



Small Business Health Options Program (SHOP)
Choice Bronze POS HSA
Benefit Summary
Non-Tiered Network Plan

The individual deductible and out-of-pocket maximum applies if you have coverage only for yourself. The family deductible and out-of-pocket maximum applies if you have coverage for yourself and one or more eligible dependents. Each individual on the family plan will only need to satisfy the individual deductible and out-of-pocket maximum, not the full family amount. Each individual's charges will accrue towards the family amounts.

Deductible and Out-of-Pocket Maximum	In-Network (INET) Member Pays	Out-of-network (OON) Member Pays
Plan deductible Individual Family (Deductible is combined for medical services and prescription drugs)	\$6,000 per member \$12,000 per family	\$20,000 per member \$40,000 per family
Separate Prescription Drug Deductible Individual Family	Included in Plan Deductible per member / per family	Included in Plan Deductible per member / per family
Out-of-Pocket Maximum Individual Family (Includes deductible, copayments and coinsurance for medical and pharmacy services)	\$7,500 per member \$15,000 per family	\$30,000 per member \$60,000 per family
Benefits	In-Network (INET) Member Pays	Out-of-network (OON) Member Pays
Provider Office Visits		
Adult/Pediatric Preventive Visits	No cost	50% coinsurance per visit
Primary Care Provider Office/ Telemedicine Visits (includes services for illness, injury, follow-up care and consultations)	50% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met

Benefits	In-Network (INET) Member Pays	Out-of-network (OON) Member Pays
Telemedicine Services (services rendered by a Teladoc® provider) Primary Care - members must be 18 or older	Primary Care, Mental Health and General Medical Services: 0% coinsurance per visit after INET plan deductible is met Dermatologist: 50% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met
Specialist Office/Telemedicine Visits	50% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met
Mental Health and Substance Abuse Office Visits	50% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met
Outpatient Diagnostic Services		
Advanced Radiology (CT/PET Scan, MRI)	50% coinsurance per service after INET plan deductible is met	50% coinsurance per service after OON plan deductible is met
Laboratory Services	50% coinsurance per service after INET plan deductible is met	50% coinsurance per service after OON plan deductible is met
Non-Advanced Radiology (X-ray, Diagnostic)	50% coinsurance per service after INET plan deductible is met	50% coinsurance per service after OON plan deductible is met
Mammography Ultrasound	50% coinsurance per service after INET plan deductible is met	50% coinsurance per service after OON plan deductible is met
Prescription Drugs - Retail Pharmacy (cost share based on 30 day supply per prescription)		
Generic Drugs Tier 1	\$20 copayment per prescription after INET plan deductible is met	50% coinsurance per prescription after OON plan deductible is met
Preferred Brand Drugs Tier 2	\$60 copayment per prescription after INET plan deductible is met	50% coinsurance per prescription after OON plan deductible is met
Non-Preferred Brand Tier 3	50% coinsurance up to a maximum of \$300 per prescription after INET plan deductible is met	50% coinsurance per prescription after OON plan deductible is met
Specialty Drugs Tier 4	50% coinsurance up to a maximum of \$500 per prescription after INET plan deductible is met	50% coinsurance per prescription after OON plan deductible is met
Prescription - Mail Order Pharmacy (up to a 90 day supply per prescription)		
Generic Drugs Tier 1	\$40 copayment per prescription after INET plan deductible is met	50% coinsurance per prescription after OON plan deductible is met
Preferred Brand Drugs Tier 2	\$120 copayment per prescription after INET plan deductible is met	50% coinsurance per prescription after OON plan deductible is met
Non-Preferred Brand Tier 3	50% coinsurance up to a maximum of \$600 per prescription after INET plan deductible is met	50% coinsurance per prescription after OON plan deductible is met

Benefits	In-Network (INET) Member Pays	Out-of-network (OON) Member Pays
Outpatient Rehabilitative and Habilitative Services (40 visits per contract year limit combined for Rehabilitative physical, speech and occupational therapies. Separate 40 visits per contract year limit combined for Habilitative speech, physical and occupational therapies.)		
Speech Therapy	50% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met
Physical and Occupational Therapy	50% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met
Other Services		
Chiropractic Services (up to 20 visits per contract year)	50% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met
Diabetic Equipment and Supplies	50% coinsurance per equipment/supply after INET plan deductible is met	50% coinsurance per equipment/supply after OON plan deductible is met
Durable Medical Equipment (DME)	50% coinsurance per equipment/supply after INET plan deductible is met	50% coinsurance per equipment/supply after OON plan deductible is met
Home Health Care Services (up to 100 visits per contract year)	25% coinsurance per visit after INET plan deductible is met	25% coinsurance per visit after OON plan deductible is met
Outpatient Services (in a hospital or ambulatory facility)	50% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met
Inpatient Services		
Inpatient hospital services include mental health, substance abuse, maternity, hospice, skilled nursing facility* and all IP settings. (*skilled nursing facility stay is limited to 90 days per contract year)	50% coinsurance per admission after INET plan deductible is met	50% coinsurance per admission after OON plan deductible is met
Emergency and Urgent Care		
Ambulance Services	50% coinsurance per service after INET plan deductible	50% coinsurance per service after INET plan deductible
Emergency Room	50% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after INET plan deductible is met
Urgent Care Centers	50% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met
Pediatric Dental Care (for members under age 26)		
Diagnostic & Preventive	No cost	50% coinsurance per visit after OON plan deductible is met
Basic Services	50% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met

Benefits	In-Network (INET) Member Pays	Out-of-network (OON) Member Pays
Major Services	50% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met
Orthodontia Services (medically necessary only)	50% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met
Pediatric Vision Care (for members under age 26)		
Prescription Eye Glasses (one pair of frames and lenses or contact lens per contract year)	Lenses: 50% after INET plan deductible is met Collection frame: 50% after INET plan deductible is met Non-collection frame: Members choosing to upgrade from a collection frame to a non-collection frame will be given a credit substantially equal to the cost of the collection frame and will be entitled to any discount negotiated by the carrier with the retailer	50% coinsurance after OON plan deductible is met
Routine Eye Exam by a Specialist (one exam per contract year)	50% coinsurance per visit	50% coinsurance per visit after OON plan deductible is met
Additional Covered Services		
Adult Routine Eye Exam by a Specialist (for members over age 26 - one exam per contract year)	50% coinsurance per visit	50% coinsurance per visit after OON plan deductible is met
Allergy Injections (Unlimited)	50% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met
Allergy Testing (one visit per contract year)	50% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met
Artificial Limbs (includes associated supplies and equipment)	20% coinsurance after INET plan deductible is met	50% coinsurance after OON plan deductible is met
Modified Food Products and Specialized Formula	50% coinsurance after INET plan deductible is met	50% coinsurance after OON plan deductible is met
Outpatient mental health, alcohol and substance abuse treatment (intensive outpatient treatment and partial hospitalization)	50% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met
Retail Clinic	50% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met

Important information

- This is a brief summary of benefits. Refer to your ConnectiCare Benefits, Inc. certificate of coverage for complete details on benefits, conditions, limitations and exclusions, or consult with your benefits manager.
- Ovarian cancer screening and monitoring services coverage and cost share details are available in your certificate of coverage.
- Mammogram screenings, breast ultrasounds, and breast MRIs – Please refer to the certificate of coverage for details.
- Insulin and noninsulin drugs are covered up to a cost share maximum of \$25 for each 30-day supply.
- Diabetes Devices and Diabetic Ketoacidosis Devices are covered up to a cost share maximum of \$100 per 30-day supply.
- Please refer to the certificate of coverage for additional cost share maximums regarding diabetic services. Some diabetic services fall under preventive care and cost share may be waived.
- An **ambulatory surgery center** is a facility that exclusively provides outpatient surgical services to patients who do not require hospitalization and whose expected stay in the center does not exceed 24 hours. Ambulatory surgery centers are not owned by a hospital.
- An **outpatient hospital facility** offers surgical procedures and related care that, in the opinion of the attending physician, can be safely performed without requiring overnight inpatient hospital care. Outpatient hospital facilities are owned by a hospital or hospital system.
- If you have questions regarding your plan, visit our website at www.connecticare.com or call us at (860) 674-5757 or 1-800-251-7722.
- To learn more about your **Teladoc®** provider benefits contact **Teladoc®** at teladoc.com/connecticare or call 1-800-835-2362 (TTY: 711).
- Out-of-Network reimbursement is based on the maximum allowable amount. Members are responsible to pay any charges in excess of this amount. Please refer to your ConnectiCare Benefits, Inc. certificate of coverage for more information.
- If you are a Massachusetts resident, please refer to your amendatory rider for Massachusetts mandated benefits for additional details of your mandated benefits.
- If you are a Massachusetts resident, this plan along with pharmacy services meets Massachusetts Minimum Creditable Coverage standards for 2023.
- Under this program covered prescription drugs 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.
- Refer to ConnectiCare's pharmacy center online at www.connecticare.com for the Value list of drugs that are not subject to the member's cost share.
- 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 cost share maximum.
- Most specialty drugs are dispensed through specialty pharmacies by mail, up to a 30-day supply. Specialty pharmacies have the same member cost share as all other participating pharmacies and are not part of ConnectiCare's voluntary mail order program. The member cost share for specialty pharmacy is different from the cost share for ConnectiCare's mail order program.
- Many services require that you obtain our Pre-Certification or Pre-Authorization prior to obtaining care. Please refer to the "*Pre-Authorization and Pre-Certification Addendum*" in your certificate of coverage for a detailed list of services or call member service at 1-800-251-7722. Without Pre-Authorization for services prescribed or rendered by Non-Participating providers, you may be responsible for the total cost of the service or benefits may be reduced by the lesser of \$500 or 50%.
- For mental health, alcohol and substance abuse services call 1-888-946-4658 to obtain Pre-Authorization.
- In-network preventive and wellness services as defined by the United States Preventive Service Task Force (USPSTF), including immunizations recommended by the Advisory Committee on Immunizations Practices at the Centers for Disease Control (CDC), and preventive care and screenings supported by the Health Resources and Services Administration (HRSA) are exempt from all cost shares under the Patient Protection and Affordable Care Act (PPACA). Visit our website at www.connecticare.com to view a list of preventive and wellness services.

2023

CONNECTICARE BENEFITS, INC.

POINT OF SERVICE (POS) HIGH DEDUCTIBLE HEALTH PLAN (HDHP)
FOR USE WITH A HEALTH SAVINGS ACCOUNT (HSA)

SMALL GROUP EXCHANGE
CERTIFICATE OF COVERAGE

ConnectiCare Benefits, 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.

This Plan has been designed to conform to Federal Internal Revenue Service (IRS) guidelines on such plans. However, the IRS has made no determination that this Plan is qualified and we make no representation to such. Whether or not an HSA used with this Plan will provide a Member with tax advantages depends on a number of circumstances, including the Member's personal coverage situation, contributions to and withdrawals from his/her HSA account, other coverage a Member may have and changes the IRS may make to its rules. Members should consult with a qualified tax advisor in determining whether and how this option may provide them with a tax benefit. We cannot guarantee and we make no representations that tax benefits will accrue to anyone covered under this Plan.

Approval by the Insurance Department does not guarantee tax qualification. Please seek the counsel of a tax advisor.

Certificate Form: HIX CBI/POS SG 01 (1/2023)

Approved for use beginning 2023

s:/gmas/2023cbi exchange and off exchange/2023/small group/2023 cbi sg exchange pos hdhp hsa certificate.doc

Certificate Product Option Form: HIX CBI/POS HDHP SG 01 (1/2023)

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the "Pre-Authorization And Pre-Certification 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

Questions When Applying For Coverage

Connecticut Health Insurance Exchange (AccessHealth CT)

(855) 805-4325

or

Connecticut Health Insurance Exchange
280 Trumbull Street
Hartford, CT 06103, or
www.accesshealthct.com

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

Dental (Pediatric Dental Services)

855 999-2329

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

Radiology Services Program (Outpatient Diagnostic X-rays And Therapeutic Procedures, Spine Surgery And Interventional Pain Management)

1-877-607-2363

Genetic Testing

1-888-835-2042

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
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)

Optum-Appeals
P.O. Box 30512
Salt Lake City, UT 84130-0512
Fax: 1-855-312-1470
Phone: 1-866-556-8166

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the "Pre-Authorization And Pre-Certification 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

ATTENTION: If you speak a foreign language, language assistance services, free of charge, are available to you. Call 1-800-251-7722 and TTY number 1-800-833-8134.

Spanish

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-251-7722 and TTY number 1-800-833-8134.

Portuguese

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-251-7722 and TTY number 1-800-833-8134.

Polish

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-251-7722 and TTY number 1-800-833-8134.

Chinese

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-251-7722 and TTY number 1-800-833-8134。

Italian

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-251-7722 and TTY number 1-800-833-8134.

French

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-251-7722 and TTY number 1-800-833-8134.

French Creole

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-251-7722 and TTY number 1-800-833-8134.

Russian

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 800-251-7722 and (телетайп: 1- TTY number 1-800-833-8134).

Vietnamese

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-251-7722 and TTY number 1-800-833-8134.

Arabic

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-251-7722 (رقم هاتف الصم والبكم: 1-800-833-8134).

Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-251-7722 and TTY number 1-800-833-8134번으로 전화해 주십시오.

Albanian

KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-800-251-7722 and TTY number 1-800-833-8134.

Hindi

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the "Pre-Authorization And Pre-Certification 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.

Tagalog

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-251-7722 and TTY number 1-800-833-8134.

Greek

ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-800-251-7722 and TTY number 1-800-833-8134.

Mon-Khmer, Cambodian

សូមជូនដំណឹងថា បើសិនជា អ្នកនិយាយភាសាខ្មែរ អ្នកអាចទទួលបានសេវាបន្ថែមដោយឥតគិតថ្លៃ។ តេឡេហ្វូន 1-800-251-7722 and TTY number 1-800-833-8134 ។

Gujarati

ચુના: જો તમે જરાતી બોલતા હો, તો િન:લ્કુ ભાષા સહાય સેવાઓ તમારા માટ ઉપલબ્ધ છ. ફોન કરો 1-800-251-7722 and TTY number 1-800-833-8134.

Take a look at the “Managed Care Rules And Guidelines” section to see if you need to obtain a Referral or have to use Participating Providers and the “Pre-Authorization And Pre-Certification 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 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 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 need to obtain a Referral or have to use Participating Providers and the "Pre-Authorization And Pre-Certification 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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Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the "Pre-Authorization And Pre-Certification 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 or the Exchange 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 or the Exchange, you are responsible for telling us or the Exchange 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

SPECIAL EXCHANGE RULES

All enrollment changes must be made through the Exchange by you or your Employer. The Exchange will have rules on how to do this. For Plans offered on the Exchange there are additional opportunities for Special Enrollment. They include:

- Your enrollment or non-enrollment in another Qualified Health Plan (QHP) was unintentional, inadvertent or erroneous and was a result of an error, misrepresentation, or inaction by an employee or representative of the Exchange,
- You adequately demonstrate to the Exchange that the health plan under which you are enrolled has substantially violated a material provision of its contract with you,
- You move and become eligible for new QHPs,
- You are a Native American Indian, as defined by section 4 of the Indian Health Care Improvement Act, and allowed to change from one QHP to another as often as once per month, or
- The Exchange determines, under federal law, that you meet other exceptional circumstances that warrant a Special Enrollment.

You must give the Exchange notice within 30 days of the above events if you wish to enroll.

Take a look at the “Managed Care Rules And Guidelines” section to see if you need to obtain a Referral or have to use Participating Providers and the “Pre-Authorization And Pre-Certification 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.

ELIGIBILITY RULES:

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 domestic partner, as long as the following conditions are met:
 - You and your domestic partner must be at least 18 years old, not legally married to each other or to any other person, and not be related to each other by blood to any degree that would bar marriage under applicable law.
 - You and your domestic partner live together in the same residence and have lived together for a 12-month period and intend to continue to live together indefinitely.
 - You and your domestic partner must be each other's sole domestic partner and intend to remain so indefinitely.
 - You and your domestic partner must be jointly responsible for each other's common welfare and financial obligations.
 - You and your domestic partner must be mentally competent to enter into a contract.

When your domestic partner is covered under this Plan, replace the term "spouse" found in this Certificate Of Coverage with "domestic partner."

