewed and recommended for use based on their quality and cost effectiveness.

   The list of covered Clinically Equivalent Alternative Drugs Or Supplies is based on clinical findings and cost review. The clinical and cost review of the drug or supply is, in most case, relative to other drugs or supplies in their therapeutic class or used to treat the same or a similar condition.

   In addition, the list is also based on the availability of over the counter medications, Generic Drugs Or Supplies, the use of one drug or supply over another by our Members, and where proper, certain clinical economic reasons.

   Generally, the program includes select Generic Drugs Or Supplies with limited Brand Name Drugs Or Supplies that are covered under this Plan.
3. When a drug or supply is not on the Clinically Equivalent Alternative Drugs Or Supplies list, it is excluded from coverage, unless it is Medically Necessary.

   In order for the excluded drug or supply to be Medically Necessary, your provider must substantiate to us, in writing, a statement that includes the reasons why use of the drug or supply is more medically beneficial than a Clinically Equivalent Alternative Drug or Supply.

The covered drugs and supplies are displayed on our web site. You should call our Member Services Department at the telephone number listed in the "Important Telephone Numbers And Addresses" section (or visit us at our web site at www.connecticare.com) to find out if a prescription drug or supply is on this list. We have the right to change the drugs or supplies on the list in our discretion.

Cost-Share Waiver Programs

From time to time, we may offer programs to support the use of more cost-effective or clinically effective prescription drugs, including Generic Drugs, home delivery drugs over the counter drugs and preferred products. Those programs may reduce or waive Cost-Shares for a limited time that you would otherwise pay under the terms of this Plan.

Member Cost-Sharing

You and your covered dependents are required to pay a Cost-Share amount for prescription drugs and covered supplies obtained under this Plan. The Cost-Share amounts you are required to pay for prescriptions are found on your Benefit Summary.

1. If you have a Plan that requires a prescription drug benefit Copayment, you will be required to pay that Copayment amount for the drug or supply or the amount we would pay for the drug or supply, whichever is the lower amount.
2. If you have a Plan that requires a prescription drug Benefit Deductible, the Deductible amount must be met in any calendar year for prescriptions subject to the prescription drug Benefit Deductible before we will begin paying for those prescriptions. Under certain options, you will not be required to meet the Deductible amount if you obtain Generic Drugs Or Supplies.

   A Benefit Deductible is considered to be met for a Member if the individual Deductible is met by the amounts paid for that Member for prescriptions covered by the Deductible.

   A family Benefit Deductible amount (two Members) is met for each Member when each Member separately meets the individual Deductible amount.

   A family Benefit Deductible amount (three or more Members) is met by combining the total expenses for prescriptions contributed by each family member, whereby no one family member incurs more than the individual Member Deductible amount, up to the family Deductible amount.

   The Deductible does not apply to any other Deductible amount you may be required to pay for Health Services under the Plan.
3. When a Deductible and Copayment or Coinsurance applies, you must pay the full prescription cost (at the amount we would pay for the drug) up to your Deductible amount. Then once the Deductible has been met, you will be responsible to pay the Copayment or Coinsurance amount listed on your Benefit Summary for each prescription, plus any applicable cost difference. The Coinsurance amount is based on the rate we would pay for the prescription.

   If you have a Plan with a drug Benefit Deductible and then a Copayment where you fulfill the Deductible requirement in a particular claim, you will pay the remaining Deductible amount for that year in addition to the remaining drug cost up to the drug's applicable Copayment amount. Here is an example. Let's say that the drug costs $26 and that you had $20 remaining on your Deductible. Let's also say the prescription drug has a Copayment amount of $10. In this example, you would be required to first pay the $20 remaining on your Deductible, then the remaining $6 of the total cost of the drug. You would pay $6, instead of the $10 Copayment amount, because the $6 balance for the drug is less than the $10 Copayment amount for that drug. In the same example, if the cost of the drug was $45, you would still be required to first pay the $20 remaining on your Deductible, but then you would be required to pay the $10 Copayment amount, because the $25 balance for the drug is more than the $10 Copayment.
4. In some plans, a different type of Cost-Share applies depending on which tier a drug or supply is in. For example, you may have to pay a Copayment for a tier one drug or supply and a Coinsurance for drugs or supplies on a different tier.
5. Amounts paid by Members as their Coinsurance responsibility, or due to any reduction in benefits do not count towards meeting the Benefit Deductible.
6. Amounts paid by Members because they must pay a price difference for a Brand Name Drug do not count towards meeting any Deductible, Coinsurance, Copayment, or Pharmacy Coinsurance Maximum.

Pharmacy Cost-Share Maximum (Maximum Out-Of-Pocket)

1. Some prescription drug Plan options have a "Pharmacy Cost-Share Maximum." To determine whether your Plan includes the Pharmacy Cost-Share Maximum option, consult your Benefit Summary. This program applies to all prescriptions filled, whether at a retail pharmacy, specialty pharmacy, or by a designated mail order vendor.

   The Pharmacy Cost-Share Maximum only applies to prescriptions filled at retail Participating Pharmacies. It DOES NOT apply to prescriptions filled at Non-Participating Pharmacies.
2. Under the Pharmacy Cost-Share Maximum option, you and your covered dependents will pay a Cost-Share amount, where applicable, for each covered prescription drug or supply received up to a specified Pharmacy Cost-Share Maximum amount per year. Once that specified

Take a look at the "Managed Care Rules And Guidelines" section to see if you have to use Participating Providers and the "Pre-Authorization And Pre-Certification (Prior Approval) Addendum" to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

maximum is met, you will no longer have to pay a Cost-Share amount for a covered prescription drug or supply for the remainder of that year, except as noted below.

You will still have to pay any Copayment applicable to a prescription drug or supply, even after the Pharmacy Cost-Share Maximum is reached, if you have a plan that has a mixed Cost-Share structure whereby you pay Copayments for some drugs and supplies and Coinsurance for others.

3. The Pharmacy Cost-Share Maximum option applies to some prescription drug Plans that have Cost-Shares. **It DOES NOT apply to all Cost-Share Plans**.

   In addition, the pharmacy Cost-Share amounts paid may not be used to satisfy any other Cost-Share provisions of your Plan.

4. Amounts paid by Members because they must pay a price difference for a Brand Name Drug are not subject to Cost-Shares and do not accrue toward meeting the Pharmacy Cost-Share Maximum.

5. The Pharmacy Cost-Share Maximum is considered to be met for a Member if the Pharmacy Cost-Share Maximum is met by the Cost-Share amounts paid for that Member in a year.

   A family Pharmacy Cost-Share Maximum (two Members) is met for each Member when each Member separately meets the Pharmacy Cost-Share Maximum.

   A family Pharmacy Cost-Share Maximum (three or more Members) is met by combining the total Cost-Share amounts for prescriptions by each family member, whereby no one family member incurs more than the individual Pharmacy Cost-Share Maximum, up to the family Pharmacy Cost-Share Maximum.

Your Benefit Summary will tell you the Pharmacy Cost-Share Maximum and the Cost-Share amount you are required to pay.

If you are enrolled in one of our High Deductible Health Plans (HDHP), the Pharmacy Cost-Share Maximum is determined as described in the "Plan Deductible" subsection of the Managed Care Rules And Guidelines" section, not as described in this subsection.

Benefit Limits

Benefit Threshold Limit

Some plans require that once a Member has obtained a certain dollar amount of prescription drug benefits, he or she must pay a certain Coinsurance amount for any drug benefits he or she gets for the remainder of the calendar year. Your Benefit Summary will tell you the threshold dollar limit and the Coinsurance amount you are required to pay after you reach that limit. The Coinsurance amount is based on the amount we would pay for the prescription.

Fill Or Refill Limit

Some plans limit benefits for prescriptions filled or refilled at a retail pharmacy to a 30-day supply at a time. This Plan also limits benefits for prescriptions filled or refilled through the Voluntary Mail Order Program to a 90-day supply at a time.

Lyme Disease Treatment Limit

Antibiotic therapy for the treatment of lyme disease is **limited to 30 days of intravenous antibiotic therapy and 60 days of oral antibiotic therapy, unless further antibiotic treatment is recommended by a board-certified rheumatologist, infectious disease specialist or neurologist**.

Prescription Drug Exclusions And Limitations

There is no coverage for:

1. All drugs or medications in a therapeutic drug class if one of the drugs in that therapeutic drug class is not a prescription drug, unless the drugs or medications are Medically Necessary.
2. Antibacterial soap/detergent, shampoo, toothpaste/gel, or mouthwash/rinse.
3. Any treatment, device, drug or supply to increase or decrease height or alter the rate of growth, including devices to stimulate growth, and growth hormones.
4. Appliances or devices, except as otherwise required by applicable law.
5. Certain prescription drugs and supplies are no longer covered when Clinically Equivalent Alternative Drugs Or Supplies are available unless otherwise required by law, or are otherwise determined by us to be Medically Necessary. In order for that drug or supply to be considered Medically Necessary, the provider who wrote the prescription must substantiate to us, in writing, a statement that includes the reasons why use of the drug or supply is more medically beneficial than the Clinically Equivalent Alternative Drug Or Supply.
6. Compounded prescriptions, unless at least one ingredient in the compounded prescription is FDA approved and the FDA component(s) of the compound is covered.
7. Drugs or medications if they include the same active ingredient or a modified version of an active ingredient and they are:
   - ♥ Therapeutically equivalent or therapeutically an alternative to a covered prescription drug, or
   - ♥ Therapeutically equivalent or therapeutically an alternative to an over-the-counter (OTC) product.

   This exclusion does not apply if the drugs or medications are determined to be Medically Necessary.
8. Drugs or preparations, devices and supplies to enhance strength, physical condition, endurance or physical performance, including performance enhancing steroids.

Take a look at the "Managed Care Rules And Guidelines" section to see if you have to use Participating Providers and the "Pre-Authorization And Pre-Certification (Prior Approval) Addendum" to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

9. Drugs that are lost, stolen, or damaged after they are dispensed by the pharmacy will not be replaced.
10. Drugs that may be purchased without a prescription, including prescription drugs with non-prescription OTC equivalents, unless the prescription version of the over the counter equivalent is determined to be Medically Necessary or as otherwise described in this member document.
11. Infant formulas, dietary or food supplements, prescription medical foods and nutritional supplies, except as otherwise described in the "Nutritional Supplements And Food Products" subsection of the "Benefits" section and this "Prescription Drug" subsection.
12. Medications for sexual dysfunction.
13. Prescription contraceptive methods used in connection with birth control, if specified on your Benefit Summary.
14. Prescription drugs or supplies:
    - ♥ Covered by Workers' Compensation law or similar laws, or covered by Workers' Compensation coverage, even if you choose not to claim those benefits, subject to applicable state law.
    - ♥ Dispensed before the Member's effective date or after his or her termination date.
    - ♥ Dispensed in a Hospital or other inpatient facility.
    - ♥ Dispensed or prescribed in a manner contrary to normal medical practice.
    - ♥ Furnished by the United States Veterans' Administration.
    - ♥ Not required for the treatment or prevention of illness or injury
    - ♥ Obtained for the use by another individual.
    - ♥ Obtained from outside of the United States by any means.
    - ♥ Provided in connection with treatment of an occupational injury or occupational illness, subject to applicable state law.
    - ♥ Refilled in excess of the number the prescription calls for, or refilled after one year from the date of the order for the prescription drug.
    - ♥ Re-packaged in unit dose form.
    - ♥ Unless the drug is included on the preferred drug guide (formulary) or a medical exception is granted
    - ♥ Used for or in preparation of Infertility treatment that is not specifically covered under the member document, including but not limited to Experimental or Investigational Infertility procedures.
    - ♥ Used for the purpose of weight gain or reduction, obesity, including but not limited to stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, appetite suppressants and other medications.
    - ♥ Used for travel.
    - ♥ Used in connection with or for a Cosmetic Treatment or hair loss, including but not limited to health and beauty aids, chemical peels, dermabrasion treatments, bleaching, creams, ointments or other treatments or supplies, to remove tattoos, scars or to alter the appearance or texture of the skin.
    - ♥ Not suggested for use by manufacturers or not approved by the federal FDA or our Pharmacy and Therapeutic Committee, unless they are Medically Necessary.
15. Smoking cessation products, except to treat nicotine addiction. When that occurs, the product must be obtained with a prescription and Pre-Authorized.

    In addition, we may also cover smoking cessation products if:
    - ♥ The Member is being actively case managed, and
    - ♥ The use of the smoking cessation product is approved by us.

    When those conditions are met, smoking cessation products may be provided as part of a health management program value-added service or as a benefit.
16. Vitamins, minerals, hematinics and supplements, except prescription pre-natal vitamins or as otherwise described in this member document.

Prescription Drug General Conditions

1. We will not be liable for any injury, claim, or judgment resulting from the dispensing of any prescription drug covered by this Plan.
2. We may use a third party administrator to administer the benefits available under this Plan.
3. All claims must be submitted to us within 180 days from the date the drug or supplies were received with the appropriate claim form and as described in the "Claims Filing, Questions And Complaints, And Appeal Process" section, "Claims Filing" subsection.

   You can call our Member Services Department at the telephone number listed in the "Important Telephone Numbers And Addresses" section to obtain the appropriate claim form.
4. Covered prescription drugs will not be denied as Experimental Or Investigational if the drug has successfully completed a Phase III clinical trial conducted by the federal Food and Drug Administration (FDA).
5. We may require the Member's treating physician to furnish us with any information about the diagnosis or prognosis of any injury or illness related to a prescription drug and about the nature, quality, and quantity of the

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prescription drug prescribed in order to determine its Medical Necessity.

6. Upon approval of new medications by the federal FDA, we reserve the right to implement Pre-Authorization criteria and to set quantity limits to promote appropriate use and to avoid abuse.
7. We do not generally coordinate benefits under this Plan. However, If you or your covered dependent have the Medicare Part D Drug program, Medicare is the primary plan over this Plan.
8. We reserve the right to designate that certain prescriptions be filled or refilled for no more than a 30-day supply at a time. When coverage is limited to a 30-day supply at a time for a drug, you will not be able to purchase that drug through our Voluntary Mail Order Program.

EXCLUSIONS AND LIMITATIONS

The following is a list of services, supplies, etc., that are excluded and/or limited under this Plan. These exclusions and limitations supersede and override the "Benefits" section, so that, even if a health care service, supply, etc. seems to be covered in the "Benefits" section, the following provisions, if applicable, will exclude or limit it.

1. Abdominoplasty, lipectomy and panniculectomy.
2. All assistive communication devices.
3. Ambulance services that are non-Emergency medical transport services to and from a provider's office for routine care or if the transport services are for a Member's convenience.
4. Any Treatment for which there is Insufficient Evidence Of Therapeutic Value for the use for which it is being prescribed.
5. Any treatment or service related to the provision of a non-covered benefit, including educational and administrative services related to the use or administration of a non-covered benefit, as well as evaluations and medical complications resulting from receiving services that are not covered ("Related Services"), unless both of the following conditions are met:
   - ♥ The Related Services are Medically Necessary acute inpatient care services needed by the Member to treat complications resulting from the non-covered benefit when such complications are life threatening at the time the Related Services are rendered, as determined by us, and
   - ♥ The Related Services would be a Health Service if the non-covered benefit were covered by the Plan.
6. Attorney fees.
7. Behavioral conditions with the following diagnoses:
   - ♥ Caffeine-related disorders,
   - ♥ Communication disorders,
   - ♥ Learning disorders,
   - ♥ Mental retardation,
   - ♥ Motor skills disorders,
   - ♥ Relational disorders,
   - ♥ Sexual deviation, or
   - ♥ Other conditions that may be a focus of clinical attention not defined as mental disorders in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders."
8. Benefits for services rendered before the Member's effective date under this Plan or after the Plan has been rescinded, suspended, canceled, interrupted or terminated, except as otherwise required by applicable law.
9. Blood and related expenses as follows:
   - ♥ Blood plasma, including other blood derivatives
   - ♥ Cord blood retrieval or storage
   - ♥ Donation expenses of the Member's relatives or friends for their blood donated for use by the Member
   - ♥ Donor services, which are provided by the Red Cross or
   - ♥ Whole blood.
10. Cardiac rehabilitation for Phase III, unless the Member:
    - ♥ Meets the criteria for enrollment into our HeartCare health management program;
    - ♥ Is being actively case managed; and
    - ♥ The rehabilitation is approved by us.

    Phase III Cardiac Rehabilitation may be covered as part of a health management program value-added service or benefit. Phase IV cardiac rehabilitation is excluded.
11. Care, treatment, services or supplies to the extent the Member has obtained benefits under:
    - ♥ Applicable law
    - ♥ Government program
    - ♥ Public or private grant, or
    - ♥ Any plan or program for which there would be no charge to the Member in the absence of this Plan

    However, services obtained in a Veteran's Home or Hospital for a non-service connected disability, or as required by applicable law, are covered. Also covered are care, treatment or services that are otherwise Medically Necessary and provided in a Veteran's Hospital.
12. Chiropractic manipulation of the cervical spine that is long term or maintenance in nature and spinal

manipulation services to treat children 12 years of age or younger for any condition.

13. Clinical trial services as follows:
    - ♥ Costs of Experimental Or Investigational medicines or devices that are not exempt from new medicine or device application by the Food and Drug Administration
    - ♥ Costs for non-Health Services
    - ♥ Costs that would not be covered by this Plan for a non-Experimental Or Investigational treatment
    - ♥ Facility, ancillary, professional services and medicine costs paid for by grants or funding for the trial
    - ♥ Routine costs that are:
        - ◆ Experimental Or Investigational,
        - ◆ Obtained by a Non-Participating Provider, unless you are enrolled in one of our **POS Plans** or you are enrolled in one of our **HMO Plans** and the clinical trial is not available through a Participating Provider,
        - ◆ Provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the Member, or
        - ◆ Services that are clearly inconsistent with widely accepted and established standards of care for a particular diagnosis
    - ♥ Transportation, lodging, food or other travel expenses for the Member or any family member or companion of the Member
14. Cosmetic Treatments and procedures, including but not limited to:
    - ♥ Any medical or Hospital services related to Cosmetic Treatments or procedures
    - ♥ Benign nevus or any benign skin lesion removal (except when the nevus or skin lesion causes significant impairment of physical or mechanical function
    - ♥ Benign seborrheic keratosis
    - ♥ Blepharoplasty, unless the upper eye lid obstructs the pupil, and blepharoplasty would result in significant improvement of the upper field of vision
    - ♥ Breast augmentation, (except as described in the "Reconstructive Surgery" or "Durable Medical Equipment (DME) Including Prosthetics" subsections of the "Benefits" section or as otherwise required by applicable law)
    - ♥ Dermabrasion
    - ♥ Excision of loose or redundant skin and/or fat after the Member has had a substantial weight loss
    - ♥ Liposuction
    - ♥ Otoplasty
    - ♥ Reduction mammoplasty for Members under age 18 (except or as described in the "Reconstructive Surgery" or "Durable Medical Equipment (DME) Including Prosthetics" subsections of the "Benefits" section or as otherwise required by applicable law)
    - ♥ Scar revision following surgery or injury (except when the scar causes significant impairment of a physical or mechanical function)
    - ♥ Sclerotherapy for varicose veins, reticular veins and spider veins
    - ♥ Septoplasty, septorhinoplasty, or rhinoplasty, unless necessary to alleviate a significant nasal obstruction
    - ♥ Skin tag removal
    - ♥ Tattoo removal
    - ♥ Treatment of craniofacial disorders, except as otherwise described in the "Craniofacial Disorders" subsection of the "Benefits" section, and
    - ♥ Vascular birthmark removal (except when the vascular birthmark causes significant impairment of physical or mechanical function).
15. Custodial Care, convalescent care, domiciliary care, or rest home care. Also care provided by home health aides that is not patient care of a medical or therapeutic nature and care provided by non-licensed professionals.
16. Dental services, including but not limited to:
    - ♥ Any service, procedure, or treatment modality not specifically listed in the "Pediatric Dental Care (Under Age 19)" subsection of the "Benefits" section as a covered Dental Service
    - ♥ For adults (Members over age 19)
    - ♥ Dental treatments, medications and supplies that are not Medically Necessary
    - ♥ Experimental Or Investigational procedures
    - ♥ Procedures to alter vertical dimension (bite height based on the resting jaw position) including but not limited to, occlusal (bite) guards and periodontal splinting appliances (appliances used to splint or adhere multiple teeth together), and restorations (filings, crowns, bridges, etc.)
    - ♥ Space maintainers for dependent children age ten or over
    - ♥ Services or supplies rendered or furnished in connection with any duplicate prosthesis or any other duplicate appliance
    - ♥ Restorations which are not of any dental health benefit, but primarily Cosmetic Treatment in nature, including, but not limited to laminate veneers

    Payment of the applicable Cost-Share of this Plan's Maximum Allowable Amount for the alternate

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service, if any, will be made toward such treatment and the balance of the cost remains the responsibility of the Member

- Personalized, elaborate, or precision attachment dentures or bridges, or specialized techniques, including the use of fixed bridgework, where a conventional clasp designed removable partial denture would restore the arch

  Payment of the applicable Cost-Share of this Plan's Maximum Allowable Amount for the alternate service, if any, will be made toward such treatment and the balance of the cost remains the responsibility of the Member

- General anesthesia, except for the following reasons:
  - Removal of one or more impacted teeth;
  - Removal of four or more erupted teeth;
  - Treatment of a physically or mentally impaired person;
  - Treatment of a child under age 11; and
  - Treatment of a Member who has a medical problem, when the attending physician requests in writing that the treating Dentist administer general anesthesia. This request must accompany the dental claim form.
- Duplicate charges
- Services incurred prior to the effective date of coverage
- Services incurred after cancellation of coverage, or losses of eligibility
- Services incurred in excess of any Contract Year maximum
- Services or supplies that are not Medically Necessary according to accepted standards of dental practice
- Services that are incomplete
- Orthodontic services for persons age 19 or over, when orthodontics is a covered Dental Service
- Sealants on teeth other than the first and second permanent molars, or applications applied more frequently than every thirty-six months or a service provided outside of ages five through fourteen
- Services such as trauma which are customarily provided under medical-surgical coverage
- More than two oral examinations of any type in any consecutive 12-month period
- More than two prophylaxes in any consecutive 12-month period
- More than one full mouth x-ray series in any period of 36 consecutive months
- More than one bitewing x-ray series in any consecutive 12-month period
- Adjustments or repairs to dentures performed within six months of the installation of the denture
- Services or supplies in connection with periodontal splinting (adhering multiple teeth together)
- Implants and Implantology services, including implant bodies, abutments, attachments and implant supported prosthesis (such as crowns, dentures, pontics, or bridgework)
- Expenses incurred for the replacement of an existing denture which is or can be made satisfactory
- Additional expenses incurred for a temporary denture
- Expenses incurred for the replacement of a denture, crown, or bridge for which benefits were previously paid, if such replacement occurs within five years from the date of the previous benefit
- Training in plaque control or oral hygiene, or for dietary instruction
- Completion of reporting forms
- Charges for missed appointments
- Charges for services and supplies which are not necessary for treatment of the injury or disease, or are not recommended and approved by the attending Dentist, or charges which are not reasonable
- Scaling and root planing which is not followed, where indicated, by definitive pocket elimination procedures. In the absence of continuing periodontal therapy, scaling and root planning will be considered a prophylaxis and subject to the limitations of that procedure
- Periodontal surgery procedures more than once per quadrant in any period of 36 consecutive months
- More than one periodontal scaling and root planning per quadrant in any consecutive 36 month period
- More than two periodontal maintenance procedures in any consecutive 12-month period, as well as periodontal therapy, periodontal maintenance procedures in the absence of benefited comprehensive
- Services for any condition covered by worker's compensation law or by any other similar legislation
- Services to correct or in conjunction with treatment of congenital malformations (e.g. congenitally missing teeth, supernumerary teeth, enamel and dental dysplasia, etc.), developmental malformation of teeth, or the restoration of teeth missing prior to the effective date of coverage
- Claims submitted more than 11 months (335 days) following the date of service

Take a look at the "Managed Care Rules And Guidelines" section to see if you have to use Participating Providers and the "Pre-Authorization And Pre-Certification (Prior Approval) Addendum" to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

17. Educational services, except as otherwise described in the "Autism Services" or "Birth To Three Program (Early Intervention Services)" sections:
    - ♥ Screening and treatment associated with learning disabilities
    - ♥ Special education and related services
    - ♥ Testing, training, rehabilitation for educational purposes.
18. Experimental Or Investigational treatment, except as otherwise described in the "Bypassing The Internal Appeal/Grievance Process" subsection of the "Claims Filing, Questions And Complaints, And Appeal/Grievance Process" section.
19. Family planning and Infertility services, including but not limited to:
    - ♥ Contraceptive drugs and devices, except to the extent applicable insurance law requires coverage for these items. When they are covered, they are covered under the "Prescription Contraception" subsection of the "Benefits" section,
    - ♥ Home births (except that complications of home births are covered),
    - ♥ Infertility services not specifically covered under the "Infertility Services" or "Prescription Drug" subsections of the "Benefits" section and/or as described in any additional amendatory Rider you receive from us, if you are a resident of the state of Massachusetts, including but not limited to the following:
        - ◆ Cryopreservation (freezing) or banking of eggs, embryos, or sperm
        - ◆ Genetic analysis and testing, except as described in the "Infertility Services" or "Genetic Testing" subsections of the "Benefits" section, including:

          All other genetic testing services, as well as genetic testing panels not endorsed by ACOG or ACMG,

          Genetic testing kits available either direct to the consumer or via a physician prescription

          Genetic testing only for the benefit of another family member

          Whole genome or whole exome genetic testing
        - ◆ Medications for sexual dysfunction, unless your Plan includes our **Supplemental Sexual Dysfunction Prescription Drug Rider**
        - ◆ Recruitment, selection and screening and any other expenses of donors (donors of eggs, embryos and sperm)
        - ◆ Reversal of surgical sterilization
        - ◆ Surrogacy and all charges associated with surrogacy such as prescription drugs or egg harvesting, fertilization or implantation
    - ♥ Labor doulas and labor coaches.
20. Foot orthotics, except if the member is diabetic and/or as described in any additional amendatory Rider you receive from us, if you are a resident of the state of Massachusetts.
21. Health club membership and exercise equipment.
22. Hearing aids, except as otherwise described in the "Durable Medical Equipment (DME), Including Prosthetics" subsection of the "Benefits" section.
23. Home health aide care that is not patient care of a medical or therapeutic nature.
24. Hypnosis (except as an integral part of psychotherapy), biofeedback (except when ordered by a physician to treat urinary incontinence) and acupuncture.
25. Infant formulas, food supplements, nutritional supplements and enteral nutritional therapy, except as provided in the "Nutritional Supplements And Food Products" or "Prescription Drug" subsections of the "Benefits" section, and/or as described in any additional amendatory Rider you receive from us, if you are a resident of the state of Massachusetts.
26. Massage, except when part of a prescribed physical or occupational therapy program, if that program is a covered benefit.
27. Medical supplies or equipment that are not considered to be durable medical equipment or disposable medical supplies or that are not on our covered list of such equipment or supplies. Examples of excluded medical supplies or equipment include:
    - ♥ Hearing aids, except as described in the "Benefits" section
    - ♥ Wigs, hair prosthetics, scalp hair prosthetics and cranial prosthetics, except as described in the "Benefits" section
    - ♥ Bed related equipment such as over the bed tables, bed wedges, pillows, custom mattresses and posturepedic mattresses
    - ♥ Hygiene related equipment such as: bath lifts, bathtub rails, bath benches, bath chairs, adaptive equipment
    - ♥ Wheelchair lifts, stair gliders, wheelchair ramps and modifications to cars or vans
    - ♥ Non-durable equipment such as orthopedic or prosthetic shoes or foot orthotics (unless diabetic), prophylactic anti-embolism stockings and compression stockings/garments except when a Member has a history of deep vein thrombosis and varicose veins

Take a look at the "Managed Care Rules And Guidelines" section to see if you have to use Participating Providers and the "Pre-Authorization And Pre-Certification (Prior Approval) Addendum" to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

- ♥ Compression and cold therapy devices following joint surgery
- ♥ DME that duplicates the function of any previously obtained equipment

28. Neuropsychological and neurobehavioral testing, except when it is performed by an appropriately licensed neurologist, psychologist or psychiatrist and when it is performed to assess the extent of any cognitive or developmental delays due to chemotherapy or radiation treatment in a child diagnosed with cancer.
29. New Treatments for which we have not yet made a coverage policy, except for drugs with FDA approval for the use for which they are prescribed.
30. Non-Emergency land or air ambulance/medical transport services to and from a physician's office for routine care or if it is for Member convenience.
31. Non-licensed professionals.
32. Non-Medically Necessary services or supplies.
33. Non-medical supportive counseling services (individual or group) for alcohol or substance abuse (e.g., Alcoholics Anonymous).
34. Non-surgical treatment of temporomandibular joint (TMJ) dysfunction or temporomandibular disease (TMD) syndrome, including but not limited to:
    - ♥ Appliances
    - ♥ Behavior modification
    - ♥ Physiotherapy
    - ♥ Prosthodontic therapy.
35. Overnight or day camps focused on illness or disability.
36. Over-the-counter (OTC) items of any kind, including but not limited to home testing or other kits and products, except as provided in the "Benefits" section.
37. Peak flow meters.

    However, peak flow meters may be covered if:
    - ♥ The Member is enrolled in our asthma health management program,
    - ♥ The member is being actively case managed, and
    - ♥ The use of the peak flow meter is approved by us.

    When the above conditions are met, peak flow meters may be provided as part of an asthma health management program value-added service or as a benefit.
38. Personal convenience or comfort items of any kind.
39. Physical therapy, occupational therapy, speech therapy or chiropractic therapy that is long term or maintenance in nature.
40. Platelet-rich-plasma for bone, wound or tendon healing.
41. Prescription drugs or supplies, including, but not limited to:

- ♥ All drugs or medications in a therapeutic drug class if one of the drugs in that therapeutic drug class is not a prescription drug, unless the drugs or medications are Medically Necessary.
- ♥ Antibacterial soap/detergent, shampoo, toothpaste/gel, or mouthwash/rinse.
- ♥ Any treatment, device, drug or supply to increase or decrease height or alter the rate of growth, including devices to stimulate growth, and growth hormones.
- ♥ Appliances or devices, except as otherwise required by applicable law.
- ♥ Certain prescription drugs and supplies are no longer covered when Clinically Equivalent Alternative Drugs Or Supplies are available unless otherwise required by law, or are otherwise determined by us to be Medically Necessary. In order for that drug or supply to be considered Medically Necessary, the provider who wrote the prescription must substantiate to us, in writing, a statement that includes the reasons why use of the drug or supply is more medically beneficial than the Clinically Equivalent Alternative Drug Or Supply.
- ♥ Compounded prescriptions, unless at least one ingredient in the compounded prescription is FDA approved and the FDA component(s) of the compound is covered.
- ♥ Drugs or medications if they include the same active ingredient or a modified version of an active ingredient and they are:
    - ◆ Therapeutically equivalent or therapeutically an alternative to a covered prescription drug, or
    - ◆ Therapeutically equivalent or therapeutically an alternative to an over-the-counter (OTC) product.

  This exclusion does not apply if the drugs or medications are determined to be Medically Necessary.
- ♥ Drugs or preparations, devices and supplies to enhance strength, physical condition, endurance or physical performance, including performance enhancing steroids.
- ♥ Drugs that are lost, stolen, or damaged after they are dispensed by the pharmacy will not be replaced.
- ♥ Drugs that may be purchased without a prescription, including prescription drugs with non-prescription OTC equivalents, unless the prescription version of the over the counter equivalent is determined to be Medically Necessary or as otherwise described in this member document.
- ♥ Infant formulas, dietary or food supplements, prescription medical foods and nutritional supplies, except as otherwise described in the "Nutritional

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Supplements And Food Products" subsections of the "Benefits".

- ♥ Medications for sexual dysfunction.
- ♥ Prescription contraceptive methods used in connection with birth control, if specified on your Benefit Summary.
- ♥ Prescription drugs, medications or supplies:
  - ◆ Covered by Workers' Compensation law or similar laws, or covered by Workers' Compensation coverage, even if you choose not to claim those benefits, subject to applicable state law.
  - ◆ Dispensed before the Member's effective date or after his or her termination date.
  - ◆ Dispensed in a Hospital or other inpatient facility.
  - ◆ Dispensed or prescribed in a manner contrary to normal medical practice.
  - ◆ Furnished by the United States Veterans' Administration.
  - ◆ Not required for the treatment or prevention of illness or injury
  - ◆ Obtained for the use by another individual.
  - ◆ Obtained from outside of the United States by any means.
  - ◆ Provided in connection with treatment of an occupational injury or occupational illness, subject to applicable state law.
  - ◆ Refilled in excess of the number the prescription calls for, or refilled after one year from the date of the order for the prescription drug.
  - ◆ Re-packaged in unit dose form.
  - ◆ Unless the drug is included on the preferred drug guide (formulary) or a medical exception is granted
  - ◆ Used for or in preparation of Infertility treatment that is not specifically covered under the member document, including but not limited to Experimental or Investigational Infertility procedures.
  - ◆ Used for the purpose of weight gain or reduction, obesity, including but not limited to stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, appetite suppressants and other medications.
  - ◆ Used for travel.
  - ◆ Used in connection with or for a Cosmetic Treatment or hair loss, including but not limited to health and beauty aids, chemical peels, dermabrasion treatments, bleaching, creams, ointments or other treatments or supplies, to remove tattoos, scars or to alter the appearance or texture of the skin.
  - ◆ Not suggested for use by manufacturers or not approved by the federal FDA or our Pharmacy and Therapeutic Committee, unless they are Medically Necessary.
- ♥ Smoking cessation products, except to treat nicotine addiction. When that occurs, the product must be obtained with a prescription and Pre-Authorized.

  In addition, we may also cover smoking cessation products if:
  - ◆ The Member is being actively case managed, and
  - ◆ The use of the smoking cessation product is approved by us.

  When those conditions are met, smoking cessation products may be provided as part of a health management program value-added service or as a benefit.
- ♥ Vitamins, minerals, hematinics and supplements, except prescription pre-natal vitamins or as otherwise described in this member document.

42. Private room accommodations or private duty nursing in a facility.
43. Routine foot care and treatment, unless Medically Necessary for neuro-circulatory conditions.
44. Routine physical exams or immunizations at an Urgent Care Center.
45. Sensory and auditory integration therapy, unless covered under the "Autism Services" or "Birth To Three Program (Early Intervention Services)" subsections of the "Benefits" section.
46. Services and supplies exceeding the applicable benefit maximums.
47. Services and supplies not specifically included in this document.
48. Services or supplies rendered by a physician or provider to himself/herself, or rendered to his/her family members, such as parents, grandparents, spouse, children, step-children, grandchildren or siblings.
49. Services required by or received at a Wilderness Camp or a boarding school, including:
    - ♥ Medications, including prophylactic
    - ♥ Physical examinations, blood tests
    - ♥ Supplies
    - ♥ Vaccinations/immunizations
50. Services required by third parties or pursuant to a court order, including:
    - ♥ Blood tests
    - ♥ Medications, including prophylactic

Take a look at the "Managed Care Rules And Guidelines" section to see if you have to use Participating Providers and the "Pre-Authorization And Pre-Certification (Prior Approval) Addendum" to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

- ♥ Physical examinations
- ♥ Supplies
- ♥ Vaccinations/immunizations.