In addition, we require that a signed "Affidavit of Domestic Partnership", or other satisfactory certification as we determine, be returned with the Enrollment Form as a condition of enrollment. If the Affidavit of Domestic Partnership is returned to the Employer, then the Employer must certify that your domestic partner meets all of the terms and conditions of eligibility. "Proof," as described in the Affidavit of Domestic Partnership, must be provided annually. If it is not, coverage under this Plan will terminate as described in this Certificate Of Coverage.

4. 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 or advanced practice registered nurse.
 - ◆ Be dependent on you or your spouse/partner for support and care because he/she has a mental or physical handicap.
 - ◆ 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 or the Exchange 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 or the Exchange 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.

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the "Pre-Authorization And Pre-Certification 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.

- **Qualified Medical Child Support Orders (QMCSO).** 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

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

If your marriage or civil union, or domestic partnership ends, you must tell us or the Exchange 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. Your newborn natural child is enrolled for coverage for the first 61 days after birth when we are notified of the birth or receive a claim for the newborn. You will be responsible for any additional Premium.

When our initial notification is a claim, your child's coverage will end on day 62, unless you notify us that you want to continue the newborn's coverage. When additional Premium is due, your notification to continue your child's coverage **MUST** be made to us within 61 days of his or her birth. You will be responsible for any additional Premium, for the first 61 days, regardless of your decision to continue coverage beyond day 61.

In some cases, we may receive a claim from another insurer that covers your newborn. Coordination of benefit rules may require that we pay the newborn's claim. In that case, we will enroll the newborn and pay claims as appropriate. You will be responsible for any Premium owed for a newborn enrolled in this manner.

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 becomes the child's legal guardian and you are signed up under this Plan.

A newly adopted child, a child for whom you become the legal guardian, and step-child must apply for coverage within 61 days of the date of the adoption (or the date on which you or your spouse become at least partially legally responsible for the adopted child's support and maintenance), or the date of your marriage to the step-child's parent, or the date you became the legal guardian.

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the "Pre-Authorization And Pre-Certification 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.

CHANGES AFFECTING ELIGIBILITY

You must tell us or the Exchange 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.
- Child reaching maximum age limit for coverage under this Plan.
- 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.

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.

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 of Participating Providers 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 a Member sees 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.

CONTINUITY OF CARE

If a Participating Provider changes network status, Members with complex care needs have up to a 90-day period of continued coverage at the In-Network Level Of Benefits to allow for a transition of care to another Participating Provider. In this circumstance, we will notify each “continuing care patient” with respect to the Participating Provider at the time of termination, notice of termination and your right to elect transitional care from such Participating Provider.

For the purpose of this provision, a “**continuing care patient**” means a Member who, with respect to a Participating Provider, is:

- Undergoing a course of treatment for a serious and complex condition,
- Undergoing a course of institutional or inpatient care,
- Scheduled to undergo non-elective surgery, including receipt of postoperative care,
- Pregnant and undergoing a course of treatment for the pregnancy; or
- Determined terminally ill and is receiving treatment for such illness.

For the purpose of this provision, the term “**terminated**” includes with respect to a Participating Provider contract, the expiration or nonrenewal, but does not include a termination of the contract for failure to meet applicable quality standards or fraud.

If the Non-Participating Provider’s services are allowed as described in this provision, his or her services will only be covered if he or she agrees to accept what we would pay other Participating Providers; does not impose cost-sharing with respect to the Member in an amount that would exceed the cost-sharing that could have been imposed if the provider was a Participating Provider under this Plan; adheres to our quality standards and provides us with the medical information we request; and adheres to our policies and practices, including obtaining any necessary Pre-Authorizations and or Pre-Certifications.

Nothing in this provision shall be construed to require the coverage of benefits that would not have been covered under this Plan if the provider remained or was a Participating Provider.

Take a look at the “Managed Care Rules And Guidelines” section to see if you need to obtain a Referral or have to use Participating Providers and the “Pre-Authorization And Pre-Certification 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 REQUIRING PRE-AUTHORIZATION OR PRE-CERTIFICATION

The Pre-Authorization Or Pre-Certification Process

When Being Treated By A Participating Provider

Participating 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 in the “[Pre-Authorization](#) And Pre-Certification Addendum.”

Changes To The Pre-Authorization Or Pre-Certification Lists

Our Pre-Authorization or Pre-Certification lists may change at any time. Read the member electronic 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 if a Member receives 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 to request Pre-Authorization or Pre-Certification. In those instances, benefits will not be reduced or denied if the Participating 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 to request the applicable Pre-Authorization or Pre-Certification, 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.

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 “Pre-Authorization And Pre-Certification 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 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.

Take a look at the “Managed Care Rules And Guidelines” section to see if you need to obtain a Referral or have to use Participating Providers and the “Pre-Authorization And Pre-Certification 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.

USING PARTICIPATING PROVIDERS AND NON-PARTICIPATING PROVIDERS

If you use Participating Providers for your care, you will be eligible for the highest level of benefits under this Plan. This is called the “In-Network Level Of Benefits.”

If you use Non-Participating Providers to order, arrange or provide you your care, then you will be eligible for a lower level of benefits, called the “Out-Of-Network Level Of Benefits.”

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.

Always Use Participating Providers For The Highest Level Of Coverage

Use your Provider Directory, visit us at our web site at <https://secured.connecticare.com/providerdirectory/>, or call us for a list of Participating Providers. Providers may end their participation with us for different reasons, so check to make sure your provider is currently participating in our network of Participating Providers before obtaining care.

You can check the professional qualifications of Participating Providers by calling us or by visiting our web site at <https://secured.connecticare.com/providerdirectory/>.

Take An Active Role

Ask your Participating Provider to refer you to Participating Providers. Ask that any laboratory or radiology analysis done on your behalf be sent to laboratories or facilities that are Participating Providers.

Very Few Exceptions To The Use Of Participating Providers

Generally, to be covered at the In-Network Level Of Benefits, all health care services and supplies must be ordered, provided and supplied by a Participating Provider, even if you believe that a Non-Participating Provider is “better” or you prefer to use a Non-Participating Provider.

The **very few exceptions** are:

- Emergency Services.
- If we or, as appropriate, our Delegated Program, issue(s) you written Pre-Authorization to use a Non-Participating Provider before you obtain the service or supply.

Except as noted above, even if you or your Eligible Dependents travel out of the Network Access Area or reside out of the Service Area for an extended length of time (e.g., you have a seasonal residence in another state), services or supplies will not be covered at the In-Network Level Of Benefits if they are received from Non-Participating Providers.

Participating Provider Reimbursement Methods

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

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

Participating Providers may tell a Member who asks the method we use to pay them.

Non-Participating Providers For The Lower Level Of Benefits

General Rules

If you use Non-Participating Providers for your care, then you are eligible to receive a lower level of benefits, called the “Out-Of-Network Level Of Benefits.”

In addition, **if you use Non-Participating Providers for your care, then IT IS YOUR RESPONSIBILITY to request Pre-Authorization or Pre-Certification before you obtain care.**

Exceptions To The General Rules

When you obtain care for an Emergency, you obtain the In-Network Level Of Benefits even if you use a Non-Participating Provider.

In addition, in very limited circumstances, if we determine Medically Necessary services are not available from a Participating Provider without unreasonable travel or delay for the Member, you can obtain the higher, 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:

- You make a request to see a Non-Participating Provider, due to the Member’s unreasonable travel to or delay in obtaining an appointment from the nearest Participating Provider.
- We or, as appropriate, our Delegated Program have determined Medically Necessary services are not available from a Participating Provider without unreasonable travel or delay to the Member.

Take a look at the “Managed Care Rules And Guidelines” section to see if you need to obtain a Referral or have to use Participating Providers and the “Pre-Authorization And Pre-Certification 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.

Other care, like routine care, prenatal care, preventive care, chemotherapy, home health care services, routine diagnostic imaging, routine laboratory tests, Urgent Care, or follow-up visits, are not covered at the In-Network Level Of Benefits when you or your covered dependents are out of the Network Access Area.

You or the Participating Provider must request Pre-Authorization by calling or writing our Clinical Review Department at:

1-800-562-6833

or

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.

IT IS YOUR RESPONSIBILITY to make sure written Pre-Authorization is received before you get any treatment by a Non-Participating Provider.

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

Non-Participating Provider Reimbursement Methods

The rate we pay for covered Health Services provided by Non-Participating Providers may vary according to the provider used or the services received. Some Non-Participating Providers may agree to give us a discounted rate 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. Professional fees paid to Non-Participating Providers are based on a percentage of what Medicare would pay.

BENEFITS FOR STUDENTS, WHILE TRAVELING OUT OF THE NETWORK ACCESS AREA OR RESIDING TEMPORARILY OUT OF SERVICE AREA AND AFTER-HOURS CARE

Coverage is available at the In-Network Level Of Benefits when your children are away at school or you or your Eligible Dependent child is traveling out of the Network Access Area, temporarily out of the Service Area or after 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 (outside of the Service Area), as long as you obtain Pre-Authorization first.

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 to find a provider in your child's area. If necessary, it will authorize appropriate care rendered by a Non-Participating Provider.

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the "Pre-Authorization And Pre-Certification 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 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.

- **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.

Traveling Out Of The Network Access Area Or Residing Temporarily Out Of Service Area

While a Member is traveling out of the Network Access Area or residing temporarily out of the Service Area, coverage is available for Emergency Services at the In-Network Level Of Benefits.

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, Urgent Care, 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.

After-Hours Care

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

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 a Participating Provider renders Medically Necessary care. In general, you are required to pay the In-Network Level Of Benefits Plan Deductible before the In-Network Level Of Benefits is paid.

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. 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 Out-Of-Network Level Of Benefits Plan Deductible has been met.

Any amount charged by the Non-Participating 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 requires that you meet an In-Network Level Of Benefits Plan Deductible that applies to most covered Health Services (**including prescription drug coverage**) before we will begin paying our portion of those benefits. After the In-Network Level Of Benefits Plan Deductible is met, benefits will be paid subject to the Member's payment of a Cost-Share amount.

When you are paying for covered Health Services under your Deductible, the amount to be paid is based on our contracted rate for the covered Health Service under the Plan. Prescription drug Deductible and Cost-Share amounts are based on the rate we would pay for the drug.

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the "Pre-Authorization And Pre-Certification 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 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, please refer to your Benefit Summary.

The In-Network Level Of Benefits Plan Deductible is met as follows:

1. If you have individual coverage under this Plan (when you are the only Member covered under the Plan), your In-Network Level Of Benefits Plan Deductible applies to all of your covered Health Services (**including prescription drug coverage**) that are not exempt from the In-Network Level Of Benefits Plan Deductible.
2. If you have family coverage under this Plan (when you and any other Eligible Dependents have coverage under your Plan), all of the covered Health Services incurred by each family member under this Plan that are not exempt from the In-Network Level Of Benefits Plan Deductible (**including prescription drug coverage**) will be applied to the In-Network Level Of Benefits Plan Deductible until the total amount specified on your Benefit Summary is met. There may be an individual maximum on this amount. Please refer to your Benefit Summary for any maximums.

Prescription Drug Coverage

Under this Plan, the Pharmacy Cost-Share Maximum is met as described above, NOT as described in the “Pharmacy Cost-Share Maximum” section of the Certificate Of Coverage.

In addition, you and your covered dependents are required to pay a Cost-Share amount for prescription drugs and covered supplies obtained under this Plan:

1. The In-Network Level Of Benefits Plan Deductible described earlier **DOES APPLY** to prescription drugs.
2. You must pay the full prescription cost (at the rate we would pay for the drug) until your In-Network Level Of Benefits Plan Deductible amount is met. Then, once the In-Network Level Of Benefits Plan Deductible has been met, you will be responsible to pay the Cost-Share amount listed on your Benefit Summary for each prescription, plus any cost difference. Coinsurance is based on the rate we would pay for the prescription. The cost difference you may be required to pay is not a covered benefit.

Amounts Members pay as their Copayment or Coinsurance or due to any reduction in benefits do not count towards meeting the Plan Deductible.

Out-Of-Network Level Of Benefits Plan Deductible

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

NOTE: Please refer to the Benefit Summary to see the amount of the Out-Of-Network Level Of Benefits Plan Deductible that you are required to pay in this Plan

An 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. 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 Out-Of-Network Level Of Benefits Plan Deductible calculation is as follows:

1. If you have individual coverage under this Plan (when you are the only Member covered under the Plan), your Out-of-Network Level Of Benefits Plan Deductible applies to all of your covered Health Services.
2. If you have family coverage under this Plan (when you and any other Eligible Dependents have coverage under your Plan), all of the covered Health Services incurred by each family member will be applied to the Out-Of-Network Level Of Benefits Plan Deductible until the total amount specified on your Benefit Summary is met.

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.

Members must pay the In-Network Level Of Benefits Plan Deductible amount as shown on the Benefit Summary before we begin paying for covered Health Services. Once the In-Network Level Of Benefits Plan Deductible is met, Members may receive covered Health Services and pay only the applicable Copayment amounts as described on the Benefit Summary.

The In-Network Level Of Benefits Plan Deductible DOES NOT apply to certain covered Health Services, but those covered Health Services are subject to the applicable Copayment amount listed on the Benefit Summary. Please refer to your Benefit Summary to find out which services are not subject to the In-Network Level Of Benefits Plan Deductible.

Take a look at the “Managed Care Rules And Guidelines” section to see if you need to obtain a Referral or have to use Participating Providers and the “Pre-Authorization And Pre-Certification 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.

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 what service 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.

Copayments vary by Plan. Your Benefit Summary will describe your Copayments, if any.

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.

Review your Benefit Summary for Coinsurance amount details.

Maximums

Benefit Maximums

Some benefits may have a benefit maximum. When a benefit does have a maximum number of visits that we will cover, the benefit maximum applies to the total number of visits 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 Maximums

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.

Your Benefit Summary describes any 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. There may be an individual maximum on this amount. Please refer to your Benefit Summary for any maximums.

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 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.

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the "Pre-Authorization And Pre-Certification 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 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 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:

- Amounts a Member pays toward any penalties or Benefit Reductions.
- Charges by a provider in excess of the Maximum Allowable Amount.
- 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 at the In-Network Level Of Benefits (paid to Participating Providers) and the Out-Of-Network Level Of 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).

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. There may be an individual maximum on this amount. Please refer to your Benefit Summary for any maximums.

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:

- Amounts a Member pays toward any penalties or Benefit Reductions.
- Charges by a provider in excess of the Maximum Allowable Amount.
- 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.

Your Benefit Summary describes any 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. There may be an individual maximum on this amount. Please refer to your Benefit Summary for any maximums.

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the "Pre-Authorization And Pre-Certification 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.

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.

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:

- Amounts a Member pays toward any penalties or Benefit Reductions.
- Charges by a provider in excess of the Maximum Allowable Amount.
- 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 and 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 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. There may be an individual maximum on this amount. Please refer to your Benefit Summary for any maximums.

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:

- Amounts a Member pays toward any penalties or Benefit Reductions.
- Charges by a provider in excess of the Maximum Allowable Amount.
- Deductibles.

Your Benefit Summary describes any Cost-Share Maximum.

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the "Pre-Authorization And Pre-Certification 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.

Out-Of-Pocket Maximums

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 as required by the Federal Internal Revenue Service (IRS) guidelines on health savings account (HSA) plans.

1. If you have individual coverage under this Plan (when you are the only Member covered under your Plan), your In-Network Level Of Benefits Out-Of-Pocket Maximum for your covered Health Services (**including prescription drug coverage**) is the amount specified for an individual on your Benefit Summaries.
2. If you have family coverage under this Plan (for yourself and any other Eligible Dependents), the In-Network Level Of Benefits Out-Of-Pocket Maximum for all of the covered Health Services (**including prescription drug coverage**) is the total amount specified for family on your Benefit Summaries. There may be an individual maximum on this amount. Please refer to your Benefit Summary for any maximums.

When the In-Network Out-Of-Pocket Maximum is met, the In-Network Level Of Benefits will be paid at 100% for the remainder of that 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
- Amounts a Member pays toward any penalties or Benefit Reductions, 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 covered at the Out-Of-Network Level Of Benefits.