51. Services obtained for foreign or domestic travel, including:
    - ♥ Camp
    - ♥ Employment
    - ♥ Insurance
    - ♥ Licensing
    - ♥ Pursuant to a court order
    - ♥ School
52. Solid organ transplant and bone marrow transplant transportation costs, including:
    - ♥ Any expenses for anyone other than the transplant recipient and the designated traveling companion
    - ♥ Any expenses other than the transportation, lodging and meals described in the "Benefits" section
    - ♥ Expenses over those described in the "Benefits" section
    - ♥ Local transportation costs while at the transplant facility
    - ♥ Rental car costs
53. Speech therapy for stuttering, lisp correction, or any speech impediment not related to illness or injury, except as described in the "Benefits" section.
54. Third party coverage, such as other primary insurance, Workers' Compensation and Medicare will not be duplicated.
55. Transportation, accommodation cost, and other non-medical expenses related to Health Services (whether they are recommended by a physician or not), except as otherwise described in the "Benefits" section.
56. Treatment of snoring in the absence of sleep apnea.
57. Vision services including, but not limited to:
    - ♥ Adult eye glasses and contact lenses
    - ♥ Eye surgeries and procedures primarily for the purpose of correcting refractive defects of the eyes, including, but not limited to:
        - ◆ Laser surgery,
        - ◆ Orthokeratology, and
        - ◆ Radial keratotomy
    - ♥ Vision and hearing examinations (except as described in the "Eye Care" and "Hearing Screenings" subsections of the "Benefits' section)
    - ♥ Vision therapy and vision training
58. War related treatment or supplies, whether the war is declared or undeclared.
59. Web visits, e-visits, and other on-line consultations or health evaluations using internet resources, as well as telephone consultations.
60. Weight loss/control treatment, programs, clinics, medications, or surgical treatment for morbid obesity.

COORDINATION OF BENEFITS (COB) AND SUBROGATION AND REIMBURSEMENT

The COB and subrogation rules (for example, our right to reclaim payments we made on a Member's behalf to treat an injury he/she received while working – Worker's Compensation) in this section apply to all benefits under this Plan. The COB rules apply when you or one of your covered Eligible Dependents has coverage under another insurance plan for the same Health Services covered under this Plan. This section explains which insurance plan pays first, second, and so on.

COORDINATION OF BENEFITS

Definitions

ALLOWABLE EXPENSE: Any expense at least a part of which is covered by at least one of the Plans covering a Member. When a Plan provides benefits, the reasonable cash value of each service that would be rendered will be considered a benefit for the purpose of this section. Any service actually provided will be considered an Allowable Expense and a benefit paid.

Allowable Expenses do not include expenses for:

- ♥ Dental care
- ♥ Hearing aid programs
- ♥ Prescription drug
- ♥ Vision care.

The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an Allowable Expense unless the patient's stay in a private room is Medically Necessary.

COORDINATION: Regarding a specific claim, the Plans determine among themselves:

- ♥ Which Plans are responsible for payment;
- ♥ Which Plan pays first, second, third, and so on; and
- ♥ How much of the claim each Plan is responsible for paying.

PLAN: Any of the following which provides benefits or services for, or because of, medical care or treatment:

- ♥ Group health insurance, group-type coverage, whether fully insured or self-insured, or any other contract or arrangement where a health benefit is provided. This includes prepayment, or any other contract or arrangement where a health benefit is provided;

- ♥ Coverage under a governmental Plan (Services covered under Title XVIII and amendments (Medicare Parts A and B) or required or provided by law. This does not include a state Plan under Medicaid (Title XIX), grants to States for Medical Assistance Programs, or the United States Social Security Act. It also does not include any Plan when, by law, its benefits are in excess of those of any private insurance program or other non-governmental program;
- ♥ Medical benefits coverage of no fault automobile or other automobile contracts.

Each contract or other arrangement for coverage under those mentioned above is a separate Plan.

General

If Members are enrolled to receive health benefits under another Plan, the benefits provided under this Plan will be coordinated with the benefits under the other Plan(s), so that neither the Member nor the provider receives the value of more than 100% of his/her medical and health care costs.

In no event will we be liable for more than we would have paid if we were the primary insurer paying for the claim.

Worker's Compensation

If you or your Eligible Dependents are injured at work, you are eligible to be covered under Worker's Compensation. If that ever happens, Worker's Compensation is always the primary and the only payor on the claims to which it pertains. Health Services are not covered by this Plan, if they are for a work related injury.

In other words, Health Services are not covered by this Plan if they:

- ♥ Are covered by a Worker's Compensation Plan; or
- ♥ Would be covered if the Member is required by law to be covered by Worker's Compensation, regardless of whether he/she has Workers' Compensation or submitted the claim; or
- ♥ Would be covered if the Member complied with the terms and conditions of the Worker's Compensation plan.

Medicaid

Medicaid is a State program with Federal matching funds that is provided under certain conditions to people, regardless of their age, when their income and resources are insufficient to pay for health care and they meet program guidelines. If the Member is also covered under Medicaid, we are always the primary payor for Health Services and we do not coordinate benefits with Medicaid.

Medicare Part D

This Plan will coordinate benefits with the Medicare Part D program for any covered drugs that are included in the Part D program if you or your Eligible Dependents have other coverage for those drugs through a Part D plan.

Automobile Insurance Policies

Automobile insurance is always the primary payor in relation to group health insurance, unless otherwise prohibited by law. Whenever Members are required to purchase basic reparations or medical pay coverage under any automobile policy by any state law, or otherwise have that kind of coverage under any automobile insurance policy, we will be entitled to charge:

- ♥ The insurer for the dollar value of those benefits to which the Member is entitled; or
- ♥ The Member for that value to the extent he/she has received payment, or would have received payment, under the basic compensation of benefits coverage under the automobile insurance policy.

Student Accident Or Sickness Insurance Policies

We do not coordinate benefits with student accident or sickness insurance policies where the student or his/her parent pays the entire premium.

Residual Market or HRA Group Contracts

We do not coordinate benefits with group contracts issued by or reinsured through the Health Reinsurance Association. We do not coordinate benefits with subscriber contracts issued by a residual market mechanism established by hospital and medical service corporations and providing comprehensive health care coverage as provided in the Connecticut Health Care Act.

Primary vs. Secondary Coverage

The specific order of responsibility for coverage and benefits payments among responsible Plans will be determined under one of the following rules:

1. The Plan that covers the individual as a policyholder or subscriber pays before the Plan that covers the individual as a dependent.
2. **BIRTHDAY RULE:** When two or more Plans cover the same child as a dependent of different persons who are called "parents" and are not separated or divorced:

   - ♥ The benefits of the Plan of the parent whose birthday falls earlier in a calendar year are paid before those of the Plan of the parent whose birthday falls later in the year.

     So, if your birthday occurs on May 1st and your spouse's birthday is on April 16th, then your spouse's Plan would pay first.

   - ♥ If both you and your spouse have the same birthday, the benefits of the Plan that covered the parent longer are paid before those of the Plan that covered the other parent for a shorter period of time.

   However, if the other Plan does not have the "Birthday Rule" described above, but instead has a rule based upon

Take a look at the "Managed Care Rules And Guidelines" section to see if you have to use Participating Providers and the "Pre-Authorization And Pre-Certification (Prior Approval) Addendum" to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule based upon the gender of the parent will determine the order of benefits.

3. When two or more Plans cover a person as a dependent child of divorced or separated parents, the order of priority for the child's benefits for the Plans will be determined in the following manner:

   - ♥ First, the Plan of the parent with custody of the child;
   - ♥ Then, the Plan of the spouse of the parent with custody of the child; and
   - ♥ Finally, the Plan of the parent not having custody of the child.

   However, if the specific terms of a court decree state that one of the parents is more responsible for the health care expenses of the child than the other, and the Plan obligated to pay or provide the benefits of that parent has actual knowledge of those terms, the benefits of that Plan pay first. This paragraph does not apply to any Claim Determination Period during which any benefits are actually paid or provided before the Plan has that actual knowledge. For purposes of this section, "Claim Determination Period" means a calendar year but will not include any part of a year during which a person has no coverage under this document, or any part of a year before the date this Coordination of Benefits provision or a similar provision takes effect.

4. The Plan that covers the Member as an active Employee or Eligible Dependent of an active Employee provides payment before a Plan that covers the Member as a former Employee or Eligible Dependent of a former Employee.
5. When none of the above rules determine the issue, a Plan has first responsibility if the Member has been enrolled or covered under that Plan longer than in the other Plan(s).
6. When the order is determined, each Plan in turn provides payment up to the limits specified in its policy or agreement. Total payment cannot exceed 100% of actual costs.

When This Plan Is Not Primary

1. You must submit the claims to your primary Plan if the provider of services does not submit the claim.
2. When we are the secondary Plan, you must submit a copy of the explanation of benefits ("EOB") form that you received from the primary Plan to us. If we receive a claim without an EOB from the primary Plan, we will deny the claim. The denial will explain that we are the secondary payor. **IT IS YOUR RESPONSIBILITY** to ensure the claim is processed with the primary Plan. You must submit your claim with the EOB from the primary Plan to us within 180 days of the date the primary Plan processed the claim. Claims for Health Services submitted more than 180 days after the date the primary Plan processed the claim will not be paid by us, except in special circumstances, as we determine.
3. In no event will this Plan be liable for more than it would have been responsible for paying if we were primary.

Rights To Receive And Release Necessary Information

We routinely send questionnaires to Members where the order of coverage and benefits among responsible Plans is in question. We reserve the right to deny any or all claims until the completed questionnaire has been returned to us.

Any person claiming services or payments under this Plan must furnish us, or our agents, any information needed to implement the coordination of benefits and subrogation provisions. For the purposes of implementing these provisions or a similar provision of any other Plan, we may, without the consent of or notice to any person, release to or obtain from any entity any information needed for such purposes to the extent permitted by law.

Facility Of Payment

If another Plan makes payments for covered Health Services that we are responsible for, we may, at our sole discretion, pay to that Plan any amounts we determine to be warranted. Amounts paid will be deemed to be payments under this Plan. To the extent of those payments, we will be fully released from liability under this Plan.

Rights Of Recovery

When payments or services have been made or arranged by us in excess of the maximum for Allowable Expenses, no matter to whom paid, we will have the right to recover the excess from any persons (including you), insurance companies, or other organizations. Our rights will be limited to the amount that you have received from another Plan.

SUBROGATION AND REIMBURSEMENT

You or your Eligible Dependents may receive or be eligible to receive Plan Benefits for an injury or an illness for which some third person, organization, or governmental entity is liable to pay damages. In these cases, in accordance with applicable law, primary payment responsibility may be through:

- ♥ A third party tortfeasor (someone who commits a wrong) or his insurer, payments under an uninsured or underinsured motorist policy
- ♥ A Worker's Compensation award or settlement
- ♥ A recovery made pursuant to a no-fault insurance policy
- ♥ Any medical payment coverage in any automobile or homeowner's insurance policy.

For claims we paid in relation to an injury or illness, we or our agent will have a lien upon the proceeds of any recovery

from that third person, organization or governmental entity. You and your Eligible Dependents agree to reimburse us, in full, without any offset or reduction under any theory of attorney or common fund, make-whole, or comparative negligence, provided, however, that if health benefits were specifically subtracted from the proceeds of a judicial award, no reimbursement of that amount of health benefits shall be required. That lien will be equal to the value of any services or payment provided or paid for under this Plan in relation to that injury or illness. The lien may, but need not, be filed with such third person, organization, or governmental entity or in any court of competent jurisdiction.

When permitted by law, we may require the Member, the Member's guardian, personal representative, estate, dependents or survivors, as appropriate, to assign the Member's claim against the third person, organization, or governmental entity to us to the extent of that right or claim. We may further require those individuals or entities to execute and deliver instruments and to take such other reasonable actions as may be necessary to secure our rights.

MEDICARE ELIGIBILITY

You and your Eligible Dependents who enroll in Medicare may still remain eligible for coverage under this Plan, subject to your Employer's eligibility rules and our policies regarding coverage of retirees. If Medicare is the primary Plan over this Plan, then you or your Eligible Dependents who have Medicare may be eligible for a reduced Medicare rate. Not all Members or Employers are eligible for the reduced rates, even if Medicare is primary for the Member.

Age 65 Or Older

1. We are the primary Plan for you and your Eligible Dependents when you are an active Employee, **if your Employer has 20 or more employees**.
2. Medicare is the primary Plan for you and your Eligible Dependents who have Medicare when you are an active Employee, **if your Employer has fewer than 20 employees**.
3. For all Employers (no matter how many employees), Medicare is the primary Plan for you and your Eligible Dependents who have Medicare when you are not an active Employee.

End Stage Renal Disease (ESRD)

1. When you or your Eligible Dependents become eligible for Medicare because of ESRD, we are the primary Plan for a period of 30 consecutive months.

   This 30-month period begins on the earlier of the following:

   - ♥ The first day of the month during which a regular course of renal dialysis starts; or
   - ♥ The first day of the month during which the Member receives a kidney transplant.

2. After the 30-month period described above ends, Medicare is primary.
3. If you or your Eligible Dependents already had Medicare as the primary Plan at the time of the initial dialysis treatment or kidney transplant, Medicare will remain as the primary Plan.

Other Medicare Eligibility (Young People With Disabilities)

1. Medicare is the primary Plan for you or your Eligible Dependents when you are an active Employee, **if your Employer has fewer than 20 employees**.
2. For all Employers (no matter how many employees), Medicare is the primary Plan for you or your Eligible Dependents if you are not an active Employee.

Age 65 And Older And Disabled

If you or your Eligible Dependents receive Medicare benefits because of a disability other than ESRD before age 65, use the rules in the "Age 65 Or Older" subsection of this section, to determine which Plan is the primary Plan when you or your Eligible Dependents do turn age 65.

CLAIMS FILING, QUESTIONS AND COMPLAINTS, AND APPEAL/GRIEVANCE PROCESS

We have the right to review any claims and the discretion to interpret and apply the terms of this Plan to determine whether benefits are payable.

CLAIMS FILING

Claims must be received by us within 180 days from the date the services, medications or supplies were received. Claims submitted more than 180 days after the date the services, medications or supplies were received will not be reimbursed.

You can find out the status of your medical claims on our web site at www.connecticare.com.

You can find out the status of your behavioral health claims (those for mental health and alcohol or substance abuse) on the OptumHealth Behavioral Solutions/UBH web site at www.liveandworkwell.com.

Bills From A Participating Provider

When you receive covered Health Services from a Participating Provider, you are responsible for paying for any non-covered services and all the Cost-Share amounts of this Plan, including the Plan Deductible (if applicable), Copayment amounts, and any Coinsurance amounts. The Participating Provider who treated the Member will file a claim with us, and any payment from us will be made to the billing Participating Provider.

Take a look at the "Managed Care Rules And Guidelines" section to see if you have to use Participating Providers and the "Pre-Authorization And Pre-Certification (Prior Approval) Addendum" to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

Special Rules If You Are Enrolled In Our HMO or POS Deductible Open Access Plans Or Our HMO Open Access HDHP Plan

An explanation of benefits ("EOB") will be sent to you, which will indicate:

- ♥ The Participating Provider's charges
- ♥ What charges in what amounts were applied to the Plan Deductible
- ♥ What charges in what amounts were paid by us
- ♥ The reasons for any adjustments to those billed charges
- ♥ The amount you are required to pay to the Participating Provider, if any.

Any amount owed to the Participating Provider must be paid directly to the Participating Provider. Contact us if the Participating Provider bills you for more than the EOB says you must pay.

If you have any questions about your claims, you should call our Members Services Department.

Bills From A Non-Participating Provider

If you or your Eligible Dependents receive care from a Non-Participating Provider, a claim must be submitted to us at the appropriate address listed in the "Important Telephone Numbers And Addresses" section.

The claim should include the following information:

- ♥ The Subscriber's name
- ♥ The patient's name and ConnectiCare ID number (including suffix)
- ♥ A complete, itemized bill for services, which includes both a description of the service and the diagnosis

  Charge card receipts and "balance due" statements are not acceptable.
- ♥ A copy of the written Pre-Authorization letter we sent to you or, as appropriate, our Delegated Program sent to you, approving the Pre-Authorization use of a Non-Participating Provider. If care by the Non-Participating Provider did not need written Pre-Authorization, then you must send us an explanation along with the claim.

  This requirement does not apply to you if you are signed up in any of our **POS Plans**.
- ♥ If the claim was a result of an Emergency or Urgent Care you or your Eligible Dependents needed while outside of the United States, make sure the itemized bill is written or translated in English and that it shows the amount you paid in U.S. dollars. We recommend that you include your charge receipt with the itemized bill.

Generally, our payment for covered Health Services provided by a Non-Participating Provider is made directly to you, and you are responsible for paying the provider of service, unless you write on the claim form that you want us to pay the provider. We will pay an ambulance company provider when there is a law that permits us to do so. We may also pay you directly, if the Non-Participating Provider does not provide us with information that we request for claim payment.

Special Rules If You Are Enrolled In Our HMO Deductible Open Access Plan Or Our HMO Open Access HDHP Plan

When coverage for treatment provided by a Non-Participating Provider is allowed, you must pay the Cost-Share amounts that you would pay if the services were given by a Participating Provider. Payment will be based on the Non-Participating Provider's billed charges. Check the "Cost-Shares You Are Required To Pay" section and your Benefit Summary to find out the Cost-Share amounts you have to pay under your Plan. If you receive treatment from a Non-Participating Provider that is not covered, you will be solely responsible for paying the Non-Participating Provider, and the amount you pay will not count toward your Plan Deductible or your Coinsurance amount.

Payment To Custodial Parent

In situations where we have not paid your Eligible Dependent children's claims directly to the provider, the law may require that we send the payment directly to the custodial parent if we are notified in writing, even if that parent is not a participant under this Plan.

Claims For Emergency Services

Review a claim for payment for Emergency Services provided by Non-Participating Hospitals or other Non-Participating Providers make sure it is complete before you send the claim to us. In some cases, emergency room claims sent to us by a Hospital may be denied, if they have missing, incomplete or improperly coded information.

If You Are Covered By Another Insurance Plan

If you or your Eligible Dependents are covered under another plan and we are the secondary carrier, you have 180 days from the date the primary plan processed the claim to submit the claim to us. Check the "Coordination Of Benefits And Subrogation" section for a description of how to determine if this Plan is the primary or secondary insurance company and any requirements applicable to you.

Remind your provider when you or your Eligible Dependents are covered under another plan, so the Member's services can be billed and paid correctly.

Refund To Us Of Overpayments

Whenever we have made payments for Health Services, including prescription drugs, either in error or in excess of the maximum amount allowed under this Plan, we have the right to recover these payments from:

Take a look at the "Managed Care Rules And Guidelines" section to see if you have to use Participating Providers and the "Pre-Authorization And Pre-Certification (Prior Approval) Addendum" to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

- ♥ Any person to or for whom the payments were made
- ♥ Any insurance companies
- ♥ Any other person or organization.

You have no right to expect future coverage for non-covered services, supplies or medicines, because of payments made by us in error.

Our right to recover our incorrect payment may include subtracting amounts from future benefit payments. You, personally and on behalf of your Eligible Dependents, must complete and send us any documents we ask for and do whatever is necessary to protect our right to recover any erroneous or excess payments.

QUESTIONS AND COMPLAINTS

You or your authorized representative can ask questions or send us complaints or Appeals/Grievances about benefits and other issues concerning this Plan. Since most questions or complaints can be resolved informally, we suggest that you contact our Member Services Department first. In addition, you may also submit a complaint by using our web site at www.connecticare.com.

Representatives are available Monday through Friday, during regular business hours, to explain policies and procedures and answer your questions. If you are calling after normal business hours, you should leave a detailed voice mail message, including your ConnectiCare ID number and your telephone number. An associate will return your telephone call during regular business hours.

In the event a problem or complaint cannot be informally resolved, a formal Appeal/Grievance process is available, as outlined below.

APPEAL/GRIEVANCE PROCESS

If you are not satisfied with a decision we or our Delegated Programs have made regarding Health Services, benefits, Pre-Authorization, Pre-Certification or claims, then you or your authorized representative may request an Appeal/Grievance on your behalf.

Of course, before pursuing the Appeal/Grievance process, you should consider seeking immediate assistance from our Member Services Department, as described in the "Questions And Complaints" subsection. Often, questions and complaints can be resolved quickly and informally by speaking with one of our representatives. However, if you choose to make use of the Appeal/Grievance process, we will not subject you to any sanctions or impose any penalties on you. You may also contact the Member Services Department to request reasonable access to and copies (free of charge) of all documents, records and other information relevant to your benefit request.

The Appeal/Grievance process is divided into two categories.

1. One category deals with the **Medical Necessity Appeal/Grievance** of a particular Health Service, such as a denial of a request for Pre-Certification of an inpatient admission or the Pre-Authorization of a certain surgical procedure.
2. The other category deals with the **Administrative (Non-Medical Necessity) Appeal/Grievance**, such as a decision that interprets the application of Plan rules and that does not relate to Medical Necessity.

In either case, the Appeal/Grievance request may be initiated orally, electronically or by mail by calling, faxing or writing us. We have designated our Member Services Department to coordinate Appeals/Grievances. Our Member Services Department can be contacted as follows:

Telephone: 1-800-251-7722

Facsimile: 1-800-319-0089 or (860) 674-2866

ConnectiCare
Member Services Appeals/Grievances
PO Box 4061
Farmington, Connecticut 06034-4061

For all behavioral health Appeals/Grievances, our behavioral health Delegated Program can be contacted as follows:

Telephone: 1-866-556-8166

Facsimile: 1-800-322-9104

OptumHealth Behavioral Solutions / UBH
Attention: Complaints and Appeals Department
1900 East Golf Road, Suite 200
Schaumburg, IL 60173

When contacting us or our behavioral health Delegated Program, you should explain why you feel the original decision should be overturned. You are entitled and encouraged to submit additional written comments, documents, records and letters and treatment notes from your health care professional and any other material relating to your benefit request for consideration. You have the right to ask your health care professional for such letters or treatment notes.

The Appeal/Grievance must be filed with ConnectiCare as soon as possible after you receive the original decision, but no later than 180 calendar days after the Pre-Authorization request was denied or 180 calendar days after the claim for benefits was denied, whichever comes first. If you fail to submit your request within the 180 calendar days, you lose your right to an Appeal/Grievance.

You may contact the Commissioner of the Insurance Department, the Division of Consumer Affairs within the Insurance Department or the Office of Healthcare Advocate at any time for assistance, complaints or upon the completion of our internal Appeal/Grievance process. Their contact information is as follows:

Take a look at the "Managed Care Rules And Guidelines" section to see if you have to use Participating Providers and the "Pre-Authorization And Pre-Certification (Prior Approval) Addendum" to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

State of Connecticut Insurance Department
Insurance Commissioner
PO Box 816
Hartford, Connecticut 06142-0816
860-297-3900

Or

The Consumer Affairs Unit
1-800-203-3447

Office of the Healthcare Advocate
P.O. Box 1543
Hartford, CT. 06144

Or

(Toll Free) 1-866-466-4446
or
http://www.ct.gov/oha
or
Email: healthcare.advocate@ct.gov

Medical Necessity Appeal

Internal Appeal Process

If you disagree with a decision regarding the **Medical Necessity** of a particular Health Service, such as a denial of a request for Pre-Certification of an inpatient admission or the Pre-Authorization of a certain surgical procedure, you may Appeal/Grieve that decision.

Our *internal* Appeal/Grievance process is designed to resolve Appeals/Grievances quickly and impartially through the use of an independent review organization of Clinical Peers (except for behavioral health reviews, which are reviewed by an appropriately licensed Clinical Peers through our behavioral health Delegated Program).

1. We will investigate your Appeal/Grievance request. If during this investigation, we acquire new or additional evidence or new or an additional scientific or clinical rationale, it will be reviewed as part of your Appeal/Grievance. We will provide such newer additional information, to you or your representative for review. You will have five business days to respond to the new or additional information before we send your Appeal/Grievance to the independent review organization.
2. The independent review organization will arrange to have the Appeal/Grievance reviewed by a Clinical Peer who was not involved in the original decision. If the Clinical Peer agrees with our decision to deny coverage, but uses new or additional information for his/her decision, then you or your authorized representative will be provided with the new or additional information and will have five business days to respond to the new or additional information before the decision is issued.
3. You or your authorized representative and your practitioner will be sent a written decision no later than 30 calendar days for pre-service and concurrent Appeals/Grievances or 60 calendar days for post service Appeals/Grievances.
4. If you are not satisfied with the decision, you or your authorized representative or any provider with your consent may be able to have the decision reviewed by Clinical Peers who have no association with us by submitting a request for an external review through the State of Connecticut Insurance Department when the Adverse Determination or final Adverse Determination involves an issue of rescission, eligibility, Medical Necessity, appropriateness, health care setting, level of care or effectiveness. Please refer to the "External Review And Expedited External Review" provision in this subsection.

Urgent Care Appeals/Grievances

You may file an Appeal/Grievance on an urgent basis with us if:

- We have issued an Adverse Determination for coverage:
  - And the time period for making a non-urgent care request determination could seriously jeopardize your or your covered dependent's life or health or ability to regain maximum function, or
  - In the opinion of a health care professional with knowledge of the medical condition, you or your covered dependent would be subject to severe pain that could not be adequately managed without the Health Services or treatment related to the Appeal/Grievance.
- Your request concerns a substance use disorder or a co-occurring mental disorder; or
- Your request concerns a mental disorder requiring inpatient services, Partial Hospitalization, residential treatment, or Intensive Outpatient Services necessary to keep you from requiring an inpatient setting.

Behavioral Health Urgent Requests

A decision on an urgent Appeal/Grievance concerning a substance use disorder, a co-occurring mental disorder or a mental disorder requiring inpatient services, Partial Hospitalization, residential treatment or intensive outpatient services necessary to keep you from requiring an inpatient setting will be made as soon as possible, taking into account your condition, **but not later than 24 hours after receipt of the request**, provided that we have the information necessary to make a determination and provided if the Urgent Care request is a concurrent review request to extend a course of treatment beyond the initial period of time or the number of treatments, such request is made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. For reviews of an Appeal/Grievance involving a concurrent review request, your treatment shall be continued without liability to you until you have been notified of the review decision.

Take a look at the "Managed Care Rules And Guidelines" section to see if you have to use Participating Providers and the "Pre-Authorization And Pre-Certification (Prior Approval) Addendum" to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

All Other Urgent Requests

A decision on an urgent Appeal/Grievance will be made as soon as possible, taking into account your condition. If we receive all of the necessary information with your Appeal/Grievance, you will receive a decision within two business days of receipt of all necessary information but **no later than 72 hours after we've received your Appeal/Grievance**, except as noted below. If we need additional information in order to make the decision, then we will contact you within 24 hours of our receipt of your Appeal/Grievance to tell you specifically what information we need, and you will have 48 hours to provide us with that information. We will make the decision no later than 24 hours after receipt of the missing information or 72 hours from the date/time the Appeal/Grievance was received when the requested information is not provided to make the determination.

If the urgent Appeal/Grievance involves an Adverse Determination of a concurrent review Urgent Care request, the treatment shall be continued without liability to you until you have been notified of the review decision.

If you are not satisfied with the urgent Appeal/Grievance decision made by us, then you, your authorized representative or any provider with your consent may request an external review through the State of Connecticut Insurance Department when the Adverse Determination or final Adverse Determination involves an issue of Medical Necessity, appropriateness, health care setting, level of care or effectiveness. Please refer to the "External Review And Expedited External Review" provision in this subsection.

Bypassing The Internal Appeal/Grievance Process

If any of the following circumstances apply, you may be able to bypass our internal Appeal/Grievance process and file a request for an expedited external review:

- ♥ You have a medical condition for which the time period for completion of an expedited internal Appeal/Grievance would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function,
- ♥ The Adverse Determination involves a denial of coverage based on a determination that the recommended or the requested Health Service or treatment is Experimental Or Investigational and your treating health care professional certifies in writing that such recommended or requested Health Service or treatment would be significantly less effective if not promptly initiated,

You, or your provider acting on your behalf with your consent, may simultaneously file a request for an internal Appeal/Grievance and an expedited external review. The independent review organization will determine whether you will be required to complete the internal Appeal/Grievance process prior to conducting the expedited external review. Please refer to the "External Review And Expedited External Review" provision in this subsection for details on filing for an expedited external review.

External Review And Expedited External Review

You or your authorized representative may file a request for an expedited external review if:

- ♥ You have a medical condition for which the time period for completion of an external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or
- ♥ The final Adverse Determination concerns an admission, availability of care, continued stay or Health Service for which you received Emergency Services but you have not been discharged from a facility, or
- ♥ The denial of coverage was based on a determination that the recommended or requested Health Service or treatment is Experimental Or Investigational and your treating health care professional certifies in writing that such recommended or requested Health Service or treatment would be significantly less effective if not promptly initiated.

Note: An expedited external review is not available when the requested services have already been provided.

1. The external review or expedited external review request must be submitted to the State of Connecticut Insurance Department in writing. The address and telephone number is as follows:

   State of Connecticut Insurance Department
   Insurance Commissioner
   PO Box 816
   Hartford, Connecticut 06142-0816

   1-860-297-3910

2. The external review request must be made within 120 calendar days of your receipt of the final denial letter. However, an expedited external review may be filed without receipt of our final denial letter. You do not need a final denial letter in order to file for an external review if we fail to strictly adhere to the requirements under the law with respect to making utilization review and benefit determinations.
3. When filing a request for an external review you will be required to authorize the release of any medical records that may be required to be reviewed for the purpose of making a decision on such request.
4. The review will require a fee of $25 payable to the State of Connecticut Insurance Department. There is a maximum fee of $75 per Member per year. This fee may be waived if you are poor or unable to pay by the State of Connecticut Insurance Commissioner. The fee is

refunded if the Adverse Determination is reversed or revised.

5. If you request an external review or an expedited external review, you will receive additional information including instructions on how to supply additional comments or materials related to your benefit request.
6. You or your authorized representative will be provided with a written decision within 45 calendar days for a standard external review, 20 calendar days for an external review involving a health care service or treatment that is experimental or investigational, 72 hours for an expedited external review or five calendar days for an expedited external review involving a health care service or treatment that is experimental or investigational. A decision on an expedited review concerning a substance use disorder, a co-occurring mental disorder or a mental disorder requiring inpatient services, Partial Hospitalization, residential treatment or Intensive Outpatient Services necessary to keep you from requiring an inpatient setting will be made as soon as possible, taking into account your condition, but not later than 24 hours.

Administrative (Non-Medical Necessity) Appeal/Grievance

If you disagree with an **Administrative (Non-Medical Necessity)** decision, such as a decision that interprets the application of Plan rules and that does not relate to Medical Necessity, you may Appeal/Grieve that decision.

1. If you file an Appeal/Grievance, we will notify you not later than three business days after we receive your Appeal/Grievance that you or your authorized representative are/is entitled to submit written materials to us to be considered when conducting a review of your Appeal/Grievance.
2. When the Appeal/Grievance is received, it will be forwarded for review.
3. A staff member who was not involved in the original decision will review the Appeal/Grievance.
4. You or your authorized representative will be provided with a written decision no later than 20 business days after we receive your Appeal/Grievance request. If we are unable to comply with this time period due to circumstances beyond our control, the time period may be extended by us for up to ten business days, provided that on or before the 20th business day we provide you or your authorized representative written notice of the extension and reason for the delay.

TERMINATION AND AMENDMENT

TERMINATION

Termination Of Your Employer's Coverage

This Plan and your Employer's coverage under this Plan will end on the earliest day that any of the following events occurs:

1. At the end of the grace period if your Employer fails to make the Premium payments due; or

   At another date after the grace period that we specify in writing to your Employer. This date will not be earlier than midnight of the third business day following the date you or your Employer receives our written notice to terminate coverage due to failure to pay the required Premium.
2. If your Employer has committed fraud (as determined by a court of competent jurisdiction), or in the event your Employer has knowingly hidden or misrepresented any material fact or circumstance in applying for coverage under this Plan.
3. In the event your Employer fails to comply with the following conditions that we may require in order for coverage to be available under this Plan:
   - ♥ Service Area requirements;
   - ♥ Employer contribution requirements; or
   - ♥ Group participation rules, which may be those pertaining to:
     - ◆ The Health Insurance Portability and Accountability Act of 1996 (HIPAA), if your Employer has at least two Employees but not more than 50; or
     - ◆ State law, if your Employer has more than 50 Employees; or
     - ◆ Failure to qualify as a legitimate employer for the purposes of securing group health insurance under State law.
4. When we terminate coverage for all Employers.
5. When your Employer's membership in a bona fide association through which this coverage is provided (as defined by federal law) ceases. This can only occur if coverage is terminated uniformly without regard to the health status of any Member covered through the Employer under this Plan.
6. At the end of the month the termination occurs if your Employer provides us with written notice at least **30 days in advance** of the requested termination date. Notification must be submitted to us on your Employer's letterhead and include the date of the requested termination.
7. On the date your Employer is liquidated, ceases to operate, no longer employs any active employees or no

longer covers any active employees with us.

8. On the date agreed upon by your Employer and us.

Termination Of Your Coverage

This Plan will end and coverage under this Plan will end on the earliest day that any of the following events occurs.

1. On the date this Plan and your Employer's coverage end.
2. On the last day of the month when you are no longer an Employee or on the date established by your Employer's termination standards.

   Your Eligible Dependent spouse's coverage will end on the last day of the month after the month which he/she is no longer an Eligible Dependent or on the date established by your Employer's termination standards if coverage continues under COBRA or Connecticut rules.

   Your Eligible Dependent child's coverage will terminate on his/her 26th birthday if it coincides with the first day of this Plan's Contract Year. Otherwise, the Eligible Dependent child's coverage will terminate at the end of the last day of the Contract Year in which the Eligible Dependent child becomes 26 years old.
3. When a Member has committed fraud (as determined by a court of competent jurisdiction), or has knowingly omitted or misrepresented any material fact or circumstance in applying for enrollment or in obtaining Plan Benefits. However, we may not contest the Member's coverage under this paragraph beyond two years from the Member's effective date of coverage under this Plan.
4. On the anniversary of the effective date of this Plan following a Member's voluntary disenrollment during an Annual Enrollment Period, or according to any other schedule agreed to by your Employer and us.
5. When a Member engages in an act of physical or verbal misconduct, which poses a threat to, or creates an intimidating, hostile or offensive working environment for:

   ♥ Providers

   ♥ Other Members

   ♥ Our employees, our affiliates or our subcontractors.
6. For a Member's repeated refusal to follow prescribed treatment that is Medically Necessary.
7. For a Member's failure to take such reasonable actions as may be necessary to protect our rights under this Plan.
8. In the event the Member has repeatedly failed to make the required Cost-Sharing payments to providers.

   If we decide to end your coverage under this provision, termination will take effect 30 days following our written notice stating our intent to end your coverage.
9. In the event you fail to send in your contribution toward Premium, as may be required by your Employer.
10. The date you no longer reside or work in the Service Area or your Eligible Dependents no longer reside with you or in the Service Area.
11. The date you and your Eligible Dependents are absent from the Service Area for more than 180 days, even if you still live or work in the Service Area, as applicable.

EXTENSION OF BENEFITS

When This Plan Is The Prior Plan

1. If a Member is an inpatient at a Hospital, Hospice, Skilled Nursing Facility, Rehabilitation Facility or Residential Treatment Facility on the date that this Plan ends with the Employer, and the Employer does not obtain replacement coverage in another plan offered or insured by us immediately after coverage under this Plan ends, this Plan will cover the costs of the Hospitalization or inpatient stay as well as the medical care relating to that Hospitalization or inpatient stay until the Member is no longer inpatient.

   Coverage will be for either the actual length of the inpatient stay or for up to 12 months, whichever is shorter. Coverage is still subject to all of the terms, conditions and rules of this Plan. To be eligible for payment, all claims for coverage must be sent in accordance with the terms of this Plan.
2. If a Member is Totally Disabled (and not confined in a health care facility) on the date this Plan is terminated with your Employer, and your Employer does not obtain any replacement coverage or obtains self-funded replacement coverage immediately after coverage under this Plan terminates, coverage will be continued under this Plan for the services related to the disabling condition for that Member without Premium.