1. If you have individual coverage under this Plan (when you are the only Member covered under your Plan), your Out-Of-Network Level Of Benefits Out-Of-Pocket Maximum for your covered Health Services (**including prescription drug coverage**) is the amount specified for an individual on your Benefit Summaries.
2. If you have family coverage under this Plan (for yourself and any other Eligible Dependents), the Out-Of-Network Level Of Benefits Out-Of-Pocket Maximum for all of the covered Health Services (**including prescription drug coverage**) is the total amount specified for family on your Benefit Summaries.

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 that 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,
- Amounts a Member pays toward any penalties or Benefit Reductions, or
- Charges by a provider in excess of the Maximum Allowable Amount.

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

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the "Pre-Authorization And Pre-Certification 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.

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.
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. 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, 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 need to obtain a Referral or have to use Participating Providers and the “Pre-Authorization And Pre-Certification 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 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.

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 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, to be Experimental Or Investigational, will be considered as a covered Health Service under this Plan until such time as 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.

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the "Pre-Authorization And Pre-Certification 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.

Certain Investigational Items Outside Of Clinical Trials

For the purposes of this subsection, an **“Investigational Item”** means a drug, biological product or device which has successfully completed a Phase One clinical trial of the FDA, but which has not yet been approved for general use by the federal drug administration (FDA) and which remains under investigation in clinical trial approved by the FDA. A **“Terminal Illness”** means a medical condition which the patient’s treating physician anticipates with reasonable medical judgment will result in a patient’s death or a state of permanent unconsciousness from which recovery is unlikely within a period of one year.

Connecticut law allows patients with a Terminal Illness who meet certain qualifications to be treated with Investigational Items outside of clinical trials. The cost of such an Investigational Item is excluded under this Plan. Any costs associated with or incurred as a result of such treatment with an Investigational Item are excluded under this Plan, beginning on the date treatment with the Investigational Item begins and ending six months after the date the treatment ends. Any costs associated with or incurred as a result of treatment with an Investigational Item which has been provided outside of the requirements of Connecticut law are excluded without limitation.

You are required to provide us with a copy of the executed written informed consent document if you begin treatment with an Investigational Item. You are responsible for reimbursing us for any costs paid by us for Investigational Items, or for costs associated with or incurred as a result of treatment with an Investigational Item that are excluded as described above.

Please refer to the other provisions in this “Experimental Or Investigational” subsection for more information about coverage of Experimental Or Investigational treatments. In addition, please refer to the “Benefits” section for more information about coverage of clinical trials.

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 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 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.

Take a look at the “Managed Care Rules And Guidelines” section to see if you need to obtain a Referral or have to use Participating Providers and the “Pre-Authorization And Pre-Certification 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.

BENEFITS

Benefits for Medically Necessary Health Services provided under this Plan are subject to all the rules of this document, including Pre-Authorization or Pre-Certification.

Some services may require Pre-Authorization or Pre-Certification to determine Medical Necessity, as well as the appropriate place of service (e.g., in a provider's office, in a Hospital, in a Hospital Outpatient Surgical Facility, in an Ambulatory Surgery Center). Please refer to the "Pre-Authorization And Pre-Certification Addendum" to find out what services require Pre-Authorization or Pre-Certification.

If you use Participating Providers for your care, you will be eligible for the highest level of benefits under this Plan. This is called the "In-Network Level Of Benefits."

If you use Non-Participating Providers to order, arrange or provide you your care, then you will be eligible for a lower level of benefits, called the "Out-Of-Network Level Of Benefits."

Not all services are covered under this Plan. While some exclusions and limitations are listed throughout the "Benefits" section, you should also read through the "Exclusions And Limitations" section to ensure you fully understand what is not covered under this Plan.

In addition, 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, including immunizations recommended by the Advisory Committee on Immunizations Practices at the Centers for Disease Control (CDC), and preventive care and screenings for infants, children, adolescents, and women supported by the Health Resources and Services Administration (HRSA) and the Institute Of Medicine (IOM) 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. You should visit our website at www.connecticare.com to view a list of the preventive and wellness services that are exempt from Member Cost-Shares or call our Member Services Department at the telephone number listed in the "Important Telephone Numbers And Addresses" section for assistance.

PREVENTIVE SERVICES

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

Routine Medical Exams And Preventive Care

Infants/Children

Infants/children have coverage for the following routine exams and preventive care.

Preventive Care Medical Services

Preventive care medical services (routine exams and preventive care) for infants/children under age 19 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 26 is covered up to the maximum benefit, as shown on your Benefit Summary.

Adults

Adults have coverage for the following routine exams and preventive care.

Preventive Care Medical Services

Preventive care medical services (routine exams and preventive care) for adults age 19 and over are covered.

Gynecological Preventive Exam Office Services

Gynecological preventive exam office services are covered.

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

Routine Eye Care

Routine eye care for Members over age 26 is covered up to the maximum benefit, as shown on your Benefit Summary.

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 member document.
- 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.
- Psychiatric, psychological, personality or emotional testing or exams.

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the "Pre-Authorization And Pre-Certification 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 (Members Under Age 26)

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.

Prosthodontics-Removable

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

Prosthodontics 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.

Prosthodontics 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) TM, which are not included in the specific categories listed above, include (where applicable) general anesthesia (administered by a Dentist), IV sedation, and behavior management.

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the "Pre-Authorization And Pre-Certification 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.

Routine Cancer Screenings

The following routine cancer screenings are **covered** as noted in the following provisions.

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.

Breast Cancer 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.

<u>Mammogram Screenings</u>	
Ages 35 to 39:	One baseline screening (including breast tomosynthesis)
Age 40 and over:	One screening mammogram (including breast tomosynthesis) per year

The following are **covered with no Cost-Share, except as noted**.

If you are enrolled in one of our HSA-compatible high deductible health plans (HDHPs), you are still responsible for meeting your Plan Deductible. Only amounts you pay for preventive breast cancer screening services will be covered with no Cost-Share, as required by applicable law.

A baseline mammogram for a Member who is 35 to 39 years of age or younger than 35 years of age, if the Member is believed to be at an increased risk for breast cancer due to any of the following:

1. A family history of breast cancer,
2. Positive genetic testing for the harmful variant of breast cancer gene one (BRCA1), breast cancer gene two (BRCA2) or other gene variant that materially increases the Member's risk for breast cancer,
3. Prior treatment for a childhood cancer, if the course of treatment for the childhood cancer included radiation therapy directed at the chest, or

4. Other indications as determined by the Member's physician, advanced practice registered nurse, physician's assistant, certified nurse midwife, or other medical provider.

Annual mammograms for a Member who is 40 years of age or older, or younger than 40 years of age if the Member is believed to be at increased risk for breast cancer due to any of the following:

1. A family history or prior personal history of breast cancer,
2. Positive genetic testing for the harmful variant of breast cancer gene one (BRCA1), breast cancer gene two (BRCA2) or other gene variant that materially increases the Member's risk for breast cancer,
3. Prior treatment for a childhood cancer, if the course of treatment for the childhood cancer included radiation therapy directed at the chest, or
4. Other indications as determined by the Member's physician, advanced practice registered nurse, physician's assistant, certified nurse midwife, or other provider.

In addition, comprehensive diagnostic and screening ultrasounds of an entire breast or breasts are **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 Member is believed to be at increased risk for breast cancer due to any of the following:

1. A family history or prior personal history of breast cancer,
2. Positive genetic testing for the harmful variant of breast cancer gene one (BRCA1), breast cancer gene two (BRCA2) or other gene variant that materially increases the Member's risk for breast cancer,
3. Prior treatment for a childhood cancer, if the course of treatment for the childhood cancer included radiation therapy directed at the chest, or
4. Other indications as determined by the Member's physician, advanced practice registered nurse, physician's assistant, certified nurse midwife, or other provider.

Further, diagnostic and screening magnetic resonance imaging (MRI) of an entire breast or breasts is **covered** in accordance with guidelines established by the American Cancer Society for a Member who is age 35 or older. or if the Member is younger than 35 years of age and believed to be at increased risk for breast cancer due to:

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the "Pre-Authorization And Pre-Certification 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.

1. A family history or prior personal history of breast cancer,
2. Positive genetic testing for the harmful variant of breast cancer gene one (BRCA1), breast cancer gene two (BRCA2) or other gene variant that materially increases the Member's risk for breast cancer,
3. Prior treatment for a childhood cancer, if the course of treatment for the childhood cancer included radiation therapy directed at the chest, or
4. Other indications as determined by the Member's physician, advanced practice registered nurse, physician's assistant, certified nurse midwife, or other provider.

Breast biopsies, prophylactic mastectomies for a Member who is believed to be at increased risk for breast cancer due to positive genetic testing for the harmful variant of breast cancer gene one (BRCA1), breast cancer gene two (BRCA2) or any other gene that materially increases the Member's risk for breast cancer, and breast reconstructive surgery for a Member who has undergone: a prophylactic mastectomy; or a mastectomy as part of the Member's course of treatment for breast cancer are also **covered**.

Any breast cancer screenings described in this subsection, which are received during the year that do not comply with the requirements described above, may be subject to the applicable Cost-Share amounts, as shown on your Benefit Summary. The Cost-Share amount depends on where the services are obtained.

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.

Cervical cancer screenings are only exempt from any Cost-Share amounts as defined by the United States Preventive Service Task Force (USPSTF) and the Health Resources and Services Administration (HRSA).

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).

Ovarian Cancer Screening

The following ovarian cancer screenings are **covered with no Cost-Share, except as noted**.

If you are enrolled in one of our HSA-compatible high deductible health plans (HDHPs), you are still responsible for meeting your Plan Deductible. Only amounts you pay for preventive ovarian cancer screening services will be covered with no Cost-Share, as required by applicable law.

Genetic testing for Members having a family history of breast or ovarian cancer,

Routine screening procedures for ovarian cancer and the office or facility visit for such screening, including "surveillance tests" for ovarian cancer for Members who are "at risk" for ovarian cancer, when ordered or provided by a physician in accordance with the standard practice of medicine;

CA-125 monitoring of ovarian cancer subsequent to treatment; and

Genetic testing of breast cancer gene one (BRCA1), breast cancer gene two (BRCA2), any other gene variant that materially increases the Member's risk for breast and ovarian cancer or any other gynecological cancer to detect an increased risk for breast and ovarian cancer when recommended by a health care provider in accordance with the United States Preventive Services Task Force recommendations for testing.

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the "Pre-Authorization And Pre-Certification 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.

“At risk” means:

- Having a family history with one or more first-or second-degree blood relatives, including a parent, sibling, child, aunt, uncle, niece, nephew, half-siblings, grandparents, or grandchildren with ovarian or breast cancer, or of nonpolyposis colorectal cancer.
- Positive genetic testing for the harmful variant of BRCA1, BRCA2 or any other gene variant that materially increases the insured’s risk for breast cancer, ovarian cancer, or any other gynecological cancers.

“Surveillance test” means annual screening using the following:

- CA-125 serum tumor marker testing,
- Transvaginal ultrasounds,
- Pelvic examination, or
- Other ovarian screening tests currently being evaluated by the U.S. Food and Drug Administration or the National Cancer Institute.

Any ovarian cancer screenings described in this subsection, which are received during the year that do not comply with the requirements described above, may be subject to the applicable Cost-Share amounts, as shown on your Benefit Summary. The Cost-Share amount depends on where the services are obtained.

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.

Mental Health Wellness Exams

Mental health wellness examinations conducted by a licensed mental health professional or the Member’s Primary Care Provider as part of a preventive visit are **covered up to 2 visits per year without Pre-Authorization and with no Cost-Share**.

A “mental health wellness examination” is a screening or assessment that seeks to identify any behavioral or mental health needs and appropriate treatment resources.

Mental health wellness examinations may include the following:

1. Observation,
2. A behavioral health screening,
3. Education and consultation on healthy lifestyle changes,
4. Referrals to ongoing treatment, mental health services, and other necessary supports,
5. Discussion of potential medication options,
6. Age-appropriate screenings or observations to understand the Member’s mental health history, personal history, and mental or cognitive state, and
7. Relevant input from an adult through screenings, interviews, or questions if appropriate.

A “licensed mental health professional” is one of the following licensed professionals:

- A professional counselor or certain people practicing under supervision,
- A physician certified in psychiatry,
- An advanced practice registered nurse (APRN) certified as a psychiatric and mental health clinical nurse specialist or practitioner,
- A psychologist,
- A marital and family therapist,
- A clinical social worker, or
- An alcohol and drug counselor.

Take a look at the “Managed Care Rules And Guidelines” section to see if you need to obtain a Referral or have to use Participating Providers and the “Pre-Authorization And Pre-Certification 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.

Other Preventive Services

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.

Newborn Care

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

Please refer to the “[Adding Dependents](#)” subsection of the “Eligibility And Enrollment” section for more information and rules regarding coverage for newborn children.

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, or at an Ambulatory Surgery Center. To locate a Participating Provider that is a Hospital Outpatient Surgical Facility or an Ambulatory Surgery Center, you can refer to our Provider Directory, visit us at our web site at <https://secured.connecticare.com/providerdirectory/>, or call us.

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

Take a look at the “Managed Care Rules And Guidelines” section to see if you need to obtain a Referral or have to use Participating Providers and the “Pre-Authorization And Pre-Certification 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.

Pre-Certification or Pre-Authorization will not be required for services that are provided to a Member following the Member’s admission to a Hospital emergency department; upon the referral of the Member’s treating physician, psychologist, or advanced practice registered nurse if there is imminent danger to the Member’s health or safety or the Member poses an imminent danger to the health or safety of others; or at an urgent crisis center.

Nothing in this provision shall preclude us from using other forms of utilization review, including, but not limited to, concurrent and retrospective review.

Inpatient Mental Health Services

Medically Necessary inpatient mental Health Services, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), 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 Disorder Services

Medically Necessary, medically monitored inpatient detoxification services and Medically Necessary, medically managed intensive inpatient detoxification services 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. These treatments have the same meanings as described in the most recent edition of the American Society of Addiction Medicine Treatment Criteria for Addictive, Substance-Related and Co-Occurring Conditions.

Substance abused disorder includes both alcohol dependency, defined as meeting the criteria for moderate to severe alcohol use disorder in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) and drug dependency, defined as meeting the criteria for moderate or severe Substance Abuse Disorder in the most recent edition of DSM.

Outpatient Mental Health And Alcohol And Substance Abuse Disorder Treatment

Medically Necessary outpatient services for the diagnosis and treatment of mental illnesses, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) 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.

Intensive Home-Based Or Evidence-Based Services

Intensive, home-based or evidence-based services designed address specific mental or nervous condition in a child or adolescent are **covered**.

Collaborative Care

Collaborative care services with specific Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes as required by applicable law and which are provided under an integrated delivery of behavioral health and primary care services by the Member's Primary Care Provider, a behavioral care manager, a psychiatric consultant and a database used by the behavioral care manager to track patient progress are **covered**.

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 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 Network Access 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 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 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.

Take a look at the “Managed Care Rules And Guidelines” section to see if you need to obtain a Referral or have to use Participating Providers and the “Pre-Authorization And Pre-Certification 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.

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.

INPATIENT SERVICES

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),
- 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 both of the 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. In this situation, we do not pay for what the provider charges during the procedure (usually called "professional fees").

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 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.

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.

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the "Pre-Authorization And Pre-Certification 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.

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.
Medically Necessary comprehensive lactation visits at home after the delivery.
- Caesarean Delivery (96-Hour Length of Stay):
Medically Necessary comprehensive lactation visits at home 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.
Medically Necessary comprehensive lactation visits at home after the delivery.

Skilled Nursing And Rehabilitation Facilities

Medically Necessary skilled nursing care is **covered up to the benefit maximum as shown on 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.

Skilled Nursing And Rehabilitation Facilities Limitations

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.

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the "Pre-Authorization And Pre-Certification 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.

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.

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.

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.

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**.

Take a look at the “Managed Care Rules And Guidelines” section to see if you need to obtain a Referral or have to use Participating Providers and the “Pre-Authorization And Pre-Certification 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.

- 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.

OTHER SERVICES

Artificial Limbs

Medically Necessary Artificial Limbs are **covered.** In addition, Medically Necessary repairs or a replacement to an Artificial Limb as determined by the Member's provider are also **covered,** unless the repair or replacement is necessitated by misuse or loss.

Benefits for Artificial Limbs are **covered at the Cost-Share amounts shown in the Benefit Summary.**

This benefit is separate from other prosthetic benefits described in other subsections of this Certificate Of Coverage.

There is no coverage for Artificial Limbs designed exclusively for athletic purposes.

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 and is appropriate for use in the home. DME is **covered after the applicable Cost-Share amount, 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.
- 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 Service, 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.

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the "Pre-Authorization And Pre-Certification 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.

- Hearing aids are **covered up to one hearing aid per ear 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, unless it is covered as replacement equipment as described below:

The original device is no longer capable of serving its original function due to:

- ◆ A changed medical condition.
- ◆ The normal growth of Member child, or
- ◆ The normal wear and tear of the equipment.
- Artificial Limbs are not covered under this subsection.

Please refer to the “Artificial Limbs” subsection.

Home Health Services

Medically Necessary home health services must be provided by a Home Health Agency. Home health services are **covered after the applicable Cost-Share amount, if any, 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 or advanced practice registered nurse 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.

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.

Take a look at the “Managed Care Rules And Guidelines” section to see if you need to obtain a Referral or have to use Participating Providers and the “Pre-Authorization And Pre-Certification 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.

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

You should use laboratories that are Participating Providers to reduce your out-of-pocket expenses.

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. Preventive maternity care office services are exempt from all Member Cost-Shares under the federal Patient Protection and Affordable Care Act (PPACA). Some diagnostic laboratory or radiology services provided in relation to maternity care may not be covered as preventive and will be subject to Cost Sharing (e.g., ultrasounds).

You should visit our website at www.connecticare.com to view a list of the preventive and wellness services that are exempt from Member Cost-Shares or call our Member Services Department at the telephone number listed in the "Important Telephone Numbers And Addresses" section for assistance.

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) and devices, as described in the "Disposable Medical Supplies And Durable Medical Equipment (DME), Including Prosthetics" subsection are **covered after the applicable Cost-Share amount as shown on your Benefit Summary**.

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

- The services must be ordered by a physician or advanced practice registered nurse.
- 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.
- Physical therapy must be provided during the 90-day period beginning on the date of the covered TMJ surgery.

There is no coverage for rehabilitative physical, occupational and speech therapy that is long term or maintenance in nature, where long term or maintenance in nature means that the treatment period for a specific condition or diagnosis is greater than a 60-day period.

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.

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the "Pre-Authorization And Pre-Certification 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.

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.

Medically Necessary covered radiology Health Services include:

- Computerized Axial Tomography (CAT).
- Magnetic Resonance Imaging (MRI).
- Positron Emission Tomography (PET).
- Nuclear cardiology.
- Bone densitometry scans.
- Ultrasound.
- 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.

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.
- All prescription contraceptive methods approved by the federal FDA, including, but not limited to:
 - ◆ Cervical caps.
 - ◆ Diaphragms.
 - ◆ Intrauterine Devices (IUDs).
 - ◆ Oral contraceptives.

NOTE: Covered at no Cost-Share when they are obtained at a Participating Pharmacy.

- For the treatment of diabetes.
- 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.

To be covered, prescription drugs must:

- Be Medically Necessary.
- Be marketed in the United States at the time of purchase.
- 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 is required to be covered under the PPACA. The OTC medications that we will cover are listed on our web site at <https://main.myconnecticare.com/pharmacy-center>.
2. You must obtain a prescription for the OTC medication from your doctor.
3. The OTC medication must be filled as a prescription at a pharmacy by the pharmacist; otherwise it will not be covered.
4. When such OTC medications are covered, they will be covered based upon age, gender and/or disease required to be covered under the PPACA.

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

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the "Pre-Authorization And Pre-Certification 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 list of OTC medications may change at any time. When the list does change, you will be notified in our member electronic 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 <https://main.myconnecticare.com/pharmacy-center>) to find out if an OTC medication is covered under this member document. We have the right to change the OTC medications on the list.

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.
- Special handling.

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

Certain specialty prescription drugs require Pre-Authorization. You can find the [list](#) of specialty drugs that need Pre-Authorization in the “Pre-Authorization And Pre-Certification Addendum.”

Specialty drugs that require Pre-Authorization should be filled through the specialty pharmacy we advise you of.

When you or your provider contacts us for Pre-Authorization of a specialty drug, if Pre-Authorization is granted, you or your provider will be notified of the telephone number to call to contact the specialty pharmacy. Specialty drugs, when Pre-Authorized by us, will be dispensed for a maximum of 30-day supply per fill. The drugs will be shipped to your doctor’s office, your home, or other location based on the type of drug or treatment.

NOTE: Even though up to a 30-day supply of a specialty drug may be delivered by mail to you, or your provider’s office or some other location, specialty drugs DO NOT have the same Cost-Share that applies to the Voluntary Mail Order program. Instead, specialty drugs have the applicable retail pharmacy Cost-Share amount listed on your Benefit Summary.

Specialized counseling and education are available to you from the specialty pharmacy regarding proper administration, storage, dosage, drug interactions, and side effects of these specialty drugs.

If the specialty drug is not available at the specialty pharmacy we advised you of, or you are out of a specialty drug or if the specialty drug ordered by your provider does not arrive in time, we will authorize the specialty drug for up to a 30-day supply at an alternate specialty pharmacy, so you can obtain the needed medication. In this instance, you will not be required to pay any additional amounts above the normal

Cost-Share amounts you would typically pay for a specialty drug under this Plan.

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 in the “Pre-Authorization And Pre-Certification Addendum.”

Updates to the list of drugs or supplies requiring Pre-Authorization are published from time to time in our member electronic 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 <https://main.myconnecticare.com/pharmacy-center>) 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, 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.

Take a look at the “Managed Care Rules And Guidelines” section to see if you need to obtain a Referral or have to use Participating Providers and the “Pre-Authorization And Pre-Certification 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 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.

Pharmacy Networks

Some Plan options include a pharmacy network of Participating Pharmacies and other Plan options include a pharmacy network of Preferred Participating Pharmacies and Non-Preferred Participating Pharmacies.

Your Benefit Summary will tell you which pharmacy network your Plan has.

Participating Pharmacies Network

If your Plan has the Participating Pharmacies network, 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 <https://main.myconnecticare.com/pharmacy-center>, 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 the Cost-Share amount you are required to pay.

Take a look at the “Managed Care Rules And Guidelines” section to see if you need to obtain a Referral or have to use Participating Providers and the “Pre-Authorization And Pre-Certification 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.

Preferred Participating Pharmacies And Non-Preferred Participating Pharmacies Network

If your Plan has the Preferred Participating Pharmacies and Non-Preferred Participating Pharmacies network, you are free to use Preferred Participating Pharmacies, Non-Preferred 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 Preferred Participating Pharmacies and Non-Preferred 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
Preferred Participating Pharmacy	Lower Member Cost
Non-Preferred Participating Pharmacy	Higher Member Cost
Non-Participating Pharmacy	Highest Member Cost

Using A Preferred Participating Pharmacy

When you and your Eligible Dependents use a Preferred 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-Preferred Participating Pharmacy or Non-Participating Pharmacy.

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

To locate a Preferred Participating Pharmacy, you can refer to our Provider Directory, visit us at our web site at <https://main.myconnecticare.com/pharmacy-center>, or call us.

Using A Non-Preferred Participating Pharmacy

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

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

To locate a Non-Preferred Participating Pharmacy, you can refer to our Provider Directory, visit us at our web site at <https://main.myconnecticare.com/pharmacy-center>, 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 Preferred Participating Pharmacy or a Non-Preferred Participating Pharmacy.

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

Prescription Drug Programs

The following provisions may apply to our Prescription Drug Programs.

Advanced Opioid Management Program

This Plan has an “Advanced Opioid Management Program.”

This program applies to prescriptions written for opioid medications.

You will be notified via letter from us, if you have been identified to be a participant in this program.

Generic Substitution Program

1. This Plan has a “Generic Substitution Program.” This program applies to prescriptions filled at Participating Pharmacies, Preferred Participating Pharmacies or Non-Preferred Participating Pharmacies (retail or specialty pharmacies) and our designated mail order vendor.
2. This Plan covers Generic Drugs Or Supplies when they are available.

Even if you request a covered Brand Name Drug Or Supply and/or even if your provider deems a covered Brand Name Drug Or Supply to be Medically Necessary and therefore prescribes a covered Brand Name Drug Or Supply, where a Generic Equivalent drug or supply is available, you will pay the difference in the cost between the Brand Name Drug Or Supply and the Generic Equivalent drug or supply, plus any applicable Cost-Share amount.

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.

Participating Pharmacies, Preferred Participating Pharmacies and Non-Preferred 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 <https://main.myconnecticare.com/pharmacy-center>) 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.

Take a look at the “Managed Care Rules And Guidelines” section to see if you need to obtain a Referral or have to use Participating Providers and the “Pre-Authorization And Pre-Certification 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.

Tiered Cost-Share Program

1. This Plan has a “Tiered Cost-Share Program.” This program applies to prescriptions filled at Participating Pharmacies, Preferred Participating Pharmacies or Non-Preferred 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 <https://main.myconnecticare.com/pharmacy-center>) to find out which tier (if any) a prescription drug or supply is in.

Mandatory Drug Substitution Program

1. This Plan has a “Mandatory Drug Substitution Program.” This program applies to prescriptions filled at Participating Pharmacies Preferred Participating Pharmacies or Non-Preferred Participating Pharmacies (retail pharmacies) and our designated mail order vendor. It **DOES NOT** pertain to prescriptions the Member receives to treat pain management.
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 Preferred Participating Pharmacy or Non-Preferred 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.

Take a look at the “Managed Care Rules And Guidelines” section to see if you need to obtain a Referral or have to use Participating Providers and the “Pre-Authorization And Pre-Certification 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 drugs on the “Mandatory Drug Substitution” list are published from time to time in our member electronic 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 <https://main.myconnecticare.com/pharmacy-center>) 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. This Plan has a “Voluntary Mail Order Program.”

Under the Voluntary Mail Order Program, you and your covered dependents may fill your prescriptions at our designated mail order vendor or at a non-designated mail order vendor.

You and your covered dependents may obtain up to a 90 or 100-day supply of prescription drugs or covered supplies through the mail order program at the applicable benefit level. Please refer to your Benefit Summary to see the day supply limit and Cost-Share amounts, including whether your Plan has a Plan Deductible or Benefit Deductible.

2. 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 our designated mail order vendor is provided to you in a separate flyer.

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. This Plan has a “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.

Take a look at the “Managed Care Rules And Guidelines” section to see if you need to obtain a Referral or have to use Participating Providers and the “Pre-Authorization And Pre-Certification 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.

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 <https://main.myconnecticare.com/pharmacy-center>) 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 covered prescription drugs and 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 the lesser of the following:
 - The applicable Copayment amount for the drug or supply, or
 - The amount we would pay for the drug or supply, or
 - The amount you would pay for the drug or the supply if you had purchased it without using the benefits of this Plan.
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 Copayment amount, as described in paragraph 1, above, or the Coinsurance amount up to your Deductible amount. Then, once the Deductible has been met, you will be responsible to pay the applicable Cost-Share 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, described in paragraph 1, above.

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.

Take a look at the “Managed Care Rules And Guidelines” section to see if you need to obtain a Referral or have to use Participating Providers and the “Pre-Authorization And Pre-Certification 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.

7. In no case will the Cost-Share amount for insulin drugs, noninsulin drugs, Diabetes Devices and Diabetes Ketoacidosis exceed:

- \$25 for each 30-day supply of a Medically Necessary covered insulin drug.
- \$25 for each 30-day supply of a Medically Necessary covered noninsulin drug, if the noninsulin drug is a glucagon drug.
- \$100 for a 30-day supply of all Medically Necessary covered Diabetes Devices and Diabetes Ketoacidosis Devices for the Member that are in accordance with the Member's diabetes treatment plan.

This \$100 cap will be applied only to those Diabetes Devices and Diabetic Ketoacidosis Devices that can be prescribed and dispensed in a 30-day supply. In addition, this \$100 cap for applicable Diabetes Devices or Diabetes Ketoacidosis Devices will be applied as a 30-day supply cumulative cap for all such devices.

All covered insulin and noninsulin drugs, if the noninsulin drug is a glucagon drug, are exempt from the Plan Deductible.

All covered Diabetes Devices and Diabetes Ketoacidosis are exempt from the Plan Deductible, unless the Member is enrolled in one of our HSA-compatible high deductible health plans (HDHPs).

Exception: A glucometer is considered preventive care and will remain exempt from the Plan Deductible.

Benefit Limits

Fill Or Refill Limit

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

Fills For Contraceptive Drugs

A 12-month supply of an FDA-approved contraceptive drug, device, or product when prescribed by a licensed physician, physician assistant, or advanced practice registered nurse (APRN) is available. The supply may be dispensed at one time or at multiple times, but a Member cannot receive a 12-month supply more than once per Plan year.

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.**

Exception Review For A Non-Covered Clinically Appropriate Drug

You, your designee or your prescribing provider may request a review of a request for a clinically appropriate drug not covered by this Plan. If there are exigent circumstances, an expedited review may be requested. If there are not exigent circumstances, the review request will be treated as a standard (non-exigent circumstances) review.

Expedited Review (Exigent Circumstances)

1. Exigent circumstances exist when a Member is suffering from a health condition that may seriously jeopardize his/her life, health, or ability to regain maximum function or when he/she is undergoing a current course of treatment using a non-formulary drug.
2. We must make our coverage determination on an expedited review request based on exigent circumstances and notify you or your designee and the prescribing provider of our coverage determination no later than 24 hours after we receive the request.
3. When we grant an exception based on exigent circumstances, we will provide coverage of the non-formulary drug for the duration of the exigency.

Standard Review (Non-Exigent Circumstances)

1. We must make our coverage determination on a standard (non-expedited) review and notify you or your designee and the prescribing provider of our coverage determination no later than 72 hours after we receive the request.
2. When we grant an exception based on non-exigent circumstances, we will provide coverage of the non-formulary drug for the duration of the prescription, including refills.

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the "Pre-Authorization And Pre-Certification 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.

External Exception Request Review

1. If we deny a request for a standard review or for an expedited review of a non-covered clinically appropriate drug as noted above, you, your designee, or your prescribing provider may request that the original exception request and subsequent denial of the request be reviewed by an independent review organization.
2. We will make our determination of the external exception review to you, your designee, or your prescribing provider of our determination no later than 72 hours following our receipt of the request, if the original request was a standard review request and no later than 24 hours if the original request was an expedited review request.
3. If we grant an external exception request review of a standard review request, we will provide coverage of the non-covered clinically appropriate drug for the duration of the prescription.

If we grant an external exception request review of an expedited review request, we will provide coverage of the non-covered clinically appropriate drug for the duration of the exigency.

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) or as required by applicable law.
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 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 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.

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, 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.
- 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.

Take a look at the “Managed Care Rules And Guidelines” section to see if you need to obtain a Referral or have to use Participating Providers and the “Pre-Authorization And Pre-Certification 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.

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.

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 on 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 are actively case managed. 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 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, or
- 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 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.

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.

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the "Pre-Authorization And Pre-Certification 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.

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. The Cost-Share amount depends on where the services are provided.

Diabetes Services

The following Medically Necessary diabetes services, including treatment for all types of diabetes are **covered**, when prescribed and dispensed pursuant to applicable law, including but not limited to:

- Laboratory and diagnostic testing and screening, including, but not limited to hemoglobin A1c testing and retinopathy screening.
- Insulin drugs:
- Noninsulin drugs, if the noninsulin drug is a glucagon drug:
- Diabetes Devices and Diabetes Ketoacidosis Devices in accordance with the Member's diabetes treatment plan.

Please refer to your Benefit Summary for the diabetic equipment and supplies Cost-Share amount.

The Cost-Share amount depends on where the services or devices 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.
- 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.
- 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.

Drug Therapy services include all drugs administered by a licensed provider.

Eye Care

IMPORTANT:

If you opt to receive optometric services or procedures that are not covered benefits under this Plan, a Participating Provider optometrist may charge you his or her usual and customary rate for such services or procedures. Prior to providing you with optometric services or procedures that are not covered benefits, the optometrist 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. To fully understand your coverage, you may wish to review this document.

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.

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the "Pre-Authorization And Pre-Certification 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.

Eyeglasses And Contact Lenses

Standard Medically Necessary prescription lenses, frames, and prescription contact lenses for Members under age 26 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 age 26 and over) for eyeglasses and contact lenses. In addition, there is also no coverage for any non-standard prescription lenses, frames, and prescription contact lenses, including tinted lenses, no matter the age of the Member.