   This coverage will continue for that Member's disability until the first of the following occurs:

   ♥ For a period of 12 months following the calendar month in which this Plan was ended; or

   ♥ Until he/she is no longer Totally Disabled.

   Proof of the disability must be sent to us within one year of the termination of this Plan.

   To be eligible for payment, all claims for coverage must be sent in accordance with the terms of this Plan.
3. If a Member is Totally Disabled (and not confined in a health care facility) on the date this Plan ends with your Employer, and your Employer obtains insured replacement coverage in another plan immediately after coverage under this Plan terminates, coverage under this Plan will end on the date this Plan is terminated, and the new plan will be responsible for all claims that occur as of the effective date of the replacement coverage.

Take a look at the "Managed Care Rules And Guidelines" section to see if you have to use Participating Providers and the "Pre-Authorization And Pre-Certification (Prior Approval) Addendum" to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

When This Plan Is The Succeeding (Replacement) Plan

1. When your Employer ends its prior group health plan and replaces it with this Plan, and a Member is inpatient at a Hospital, Skilled Nursing Facility, Rehabilitation Facility, or Residential Treatment Facility on the effective date of this Plan, the coverage under this Plan will be effective, but this Plan will not cover the costs of that Hospitalization or inpatient stay or any medical care relating to that Hospitalization or inpatient stay if these costs are the responsibility of a previous insurance company. You should notify us when an inpatient stay occurs. When this Plan is a replacement plan and becomes responsible for covering a Member who is inpatient on the effective date of this Plan, reasonable transition of care benefits will be available to allow the Member to use his/her current Non-Participating Providers to treat the condition related to the confinement for a period of time during which it is clinically appropriate to require use of those current Non-Participating Providers. During the transition period, benefits for the condition related to the confinement will not be reduced because the current providers do not participate in our network, or because services were pre-certified by the Member's prior carrier but not by us.
2. When your Employer ends its prior group health plan and replaces it with this Plan, this Plan will pay benefits for a Member who is Totally Disabled (but not confined in a health care facility), on the date this Plan became effective, but this Plan will not cover the disabling condition if coverage for the disabling condition is the responsibility of a previous insurance company. Reasonable transition of care benefits will be available for treatment of the disabling condition, allowing the new Member to use his/her current Non-Participating Providers for a period of time during which it is clinically appropriate to require use of those current providers. During the transition period, benefits for treatment of the disabling condition will not be reduced because the current providers do not participate in our network, or because services were pre-certified by the Member's prior carrier but not by us.

Your Employer must continue group coverage for you and your Eligible Dependents during your absence due to illness or injury, not to exceed 12 months from the beginning of the absence. Your Employer may charge you for this continuation, but no more than what would be charged if you had continued to be an active covered employee. This continuation will end earlier if you and your Eligible Dependents no longer meet the eligibility requirements of this Plan. In that event, the Member may be eligible for continued coverage under COBRA.

NOTICE OF PLAN TERMINATION

In the event this Plan is ended with your Employer, your Employer must provide you with 15 days' notice before this Plan ends.

AMENDMENT

We may change this document by providing 60 days' written notice to your Employer.

COBRA AND CONTINUATION OF COVERAGE

As the result of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and Connecticut law, a "Qualified Beneficiary" is offered the ability to continue coverage under this Plan when a "Qualifying Event" occurs.

THE FOLLOWING IS A SUMMARY ONLY of the circumstances under which a Member may be eligible for continued group coverage under the COBRA and Connecticut rules. The Employer is responsible for notifying the Member of these rights and for administering COBRA and Connecticut rules.

In addition, Trade Adjustment Assistance (TAA)-eligible individuals and their dependents, as well as those who receive benefits from the Pension Benefit Guaranty Corporation (PBGC) and their dependents, may be eligible for extended COBRA coverage. Have your Employer contact us if you are eligible for TAA or PBGC benefits.

Your Right To Continue Benefits

If coverage under this Plan were to terminate due to a "Qualifying Event," a "Qualified Beneficiary" (you or your Eligible Dependents) may elect to continue coverage for up to 30 months, 36 months or longer, based on the Qualifying Event(s) which occurred.

1. You and your Eligible Dependents may continue coverage **up to 30 months** when coverage terminates due to a reduction in your hours, leave of absence, or termination of your employment for reasons other than gross misconduct.
2. You and your Eligible Dependents may continue coverage until you experience an event listed in the "Special Termination Of Continuation Coverage Conditions" section, if you experience a reduction, leave of absence or termination of employment as a result of your eligibility to receive Social Security income.
3. Coverage may continue **for up to 36 months** for the following persons:
   - ♥ A covered child who ceases to be an Eligible Dependent.
   - ♥ A covered spouse and dependents if you die.
   - ♥ A covered spouse and dependents whose coverage ceases due to divorce or legal separation from you.
   - ♥ A covered spouse and dependents if coverage ceases due to your entitlement for Medicare.

Take a look at the "Managed Care Rules And Guidelines" section to see if you have to use Participating Providers and the "Pre-Authorization And Pre-Certification (Prior Approval) Addendum" to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

A child who is born to, or adopted by, you during the continuation period is also a Qualified Beneficiary entitled to continuation. There is a special continuation period for you if you are retired and your Employer declares bankruptcy under Title 11 of the United States Code and you and your Eligible Dependents lose substantial coverage within one year before or after the date the bankruptcy proceedings commenced.

If continuation is elected, coverage will continue as though a Qualifying Event had not occurred. Any accumulation of Deductibles, Coinsurance or benefits paid prior to the Qualifying Event, which had been credited toward any Deductible, Coinsurance or benefit maximums of this Plan, will be retained as they would have been had the Qualifying Event not occurred.

During Annual Enrollment Periods, an individual with continuation of coverage has the same rights as active Employees to change his/her coverage or to add or eliminate coverage for Eligible Dependents covered by this Plan.

If, after the first Qualifying Event, another Qualifying Event occurs, coverage can be continued for an additional period, up to a total of 36 months from the date coverage under this Plan would have first stopped. If the Subscriber retires and becomes entitled to Medicare within 18 months after retirement, the Subscriber's dependent Qualified Beneficiaries are entitled to continuation for up to 36 months beginning with the date of retirement. If the Subscriber becomes entitled to Medicare and then later retires (or otherwise stops working or has reduced hours resulting in loss of coverage), the Subscriber's dependent Qualified Beneficiaries are entitled to continuation for the greater of:

- ♥ Up to 36 months from the date of Medicare entitlement; or
- ♥ Up to 30 months from the date of the retirement or layoff, leave of absence, reduction in hours or employment termination for reasons other than gross misconduct.

The Subscriber is entitled to continuation for up to 30 months from the date of retirement, layoff, leave of absence, or reduction in hours or employment termination for reasons other than gross misconduct, or until he/she experiences an event listed in the "Special Termination Of Continuation Coverage Conditions" section, if the retirement or reduction in hours results from eligibility to receive Social Security income.

These group continuation provisions do not apply to newborn children who are covered only for 61 days after birth, unless the newborn children are properly enrolled in this Plan as Eligible Dependents within 61 days of their birth.

Notification Requirements

In order to be eligible for continuation, you must provide notice to your Employer within 60 days of the date of the following Qualifying Events:

- ♥ Your marriage is dissolved.
- ♥ You become legally separated from your spouse/partner.
- ♥ Your dependent child no longer qualifies as your Eligible Dependent.

Your Employer must give you complete instructions on how to elect continuation.

Qualified Beneficiary Election Period

A Qualified Beneficiary has until the later of 60 days after the date coverage would have stopped due to the Qualifying Event or 60 days after the date notice of the right to continue coverage is sent to notify the COBRA administrator whether or not to continue coverage.

Trade Adjustment Act Election Period

A special COBRA election period may be available if you become eligible for trade adjustment assistance (TAA) under the Trade Act of 2002. If you did not elect COBRA previously for loss of coverage related to TAA, the special COBRA election period begins on the first day of the month in which you become eligible for TAA and lasts for 60 days, EXCEPT that you may not elect COBRA more than six months after your TAA-related loss of coverage. If you elect COBRA during this special election period, the COBRA coverage will begin on the first day of the special election period. However, the COBRA coverage will end on the same date it would have terminated if you had elected COBRA when you first became eligible for it.

Payments

The Qualified Beneficiary has 45 days from the date of the election to make the first payment of premium. The first payment will include any payment for the coverage before the date of the election. For example, if the election to continue coverage is made 60 days following the Qualifying Event and payment is made 45 days following the election, a total of three months premium must be paid on that date. The premium to continue coverage will be determined by your Employer in accordance with the law.

Termination Of Continuation Coverage

Continuation of coverage shall not continue beyond the date on which any one of the following events happens:

- ♥ The person reaches the maximum period of continuation of benefits (30 months or 36 months from the date of the Qualifying Event).
- ♥ This Plan stops being in force. If your Employer offers another group health plan, coverage may continue under that plan.

Take a look at the "Managed Care Rules And Guidelines" section to see if you have to use Participating Providers and the "Pre-Authorization And Pre-Certification (Prior Approval) Addendum" to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

- ♥ 30 days after the required payment for the coverage is due and not made.
- ♥ After electing continuation, the person becomes covered under any other group health plan or becomes entitled to Medicare. This does not apply if the other group health plan excludes or limits coverage on a person's pre-existing condition. If you or your Eligible Dependents are already covered under any other group health plan or Medicare before electing continuation coverage, you may still elect continuation coverage under this Plan.

Special Termination Of Continuation Coverage Conditions

If your retirement, reduction in hours or employment termination results from your eligibility to receive Social Security income, continuation of coverage for you and your dependents ends on the earliest of the following to occur:

- ♥ This Plan is no longer in force with your Employer;

  If your Employer offers another health plan, coverage may continue under that plan.
- ♥ 30 days after the required payment for coverage has not been made;
- ♥ The date you become eligible for Medicare; or
- ♥ The date you become eligible for other group coverage.

Subject to our review and approval, some Employers may have continuation policies that provide for additional terms of continuation coverage.

YOUR RIGHT TO CONTINUE BENEFITS WHEN CALLED UP TO ACTIVE MILITARY SERVICE

If coverage under this Plan stops because you have to leave work because you were called up to active military service, you and your Eligible Dependents may elect to continue coverage under terms similar to COBRA for **up to 24 months** after your absence from work begins or for your period of active duty service, whichever is shorter. The Premium to continue coverage will be determined by your Employer in accordance with the law. The COBRA rules for payment of Premium and termination of coverage procedures will apply to this continuation coverage.

In order for you to be eligible for this continued coverage, you, or your commanding officer, must give your Employer advance written or oral notice of your call up to active military service, unless military necessity prevents that notice or communication of that notice is not possible.

Any illnesses or injuries determined by the Secretary of Veterans Affairs to have been incurred in or aggravated during the call up to active military service will not be covered under this Plan.

CONVERSION PRIVILEGE

Connecticut State Health Reinsurance Association (HRA) Conversion

If a Member ceases to be covered by this Plan (whether or not the Plan has terminated with the Employer), he/she may apply for conversion through the Connecticut Health Reinsurance Association (HRA). The former Member must apply for the conversion within 31 days of his/her loss of coverage under this Plan. The terms of coverage under the HRA plan are subject to the rules and regulations of the HRA in force at the time of conversion.

PREMIUM PAYMENT

We determine the amount, time and manner of the payment of Premium. Our determination is subject to approval by the Connecticut Insurance Department.

1. All Premiums must be sent to us in accordance with our payment instructions, and according to the rates in force on behalf of the number of Members covered under this Plan.
2. All Premiums are due and payable on the first day of the month for which coverage is applicable and the first day of each calendar month after that. A grace period of 31 days is allowed. This means that if payment is not made on or before the date it is due, it may be paid during the grace period. If payment is not made during the grace period, this Plan will end on the last day of the grace period. When the Plan is cancelled for non-payment of Premium, the payment of such Premium is still due, including the amount of Premium accumulated during the grace period.

   Payment must reach us in time for us to complete our posting process in order for it to be considered paid by the end of the grace period.

   If Premium is not paid as described above, coverage under this Plan will end.
3. We may add a late payment charge of one percent (1%) per month for any Premium paid after the grace period.
4. Our bills take into account the membership changes we have been notified of and that we have processed. Premium payment must be sent as billed, unless another payment method has been mutually agreed upon between your Employer and us. Membership changes received and processed afterward will be reflected on the next bill.
5. Premiums may be increased by us on the beginning of any Contract Year or when otherwise mutually agreed upon by the Employer and us. We will provide 30 days' notice of a Premium increase. We may also increase Premium if benefits under this Plan are changed due to State or Federal law requirements. Such change will be made effective as of the effective date of the change in benefits. The Employer will be notified of the increase as soon as practical.

Take a look at the "Managed Care Rules And Guidelines" section to see if you have to use Participating Providers and the "Pre-Authorization And Pre-Certification (Prior Approval) Addendum" to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

6. The Employer must notify us prior to the date on which a Member's coverage is to end under this Plan in order for that Member's coverage to end on that date. This notification must be sent to us in writing and can be done electronically, if the Employer typically transfers eligibility information electronically to us.

   In the event the Employer fails to provide us with this notice and continues to make Premium payments for that Member, we will refund only up to two months of Premium payment from the first of the month in which notification to us was received. However, if Plan Benefits were provided to that Member during the period for which Premium would be refunded, we may elect not to refund the Premium for that period.

7. If coverage begins at any time up through the 15th day of a month, a whole month's Premium is due. If coverage begins after the 15th day of a month, no Premium is due for that month. If coverage ends at any time up through the 15th day of a month, no Premium is due for that month. If coverage ends on or after the 16th day of a month, a whole month's Premium is due.

GENERAL PROVISIONS

1. The Employer agrees that, during every Contract Year, there will be an Annual Enrollment Period of at least two weeks in which an Employee and/or the Employee's dependents may sign up in this Plan. This is the only time that an Employee and/or the Employee's dependents are permitted to sign up for coverage under this Plan, except as provided in the "Eligibility And Enrollment" section. It is the responsibility of the Employer to provide advance notification of the Annual Enrollment Period to its Employees and COBRA beneficiaries.
2. You and the Employer agree to cooperate with us and to follow our rules and instructions in all administrative matters required for the administration of this Plan.
3. We contract with Participating Providers to make sure that you will not be billed for any Health Services that are covered by this Plan. You are responsible for services billed that are subject to subrogation and coordination of benefits and applicable copayments, deductibles and coinsurance you are required to pay if you or your Eligible Dependents are covered by another plan and that other plan is determined to be the primary plan. In this case, a Participating Provider may bill you for copayments, deductibles and coinsurance due under that other plan (the primary plan). Check the "When This Plan Is Not Primary" provision of the "Coordination Of Benefits" section to find out your responsibilities.
4. Upon our request, the Employer agrees to supply us with copies of all summary plan descriptions prepared and distributed by the Employer which describe our Plan Benefits.
5. By being covered under this Plan, you and your Eligible Dependents accept all of the rules of this Plan.
6. No legal action can be brought against us under this Plan, unless it starts within 12 months from the date the complained of services were rendered.
7. We will have no liability for benefits other than as provided by this Plan.
8. The benefits of this Plan are not transferable and may not be assigned to any third party, except when the Member indicates on the claim form that payment should be sent directly to the provider of the covered Health Service or when an ambulance company provider is entitled to be paid directly according to the law.
9. We may establish reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of this Plan.
10. If ended for any reason, this Plan may be restored only at our discretion, and then the Plan may be subject to an additional fee as determined by us.
11. This document is the entire contract and understanding between us and the Employer and between us and the Members. It replaces all prior agreements and understandings relating to the subject matter. Except as otherwise described in this document, this document may be changed, waived, discharged or ended only when done in writing and signed by the party against which enforcement of the change, waiver, discharge or termination is sought.
12. If any portion of this document is or becomes, for any reason, invalid or unenforceable, that portion will be ineffective only to the extent of the invalidity or unenforceability and the remaining portion or portions will nevertheless be valid, enforceable and of full force and effect.
13. This Plan will be administered according to the laws of the State of Connecticut, but only to the extent those laws are not preempted by the Employee Retirement Income Security Act (ERISA) or other federal law.
14. In the event the Employer transfers eligibility information electronically to us regarding you or your Eligible Dependents, the Employer agrees to the following:

    - To require its Employees to enroll in this Plan on behalf of themselves and any Eligible Dependents by:
      - Completing and signing an Enrollment Form; or
      - Telephonic or computer enrollment using a script (the content of the script must include information we provide to the Employer in writing), along with a written acknowledgment concerning the terms of this Plan, particularly authorizing the transfer of confidential information; or
      - Telephonic or computer enrollment, with a written acknowledgment concerning the terms of this

Take a look at the "Managed Care Rules And Guidelines" section to see if you have to use Participating Providers and the "Pre-Authorization And Pre-Certification (Prior Approval) Addendum" to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

Plan, particularly authorizing the transfer of confidential information.

- ♥ If Enrollment Forms or Acknowledgments are used as described above, the Employer agrees to maintain these completed Enrollment Forms and Acknowledgments for not less than ten years following the date the Employee who is the subject of the form or Acknowledgment has ended participation in this Plan.
- ♥ The Employer agrees to provide the original or a copy of any individual Enrollment Form or Acknowledgment to us, upon our request, for our use in administering this Plan. We will return the Enrollment Form or Acknowledgment, if it was an original, when we are finished using it.
- ♥ The Employer agrees to provide us with timely, accurate enrollment information on an "Enrollment File" in accordance with a schedule, and in a format and layout that we agree to.
- ♥ The Employer agrees to pay us an additional charge, as we specify, for programming work we require for changes the Employer wishes to make to the standard format or layout of the Enrollment File we agree to. We will bill the Employer for any additional charge in the month following the completion of the programming. The bill will be due upon receipt and payable within 15 calendar days following receipt by the Employer.