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 disorder. The Cost-Share amount depends on where the test is performed.

Coverage will be available in the following circumstances **AND** when the result of the genetic testing will affect a Member's treatment:

1. The Member must have received genetic counseling and a proper evaluation consisting of a complete history, physical examination, conventional diagnostic studies and pedigree analysis. After the proper evaluation, there must remain the possibility of a genetic diagnosis.
2. A Member must be at risk of inheriting or transmitting a genetic disorder, including but not limited to the following disorders:
 - Familial adenosis polyposis (FAP).
 - Hereditary Breast and Ovarian Cancer Syndrome (BRCA).
 - Hereditary non-polyposis colorectal cancer (HNPCC).
 - Medullary thyroid cancer and multiple endocrine neoplasia type 2, MEN2 (RET).
3. Genetic testing is used to guide medication therapy for the treatment of lymphoma, leukemia, or inflammatory bowel disease.
4. Genetic testing is used for prenatal genetic testing associated with chorionic villus sampling and/or amniocentesis. Pre-Authorization is required **ONLY** for prenatal genetic testing for DNA diagnosis.
5. 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 by this Plan.

There is no coverage for:

- Genetic testing kits available either direct to the consumer or via a physician prescription.
- Genetic testing only for the benefit of another family member.

Health Management And Incentive Programs

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 us or our Delegated 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.

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the "Pre-Authorization And Pre-Certification 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.

Incentive Programs

We may offer incentives from time to time, at our discretion, in order to introduce you to covered programs and services available under this Plan, incent you to access certain medical services, and use online tools that enhance your coverage and services.

The purpose of these incentives include, but are not limited to, making you aware of cost effective benefit options or services, helping you achieve your best health, and encouraging you to update member-related information.

These incentives may be offered in various forms, including but not limited to:

- Contributions to health savings accounts,
- Fitness center membership and reimbursement,
- Gift cards,
- Health related merchandise,
- Modification to Cost-Share amounts,
- Premium discounts or rebates,
- Retailer coupons, or
- Any combination of these.

Acceptance of these incentives is voluntary as long as ConnectiCare offers the incentives program. We may discontinue an incentive for a particular covered program or service at any time. If you have any questions about whether receipt of an incentive or retailer coupon results in taxable income to you, we recommend that you consult your tax advisor.

The award of any such incentive shall not depend upon the result of a wellness or health improvement activity or upon a Member's health status.

Hospice Care

Medically Necessary Hospice care is **covered at the applicable Inpatient Hospital Services, Including Room & Board or Home Health Services Cost-Share amounts as shown on your Benefit Summary**, if the Member has a life expectancy of six months or less. 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. The Cost-Share amount depends on where the services are provided.

Hospital Care

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

Infertility Services

Benefits

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:**

- 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 as part of a covered 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.

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.

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the "Pre-Authorization And Pre-Certification 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.

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.

If you are enrolled in our **Passage Plans** (a Plan that requires Referrals), then services will not be covered unless you obtain a Referral from your 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.

In addition, oral medicines needed to treat Infertility must be prescribed by the treating provider to be covered.

There is no coverage for:

- All Infertility services following voluntary sterilization where no successful reversal has been made.
- Banking of eggs, embryos, or sperm.
- Cryopreservation (freezing) of eggs or sperm.
- Genetic analysis and testing, except as described above or in the “[Genetic Testing](#)” section.
- Medicines for sexual dysfunction, unless your Plan includes our **Supplemental Sexual Dysfunction Prescription Drug Rider**.
- Recruitment, selection and screening of donors or gestational carriers.
- Reversal of surgical sterilization.
- Surrogacy and all charges associated with surrogacy arrangements such as prescription drugs, fertilization or implantation, except if provided to a Member.

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 on your Benefit Summary.

Neuropsychological Testing

Medically Necessary psychological, neuropsychological or neurobehavioral testing is **covered**.

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 and are to be used for the total caloric needs of the Member.

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.

Take a look at the “Managed Care Rules And Guidelines” section to see if you need to obtain a Referral or have to use Participating Providers and the “Pre-Authorization And Pre-Certification 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.

Modified Food Products For Inherited Metabolic Diseases

Medically Necessary modified food products (low protein) and amino acid modified preparations are **covered at the Modified Food Products and Specialized Formulas Drug Cost-Share amount listed on your Benefit Summary**.

Modified food products and amino acid 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.

Other Specialized Formulas

Specialized formulas are **covered at the Modified Food Products and Specialized Formulas Drug Cost-Share amount listed on your Benefit Summary**.

Specialized formulas are **covered** 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.

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

Observation Beds

Observation beds are **covered after the applicable Outpatient Services Cost-Share amount described on your Benefit Summary** when a Member is placed in a bed attached to an emergency department, outpatient department or operating facility for less than 24-hours at a time. Observation beds are not staffed overnight and are not part of a Hospital's bed complement.

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the "Pre-Authorization And Pre-Certification 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.

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.

Pain management services include acupuncture, as long as the treatment is ordered by a pain management specialist who is credentialed by the American Academy of Pain Management or who is a board-certified anesthesiologist, physiatrist, neurologist, oncologist or radiation oncologist with additional training in pain management.

Renal Dialysis

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

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.

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**.

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 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

Male 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.

Female sterilization services provided by a doctor are **covered without any Cost-Sharing amount**.

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 elective terminations of pregnancy per lifetime**. The Cost-Share amount depends on where the procedures are provided.

Telemedicine Services

Pursuant to Public Act 22-81, Telemedicine services for medical advice, diagnosis, care or treatment are **covered** to the same extent coverage is provided for an in-person visit.

Telemedicine services are **covered after the Cost-Share amount, as shown on your Benefit Summary**. The Cost-Share amount will be the same amount you would pay if the service was provided through an in-person service between you and your provider.

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.
- Provided in conjunction with authorized home care services.

If wound care supplies are not being provided in conjunction with covered home care services then the applicable Cost-Share amount will apply.

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**. Supplies will be **covered after the applicable Cost-Share amount**. The Cost-Share amount depends on where the supplies are obtained.

Take a look at the “Managed Care Rules And Guidelines” section to see if you need to obtain a Referral or have to use Participating Providers and the “Pre-Authorization And Pre-Certification 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.

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. All assistive communication devices.
2. 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.
3. Any Treatment for which there is Insufficient Evidence Of Therapeutic Value for the use for which it is being prescribed.
4. 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 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, or
 - As required by applicable law.
5. Artificial Limbs designed exclusively for athletic purposes.
6. Attorney fees.
7. Mental health care and substance-related and addictive disorders:
 - Services performed in connection with conditions not classified in the current edition of the “International Classification of Diseases section on Mental and Behavioral Disorders” or “Diagnostic and Statistical Manual of the American Psychiatric Association.”
 - Outside of an assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention, but are specifically noted not to be mental disorders within the current edition of the “Diagnostic and Statistical Manual of the American Psychiatric Association.”
 - Outside of an assessment, services as treatments for the primary diagnoses of learning disabilities, pyromania, kleptomania, gambling disorder, and paraphilic disorders.
- Services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes.
- Tuition or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the Individuals With Disabilities Education Act.
- Outside of an assessment, unspecified disorders for which the provider is not obligated to provide clinical rationale as defined in the current edition of the “Diagnostic and Statistical Manual of the American Psychiatric Association.”
- Transitional living, sober living and halfway house services.
- Non-medical 24-hour withdrawal management.
- High intensity residential care, including American Society of Addiction Medicine (ASAM) criteria, for Members with substance-related and addictive disorders who are unable to participate in their care due to significant cognitive impairment.
- Wilderness, adventure, outdoor programming which include equine and other animal assisted services.
- Services provided in unlicensed, and, or non-accredited program. treatment or services that are non-professionally directed.
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. Body piercing.
11. Cardiac rehabilitation for Phase III, unless the Member:
 - Is being actively case managed.
 - 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.

Take a look at the “Managed Care Rules And Guidelines” section to see if you need to obtain a Referral or have to use Participating Providers and the “Pre-Authorization And Pre-Certification 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.

12. 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.

13. Chiropractic therapy that is long term or maintenance in nature.

14. 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 (FDA).
- 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,
 - ◆ 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.

15. Cosmetic Treatments and procedures, including but not limited to:

- Any medical or Hospital services related to Cosmetic Treatments or procedures.
- Abdominoplasty, lipectomy, panniculectomy or excision of loose or redundant skin and/or fat after the Member has had a substantial weight loss, unless documented in photographs with skin breakdown, ulcer that persist despite alternative treatments.
- Repair of diastasis recti, abdominal liposuction or suction assisted lipectomy of the abdomen.
- Benign nevus or any benign skin lesion removal (except when the nevus or skin lesion causes significant impairment of physical or mechanical function).
- 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 the law).
- Dermabrasion or other procedures to plane the skin, including, but not limited to:
 - ◆ Acne related services such as blue light treatment of acne, injections to raise acne scars, and removal of acne cysts.
 - ◆ Electrolysis.
 - ◆ Scar revision following surgery or injury (except when the scar causes significant impairment of a physical or mechanical function).
 - ◆ Skin tag removal.
 - ◆ Tattooing or removal, unless covered under reconstructive surgery policy.
- Liposuction.
- Phototherapy or laser therapy for the treatment of skin conditions, except for the treatment of psoriasis.
- 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).
- Reversal of inverted nipples unless described in reconstructive surgery policy.
- Sclerotherapy for varicose veins, reticular veins and spider veins.

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the "Pre-Authorization And Pre-Certification 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.

- Septoplasty, septorhinoplasty or rhinoplasty unless Medically Necessary.
 - Treatment of craniofacial disorders, except as described in the “[Craniofacial Disorders](#)” subsection of the “Benefits” section.
 - Varicose vein treatment, except when there is a history of ulcers or bleeding from a varicose vein.
 - Vascular birthmark removal unless serious life-threatening complications including infection, bleeding, and dependent on the location by interfere with ADLs.
16. Custodial Care, convalescent care, domiciliary care, long term care or rest home care, except for Custodial Care in connection with extended day treatment programs as required by applicable federal or state law. Also care provided by home health aides that is not patient care of a medical or therapeutic nature or is provided in the absence of a skilled service and care provided by non-licensed professionals.
17. Dental services, including but not limited to:
- Any service, procedure, or treatment modality not specifically listed in the “Pediatric Dental Care (Members Under Age 26)” subsection of the “Benefits” section as a covered Dental Service.
 - For adults (Members age 26 and over).
 - 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 (fillings, crowns, bridges, etc.).
 - Space maintainers for dependent children age 13 and over (once per quarter or arch per lifetime).
 - 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.
 - ◆ 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 Members age 26 and 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 filling per tooth surface in any consecutive 24-month period.

Take a look at the “Managed Care Rules And Guidelines” section to see if you need to obtain a Referral or have to use Participating Providers and the “Pre-Authorization And Pre-Certification 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.

- More than one full mouth x-ray series in any period of 36 consecutive months.
 - Bitewing x-rays or vertical bitewing x-rays in excess of eight films 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 periodontal therap.,
 - Services for any condition covered by workers' 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), 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.
18. Educational services, except for educational services in connection with extended day treatment program as required by applicable federal or state law and except as 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.
19. Experimental Or Investigational treatment, except as otherwise described in the "[Bypassing The Internal Appeal Process](#)" subsection of the "Claims Filing, Questions And Complaints, And Appeal Process" section.
20. Facelift surgery, or rhytidectomy
21. 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 Drugs](#)" 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:
 - ◆ All Infertility services following voluntary sterilization where no successful reversal has been made.
 - ◆ Banking of eggs, embryos, or sperm.
 - ◆ Cryopreservation (freezing) of eggs or sperm.
 - ◆ Genetic analysis and testing, except as otherwise described above or in the "Genetic Testing" section.
 - ◆ Medications for sexual dysfunction, unless your Plan includes our ***Supplemental Sexual Dysfunction Prescription Drug Rider***.

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the "Pre-Authorization And Pre-Certification 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.

- ◆ Recruitment, selection and screening of donors or gestational carriers.
 - ◆ Reversal of surgical sterilization.
 - ◆ Surrogacy and all charges associated with surrogacy arrangements such as prescription drugs, fertilization or implantation, except if provided to a Member.
 - Labor doulas and labor coaches.
22. 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.
 23. Genetic analysis and testing, except as described in the “Infertility Services” or “Genetic Testing” subsections of the “Benefits” section, including:
 - Genetic testing kits available either direct to the consumer or via a physician prescription.
 - Genetic testing only for the benefit of another family member.
 24. Health club membership and exercise equipment.
 25. Hearing aids, except as otherwise described in the “Durable Medical Equipment (DME), Including Prosthetics” subsection of the “Benefits” section.
 26. Home health aide care that is not patient care of a medical or therapeutic nature.
 27. Hypnosis (except as an integral part of psychotherapy), biofeedback (except when ordered by a physician to treat urinary incontinence) and acupuncture, except when acupuncture is provided as part of pain management.
 28. 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.
 29. Injection of collagen or other fillers or bulking agents to enhance appearance.
 30. Massage, except when part of a prescribed physical or occupational therapy program, if that program is a covered benefit.
 31. 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, lymphedema, lymphedema related to cancer or a cancer related procedure.
 - Compression and cold therapy devices.
 - DME that duplicates the function of any previously obtained equipment.
 32. 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.
 33. Non-licensed professionals.
 34. Non-Medically Necessary services or supplies, except as required by applicable federal or state law.
This includes services that do not meet our medical policy, clinical coverage or benefit policy guidelines.
 35. Non-medical supportive counseling services (individual or group) for alcohol or substance abuse (e.g., Alcoholics Anonymous).
 36. Non-surgical treatment of temporomandibular joint (TMJ) dysfunction or temporomandibular disease (TMD) syndrome, including but not limited to:
 - Appliances.
 - Behavior modification.
 - Physiotherapy.
 - Prosthodontic therapy.
 37. Otoplasty.
 38. Overnight or day camps focused on illness or disability.

Take a look at the “Managed Care Rules And Guidelines” section to see if you need to obtain a Referral or have to use Participating Providers and the “Pre-Authorization And Pre-Certification 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.

39. 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.

40. 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.
- 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.

41. Personal convenience or comfort items of any kind.

42. Platelet-rich-plasma for bone, wound or tendon healing.

43. 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 Supplements And Food Products](#)” subsections of the “[Benefits](#)” section.
- Medications for sexual dysfunction.
- 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.

Take a look at the “[Managed Care Rules And Guidelines](#)” section to see if you need to obtain a Referral or have to use Participating Providers and the “[Pre-Authorization And Pre-Certification 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.

- ◆ 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 as described on your Benefit Summary, or to treat nicotine addiction. For nicotine addiction treatment, 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, and

- Vitamins, minerals, hematinics and supplements, except prescription pre-natal vitamins or as otherwise described in this member document.

44. Rehabilitative physical therapy, occupational therapy, or speech therapy that is long term or maintenance in nature, where long term or maintenance in nature means that the treatment period for a specific condition or diagnosis is greater than a 60-day period.

- 45. Private room accommodations or private duty nursing in a facility.
- 46. Routine foot care and treatment, unless Medically Necessary for neuro-circulatory conditions.
- 47. Routine physical exams or immunizations at an Urgent Care Center.
- 48. Screening and/or testing required for public health surveillance, travel, education, employment, or returning to employment, except as required by law.
- 49. Sensory and auditory integration therapy, unless covered under the “Autism Services” or “Birth To Three Program (Early Intervention Services)” subsections of the “Benefits” section.
- 50. Services and supplies exceeding the applicable benefit maximums.
- 51. Services and supplies not specifically included in this document.
- 52. Services, drugs, medications or supplies obtained outside of the United States, except for Emergency Services.
- 53. 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.
- 54. Services required by or received at a Wilderness Camp or a boarding school, including:
 - Medications, including prophylactic.
 - Physical examinations, blood tests.
 - Supplies.
 - Vaccinations/immunizations.
- 55. Services required by third parties or pursuant to a court order, including:
 - Blood tests.
 - Medications, including prophylactic.
 - Physical examinations.
 - Supplies.
 - Vaccinations/immunizations.

This exclusion does not apply to covered substance abuse Health Services that were provided to a Member pursuant to a court order.

Take a look at the “Managed Care Rules And Guidelines” section to see if you need to obtain a Referral or have to use Participating Providers and the “Pre-Authorization And Pre-Certification 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.

56. Services obtained for foreign or domestic travel, including:
 - Camp.
 - Employment.
 - Insurance.
 - Licensing.
 - Pursuant to a court order.
 - School.
57. 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.
58. Speech therapy for stuttering, lisp correction, or any speech impediment, except as described in the “[Benefits](#)” section.
59. Telemedicine consultation services not specifically covered under the “[Telemedicine Services](#)” subsection of the “[Benefits](#)” section, including but not limited to:
 - Costs for asking for Pre-Authorizations or Pre-Certifications.
 - Costs for diet counseling or prescriptions for Drug Enforcement Administration (DEA) controlled substances or lifestyle drugs, such as sexual dysfunction, diet drugs or hair growth drugs.
 - Costs for furnishing and/or receiving medical records and reports.
 - Costs for getting answers to billing, insurance coverage or payment questions.
 - Costs for provider to provider discussions.
 - Costs for Referrals to providers outside the online care pane.,
 - Costs for reporting normal lab or other test results.
 - Costs for requesting office visits.
 - Costs for research services by providers not directly responsible for your care.
 - Costs for services not documented in provider records.
- Costs from an outside laboratory or shop for services in connection with an order involving devices (e.g., prosthetics, orthotics) which are manufactured by that laboratory or shop, but which are designed to be fitted and adjusted by the attending physician.
- Fees associated with data usage on a mobile phone or fees for short message service (SMS)/text messaging.
- Membership, administrative, or access fees charged by physicians or other providers. Examples of administrative fees include, but are not limited to:
Fees charged for educational brochures or calling a patient to provide their test results.
- Provider or Hospital fees for technical costs or facility fees for the provision of Telemedicine services.
- Telemedicine services involving the use of electronic-mail, facsimile, texting or audio-only telephone, except as required by Public Act 22-81.
60. Thigh, leg, hip, or buttock lift procedures.
61. Third party coverage, such as other primary insurance, Workers' Compensation and Medicare will not be duplicated.
62. 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.
63. Treatment of melasma.
64. Treatment of snoring in the absence of sleep apnea.
65. 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.
 - ♦ Radial keratotomy.
 - Non-standard prescription lenses, frames, and prescription contact lenses, including tinted lenses.
 - Vision and hearing examinations (except as described in the “[Eye Care](#)” and “[Hearing Screenings](#)” subsections of the “[Benefits](#)” section).
 - Vision therapy and vision training
66. War related treatment or supplies, whether the war is declared or undeclared.
67. Weight loss/control treatment, programs, clinics, medications, or surgical treatment for morbid obesity.

Take a look at the “[Managed Care Rules And Guidelines](#)” section to see if you need to obtain a Referral or have to use Participating Providers and the “[Pre-Authorization And Pre-Certification 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.

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 – workers' 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.
- 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.
- 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.

Workers' Compensation

If you or your Eligible Dependents are injured at work, you are eligible to be covered under workers' compensation. If that ever happens, workers' 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 workers' compensation plan, or
- Would be covered if the Member is required by law to be covered by workers' 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 workers' 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.

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the "Pre-Authorization And Pre-Certification 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.

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 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.
- 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).

Take a look at the “Managed Care Rules And Guidelines” section to see if you need to obtain a Referral or have to use Participating Providers and the “Pre-Authorization And Pre-Certification 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. 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 workers' 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.

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the "Pre-Authorization And Pre-Certification 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.

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 enrolled in 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 (Under 65 And Disabled)

1. Medicare is the primary Plan for you or your Eligible Dependents when you are an active Employee, **if your Employer has fewer than 100 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 after 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.

TERMINATION AND AMENDMENT

SPECIAL EXCHANGE TERMINATION RULES

Either you or your Employer may cancel your coverage and/or your Eligible Dependent’s coverage through the Exchange. The Exchange will have rules on how to do this. You may cancel coverage by sending a written notice to either the Exchange or us. The date that coverage will end will be either:

- The date that you ask for coverage to end, if you provide written notice within 14 days of that date; or
- 14 days after you ask for coverage to end, if you ask for a termination date more than 14 days before you gave written notice. We may agree in certain circumstances to allow an earlier termination date that you request.

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 month for which payment was received when your Employer fails to pay within the standard 30-day grace period. You will be liable for all claims incurred after this Certificate Of Coverage is terminated; or

At another date after the grace period that we or the Exchange specifies specify in writing to your Employer. This date will not be earlier than midnight of the third business day following the date your Employer receives 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.

Take a look at the “Managed Care Rules And Guidelines” section to see if you need to obtain a Referral or have to use Participating Providers and the “Pre-Authorization And Pre-Certification 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.

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. At the end of the month the termination occurs if your Employer provides us or the Exchange with written notice at least **30 days in advance** of the requested termination date. Notification must be submitted to us or the Exchange on your Employer's letterhead and include the date of the requested termination.
6. 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.
7. On the date agreed upon by your Employer and us.
8. On the date your Employer no longer provides health insurance coverage through the Exchange.
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.

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, except as noted.

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.

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.
12. Termination of coverage by you is effective on the last day of the month. Notification to terminate coverage must be provided to us or the Exchange no later than the day before the last day of the month in which you request termination of coverage.

If you notify us or the Exchange on the day prior to the last day of the month and no claims are payable on your behalf for that month, we will allow you to retroactively terminate your coverage. The earliest termination date will be the last day of the month prior. Any request to retroactively terminate your coverage can be done orally or in writing.

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the "Pre-Authorization And Pre-Certification 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 example: If you are looking to terminate coverage for the month of April, you must notify us or the Exchange on or before April 29th, we will allow you to terminate coverage, effective March 31, if no claims are payable on your behalf for the month of April. However, if you notify us or the Exchange on or after April 30th, and/or there are claims that are payable for the month of April, we will not accept your request and termination will be processed for April 30 and premium will be due and collected for the month of April.

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

This Certificate Of Coverage is subject to amendment and modification in accordance with any of its terms, the Evidence Of Agreement, or by mutual agreement between the Employer and us without the permission or involvement of any Member. Changes will not be effective until the date specified in the written notice we give to the Employer about the change.

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.

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.

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the "Pre-Authorization And Pre-Certification 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, 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.
- 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.

Take a look at the “Managed Care Rules And Guidelines” section to see if you need to obtain a Referral or have to use Participating Providers and the “Pre-Authorization And Pre-Certification 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 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.

CLAIMS FILING, QUESTIONS AND COMPLAINTS, AND APPEAL 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 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 is responsible for filing claims with us in accordance with their provider contract and any payment from us will be made to the billing Participating Provider.

Special Rules If You Are Enrolled In Our POS Deductible Open Access Plans

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.

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 web site at www.liveandworkwell.com.

If you have any questions about your claims, you should call our Members Services Department.

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the "Pre-Authorization And Pre-Certification 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.

Claims 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.
- 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, with the following exceptions:

- We will pay an ambulance company provider directly when there is a law that permits us to do so.
- We will reimburse the Non-Participating Provider directly when the covered services are rendered in Connecticut by the Non-Participating Provider for the diagnosis or treatment of a substance use disorder, if the provider is otherwise eligible for reimbursement under this Plan.

We may also pay you directly, if the Non-Participating Provider does not provide us with information that we request for claim payment.

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 web site at www.liveandworkwell.com.

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:

- 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.

Take a look at the “Managed Care Rules And Guidelines” section to see if you need to obtain a Referral or have to use Participating Providers and the “Pre-Authorization And Pre-Certification 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.

Assignment Of Benefits

Except for dental benefits, the benefits of this Plan are not transferable to any third party. When you or your Eligible Dependents see a Preferred Participating Provider or a Participating Provider, they will usually bill us directly. When you or your Eligible Dependents see a Non-Participating Provider for covered Health Services, other than covered Dental Services, we may choose to pay you or to pay the provider directly. To the extent allowed by law, we will not accept an assignment to a Non-Participating Provider.

QUESTIONS AND COMPLAINTS

You or your authorized representative can ask questions or send us complaints or Appeals 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 process is available, as outlined below.

APPEAL 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 on your behalf.

Of course, before pursuing the Appeal 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 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 process is divided into two categories.

1. One category deals with the **Medical Necessity Appeal** 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**, such as a decision that interprets the application of Plan rules and that does not relate to Medical Necessity.

In either case, the Appeal 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. 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
PO Box 4061**

Farmington, Connecticut 06034-4061

For all behavioral health Appeals, our behavioral health Delegated Program can be contacted as follows:

Telephone: 1-866-556-8166

Facsimile: 1-855-312-1470

**Optum-Appeals
P.O. Box 30512**

Salt Lake City, UT 84130-0512

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 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.

Take a look at the “Managed Care Rules And Guidelines” section to see if you need to obtain a Referral or have to use Participating Providers and the “Pre-Authorization And Pre-Certification 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.

You may contact the Commissioner of the State of Connecticut 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 process. Their contact information is as follows:

**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

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 that decision.

Our *internal* Appeal process is designed to resolve Appeals 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 Peer through our behavioral health Delegated Program).

1. We will investigate your Appeal 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. 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 to the independent review organization.

2. The independent review organization will arrange to have the Appeal 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 or 60 calendar days for post service Appeals.
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

You may file an Appeal 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.
- 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.

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the "Pre-Authorization And Pre-Certification 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 Urgent Requests

A decision on an urgent Appeal 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 involving a concurrent review request, your treatment shall be continued without liability to you until you have been notified of the review decision.

All Other Urgent Requests

A decision on an urgent Appeal will be made as soon as possible, taking into account your condition. If we receive all of the necessary information with your Appeal, you will receive a decision within two business days of receipt of all necessary information but **no later than 48 hours after we've received your Appeal or within 72 hours after receiving your request if any portion of the 48-hour period falls on a weekend**, 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 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 was received when the requested information is not provided to make the determination.

If the urgent Appeal 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 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 Process

If any of the following circumstances apply, you may be able to bypass our internal Appeal 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 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 and an expedited external review. The independent review organization will determine whether you will be required to complete the internal Appeal 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.

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the "Pre-Authorization And Pre-Certification 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.

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. 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.
5. You or your authorized representative will be provided with a written decision from the Independent Review Organization (IRO) 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, 48 hours for an expedited external review (except when any portion of the 48 hours falls in a weekend) or five calendar days for an expedited external review involving a health care service or treatment that is Experimental Or Investigational, from the IRO's receipt of the request. 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 from the IRO's receipt of the request.

Administrative (Non-Medical Necessity) Appeal

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 that decision.

1. If you file an Appeal, we will notify you not later than three business days after we receive your Appeal 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.
2. When the Appeal is received, it will be forwarded for review.
3. A staff member who was not involved in the original decision will review the Appeal.
4. You or your authorized representative will be provided with a written decision no later than 20 business days after we receive your Appeal 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.

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.

SPECIAL EXCHANGE PREMIUM PAYMENT RULES

Your Employer is responsible for paying Premium under this Plan. Payment of Premium is payable to the Exchange. The Exchange will have rules on how to do this.

1. All Premiums must be sent to us or the Exchange 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 or as described in the "Termination Of Your Employer's Coverage" subsection of the "Termination And Amendment" section. 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.

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the "Pre-Authorization And Pre-Certification 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.

Payment must reach us or the Exchange 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.
6. The Employer must notify us or the Exchange 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 or the Exchange in writing and can be done electronically, if the Employer typically transfers eligibility information electronically to us or the Exchange.

In the event the Employer fails to provide us or the Exchange 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 or the Exchange 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. We may establish reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of this Plan.
9. 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.
10. This document replaces all prior agreements and understandings relating to the subject matter. Except as otherwise described in this document, this document may be waived, discharged or ended only when done in writing and signed by the party against which enforcement of the waiver, discharge or termination is sought.

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the "Pre-Authorization And Pre-Certification 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.

11. 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.
12. 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.
13. In the event the Employer transfers eligibility information electronically to us or the Exchange 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 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 or the Exchange 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.
14. Participating Providers are not our employees or agents. They are independent contractors with the responsibility for determining and providing health care for their patients.
15. 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.
16. 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.
17. This Plan does not limit coverage for conditions just because you had the condition before you became covered under the Plan.
18. 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.
19. If you receive a Surprise Bill, we may not impose a Cost-Share or other out-of-pocket expense that is greater than the Cost-Share or other out-of-pocket expense that would be imposed if those services were rendered by a Participating Provider.

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the "Pre-Authorization And Pre-Certification 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.

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 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 during a "Special Enrollment Period" pursuant to applicable federal law.

APPEAL

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.

ARTIFICIAL LIMB

An Artificial Limb is a device to replace, in whole or part, an arm or a leg, including a device that contains a microprocessor. If such microprocessor-equipped device is determined by the Member's health care provider to be Medically Necessary.

AUTISM SPECTRUM DISORDERS (ASD)

The autism spectrum disorder as set forth in the most recent edition of the "Diagnostic and Statistical Manual of Mental Disorders."

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, and other decisions made under the terms of the Behavioral Health Program, such determinations, Pre-Authorizations or Pre-Certifications, 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 and consistent with the services and interventions designated by the Commissioner of Developmental Services pursuant to subsection (1) of section 17a-215c, as amended, 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 ASD services provider for each ten hours of Behavioral Therapy.

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the "Pre-Authorization And Pre-Certification 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.

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 manage 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.
- 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 a doctoral level psychology degree with training and 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 doctoral level psychology degree with training and 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.

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.

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the "Pre-Authorization And Pre-Certification 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 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.

CONNECTICARE, WE, US OR OUR

ConnectiCare Benefits, Inc., the health maintenance organization 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.

In addition, Deductibles, Copayments and/or Coinsurance amounts will not exceed the lesser of:

1. The amount paid to the provider or vendor for the covered Health Service, including all discounts, rebates, and adjustments by us or an intermediary,
2. An amount calculated based on how much the health service provider or vendor charges after any discount and any amount due to or charged by an entity affiliated with us, or
3. The amount a Member would have paid to the provider or vendor without using his or her insurance.

When calculating a Member's liability for Deductibles, Copayments, Coinsurance, or other out-of-pocket expenses for a covered Health Service, credit will be given for any discount provided or payment made by a third party for the amount of, or any portion of the amount of, Deductibles, Copayments, Coinsurance, or other out-of-pocket expenses for the covered Health Services, as required by applicable law.

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.

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

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the "Pre-Authorization And Pre-Certification 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 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 Deductible and shall be the Member's financial responsibility.

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, 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.

DIABETES DEVICES

A device, including, but not limited to, a blood glucose test strip, glucometer, continuous glucometer, lancet, lancing device or insulin syringe, that is a legend device or nonlegend device, and used to cure, diagnose, mitigate, prevent or treat diabetes or low blood sugar.

DIABETIC KETOACIDOSIS DEVICE

A device that is a legend or nonlegend device, and used to screen for or prevent diabetic ketoacidosis.

DRUG THERAPY

A product administered by a health care professional for use in the diagnosis, cure, treatment, or prevention of disease.

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the "Pre-Authorization And Pre-Certification 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.

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.

EXCHANGE (ACCESS HEALTH CT)

The Connecticut Health Insurance Exchange (access health CT) was established as a quasi-public agency to satisfy the requirements of the federal Affordable Care Act. The Exchange is a marketplace where eligible individuals and small groups will be able to shop for and purchase health insurance coverage.

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 (GENERIC)

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.

Take a look at the “[Managed Care Rules And Guidelines](#)” section to see if you need to obtain a Referral or have to use Participating Providers and the “[Pre-Authorization And Pre-Certification 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 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.
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.
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 an individual who is unable to conceive or produce conception or sustain a successful pregnancy during a period of one year or such treatment is Medically Necessary.

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 (if you are enrolled in one of our **Passage Plans** - a Plan that requires Referrals) to a Participating Provider. The In-Network Level Of Benefits under this Plan is described in the Member's Benefit Summary.

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the "Pre-Authorization And Pre-Certification 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.

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 Maximum Allowable Amount is the maximum amount of reimbursement we will allow for services and supplies:

- That are covered Health Services.
- That are Medically Necessary.
- That are provided in accordance with all applicable Pre-Authorization and/or Pre-Certification guidelines, utilization review or other requirements set forth in this member document.