15. Participating Providers are not our employees or agents. They are independent contractors with the responsibility for determining and providing health care for their patients.
16. A Participating Provider may refuse to provide services or treatment to you or your Eligible Dependents if you do not pay the required Cost-Share amounts required under this Plan.
17. We are not responsible for your decision to receive treatment, services or supplies provided by Participating Providers, nor are we responsible or liable for the treatment, services or supplies provided by Participating Providers.
18. As the result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), if your or your Eligible Dependent's coverage ends under the Plan, we will automatically provide you with a Certificate of Creditable Coverage which can be presented to a subsequent insurance company to reduce or eliminate pre-existing condition limitations. You may request additional Certificates for a period of up to 24 months from the date your or your Eligible Dependent's coverage ends. In some instances, your Employer performs these duties for us.
19. This Plan does not limit coverage for conditions just because you had the condition before you became covered under the Plan.
20. When this Plan calculates benefits on a calendar year, the Plan calculates benefits on a calendar year basis, even if the Plan year is different from the calendar year. This means that changes to your benefit plan become effective upon renewal, but, when renewal is in the middle of the calendar year, the benefits already used during the calendar year will continue to count toward the total benefits available to you for that calendar year. Check your Benefit Summary to see if benefits for your Plan are covered per calendar year or per Contract Year.

DEFINITIONS

The following defined terms have special meaning and may be found throughout this document. They are referenced using capital letters like this (Upper Case).

ADVERSE DETERMINATION

The denial, reduction, termination or failure to provide or make payment, in whole or in part, for a benefit under this Plan requested by a Member or a Member's treating health care professional, based on a determination by us or our Delegated Program:

- ♥ That, based upon the information provided,
  - ◆ Upon application of any utilization review technique, such benefit does not meet our requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness, or
  - ◆ Is determined to be Experimental Or Investigational.
- ♥ Of a Member's eligibility to participate in this Plan; or

Any prospective review, concurrent review or retrospective review determination that denies, reduces or terminates or fails to provide or make payment, in whole or in part, for a benefit under this Plan requested by a Member or a Member's treating health care professional.

An Adverse Determination includes a rescission of coverage determination for Appeal/Grievance purposes.

AMBULATORY SURGERY CENTER

An entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients not requiring Hospitalization and whose expected stay in the center does not exceed 24 hours. It is further defined as a facility that is not owned by a Hospital and which bills for its services under its own unique tax identification number.

ANNUAL ENROLLMENT PERIOD

A period of time jointly agreed upon by us and your Employer during which Employees and their Eligible Dependents may enroll in this Plan. You and your Eligible Dependents may also apply for enrollment in this Plan

Take a look at the "Managed Care Rules And Guidelines" section to see if you have to use Participating Providers and the "Pre-Authorization And Pre-Certification (Prior Approval) Addendum" to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

during a "Special Enrollment Period" pursuant to applicable Federal law.

APPEAL/GRIEVANCE (GRIEVE)

A written complaint or, if the complaint involves an urgent care request, an oral complaint, submitted by or on behalf of a Member regarding:

- The availability, delivery or quality of Health Services, including a complaint regarding an Adverse Determination made pursuant to utilization review;
- Claims payment, handling or reimbursement for Health Services; or
- Any matter pertaining to the contractual relationship between the Member and us.

AUTISM SPECTRUM DISORDERS (ASD)

The pervasive developmental disorders set forth in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders," including but not limited to autistic disorder, Rett's disorder, childhood disintegrative disorder, Asperger's disorder, and pervasive developmental disorder not otherwise specified.

BEHAVIORAL HEALTH PROGRAM

A Delegated Program under which we may provide for management, administration and a network of providers for mental health, and alcohol and substance abuse services, under this Plan. In some instances the Behavioral Health Program may be managed and administered by a Delegated Program under contract with us. In that event, when this document refers to determinations, Pre-Authorizations or Pre-Certifications, Referrals and other decisions made under the terms of the Behavioral Health Program, such determinations, Pre-Authorizations or Pre-Certifications, Referrals and other decisions are made by the Delegated Program on behalf of us and we have the ultimate authority to make these discretionary decisions.

BEHAVIORAL THERAPY

Any interactive Behavioral Therapy derived from evidence-based research, including but not limited to "Applied Behavioral Analysis," cognitive behavioral therapy, or other therapies supported by empirical evidence of the effective treatment of individuals diagnosed with ASD.

"Applied Behavioral Analysis" means the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, including the use of direct observation, measurement and functional analysis of the relationship between environment and behavior, to produce socially significant improvement in human behavior. Supervision requires at least one hour of face-to-face supervision of the autism services provider for each ten hours of Behavioral Therapy.

BENEFIT REDUCTION

A Benefit Reduction is a reduction in benefits, which applies when a Member enrolled in a **POS Plan** fails to obtain the Pre-Authorization or Pre-Certification for certain Medically Necessary health care services that require Pre-Authorization or Pre-Certification prior to the receipt of these services from or arranged by a Non-Participating Provider.

BENEFIT SUMMARY

The document that summarizes the benefits provided under this Plan and that lists the Copayments, Deductibles and Coinsurance levels that you are required to pay for Health Services as well as benefit and Out-Of-Pocket Maximums, if applicable.

BRAND NAME DRUG OR SUPPLY

A drug or supply manufactured and approved by federal FDA standards that has a proprietary trade name selected by the manufacturer used to describe and identify it.

CASE MANAGEMENT

The process for identifying Members with specific health care needs in order to help in the development and implementation of a plan that efficiently uses health care resources to help the Member manage his/her health.

CASE MANAGER

An individual, usually a registered nurse, who is responsible for developing and implementing a plan of care that takes into account benefit structure, accepted industry and internal standards, and cost effectiveness in order to help the Member mange his/her health.

CERTIFICATE OF COVERAGE

This document, and including the applicable Benefit Summary, Evidence Of Agreement, Riders, insert pages and Enrollment Forms.

CLINICALLY EQUIVALENT ALTERNATIVE DRUG OR SUPPLY

A drug or supply in the same category as an excluded drug or supply, and determined by us to be an effective alternative.

CLINICAL PEER

A physician or other health care professional who:

- Holds a non-restricted license in a state of the United States and in the same or similar specialty as typically manages the medical condition, procedure or treatment under review, and
- For a review concerning a child or adolescent substance use disorder or mental disorder, holds a national board certification in child and adolescent psychiatry or psychology and has training or clinical experience in the treatment of child and adolescent substance use disorder or mental disorder as applicable, or for a review concerning an adult substance use or mental disorder holds a national board certification in psychiatry or psychology and has training or clinical experience in the treatment of adult substance use or mental disorders as applicable.

COBRA

The Federal Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, and regulations issued thereunder.

Take a look at the "Managed Care Rules And Guidelines" section to see if you have to use Participating Providers and the "Pre-Authorization And Pre-Certification (Prior Approval) Addendum" to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

COINSURANCE
The percentage of the cost of benefits under this Plan that you or we are legally responsible to pay.

Except as otherwise required by law, the Coinsurance amount will be calculated based on the lesser of:

- ♥ The physician's or provider's charge for a Health Service at the time it is provided; or
- ♥ The contracted rate with the physician or provider for the Health Service.

If you are enrolled in one of our **POS Plans**, Coinsurance means the percentage of the Maximum Allowable Amount that you are legally responsible to pay after any applicable Deductible is met.

When Coinsurance applies as a result of the In-Network Level Of Benefits, except as otherwise required by law, the Coinsurance amount will be calculated based on the lesser of:

- ♥ The physician's or provider's charge for the Health Service at the time it is provided; or
- ♥ The contracted rate with the physician or provider for the Health Service.

When Coinsurance applies as a result of the Out-Of-Network Level Of Benefits, except as otherwise required by law, the Coinsurance amount will be calculated based on the Maximum Allowable Amount.

A charge by a physician or provider for a Health Service eligible for the Out-Of-Network Level Of Benefits that is in excess of the Maximum Allowable Amount is not considered Coinsurance and shall be the Member's financial responsibility.

COINSURANCE MAXIMUM
Generally, the Member's maximum payment liability per year for Coinsurance for Health Services covered at the In-Network Level Of Benefits or separately at the Out-Of-Network Level Of Benefits, as listed in the Member's Benefit Summary. Check the "Managed Care Rules And Guidelines" section for more information about how the Coinsurance Maximum applies to your Plan.

CONNECTICARE, WE, US OR OUR
ConnectiCare Insurance Company, Inc., the company insuring this Plan.

CONTRACT YEAR
A period of 12 months beginning on the effective date of this Plan, and each 12-month period following the first one. A shorter or longer period of time may be agreed upon in writing by us and the Employer.

COPAYMENT MAXIMUM
Generally, the Member's maximum payment liability per year for Copayments for Health Services covered at the In-Network Level Of Benefits as listed in the Member's Benefit Summary. Check the "Managed Care Rules And Guidelines" section for more information about how the Copayment Maximum applies to your Plan.

COPAYMENTS
One flat fee you pay per day per provider (or provider group) for certain Plan Benefits under this Plan.

COSMETIC TREATMENTS
Any dental, medical or surgical treatment for which the primary purpose is to change appearance as we determine in our sole discretion.

COST-SHARE
The amount of allowed charges which the Member is required to pay for covered Health Services. Cost-Shares can be Deductibles, Copayments and/or Coinsurance amounts.

COST-SHARE MAXIMUM
Generally, the Member's maximum payment liability per year for Copayment and Coinsurance as listed in the Benefit Summary. Check the "Managed Care Rules And Guidelines" section for more information about how the Cost-Share Maximum applies to your Plan.

CUSTODIAL CARE
Those services and supplies furnished to a Member who has a medical condition that is chronic or non-acute in nature which, at our discretion, either:

1. Are furnished primarily to assist the patient in maintaining activities of daily living, whether or not the Member is disabled, including, but not limited to, bathing, dressing, walking, eating, toileting and maintaining personal hygiene; or
2. Can be provided safely by persons who are not medically skilled, with a reasonable amount of instruction, including, but not limited to, supervision in taking medication, homemaking, supervision of the patient who is unsafe to be left alone and maintenance of bladder catheters, tracheotomies, colostomies/ileostomies and intravenous infusions (such as TPN) and oral or nasal suctioning.

These services and supplies are considered Custodial and are not reimbursed or paid, no matter who performs them, even if you do not have a family member, friend or other person to perform them. If skilled home health care services have been Pre-Authorized, the covered Health Services may, under some circumstances, include custodial services, if provided by a home health aide in direct support of the approved skilled home health care.

DEDUCTIBLE
The total amount that you must pay during the year toward certain benefits under this Plan before we will begin paying for those benefits. Check your Benefit Summary to see if benefits for your Plan are covered per calendar year or per Contract Year and which benefits are subject to a Deductible.

Benefit Deductibles: This Plan may have specific Benefit Deductibles that apply separately to certain

services. The specific Benefit Deductibles must be met by the Member each year before we will begin paying for those benefits. Anything paid by a Member for those benefits does not count towards meeting the Plan Deductible (if this Plan has one). Check your Benefit Summary to see the Benefit Deductibles that may apply to this Plan.

Plan Deductible: Some Plan options require you to pay a Plan Deductible. A Plan Deductible is a specific amount each Member must pay in any year towards certain covered Health Services before we will begin paying our portion of those benefits. After the Plan Deductible is met, benefits will be paid subject to the Member's payment of either a Copayment amount or a Coinsurance amount. Check your Benefit Summary to see if a Plan Deductible applies to you.

DELEGATED PROGRAM

An outside company that we may use to manage and administer certain categories of benefits or services provided under this Plan.

When this document refers to determinations, Pre-Authorizations or other decisions made under the terms of that Delegated Program, such determinations, Pre-Authorizations, Referrals or other decisions are made by the outside company on our behalf.

DENTAL SERVICES

Those diagnostic and therapeutic, medical, surgical services and supplies that are Medically Necessary and available to you and your covered dependents under this Plan. Dental Services must be provided or rendered by a licensed Dentist, dental hygienist, or dental assistant within the scope of his or her license or authorization in accordance with the laws and regulations of the governmental authority having jurisdiction.

DENTIST

Dentist means any licensed Dentist (D.D.S., D.M.D.) who is actively engaged in the practice of Dentistry, including the following:

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

Oral and Maxillofacial Surgeon: A dental specialist whose practice is limited to the diagnosis, surgical and adjunctive treatment of diseases, injuries, deformities, defects and esthetic aspects of the oral and maxillofacial regions.

Orthodontist: A dental specialist whose practice is limited to the interception and treatment of malocclusion of the teeth and surrounding structures.

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

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

DENTISTRY (DENTAL CARE)

Dentistry (Dental Care) means:

- The diagnosis and treatment of diseases or lesions of the mouth and surrounding and associated structures;
- Replacement of lost teeth by artificial ones;
- The diagnosis or correction of malposition of the teeth; or
- The furnishing, supplying, constructing, reproducing or repairing of any prosthetic denture, bridge appliance or any other structure to be worn in the mouth; or the placement or adjustment of such appliance or structure in the human mouth.

DRUG THERAPY

A product administered by a health care professional for use in the diagnosis, cure, treatment, or prevention of disease.

ELIGIBLE DEPENDENTS

Persons, other than you (the Subscriber), who are eligible to be enrolled as Members under this Plan and as described in the "Eligibility And Enrollment" section.

EMERGENCY

The sudden and unexpected onset of an illness or injury with severe symptoms whereby a Prudent Layperson, acting reasonably, would believe that emergency medical treatment is needed.

An Emergency related to mental health care exists when a Member is at risk of suffering serious physical impairment or death; or of becoming a threat to himself/herself or others; or of significantly decreasing his/her functional capability if treatment is withheld for greater than 24 hours.

The presenting symptoms of the patient, as coded by the provider on the appropriate claim form or the final diagnosis, whichever reasonably indicates an emergency medical condition, shall be the basis for determining whether such services are for an Emergency. Determination of whether a condition is an Emergency for purposes of this Plan rests exclusively within our discretionary authority.

EMERGENCY SERVICES

Evaluation of an emergency medical condition and treatment to keep the condition from getting worse.

EMPLOYEE

You, if you are or were an employee of the Employer and eligible to be enrolled as a Subscriber under this Plan as described in the "Eligibility And Enrollment" section. The term Employee also includes owners of corporations and partners of partnerships, provided the owner or partner devotes the same time to the business of the Employer that an Employee must work in order to be covered under this Plan.

EMPLOYER
A business entity that meets our underwriting requirements, that is accepted by us, and that has entered into an Evidence Of Agreement with us.

ENROLLMENT FORM
The application form provided or approved by us, used to enroll or disenroll you and/or your Eligible Dependents.

EVIDENCE OF AGREEMENT
The agreement between us and the Employer, which includes this document and establishes such provisions as: Premiums; the Plan effective date; the effective date of coverage for Employees and Eligible Dependents.

EXPERIMENTAL OR INVESTIGATIONAL
A service, supply, device, procedure or medication (collectively called "Treatment") will, in our sole discretion, be considered Experimental Or Investigational if any of the following conditions are present:

1. The prescribed Treatment is available to you or your Eligible Dependents only through participation in a program designated as a clinical trial, whether a federal Food and Drug Administration (FDA) Phase I or Phase II clinical trial, or an FDA Phase III experimental research clinical trial or a corresponding trial sponsored by the National Cancer Institute, or another type of clinical trial; or
2. A written informed consent form or protocols for the Treatment disclosing the experimental or investigational nature of the Treatment being studied has been reviewed and/or has been approved or is required by the treating facility's Institutional Review Board, or other body serving a similar function or if federal law requires such review and approval; or
3. The prescribed Treatment is subject to FDA approval and has not received FDA approval for any diagnosis or condition.

If a Treatment has multiple features and one or more of its essential features is Experimental Or Investigational based on the above criteria, then the Treatment as a whole will be considered to be Experimental Or Investigational and not covered.

GENERIC DRUG OR SUPPLY (GENERICS)
A drug or supply manufactured and approved by federal FDA standards that has the same active ingredients as the original Brand Name Drug Or Supply and is classified as a generic by a nationally recognized source and recognized by us as a Generic Drug Or Supply.

GENERIC EQUIVALENT
A Generic Drug Or Supply that is therapeutically equivalent to the Brand Name Drug Or Supply and that meets the composition, safety, strength, purity and quality standards of the federal FDA and that, for coverage, we require be substituted for a Brand Name Drug Or Supply. Not all Brand Name Drugs with Generic Equivalents are required to be substituted.

HEALTH SERVICES
Those diagnostic and therapeutic, medical, surgical, and mental health services and supplies that are Medically Necessary and available to you and your Eligible Dependents under this Plan. Health Services must be provided or rendered by a licensed health care provider within the scope of his/her its license or authorization in accordance with the laws and regulations of the governmental authority having jurisdiction.

HOME HEALTH AGENCY
A duly licensed agency where:

1. Nursing care is provided by a registered nurse or licensed practical nurse;
2. Home health aide services consisting of patient care of a medical or therapeutic nature are provided by someone other than a registered or licensed practical nurse;
3. Physical, occupational or speech therapy is provided;
4. Certain medical supplies, drugs and medicines prescribed by a physician and laboratory services to the extent such services would be covered if Medically Necessary, as we determine, are provided; and
5. Medical social services are provided by a qualified Masters-prepared social worker to or for the benefit of a terminally ill Member (i.e., having a life expectancy of six months or less).

HOSPICE
An agency that provides counseling and incidental medical services for a terminally ill (i.e., having a life expectancy of six months or less) individual. To be a Hospice, the agency must:

1. Be licensed in accordance with all applicable laws;
2. Provide 24-hour-a-day, seven days-a-week service;
3. Be under the direction of a duly qualified physician;
4. Have a nurse coordinator who is a registered graduate nurse with clinical experience, including experience in caring for terminally ill patients;
5. Have as its main purpose the provision of hospice services;
6. Have a full-time administrator;
7. Maintain written records of services given to the patient; and
8. Maintain malpractice insurance coverage.

For purposes of this Plan, a Home Health Agency that provides hospice care in the home or a hospice, which is part of a Hospital, will be considered a Hospice.

HOSPITAL
An institution duly licensed as a hospital by the governmental authority having jurisdiction and a mobile field

hospital when isolation care and Emergency Services are provided.

HOSPITALIZATION

Health Services rendered by a Hospital as either:

Inpatient Hospitalization: Those services rendered to a patient while that patient is assigned to a specific bed and location, and registered as an "inpatient" at a Hospital; or

Partial Hospitalization/Day Treatment Program: Those covered behavioral health services which are rendered in a facility or Hospital-based program that provides services for at least 20 hours per week.

HOSPITAL OUTPATIENT SURGICAL FACILITY (HOSF)

A facility owned by a Hospital or hospital system offering a surgical procedure and related care that in the opinion of the attending physician can be safely performed without requiring overnight inpatient Hospital care. A HOSF is included within the Hospital license and the Medicare or Medicaid certification of the Hospital itself. Services rendered by the HOSF are billed utilizing the Hospital's own tax identification number or a tax identification number unique to the Hospital or hospital system.

INDIVIDUAL PRACTICE ASSOCIATION OR IPA

An individual practice association or other organization of providers, including but not limited to a physician-hospital organization (PHO) and a group practice that has entered into a services arrangement with us or an affiliate or subcontractor of ours to provide Health Services to Members under this Plan.

INFERTILITY

The condition of a presumably healthy individual who is unable to conceive or produce conception or sustain a successful pregnancy during a period of one year.

IN-NETWORK LEVEL OF BENEFITS

Generally, the maximum level of benefits under this Plan available for Health Services provided to a Member directly by his/her Primary Care Provider (PCP) or upon Referral from his/her PCP or, for mental health and alcohol and substance abuse care, from our Behavioral Health Program, to a Participating Provider if you are enrolled in one of our **POS Plans**. The In-Network Level Of Benefits under this Plan is described in the Member's Benefit Summary.

INSUFFICIENT EVIDENCE OF THERAPEUTIC VALUE

Insufficient Evidence Of Therapeutic Value occurs when we determine in our sole discretion that either:

1. There is not enough evidence to prove that the service, supply, device, procedure or medication (collectively called "Treatment") directly results in the restoration of health or function for the use for which it is being prescribed, whether or not alternative Treatments are available; or
2. There is not enough evidence to prove that the Treatment results in outcomes superior to those achieved with reasonable alternative Treatments which are less intensive or invasive, or which cost less and are at least equally effective for the use for which it is being prescribed.

There may be Insufficient Evidence Of Therapeutic Value for a Treatment even when a Treatment has been approved by a regulatory body or recommended by a health care practitioner, and the Treatment will not be covered.

INTENSIVE OUTPATIENT (IOP)

The level of behavioral health care which is less intensive than Partial Hospitalization, but more intensive than outpatient services. Typically, IOP services are customized to meet the individual patient's needs, but have the capacity for a maximum of three to five encounters per week of less than four hours each in duration. The range of services offered is designed to address a mental health or substance abuse disorder in a coordinated, interdisciplinary treatment modality.

MAXIMUM ALLOWABLE AMOUNT

The amount on which we base our reimbursement for covered Health Services provided by Non-Participating providers, if you are enrolled in any of our **POS Plans**, which may be less than the amount billed for those covered Health Services. We calculate the Maximum Allowable Amount as the lesser of the amount billed by the Non-Participating Provider or, where applicable, the amount determined by one of the methods described below. In addition, the Maximum Allowable Amount is not the amount that we pay for a covered Health Service. The actual payment will be reduced by applicable Deductibles(s), Coinsurance, Copayment(s), Benefit Reduction amounts and other applicable adjustments described in this document. In no case will our reimbursement exceed the benefit maximum described in this document.

We have the sole authority to determine what we use for the Maximum Allowable Amount. The Maximum Allowable Amount can change from time to time, as well as the criteria we will use to determine the Maximum Allowable Amount.

Only charges that you are legally required to pay for a Health Service will count towards the Maximum Allowable Amount. So, if the physician or provider is not charging you for part or all of the Health Service and you are therefore not legally obligated to pay for that waived amount, we will not count that waived amount towards the Maximum Allowable Amount.

1. We may contract with vendors that have fee arrangements with Non-Participating Providers (Third Party Networks). If you utilize a Non-Participating Provider in a Third Party Network, the Maximum Allowable Amount will be determined based on our contract with the Third Party Network. Where the terms of our contract with the Third Party Network require, we will use the contract fee between the Non-Participating Provider and the Third Party Network as the Maximum

Allowable Amount. For other arrangements, we will determine the Maximum Allowable Amount as the lesser of the contract fee, or billed charges or the amount determined by one of the methods described below.

2. We may, at our option, refer a claim for the Out-Of-Network Level Of Benefits covered Health Service to a fee negotiation service to negotiate the Maximum Allowable Amount with the Non-Participating Provider. In that situation, if the Non-Participating Provider agrees to a negotiated Maximum Allowable Amount, you will not be responsible for the difference between the Maximum Allowable Amount and the billed charges. You will be responsible for any applicable Deductible(s), Coinsurance and/or Copayment(s) at the Out Of Network Level Of Benefits, as well as any Benefit Reduction amounts.
3. For physician and other professional covered Health Services, we may utilize a designated percentage of Resource Based Relative Value System (RBRVS) determined by us based on a percentage of Medicare. When no amount specified by the Centers for Medicare and Medicaid Services (CMS) at a percentage of RBRVS exists, a percentage of charges, as determined by us, will be used instead.

   As applicable, when the Employer chooses and pays the appropriate Premium for a higher percentage of Medicare than our standard described above, the percentage amount used to determine the Maximum Allowable Amount under this Plan will be specified in the Evidence Of Agreement.
4. For inpatient and outpatient Hospital covered Health Services, we may utilize a method developed by a company that uses Hospital cost to charge (C2C) ratio. This method analyzes charges based upon the Hospitals': financial and statistical information as submitted to the federal government; cost of providing covered Health Services; and the median mark up by revenue center for Hospitals in that geographic area. These values are then compared to the actual billed charges. If the Hospital accepts the C2C determination, it will become the Maximum Allowable Amount for the services rendered, at that time.
5. Where prescription drugs (e.g., IV therapy claims) are administered by a Non-Participating Provider, and covered as a medical benefit, we will determine the Maximum Allowable Amount using the Average Wholesale Price (AWP), as determined by us.
6. For a prescription drug or supply obtained at a pharmacy, the Maximum Allowable Amount will be the lesser of the actual charge for the medication or supply or the negotiated contracted rate for that medication or supply that we would have paid, if the medication or supply had been obtained at a Participating Pharmacy.
7. For Dental Services, the amount of a provider's billed charge for a Dental Service, which we use to determine what we reimburse under this Plan is the Maximum Allowable Amount. Only charges that you are legally required to pay for a Dental Service will count towards the Maximum Allowable Amount. So, if the Dentist or provider is not charging you for part or all of the Dental Service and you are therefore not legally obligated to pay for that waived amount, we will not count that waived amount towards the Maximum Allowable Amount.

In the event that the billed charges for the Non-Participating Provider are more than the Maximum Allowable Amount, you are responsible for any amounts charged in excess of the Maximum Allowable Amount, except where the Non-Participating Provider's fee is determined by references to a Third Party Network contract or the Non-Participating Provider agrees to a negotiated Maximum Allowable Amount.

Whenever you obtain covered Health Services from a Non-Participating Provider, you are responsible for applicable Deductibles(s), Coinsurance, Copayment(s) and/or Benefit Reduction Amounts.

MEDICALLY NECESSARY OR MEDICAL NECESSITY

Medical Health Services that a health care practitioner, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

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

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

When used with Dental Services, Medically Necessary means a necessary dental procedure or service as determined by a Dentist to either establish or maintain a patient's oral health. Such determinations are based on the professional diagnostic judgment of the Dentist and the standards of care that prevail in the professional community. The practitioner determines the care, but coverage of the care under this Plan is subject to Dental Necessity as determined by us. We use

input from local Dentists, including specialists, to approve, and in some cases develop our Dental Necessity protocols.

To be Medically Necessary, dental treatment must be:

For illness or injury: This means the treatment must be for a diagnosis that is commonly recognized as a disease or injury;

Therapeutic: This means there must be a reasonable expectation the treatment will directly result in the restoration of health or function;

Required: This means there must be no reasonable alternative treatment which is less intensive or invasive, or which costs less and is at least equally effective;

Not Experimental Or Investigational: and

Not elective and not for Cosmetic Treatment purposes.

MEDICARE
Title XVIII of the Social Security Act, including amendments.

MEMBER, YOU, AND YOUR ELIGIBLE DEPENDENTS
A person enrolled in this Plan, including you and your Eligible Dependents.

NETWORK ACCESS AREA
The geographical area consisting of the State of Connecticut and Hampden, Hampshire, and Franklin counties in Massachusetts.

NETWORK PROVIDER
A provider or facility that has a contract to provide health care services through a designated network vendor outside the Network Access Area. These providers or facilities are not listed in our Provider Directory. To locate a Network Provider, you can refer to the back of your ID Card to identify the Network Provider vendor and for instructions on obtaining a list of Network Providers, or visit our web site at www.connecticare.com, or call the appropriate telephone number listed in the "Important Telephone Numbers And Addresses" section.

Note: Network Providers may NOT be used at the In-Network Level Of Benefits inside the Network Access Area, unless the Network Provider is also a Participating Provider.

NEW TREATMENTS
New Treatments are new supplies, services, devices, procedures or medications, or new uses of existing supplies, services, devices, procedures or medications, for which we have not yet made a coverage policy.

NON-PARTICIPATING HOSPITAL
A Hospital that is not a Participating Hospital.

NON-PARTICIPATING PHARMACY
A pharmacy that does not have a contract with us to provide covered prescription drugs and supplies to you and your Eligible Dependents.

A Non-Participating Pharmacy is a pharmacy that when used by a Member typically provides the lowest level of benefits, because out of pocket Cost-Shares are the highest.

NON-PARTICIPATING PHYSICIAN OR NON-PARTICIPATING PROVIDER
A health care practitioner or facility that does not have a contract with us to provide Health Services to you and your Eligible Dependents. You may pay more to see a Non-Participating Provider.

OUT-OF-NETWORK LEVEL OF BENEFITS
Generally, a lesser level of benefits than the In-Network Level Of Benefits under this Plan available for Health Services provided to a Member when the Health Services are not eligible for benefit coverage at the In-Network Level Of Benefits if you are enrolled in one of our **POS Plans**. Except in cases of Emergencies or as otherwise provided in this document, Health Services obtained from or arranged by Non-Participating Providers or from Participating Providers without a Referral (where a Referral is necessary) from the Member's Primary Care Provider (PCP) or for mental health and alcohol and substance abuse care, without a Referral (where a Referral is necessary) from our Behavioral Health Program, are payable at the Out-Of-Network Level Of Benefits. The Out-Of-Network Level Of Benefits for benefits under this Plan is the Coinsurance percentage described in the Member's Benefit Summary multiplied by the Maximum Allowable Amount charges after any Copayments or Deductible is applied. If the Out-Of-Pocket Maximum is met for a Member in a year, then the Out-Of-Network Level Of Benefits is modified as described in the definition of Out-Of-Pocket Maximum for the remainder of that year.

OUT-OF-PLAN SERVICES
Health care services rendered by a Non-Participating Provider, when you are enrolled in one of our **HMO Plans**, where Participating Providers must be used.

OUT-OF-POCKET MAXIMUM
Generally, the maximum Cost-Share amount a Member pays per year for Health Services, as listed in the Member's Benefit Summary.

PARTICIPATING HOSPITAL
A Hospital that has entered into an agreement with us, an IPA or an affiliate or subcontractor of ours to provide certain Health Services to you and your Eligible Dependents.

PARTICIPATING PHARMACY
A pharmacy that has entered into an agreement with us, an IPA or an affiliate or subcontractor of ours to provide covered prescription drugs, medications and supplies to you and your Eligible Dependents.

Take a look at the "Managed Care Rules And Guidelines" section to see if you have to use Participating Providers and the "Pre-Authorization And Pre-Certification (Prior Approval) Addendum" to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

A Participating Pharmacy is a pharmacy that when used by a Member typically provides a higher level of benefits, because out-of-pocket Cost-Shares are lower.

A Participating Pharmacy does not include a Hospital pharmacy, even if the Hospital is a Participating Hospital.

PARTICIPATING PHYSICIAN

A health care professional duly licensed to practice as a physician who has entered into an agreement with us, an IPA, or an affiliate or a subcontractor of ours to provide certain Health Services to you and your Eligible Dependents.

PARTICIPATING PROVIDER

A health care practitioner or facility, including a Dentist, Participating Physician, Participating Pharmacy, Participating Hospital or other similar practitioner or facility, that is duly licensed to provide health care services and that has entered into an agreement with us, an IPA or an affiliate or a subcontractor of ours to provide certain Dental Services or Health Services to you and your Eligible Dependents.

Participating Providers do not include Hospital-based clinics, even if the Hospital is a Participating Hospital, unless the Hospital clinic is specifically contracted with us.

PLAN

The program operated by us providing coverage for Health Services for Members upon which we and your Employer have agreed.

PLAN BENEFITS

Health Services covered as specified in this document.

PRE-AUTHORIZATION OR PRE-AUTHORIZED

The authorization, based on Medical Necessity, needed from us, or the applicable Delegated Program, in advance of the Member's receipt of certain specified Health Services.

Pre-Authorization also includes the written authorization from us, or the applicable Delegated Program, needed in advance of the Member's receipt of Health Services from a Non-Participating Provider in order to have those services or supplies covered at the highest level of benefits under the Plan.

PRE-CERTIFICATION OR PRE-CERTIFIED

The registration and approval process, based on Medical Necessity, needed in advance of the Member's Partial Hospitalization or inpatient admission to a Hospital, Hospice, Residential Treatment Facility, Rehabilitation Facility or Skilled Nursing Facility that is obtained from us, or the applicable Delegated Program.

PREMIUM

The regular payments required to be made to us by you or the Employer under this Plan for coverage to remain in effect.

PRIMARY CARE PROVIDER OR PCP

A physician, advanced practice registered nurse (APRN), or a nurse practitioner who is a Participating Provider selected by or assigned to the Member, who is normally engaged in one of the following primary care specialties:

- ♥ Family medicine
- ♥ Internal medicine
- ♥ Pediatrics; and

who is eligible to be listed as a PCP in the Provider Directory.

PROVIDER DIRECTORY

The listing of Participating Providers compiled and prepared for our benefit plans.

PRUDENT LAYPERSON

A person who is without medical training and who draws on his/her practical experience when making a decision regarding whether Emergency medical treatment is needed. A Prudent Layperson will be considered to have acted "reasonably" if other similarly situated laypersons would have believed, on the basis of observation of the medical symptoms at hand, that Emergency medical treatment was necessary.

RADIOLOGY SERVICES PROGRAM

A Delegated Program under which we may provide for management, administration and a network of providers for outpatient diagnostic x-rays and therapeutic procedures under this Plan. In some instances the Radiology Services Program may be managed and administered by a Delegated Program under contract with us. In that event, when this document refers to determinations, Pre-Authorizations, Referrals and other decisions made under the terms of the Radiology Services Program, such determinations, Pre-Authorizations, Referrals and other decisions are made by the Delegated Program on behalf of us and we have the ultimate authority to make these discretionary decisions.

REFERRAL

An approval communicated to us by the Member's Primary Care Provider (PCP) (or the covering physician designated by the Member's PCP), an OB/GYN that is a Participating Physician, or for mental health and alcohol and substance abuse care, from our Behavioral Health Program, which the Member must obtain prior to his/her receipt of health care services from Specialist Physicians and other Participating Providers in order to be eligible for benefits at the highest level of benefits

REHABILITATION FACILITY

A Hospital or other facility that provides restorative physical and occupational therapy treatment and is licensed and accredited as a rehabilitation facility by the governmental or other authority having jurisdiction.

RESIDENTIAL TREATMENT FACILITY

A treatment center for children and adolescents that provides residential care and treatment for emotionally disturbed individuals and is licensed and accredited by the governmental authority having jurisdiction.

Take a look at the "Managed Care Rules And Guidelines" section to see if you have to use Participating Providers and the "Pre-Authorization And Pre-Certification (Prior Approval) Addendum" to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

RIDER
A written amendment that modifies the terms and conditions of this document.

SKILLED NURSING FACILITY
An institution or distinct part of an institution that is duly licensed as a skilled nursing facility by the governmental authority having jurisdiction.

SPECIALIST PHYSICIAN
A physician specialist (other than the Member's PCP) who focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of health care.

SUBSCRIBER OR YOU
You, when you are enrolled in this Plan and eligible to receive Plan Benefits.

TOTALLY DISABLED
With respect to an Employee, the inability of the Employee because of an injury or disease, to perform the duties of any occupation for which the Employee is suited by reason of education, training or experience, and, with respect to an Eligible Dependent, the inability of the Eligible Dependent, because of an injury or disease, to engage in substantially all of the normal activities of persons of like age and sex in good health.

URGENT CARE
Health Services for the treatment of a sudden and unexpected onset of illness or injury requiring care within 24 hours that can be treated in a physician's office or in an Urgent Care Center.

URGENT CARE CENTER OR WALK-IN-CENTER
A facility duly licensed to provide Urgent Care.

UTILIZATION MANAGEMENT
The process of evaluating and determining the coverage for and the appropriateness of medical care services, as well as providing any needed assistance to the clinician or the patient in cooperation with other parties, to ensure appropriate use of resources. Utilization Management includes Pre-Authorization or Pre-Certification, concurrent review, retrospective review, discharge planning and Case Management.

WILDERNESS CAMP
A camp that provides behavioral health intervention for children and adolescents with emotional, addiction, and or psychological problems. The intervention typically involves immersion in the wilderness or wilderness like setting, group living with peers, the administration of individual and group therapy sessions, and educational/therapeutic curricula, including back country travel, wilderness living skills and horseback riding.

PLAN DESCRIPTION ADDENDUM

This addendum, in conjunction with this document, any applicable Rider and the Provider Directory constitutes compliance with the disclosure requirements of Connecticut law, "AN ACT CONCERNING MANAGED CARE," regarding Plan Descriptions.

We are a for-profit health care center, organized under the Connecticut Business Corporations Act. If our status should change, you will be notified in our member newsletter.