The Maximum Allowable Amount may vary depending upon whether the provider is a Preferred Participating Provider or Participating Provider or a Non-Participating Provider.

The actual payment will be reduced by applicable Deductible(s), Coinsurance, Copayment(s), Benefit Reduction amounts and other applicable adjustments described in this document. In no case will our reimbursement exceed the maximum benefit described in this document except as required by law.

For a Preferred Participating Provider or Participating Provider covered Health Service, the Maximum Allowable Amount is the rate the provider has agreed with us to accept as reimbursement for a covered Health Service.

Except as required otherwise by law, for a Non-Participating Provider covered Health Service, the Maximum Allowable Amount may be determined, in our sole authority, by one of the following:

1. An amount based on reimbursement or cost information from the Centers for Medicare and Medicaid Services ("CMS"). When basing the Maximum Allowable Amount upon the level or method of reimbursement used by CMS, we will update such information, which is unadjusted for geographic locality, no less than annually.
2. An amount based on or derived from the total charges billed by the Non-Participating Provider.
3. 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.
4. 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.

Providers who are not contracted for a product, but are contracted for other products with us are also considered Non-Participating Providers. The Maximum Allowable Amount for services from these Non-Participating Providers will be one of the methods shown above, unless the contract between us and that provider specifies a different amount.

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the "Pre-Authorization And Pre-Certification 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 a Member receives covered Health Services from a provider, we will, to the extent applicable, apply claim processing rules to the claim submitted for those covered Health Services. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the procedure and diagnosis codes included in the claim. Applying these rules may affect our determination of the Maximum Allowable Amount. Our application of these rules does not mean that the covered Health Services a Member received were not Medically Necessary. It means we have determined that the claim was submitted inconsistent with procedure coding rules and/or reimbursement policies.

For example, your provider may have submitted the claim using several procedure codes when there is a single procedure code that includes all the procedures that were performed. When this occurs, the Maximum Allowable Amount will be based on the single procedure code, rather than a separate Maximum Allowable Amount for each billed code. Likewise, when multiple procedures are performed on the same day by the same provider, we may reduce the Maximum Allowable Amounts for those secondary and subsequent procedures because reimbursement at 100% of the Maximum Allowable Amount for those procedures would represent duplicative payment for components of the primary procedure that may be considered incidental or inclusive.

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.

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.
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.

Not elective and not for Cosmetic Treatment purposes.

MEDICARE

Title XVIII of the Social Security Act, including amendments.

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the "Pre-Authorization And Pre-Certification 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.

MEMBER, YOU, AND YOUR ELIGIBLE DEPENDENTS

A person enrolled in this Plan, including you and your Eligible Dependents.

NETWORK ACCESS AREA

Those geographic areas where contracted health care facilities, practitioners, and pharmacies provide benefits for covered Health Services under this Plan. To locate contracted health care facilities, practitioners, and pharmacies that are in the Network Access Area, visit our web site at <https://secured.connecticare.com/providerdirectory/>, or call the appropriate telephone number listed in the “Important Telephone Numbers And Addresses” section.

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.

NON-PREFERRED 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.

A Non-Preferred Participating Pharmacy is a pharmacy that when used by a Member typically provides a lower level of benefits, because out-of-pocket Cost-Shares are higher.

A Non-Preferred Participating Pharmacy does not include a Hospital pharmacy even if the Hospital is a Participating Hospital.

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. Except in cases of Emergencies or as otherwise provided in this document, Health Services obtained from or arranged by Non-Participating Providers, 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-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.

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.

Take a look at the “Managed Care Rules And Guidelines” section to see if you need to obtain a Referral or have to use Participating Providers and the “Pre-Authorization And Pre-Certification 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 PROVIDER

A health care practitioner or facility, including a Dentist, Participating Physician, Participating Pharmacy, Participating Hospital or other similar practitioner (including an advanced practice registered nurse) 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 and prescription drugs and supplies.

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.

PREFERRED PARTICIPATING PHARMACY

A select 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.

A Preferred 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 Preferred Participating Pharmacy does not include a Hospital pharmacy, even if the Hospital is a Participating Hospital.

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.

QUALIFIED HEALTH PLAN OR QHP

A health plan that has in effect a certification issued or recognized by each Exchange through which such health plan is offered.

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, and other decisions made under the terms of the Radiology Services Program, such determinations, Pre-Authorizations, 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), 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

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the "Pre-Authorization And Pre-Certification 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.

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.

RIDER

A written amendment that modifies the terms and conditions of this document.

SERVICE AREA

The State of Connecticut, including all cities and towns in the State of Connecticut.

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.

SURPRISE BILL

A bill for health care services that you receive for services rendered by a Non-Participating Provider, where those services were rendered by a Non-Participating Provider at a Participating Provider facility, during a service or procedure performed by a Participating Provider during a service or procedure previously Pre-Certified or Pre-Authorized by us and you did not knowingly elect to obtain those services from the Non-Participating Provider.

A Surprise Bill also includes a bill for clinical laboratory services, other than Emergency Services, that you receive for laboratory services rendered by a Non-Participating Provider, where those services were rendered by a Non-Participating Provider upon a referral by a Participating Provider.

A Surprise Bill does not include a bill for health care services received by you when a Participating Provider was available to render the services and you knowingly elected to obtain the services from a Non-Participating Provider.

TELEMEDICINE (TELEHEALTH)

Pursuant to Public Act 22-81, telemedicine means the mode of delivering health care or other health services via information and communication technologies to facilitate the diagnosis, consultation and treatment, education, care management and self-management of a patient's physical, oral and mental health, and includes interaction between the patient at the originating site and the telemedicine provider at a distant site, synchronous interactions, asynchronous store and forward transfers or remote patient monitoring.

Telemedicine does not include:

- Interaction through facsimile,
- Texting,
- Electronic mail, or
- Audio-only telephone, unless the telemedicine provider is a Participating Provider.

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 distinguished from an emergency department or primary care setting, which is duly licensed as an outpatient clinic to provide Urgent Care and that offers such services without the requirement of an appointment, provides services during times of the day, weekends, or holidays when primary care provider offices are not customarily open to patients, and offers, at a minimum, the following

- Ability to employ minimal resuscitative methods.
- Administration of fluids intravenously.
- Diagnostic imaging.

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the "Pre-Authorization And Pre-Certification 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.

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.

EXPLANATION OF BENEFITS (EOBS) DISCLOSURE ADDENDUM

We will issue Explanations of Benefits (EOBs) to Members covered under this Plan.

The Subscriber or a Member, if he or she is legally capable of consenting to the provision of covered Health Services, may make a written request that we not issue EOBs or that we issue EOBs solely to the Subscriber or to the Member and specify the preferred method of receipt for the EOB.

The preferred method may be:

- Mailing EOBs to the Subscriber's or Member's mailing address or another mailing address specified by the Subscriber or Member, or
- Making EOBs available to the Subscriber or Member through electronic means, provided the access is in compliance with applicable state and federal regulations pertaining to data security.

The preferred method noted above will be valid until the Subscriber or Member submits a written request for a different method.

Nothing in this disclosure will be construed to limit the Subscriber's or Member's ability to request review of an adverse determination.

NON-DISCRIMINATION DISCLOSURE ADDENDUM

ConnectiCare complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sexual orientation, gender or gender identity. ConnectiCare does not exclude people or treat them differently because of race, color, national origin, age, disability, or sexual orientation, gender or gender identity.

ConnectiCare:

- Provides free aids and services to people with disabilities to communicate effectively with us including qualified interpreters and information in alternate formats.
- Provides free language services to people whose primary language is not English, including translated documents and oral interpretation.

If you need these services, contact The Committee for Civil Rights.

If you believe that ConnectiCare has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: The Committee for Civil Rights, ConnectiCare, 175 Scott Swamp Road, Farmington, CT 06034, 1-800-251-7722, and TTY number 1-800-833-8134. You can file a grievance in person at 175 Scott Swamp Road, Farmington, CT, or by mail, or fax (860) 674-2232. If you need help filing a grievance, The Committee for Civil Rights is available to help you. You can also file a civil rights complaint with the U.S., Department of Health and Human Services, Office for Civil Rights, electronically through the Office of Civil Rights Complaint Portal, available at: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human services

200 Independence Avenue, SW

Room 509F, HHH Building

Washington, DC 20201

1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at:
<http://www.hhs.gov/ocr/office/file/index.html>.

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the "Pre-Authorization And Pre-Certification 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.

**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, visit our website at <https://secured.connecticare.com/providerdirectory/> or call us.

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, visit our website at <https://secured.connecticare.com/providerdirectory/> or call us.

PLAN DESCRIPTION ADDENDUM

This addendum, in conjunction with your member 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 electronic newsletter.

We are also accredited by the National Committee for Quality Assurance (NCQA).

The following information is a summary of our 2021 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 within our utilization review process. This information does not include review data for benefits managed or administered by an outside company under its own Connecticut utilization review license.

Utilization Review Data

	ConnectiCare Benefits, Inc.
Requests for Certification	41,006 (13.82%)
Certification Denials	8,129 (8.07%)
Number of Appeals of Denials	656 (8.73%)
Number of Denials Reversed Upon Appeal	478 (6.67%)

Below are the medical loss ratios for 2021.

Medical Loss Ratios

State Medical Loss Ratio

94.9%

Federal Medical Loss Ratio

96.2%

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 2021, 55.8% 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.

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the "Pre-Authorization And Pre-Certification 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.

PRE-AUTHORIZATION AND PRE-CERTIFICATION ADDENDUM

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

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) Prosthetics, Orthotics

DME including, but not limited to the following items (if a covered benefit): Customized wheelchairs, functional electric stimulators, high frequency chest wall oscillation devices, Bilevel (BiPAP), demand positive airway pressure (DPAP), variable positive airway pressure (VPAP), adaptive servoventilation (VPAP Adapt SV), auto-titrating positive airway pressure (AutoPap) and Continuous Positive (CPAP)

Orthotics

Prosthetics including, but not limited to major limbs

Elective Services & Surgical Procedures such as:

Applied Behavioral Analysis (ABA) for the treatment of Autism Spectrum Disorder (ASD) (if a covered benefit)*

Arthroplasty

Arthroscopy

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)

Cartilage implants (autologous chondrocyte implantation)

Clinical trials

Cochlear and other auditory implants

Congenital heart disease treatment

Cosmetic surgery/services used for Medically Necessary treatment (if a covered benefit)

Coverage at an in-network benefit level for out-of-network provider or facility unless services are due to an Emergency.

Craniofacial treatment

Deep brain stimulation

eClipse vaginal insert for fecal incontinence treatment

Foot surgery

Functional endoscopic sinus surgery

Gastric bypass surgery, including laparoscopic (if a covered benefit)

Gastric electrical stimulation

Gender reassignment surgery

Genetic testing*** to include BRCA

Interventional pain management services for chronic back pain (including, - facet and epidural injection, minimally invasive spine procedures and pain pumps), Sacroiliac joint injection **

Mammoplasty (breast augmentation or reduction) (non-mastectomy for cancer)

Oral appliances for the treatment of obstructive sleep apnea

Oral surgery (if a covered benefit)

Osteochondral grafting

Reconstructive surgery (not applicable to reconstructive surgery in conjunction with a mastectomy for breast cancer)

Sleep studies and treatment of sleep apnea

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)

Spinal cord stimulators for pain management

Spine surgery procedures (open and minimally invasive) including artificial intervertebral disc (if a covered benefit)**

Surgical correction of chest wall deformities

Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve

Vagus nerve stimulation

Varicose vein surgery (if a covered benefit)

Ventricular assist devices

Home Health Care:

Home health services including home health aides, skilled nursing visits, PT, OT, Speech, IV infusion

Hospice care

Infertility Services

Intensive Outpatient Treatment Programs (IOP)*

Insufficient Evidence of Therapeutic Value

Services, supplies, devices, or procedures for which there is Insufficient Evidence Of Therapeutic Value

Interventional Cardiology

Including, but not limited to: Implantable cardiac defibrillators, pacemakers, heart catheterizations, stress echocardiograms myocardial perfusion imaging**

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Outpatient Radiological Services (except when such radiological services are done in conjunction with a biopsy or other surgical procedure) such as:**

- Radiation therapy for cancer, including proton beam therapy
- 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
- Transesophageal echocardiology
- Transthoracic echocardiology

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)*

Psychological Testing Over 5 Hours (1 to 5 hours requires notification only)*

Transcranial Magnetic Stimulation*

Site of Service Programs:

Pre-Authorization may be required to determine the medically appropriate place of services (e.g., in a provider's office, in a Hospital, in a Hospital Outpatient Surgical Facility, in an Ambulatory Surgery Center) for procedures such as, but not limited to:

- Dermatology procedures
- Gastrointestinal procedures
- Ophthalmologic procedures
- Orthopedic procedures
- Urologic procedures

***Pre-Authorization is conducted by OptumHealth Behavioral Solutions - 1-888-946-4658**

****Pre-Authorization is conducted by NIA Magellan – 1-877-607-2363**

*****Pre-Authorization is conducted by eviCore - 1-888-835-2042**

You Need Pre-Authorization For The Following Prescription Drugs:

Abiraterone Acetate
Actemra
Actemra Actpen
Acthar
Acticlate
Actimmune
Actiq
Actonel
Actoplus Met
Actos
Acular
Acular Ls
Acyclovir
Aczone
Adalat Cc
Adapalene
Adbry
Adcetris
Adempas
Adhansia Xr
Advair Diskus
Advair Hfa
Adzenys Er
Adzenys Xr-Odt
Aimovig Autoinjector
Airduo Digihaler
Ajoy
Ajoy Autoinjector
Akliel
Ala-Scalp Hp
Aldurazyme
Alecensa
Allzital
Alocril
Alomide
Altabax
Altreno
Alunbrig
Alyq
Ambrisentan
Aminonide
Amerge
Amzeeq
Analpram-Hc
Anaprox Ds
Androderm
Apexicon E
Aplenzin
Apomorphine HCl
Apretude
Aptensio Xr
Arazlo
Arcalyst
Aricept
Arikayce

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Armodafinil	Calan Sr
Arthrotec	Calcipotriene-Betamethasone Dp
Arzerra	Calquence
Astagraf Xl	Cambia
Atelvia	Camzyos
Atgam	Capecitabine
Aubagio	Capex Shampoo
Austedo	Caprelsa
Avar-E Ls Cream	Carbaglu
Avidoxy Dk	Carbidopa
Avita	Carbinoxamine
Avonex Administration Pack	Cardura
Avonex Pen	Cardura Xl
Ayvakit	Carglumic Acid
Azelastine-Fluticasone	Carvykti
Azelex	Cayston
Azilect	Celecoxib
Azstarys	Centany
Bafiertam	Centany At
Balversa	Ceprotin
Banzel	Cequa
Bavencio	Cerdelga
Belbuca	Cerezyme
Beleodaq	Chemet
Belsomra	Chenodal
Benlysta	Cholbam
Benzaclin	Chorionic Gonadotropin
Benzamycin	Cibinqo
Beser	Ciclodan
Betamethasone Valerate	Cinryze
Betapace	Cleocin T
Betapace Af	Clindacin Etz
Betaseron	Clindacin Pac
Bethkis	Clindamycin Phos-Tretinoin
Bexarotene	Clobazam
Binosto	Clobetasol Emulsion
Bivigam	Clobetasol Propionate
Blincyto	Clobex
Boniva	Clodan
Bosentan	Cloderm
Bosulif	Clovique
Botox	Colestid
Braftovi	Cometriq
Breo Ellipta	Condylox
Briviact	Conzip
Bronchitol	Copaxone
Brukinsa	Copiktra
Bryhali	Cordran
Buphenyl	Coreg Cr
Buprenorphine	Coremino
Buprenorphine Hydrochloride	Corgard
Bydureon Bcise	Cotellic
Byetta	Cotempla Xr-Odt
Bylvay	Cresemba
Cablivi	Cutivate
Cabometyx	Cuvitru
Caduet	Cyclobenzaprine Hcl