We are also accredited by the National Committee for Quality Assurance (NCQA).

The following information is a summary of our 2011 utilization review data with respect to the number of certifications requested; the number of admissions, services, procedures or extension of stays not certified; and the number of denials upheld or reversed on Appeals/Grievances within our utilization review process. This information includes review data for benefits managed or administered by an outside company under its own Connecticut utilization review license.

Utilization Review Data

	ConnectiCare Insurance Company, Inc.
Requests for Certification	11,759
Certification Denials	1,109 (9.4%)
Number of Appeals of Denials	119 (10.7%)
Number of Denials Reversed Upon Appeal	63 (52.9%)

Below are the medical loss ratios for 2011.

Medical Loss Ratios
ConnectiCare Insurance Company, Inc.
State Medical Loss Ratio

73.3%

Federal Medical Loss Ratio

80.4%

Quality Improvement Program

1. Based on the **HEDIS (Healthcare Effectiveness Data and Information Set) CAHPS (Consumer Assessment of Healthcare Providers and Systems) Member Satisfaction** study for 2011, 58.1% of our Members gave us an 8 or above when they were asked to rate our health plan on a scale ranging from worst health plan ("0") to the best health plan ("10").
2. ConnectiCare makes information about its Quality Improvement Program available to all Members, including information about the quality information program, including goals, processes and outcomes as they relate to Member health and service. You may access this information at www.connecticare.com. If you would like

a written copy, you should call our Member Services Department.

3. Connecticut law requires the Connecticut Insurance Department to develop and distribute a consumer report card, which compares:

   ♥ All applicable licensed managed care organizations, and

   ♥ The 15 largest licensed health insurers that use provider networks not included above.

PATIENT PROTECTION AND AFFORDABLE CARE ACT (PPACA) ADDENDUM

PRIMARY CARE PROVIDERS (PCP)S

ConnectiCare generally allows the designation of a Primary Care Provider (PCP). You have the right to designate any PCP who participates in our network and who is available to accept you or your family members. For information on how to select a PCP, and for a list of the PCP Participating Providers, call us at (860) 674-5757 or 1-800-251-7722.

For children, you may designate a pediatrician as the PCP.

You do not need Pre-Authorization from ConnectiCare or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining Pre-Authorization or Pre-Certification for certain services, following a pre-approved treatment plan, or procedures for making Referrals. For a list of Participating Providers who specialize in obstetrics or gynecology, call us at (860) 674-5757 or 1-800-251-7722.

PRE-AUTHORIZATION AND PRE-CERTIFICATION (PRIOR APPROVAL) ADDENDUM

You Need Pre-Authorization Or Pre-Certification For The Following:

Admissions:
- Hospital admissions that are elective or not the result of an Emergency, including: Acute Hospitals admissions* Partial Hospitalizations Programs (PHP)* Rehabilitation Facility admissions* Residential Treatment Facilities*
- Skilled Nursing Facility admissions
- Sub-acute care admissions

Ambulance/Medical Transportation:
- Land or air ambulance/medical transport that is not due to an Emergency

Durable Medical Equipment (DME) And Prosthetics
- Pre-Authorization will only be required for the following items (if a covered benefit): real time continuous blood glucose monitors, customized wheelchairs and scooters, osteogenic stimulators (including spinal, non-spinal and ultrasound). Electronic or Myoelectric Prosthetic/artificial lower limbs, including the purchase, replacement and repair of whole limb or part of limb, and mechanical stretching devices

Elective Services & Procedures:
- Applied Behavioral Analysis (ABA) for the treatment of Autism Spectrum Disorder (ASD) (if a covered benefit)*
- Artificial Intervertebral Disc (if a covered benefit)
- Clinical trials
- Cardiac monitoring with Mobile Cardiac Outpatient Telemetry or continuous computerized daily monitoring with auto-detection (no Pre-Authorization is required for standard Holter monitors or loop event recording devices)
- Craniofacial treatment
- Dental anesthesia in an ambulatory surgery facility
- Extended outpatient behavioral health treatment visits beyond 45 – 50 minutes in duration with or without medication management*
- Gastric bypass surgery, including laparoscopic (if a covered benefit)
- Genetic testing - only the following genetic testing **DOES NOT** require Pre-Authorization:
  - Routine chromosomal analysis (e.g., peripheral blood or tissue culture, chorionic villus sampling, amniocentesis),
  - Chromosomal microarray analysis for children/adults,
  - FISH testing for lymphoma or leukemia, and
  - Molecular pathology analyses for Cystic Fibrosis, Factor V Leiden, Prothrombin, Hereditary Hemochromatosis and Fragile X
- Gynecomastia surgery (if a covered benefit)
- Hospital clinics, non-contracted or out of the Service Area
- Mammoplasty (breast augmentation or reduction) if a covered benefit)
- Oncotype DX breast cancer test
- Oral appliances for the treatment of Obstructive Sleep Apnea
- Oral surgery (if a covered benefit)
- Reconstructive surgery
- Solid organ transplants (except cornea) and bone marrow transplants (all transplant Pre-Authorizations must be done at least ten business days prior to services being rendered)
- Varicose vein surgery (if a covered benefit)
- Ventricular Assist Devices

Home Health Care:
- Home health services
- Hospice care

Infertility Services

Intensive Outpatient Treatment Programs (IOP*)

Injectable Drugs & Nutritional Supplements:
- Nutritional supplements and food products, including modified food products for inherited metabolic diseases and specialized formulas (if a covered benefit)

Neuropsychological Testing (behavioral health* and medical purposes) except for neuropsychological testing ordered by a doctor to determine the extent of any cognitive or developmental delays due to chemotherapy or radiation treatment in a child diagnosed with cancer

Outpatient Radiological Services (except when such radiological services are done in conjunction with a biopsy or other surgical procedure):
- Radiation Therapy for Breast, Lung, Prostate, Colon and Rectal Cancer
- Stereotactic Radiosurgery and Stereotactic Body Radiation Therapy for all diagnosis
- Bone mineral density exams ordered more frequently than every 23 months
- CT scans (all diagnostic exams)
- MRI/MRA (all examinations)
- Nuclear cardiology
- PET scans
- Stress echocardiograms

Outpatient Rehabilitative Services:
- Occupational therapy
- Physical therapy
- Speech therapy (including specialty Hospitals, acute care Hospitals and providers of rehabilitation services)

Outpatient Electro-Convulsive Treatment (ECT)*

Outpatient Behavioral Health Treatment Provided in a Member's Home*

Outpatient Treatment of Opioid Dependence*

Psychological Testing Over 4 Hours*

***Pre-Authorization is conducted by OptumHealth Behavioral Solutions - 1-888-946-4658**

Take a look at the "Managed Care Rules And Guidelines" section to see if you have to use Participating Providers and the "Pre-Authorization And Pre-Certification (Prior Approval) Addendum" to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

Prescription drugs

You should call our Member Services Department at the telephone number on this page (or visit us at our web site at www.connecticare.com) to find out if a prescription drug may only be filled through a specific vendor and where you can have the prescription filled. We have the right to change the drugs on the list in our discretion.

You Need Pre-Authorization For The Following Prescription Drugs:

Abilify
Absorica
Abstral
Aciphex
Actemra
Acthar Gel
Actiq
Actonel
Actoplus Met
Acne-Brand Name Oral Agents; Doryx, Dynacin, Adoxa, Myrac, Soladyn, Minocin PAC
Adcetris
Adcirca
Adoxa
Affinitor
Aldurazyme
Alimta
AlleRx
Alsuma
Altoprev
Alpha 1-Proteinase Inhibitors (All)
Ambien CR
Amevive
Ampyra
Amrix
Amturnide
Androderm
Androgel
Antara
Anzemet
Aplenzin
Apokyn
Aralast
Arcalyst
Aricept
Arthrotec
Arzerra
Ascensia Test Strips
Astepro
Atacand
Atelvia
Aubagio
Avandamet
Avandaryl
Avandia
Avastin
Avidoxy
Avinza
Avodart
Avonex
Axert
Axiron
Azor
Beconase AQ
Benicar/Benicar HCT
Benlysta
Berinert
Betaseron
Bexxar
Binosto
Blood Clotting Factors (All)
Boniva Injection
Boniva Tablets
Bosulif
Botox
Bravelle
Brovana
Buphenyl
Bydureon
Byetta
Cabergoline (Dostinex)
Cambia
Campral
Caprelsa
Cardura XL
Cayston
Celebrex
Cerezyme
Cesamet
Cetrotide
Chantix
Cholesterol Lowering Drugs: Altoprev, Lescol/XL, Vytorin
Cimzia
Cinryze
Clarinex / D
Clobex
Clolar
Clomid
CNL Nail kit
Coartem
Cometriq
Compounded Medications
Contraceptives
Conzip
Copaxone
Coreg CR
Crestor
Crinone
Cuvposa
Cymbalta
Dacogen
Daliresp
Detrol / LA

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Dexilant
Differin
Dificid
Diovan/Diovan HCT
Doryx
Dostinex
Dovonex
Duetact
Duexis
Dymista
Dynacin
Dysport
Edarbi
Edarbyclor
Edluar
Egrifta
Elaprase
Elelyso
Eloxatin
Enablex
Enbrel
Endometrin
Erbitux
Erivedge
Euflexxa
Evoclin
Exalgo
Exelon/Exelon patch
Exforge/Exforge HCT
Exjade
Extavia
Eylea
Fabrazyme
Fanapt
Fenoglide
Fentanyl citrate oral
Fentora
Fexmid
Fibrocor
Firazyr
Flector Patch
Flolan
Fluoxetine 60mg capsules
Follistim AQ
Folotyn
Fortamet
Fortesta
Forfivo XL
Fosamax plus D
Frova
Fulyzaq
Fuzeon
Ganirelix
Gastrocrom
Gattex
Gelnique
Gel-One
Genotropin
Gilenya
Glassia
Gleevec
Glumetza
Gonal-F
Gralise
Growth Hormones (All)
Halaven
HCG (chorionic gonadotropin)
Herceptin
Hizentra
Horizent
Humatrope
Humira
Hyalgan
Hycamtin
Iclusig
Ilaris
Implanon
Incivek
Increlex
Infergen
Infertility Medications (All)
Injectable Drugs (All): excluding insulin
Inlyta
Interferons (All)
Intermezzo
Intron-A
Intuniv
Invega
Invokana
Iressa
Istodax
IV Immune Globulin (IVIG)
Ixempra
Jakafi
Jevtana
Juxtapid
KadianKadcyla
Kalbitor
Kalydeco
Kazano
Kineret
Klonopin Wafers
Kombiglyze XR
Korlym
Krystexxa
Kuvan
Kynamro
Kyprolis
Kytril
Lamictal ODT
Lamictal XR
Lamisil Oral Granules
Latuda
Lazanda

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Lescol/XL
Letairis
Liptruzet
Livalo
Lotronex
Lovaza (formerly Omacor)
Lumigan
Lumizyme
Lunesta
Luveris
Luvox CR
Luxiq
Lyrica
Macugen
Makena (17P)
Marinol
Maxalt/Maxalt MLT
Mekinist
Menopur
Mepron Metozolv
Micardis/Micardis HCT
Minocin Combo Pack
Mirena
Mozobil
Myobloc
Myozyme
Myrac
Myrbetriq
Naglazyme
Namenda
Naprelan
Nasacort AQ
Nasarel
Nesina
Nexavar
Nexium
Nexplanon
Nimotop
Norditropin
Novarel
Novolog/Novolin
Novoseven
NPlate
Nuedexta
Nulojix
Nutropin/AQ
Nuvigil
Oforta
Oleptro
Olux
Olux E
Omnaris
Omontys
Omnitrope
One Touch Test Strips
Onglyza
Onsolis
Oracea
Oravig
Orencia
Orfadin
Orthovisc
Oseni
Ovidrel
Oxandrin
Oxtellar XR
Oxytrol
Ozurdex
Patanase
Pegasys
Peg-Intron
Pennsaid
Perjeta
Pexeva
Pomalyst
Ponstel
Prevacid (Rx)
Prialt
Prilosec (Rx)
Pristiq
Prolastin
Proleukin
Prolia
Promacta
Procysbi
Protonix (brand)
Provenge
Provigil
Prozac Weekly
Qnasl
Qualaquin
Qutenza
Ravicti
Rapaflo
Rayos
Razadyne
Rebetol (ribavirin)
Rebetron
Rebif
Regranex
Relistor
Relpax
Remicade
Remodulin
Repronex
Retisert
Revatio
Revlimid
Rhinocort AQ
RiaStap Ribavirin
Risperdal Consta
Rituxan

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Rybix ODT
Ryzolt ER
Saizen
Sanctura
Sancuso
Sarafem
Signifor
Silenor
Simponi
Skyla
Smoking Cessation Medications
Solodyn
Soliris
Solzira
Somavert
Sorilux foam
Sporanox
Sprix
Sprycel
Steroids, Anabolic
Stavzor
Stelara
Stivarga
Striant
Strattera
Subsys
Sucraid
Sumavel Dosepro
Supartz
Supprelin LA
Sutent
Sylatron
Symlin
Synagis
Synarel
Synribo
Synvisc (hyaluronate sodium)
Tafinlar
Tarceva
Tasigna
Tecfidera
Tekamlo
Tekturna
Temodar
Testim
Testosterone (All)
Tevetan/Tevetan HCT
TevTropin
Thalomid
Thyrogen
Tobi
Tofranil PM
Torisel
Toviaz
Tracleer
Travatan/Travatan Z
Travel Medication: including Malarone, Larium and Aralen
Treanda
Tretin X
Treximet
Triglide
Tribenzor
Trospium
Twynsta
Tykerb
Tysabri
Tyvaso
Uloric
Ultram ER
Valturna
Vanos
Vantas
Vascepa
Vectibix
Velcade
Venlafaxine ER
Ventavis
Verdeso
Vesicare
Victoza
Victrelis
Vidaza
Viibryd
Vimovo
Vivitrol
Voltaren Gel
Votrient
Vpriv
Vusion
Vytorin
Weight Loss Medication (if covered by your plan); Meridia, Xenical, Ionamin, Tenuate, etc
Welchol
Xalkori
Xeljanz
Xeloda
Xenazine
Xeomin
Xgeva
Xiaflex
Xolair
Xtandi
Xyntha
Xyrem (Sodium Oxybate)
Yervoy
Zaltrap
Zanaflex Caps
Zavesca
Zegerid
Zelboraf
Zemaira
Zetonna
Zipsor

Take a look at the "Managed Care Rules And Guidelines" section to see if you have to use Participating Providers and the "Pre-Authorization And Pre-Certification (Prior Approval) Addendum" to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

Zolinza
Zolpimist
Zomig
Zortress
Zuplenz
Zyban
Zyflo CR
Zytiga

You Need Pre-Authorization For The Following Specialty Prescription Drugs:

Growth Hormone including:
Accretropin
Genotropin
Humatrope
Increlex
Norditropin
Nutropin
Nutropin AQ
Saizen
Serostim
TevTropin

Blood Clotting Factors including:
Advate
Alphanate
Benefix
Helixate
Humate P
Kogenate FS
Monarc M
NovoSeven
Recombinate
Xyntha

Hepatitis C Treatments including:
Copegus
Incivek
Infergen
Peg Intron
Pegasys
Rebetol
Rebetron
Ribavirin
Sylatron
Victrelis

LHRH Agonists including;
Eligard
Lupron
Trelstar
Viadur
Vantas
Zoladex

Multiple Sclerosis Treatments including:
Aubagio
Avonex
Betaseron
Copaxone
Extavia
Gilenya
Rebif
Tecfidera
Tysabri

Other Drugs including:
Acthar
Actimmune
Actiq
Apokyn
Aralast
Benlysta
Berinert
Botox (botulinium toxin type A)
Cayston
Cerezyme
Cinryze
Egrifta
Elaprase
Exjade
Fabrazyme
Fentora
Firazyr
Folotyn
Gattex
Ilaris
IVIG (Immuneglobulin)
Jakafi
Jetrea
Kalbitor
Kalydeco
Krystexxa
Kuvan
Lucentis
Macugen
Naglazyme
Nplate
Nulojix
Onsolis
Orfadin
Prolastin
Prolia
Promacta
Reclast
Riastap
Signifor
Soliris
Synagis
Thyrogen
Xenazine
Xolair
Zyrem
Zavesca
Zemaira

Oral Oncology Agents Including:
Afinitor
Bosulif
Caprelsa
Cometriq

Take a look at the "Managed Care Rules And Guidelines" section to see if you have to use Participating Providers and the "Pre-Authorization And Pre-Certification (Prior Approval) Addendum" to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

Erivedge
Gleevec
Hycamtin
Iclusig
Inlyta
Iressa
Nexavar
Oforta
Revlimid
Sprycel
Stivarga
Sutent
Tarceva
Tasigna
Temodar
Thalomid
Tykerb
Votrient
Xalkori
Xeloda
Xtandi
Zelboraf
Zolinza
Zortress
Zytiga

Psoriasis/Rheumatoid Arthritis/Crohn's Disease Treatments including:

Actemra
Amevive
Cimzia
Enbrel
Humira
Orencia
Remicade
Rituxan RA
Simponi
Stelara
Xeljanz

Pulmonary Hypertension Drugs including:

Adcirca
Flolan
Letairis
Remodulin
Revatio
Tracleer
Tyvaso
Ventavis

Infertility Drugs including:

Bravelle
Cetrotide
Chorionic Gonadotropin (HCG)
Follistim AQ
Ganirelix
Gonal-F
Luveris
Makena
Menopur
Novarel
Ovidrel
Pregnyl
Repronex

Viscosupplements including:

Euflexxa
Gel-One
Hyalgan
Orthovisc
Supartz
Synvisc
Synvisc One

In addition, any drug that is newly available to the market will also require Pre-Authorization until such time as we re-publish our list of drugs requiring Pre-Authorization.

Take a look at the "Managed Care Rules And Guidelines" section to see if you have to use Participating Providers and the "Pre-Authorization And Pre-Certification (Prior Approval) Addendum" to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.