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Cyclosporine	Dupixent Pen
Cystagon	Dutasteride
Cystaran	Dutasteride-Tamsulosin
Dacogen	Dyanavel Xr
Dalfampridine Er	Dymista
Daraprim	Dysport
Darzalex	Ec-Naprosyn
Daurismo	Edluar
Daypro	Egrifta Sv
Daytrana	Elaprase
Dayvigo	Elepsia Xr
Decitabine	Eligard
Deferasirox	Eliquis
Deferiprone	Emgality
Deferiprone (3 Times A Day)	Emgality Syringe
Demser	Empaveli
Depakote	Empliciti
Depakote Er	Enbrel
Depakote Sprinkle	Endari
Depen	Enjaymo
Depo-Testosterone	Enspryng
Derma-Smoothe-Fs	Enstilar
Desonide	Entyvio
Desoximetasone	Enzoclear
Desrx	Epclusa
Desvenlafaxine Er	Epidiolex
Desvenlafaxine Succinate Er	Epiduo Forte
Dexabliss	Epifoam
Dexamethasone	Epoprostenol Sodium
Dexedrine	Erbitux
Dexilant	Erivedge
Diacomit	Erleada
Dibenzylamine	Erlotinib Hcl
Diclofenac Sodium	Erwinase
Differin	Erwinaze
Diflorasone Diacetate	Esbriet
Dihydroergotamine Mesylate	Esgic
Dimethyl Fumarate	Esomeprazole Magnesium
Diprolene	Eucrisa
Diskets	Everolimus
Ditropan Xl	Evoclin
Dojolvi	Evrysdi
Donepezil Hcl	Exelon
Doptelet	Exkivity
Dovonex	Exservan
Doxepin Hcl	Eysuvis
Doxycycline Hyclate	Fabrazyme
Doxycycline Monohydrate	Farxiga
Dronabinol	Farydak
Droxidopa	Fasenra
Duetact	Fasenra Pen
Duexis	Faslodex
Dulera	Febuxostat
Duloxetine Hcl	Feldene
Duobrii	Fenofibrate
Duopa	Fenoglide
Dupixent	Fenoprofen Calcium

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Fentanyl	Horizant
Fentanyl Citrate	Humira
Ferriprox	Humira Pediatric
Ferrlecit	Hycamtin
Fetzima	Hydrocodone Bitartrate Er
Fexmid	Hydrocortisone Butyrate
Fibricor	Hydromorphone Er
Finacea	Hydroxyprogesterone Caproate
Fioricet	Hyqvia
Firdapse	Hysingla Er
Flebogamma Dif	Ibandronate Sodium
Flector	Ibrance
Flolan	Ibuprofen-Famotidine
Flolipid	Icatibant
Flomax	Iclusig
Flunisolide	Icosapent Ethyl
Fluocinonide	Idhifa
Fluoxetine Hcl	Ilaris
Flurandrenolide	Imatinib Mesylate
Fluticasone Propionate	Imbruvica
Fluticasone-Salmeterol	Imfinzi
Fluvoxamine Maleate	Imlygic
Fml	Impavido
Folotyn	Inbrija
Fortamet	Increlex
Forteo	Infed
Fortesta	Inflectra
Fosamax	Ingrezza
Fosamax Plus D	Ingrezza Initiation Pack
Prova	Injectafer
Fulvestrant	Inlyta
Galafold	Inova
Gammagard Liquid	Inova 4-1
Gammagard S-D	Inova 8-2
Gammaplex	Inveltys
Gamunex-C	Iressa
Gattex	Ivermectin
Gavreto	Ixempria
Gazyva	Jakafi
Gilenya	Jalyn
Gilotrif	Janumet
Glatiramer Acetate	Janumet Xr
Glatopa	Januvia
Glyxambi	Jardiance
Gonal-F	Jatenzo
Gonal-F Rff	Jevtana
Gonal-F Rff Redi-Ject	Jornay Pm
Gralise	Jublia
Grastek	Juxtapid
Haegarda	Jynarque
Halaven	Kadcyla
Halcinonide	Kalbitor
Halog	Kalydeco
Hc Pramoxine	Kanuma
Hetlioz	Kapvay
Hetlioz Lq	Karbinal Er
Hidex	Kenalog

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Kerendia
 Kesimpta Pen
 Ketoprofen
 Keveyis
 Keytruda
 Kimmtrak
 Kitabis Pak
 Klaron
 Korsuva
 Koselugo
 Krystexxa
 Kuvan
 Kynmobi
 Lacrisert
 Lamictal Xr
 Lansoprazole
 Lapatinib
 Latanoprost
 Lemtrada
 Lenalidomide
 Lenvima
 Lescol Xl
 Leukine
 Licart
 Lidocaine
 Linezolid
 Livalo
 Livmarli
 Livtency
 Lodine
 Lodosyn
 Lonsurf
 Lopressor
 Lorbrema
 Lorzone
 Lotemax
 Lotemax Sm
 Lovaza
 Lumakras
 Lumigan
 Lumizyme
 Lupron Depot
 Lupron Depot-Ped
 Luxiq
 Lynparza
 Makena
 Marinol
 Mavenclad
 Mayzent
 Mekinist
 Mektovi
 Meloxicam
 Metformin Hcl
 Metformin Hcl Er
 Methadone Hcl
 Methadose
 Methergine

Methylergonovine Maleate
 Methylphenidate Er
 Metrocream
 Metrogel
 Metyrosine
 Miglustat
 Migranal
 Minocycline Hcl Er
 Minolira Er
 Mirvaso
 Mobic
 Modafinil
 Mometasone Furoate
 Monodox
 Morgidox
 Morphine Sulfate Er
 Ms Contin
 Mupirocin
 Myalept
 Mydayis
 Myfembree
 Myobloc
 Naglazyme
 Nalfon
 Namenda
 Namzaric
 Naprelan
 Naprosyn
 Naproxen
 Naproxen Sodium Er
 Naproxen-Esomeprazole Mag
 Nascobal
 Natesto
 Natpara
 Nayzilam
 Nerlynx
 Neuac
 Nexavar
 Nexletol
 Nexlizet
 Nexvazyme
 Nilandron
 Nilutamide
 Ninlaro
 Nitisinone
 Nityr
 Nocdurna
 Nolix
 Nourianz
 Noxafil
 Nplate
 Nubeqa
 Nucala
 Nucort
 Nuedexta
 Nuplazid
 Nurtec Odt

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Obredon	Procardia Xl
Ocaliva	Procrit
Ocrevus	Proctocort
Octagam	Proleukin
Octreotide Acetate	Promacta
Odactra	Proscar
Odomzo	Protopic
Ofev	Prudoxin
Olux	Psorcon
Olux-E	Pulmozyme
Omega-3 Acid Ethyl Esters	Pyrimethamine
Omeprazole-Sodium Bicarbonate	Pyrukynd
Oncaspar	Qudexy Xr
Onexton	Questran
Onfi	Questran Light
Opdualag	Quillichew Er
Opsumit	Quillivant Xr
Opzelura	Qulipta
Oralair	Ragwitek
Orenitram Er	Rasuvo
Orfadin	Ravicti
Oriahnn	Rayos
Orilissa	Razadyne Er
Orkambi	Rebif
Orladeyo	Rebif Rebidose
Oseni	Relafen
Osmolex Er	Relexxii
Otezla	Relistor
Oxervate	Remodulin
Oxtellar Xr	Repatha Pushtronex
Oxycontin	Repatha Sureclick
Oxymorphone Hcl Er	Repatha Syringe
Oxytrol	Restasis
Ozempic	Restasis Multidose
Palynziq	Retevmo
Pandel	Retin-A
Pantoprazole Sodium	Retin-A Micro Pump
Paroxetine Er	Revatio
Paroxetine Mesylate	Revlimid
Paxil	Reyvow
Paxil Cr	Rezurock
Pemazyre	Rhofade
Penicillamine	Ribavirin
Perjeta	Rilutek
Phenoxybenzamine Hcl	Riluzole
Pimecrolimus	Rinvoq
Pirfenidone	Riomet
Plegridy	Riomet Er
Pomalyst	Ritalin La
Ponvory	Rosadan
Posaconazole	Roszet
Pramosone	Rozlytrek
Pramoxine Hcl W/Hydrocortisone	Rubraca
Pregabalin Er	Ruconest
Prestalia	Rufinamide
Pretomanid	Ruzurgi
Privigen	Rybelsus

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Rydapt	Synjardy
Rylaze	Synjardy Xr
Ryvent	Synribo
Sabril	Syprine
Sajazir	Tabrecta
Samsca	Taclonex
Sandostatin	Tacrolimus
Sapropterin Dihydrochloride	Tadalafil
Savella	Tafinlar
Scalacort Dk	Tagrisso
Segluromet	Takhzyro
Serostim	Taltz Autoinjector
Seysara	Taltz Autoinjector (2 Pack)
Signifor	Taltz Autoinjector (3 Pack)
Sildenafil Citrate	Taltz Syringe
Silenor	Talzenna
Simponi	Taperdex
Simponi Aria	Tarceva
Sirturo	Targadox
Sivextro	Targretin
Skyrizi	Tarpeyo
Skyrizi (2 Syringes) Kit	Tasigna
Skyrizi Pen	Tasmar
Sod Ferric Gluconate Complex	Tavaborole
Sodium Phenylbutyrate	Tavalisse
Soliris	Tazarotene
Solodyn	Tazverik
Somatuline Depot	Tegsedi
Somavert	Temodar
Soolantra	Temovate
Spritam	Temozolomide
Sprix	Tenoretic
Sprycel	Tenormin
Steglatro	Teriparatide
Steglujan	Testopel
Stelara	Testosterone
Stivarga	Testosterone Cypionate
Strensiq	Testosterone Enanthate
Stromectol	Tetrabenazine
Sucraid	Texacort
Sular	Thalomid
Sumatriptan Succ-Naproxen Sod	Thiola
Sunitinib Malate	Thiola Ec
Sunosi	Tibsovo
Sutent	Tiglutik
Sylvant	Tiopronin
Symbicort	Tobi Podhaler
Symdeko	Tobramycin Sulfate
Symlinpen 120	Tolcapone
Symlinpen 60	Tolmetin Sodium
Sympazan	Tolvaptan
Synagis	Topicort
Synalar	Topiramate Er
Synalar Ts	Topotecan HCl
Synarel	Tosymra
Syndros	Tovet Emollient
Synera	Tracleer

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Tramadol HCl Er	Vimizim
Travoprost	Vimpat
Tremfya	Vistogard
Treprostinil	Vitrakvi
Tretinoin	Vizimpro
Tretinoin Microsphere	Vogelxo
Tretin-X	Vonjo
Triamcinolone Acetonide	Voriconazole
Trianex	Vosevi
Triderm	Votrient
Tridesilon	Voxzogo
Trientine Hcl	Vumerity
Trijardy Xr	Vyndamax
Trikafta	Vyndaqel
Trilipix	Vyvanse
Trintellix	Vyzulta
Triptodur	Wakix
Tritocin	Welireg
Trokendi Xr	Wixela Inhub
Trudhesa	Wynzora
Trulicity	Xalkori
Tukysa	Xarelto
Turalio	Xeljanz
Tussicaps	Xeljanz Xr
Tuzistra Xr	Xeloda
Twynéo	Xeomin
Tykerb	Xepi
Tymlos	Xermelo
Tyrvaya	Xgeva
Tysabri	Xhance
Tyvaso	Xifaxan
Ubrelvy	Xigduo Xr
Ukoniq	Xiidra
Unituxin	Xolair
Uptravi	Xospata
Valchlor	Xtandi
Valtoco	Xuriden
Vanoxide-HC	Xyosted
Vascepa	Yervoy
Vecamyl	Yonsa
Vectibix	Zaltrap
Veletri	Zarxio
Venclexta	Zcort
Venclexta Starting Pack	Zejula
Venlafaxine HCl Er	Zelboraf
Venofer	Zembrace Symtouch
Ventavis	Zepatier
Verelan	Zeposia
Verelan Pm	Zerviate
Verzenio	Ziac
Vfend	Ziana
Vfend Iv	Zileuton
Vibramycin	Zokinvy
Viekira Pak	Zoladex
Vigabatrin	Zolinza
Vigadrone	Zolmitriptan
Vijoice	Zolpimist

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Zomig
Zonalon
Zontivity
Zorbtive
Zovirax
Ztlido
Zydelig
Zyflo
Zykadia
Zypitamag
Zynox

Specialty Drugs:

Specialty drugs that require Pre-Authorization should only be filled through specialty pharmacies that are Participating Pharmacies, unless you qualify for an exception. The list of specialty drugs that have this requirement is, as follows. 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**

Growth Hormone including:

Serostim
Zorbtive

Blood Clotting Factors including:

Ceprothin
Tavalisse

Hepatitis C treatments including:

Epclusa
Viekira Pak
Vosevi

LHRH Agonists including:

Eligard
Zoladex

Multiple Sclerosis Treatments including:

Aubagio
Avonex
Bafiertam
Betaseron
Copaxone
Gilenya
Glatiramer
Glatopa
Mavenclad
Mayzent
Ocrevus
Rebif
Vumerity

Other Drugs including:

Acthar Gel
Actimmune
Aldurazyme
Arcalyst
Arzerra
Atgam

Bivigam
Bronchitol
Bylvay
Carbaglu
Carglumic
Cerdelga
Cinryze
Cuvitru
Dacogen
Dalfampridine Er
Darzalex
Decitabine
Deferasirox
Dojolvi Liquid
Droxidopa
Dupixent
Dysport
Elaprase
Empliciti
Enspryng
Entyvio
Epidiolex
Erbitux
Erwinaze
Esbriet
Evrysdi
Fabrazyme
Fasenra
Faslodex
Flebogamma Dif
Folotyn
Fulvestrant
Galafold
Gammagard Liquid
Gattex
Gazyva
Haegarda
Halaven
Hetlioz
Icatibant
Ilaris
Imfinzi
Increlex
Inflectra
Jevtana
Kadcyla
Kalbitor
Kalydeco
Kuvan
Leukine
Lumizyme
Miglustat
Myalept
Myobloc
Naglazyme
Natpara
Nucala

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Nuplazid
 Ocaliva
 Ofev
 Oncaspar
 Orkambi
 Oxervate
 Palynziq
 Perjeta
 Pirfenidone
 Proleukin
 Ravicti
 Ribavirin
 Ruconest
 Sajazir
 Samsca
 Signifor
 Soliris
 Somatuline Depot
 Somavert
 Sylvant
 Symdeko
 Synagis
 Takhzyro
 Tegsedi
 Tetrabenazine
 Thalomid
 Topotecan
 Trikafta
 Tysabri
 Valchlor
 Vectibix
 Vimizim
 Voxzogo
 Vyndaqel
 Xeomin
 Xolair
 Yervoy
 Zaltrap
 Zarxio
 Zepatier
 Zeposia

Oral Oncology Agents Including:

Alecensa
 Alunbrig
 Bosulif
 Cabometyx
 Capecitabine
 Cotellic
 Daurismo
 Erivedge
 Erleada
 Erlotinib Hcl
 Farydak
 Gilotrif
 Hycamtin
 Ibrance
 Idhifa

Imatinib Mesylate
 Inlyta
 Ixemptra
 Jakafi
 Lapatinib
 Lenvima
 Lonsurf
 Lorbrema
 Lumakras
 Lynparza
 Mekinist
 Nerlynx
 Nexavar
 Ninlaro
 Nubeqa
 Odomzo
 Pomalyst
 Retevmo
 Revlimid
 Rozlytrek
 Rydapt
 Sprycel
 Stivarga
 Sutent
 Tabrecta
 Tafinlar
 Tagrisso
 Talzenna
 Tarceva
 Tassigna
 Temodar
 Temozolomide
 Tykerb
 Verzenio
 Vioice
 Vitrakvi
 Vizimpro
 Votrient
 Xalkori
 Xeloda
 Xtandi
 Yonsa
 Zelboraf
 Zolanza
 Zykadia

**Psoriasis/Rheumatoid
 Treatments including:**

Actemra
 Benlysta
 Enbrel
 Humira
 Ibandronate
 Krystexxa
 Otezla
 Rinvoq
 Simponi
 Skyrizi

Arthritis/Crohn's Disease

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Stelara
Taltz
Tremfya
Tymlos
Xeljanz

Pulmonary Hypertension Drugs including:

Adempas
Ambrisentan
Bosentan
Flolan
Opsumit
Orenitram
Remodulin
Revatio
Sildenafil
Tracleer
Treprostinil
Tyvaso
Uptravi
Veletri
Ventavis

Infertility Drugs including:

Gonal-F

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.

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