ConnectiCare

ConnectiCare Insurance Company Inc.

Individual Market
FlexPOS Platinum Alternative
Benefit Summary
Non-Tiered Network Plan

FlexPOS Network - Includes Providers in Connecticut, New York through EmblemHealth Prime and Nationally through First Health network

Deductible and Out-of-Pocket Maximum	**In-Network (INET) Member Pays**	**Out-of-Network (OON) Member Pays**
Plan deductible Individual Family	$1,200 per member $2,400 per family	$5,000 per member $10,000 per family
Separate Prescription Drug Deductible Individual Family	$200 per member $400 per family	$350 per member $700 per family
Out-of-Pocket Maximum Individual Family (Includes deductible, copayments and coinsurance)	$3,000 per member $6,000 per family	$8,000 per member $16,000 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)	$20 copayment per visit	50% coinsurance per visit after OON plan deductible is met
Telemedicine Services (services rendered by a Teladoc® provider)	No cost	50% coinsurance per visit after OON plan deductible is met
Specialist Office/Telemedicine Visits	$30 copayment per visit	50% coinsurance per visit after OON plan deductible is met
Mental Health and Substance Abuse Office Visits	$20 copayment per visit	50% coinsurance per visit after OON plan deductible is met
Outpatient Diagnostic Services		

Benefits	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Advanced Radiology (CT/PET Scan, MRI)	$70 copayment per service up to a combined annual maximum of $350 for MRI and CAT scans; $400 for PET scans after INET plan deductible is met at a Hospital Facility $70 copayment per service up to a combined annual maximum of $350 for MRI and CAT scans; $400 for PET scans at a Freestanding Facility	50% coinsurance per service after OON plan deductible is met
Laboratory Services	$10 copayment per service	50% coinsurance per service after OON plan deductible is met
Non-Advanced Radiology (X-ray, Diagnostic)	$40 copayment per service	50% coinsurance per service after OON plan deductible is met
Mammography Ultrasound	$40 copayment per service	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	$5 copayment per prescription	50% coinsurance per prescription after OON prescription drug deductible is met
Preferred Brand Drugs Tier 2	$20 copayment per prescription	50% coinsurance per prescription after OON prescription drug deductible is met
Non-Preferred Brand Tier 3	$60 copayment per prescription after INET prescription drug deductible is met	50% coinsurance per prescription after OON prescription drug deductible is met
Specialty Drugs Tier 4	50% coinsurance up to a maximum of $250 per prescription after INET prescription drug deductible is met	50% coinsurance per prescription after OON prescription drug deductible is met
Prescription – Mail Order Pharmacy (up to a 90 day supply per prescription)		
Generic Drugs Tier 1	$10 copayment per prescription	50% coinsurance per prescription after OON prescription drug deductible is met
Preferred Brand Drugs Tier 2	$40 copayment per prescription	50% coinsurance per prescription after OON prescription drug deductible is met
Non-Preferred Brand Tier 3	$120 copayment per prescription after INET prescription drug deductible is met	50% coinsurance per prescription after OON prescription drug 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	$30 copayment per visit	50% coinsurance per visit after OON plan deductible is met
Physical and Occupational Therapy	$25 copayment per visit	50% coinsurance per visit after OON plan deductible is met
Other Services		
Chiropractic Services (up to 20 visits per calendar year)	$40 copayment per visit	50% coinsurance per visit after OON plan deductible is met
Diabetic Equipment and Supplies	10% coinsurance per equipment/ supply	50% coinsurance per equipment/ supply after OON plan deductible is met
Durable Medical Equipment (DME)	10% coinsurance per equipment/ supply	50% coinsurance per equipment/ supply after OON plan deductible is met
Home Health Care Services (up to 100 visits per calendar year)	No cost	25% coinsurance per visit after separate $50 deductible is met
Outpatient Services (in a hospital or ambulatory facility)	10% coinsurance per visit after INET plan deductible is met at an Outpatient Hospital Facility $200 copayment per visit at an Ambulatory Facility	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 calendar year)	10% 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	0% coinsurance after INET plan deductible is met	0% coinsurance after INET plan deductible is met
Emergency Room	$100 copayment per visit after INET plan deductible is met	$100 copayment per visit after INET plan deductible is met
Urgent Care Centers	$50 copayment per visit	50% coinsurance per visit after OON plan deductible is met
Pediatric Dental Care (for children under age 26)		
Diagnostic & Preventive	No cost	50% coinsurance per visit after OON plan deductible is met

Benefits	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Basic Services	20% coinsurance per visit	50% coinsurance per visit after OON plan deductible is met
Major Services	20% coinsurance per visit	50% coinsurance per visit after OON plan deductible is met
Orthodontia Services (medically necessary only)	20% coinsurance per visit	50% coinsurance per visit after OON plan deductible is met
Pediatric Vision Care (for children under age 26)		
Prescription Eye Glasses (one pair of frames and lenses or contact lens per calendar year)	Lenses: $0 Collection frame: $0 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	Not covered
Routine Eye Exam by a Specialist (one exam per calendar year)	$40 copayment per visit	50% coinsurance per visit after OON plan deductible is met
Additional Covered Services		
Adult Routine Eye Exam by a Specialist - over age 26 (one exam per calendar year)	$40 copayment per visit	50% coinsurance per visit after OON plan deductible is met
Allergy Injections (up to 20 visits per year)	See primary care or specialist office visits	50% coinsurance per visit after OON plan deductible is met
Allergy Testing (up to one visit per year)	See primary care or specialist office visits	50% coinsurance per visit after OON plan deductible is met
Artificial Limbs (includes associated supplies and equipment)	10% coinsurance	50% coinsurance after OON plan deductible is met
Outpatient mental health, alcohol and substance abuse treatment (intensive outpatient treatment and partial hospitalization)	No cost	50% coinsurance per visit after OON plan deductible is met
Retail Clinic	$20 copayment per visit	50% coinsurance per visit after OON plan deductible is met

Important information

- This is a brief summary of benefits. Refer to your ConnectiCare Insurance Company, Inc. policy for complete details on benefits, conditions, limitations and exclusions. All benefits described are per member per calendar year.
- Mammogram screenings, breast ultrasounds, and breast MRIs – Please refer to the policy 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 policy 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®** 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 Insurance Company, Inc. policy for more information.
- 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 drugs or supplies clinical effectiveness and cost, not on whether it is a generic drug or supply or brand name drug or supply.
- 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, coinsurance or cost share maximum.
- Most specialty drugs are dispensed through specialty pharmacies by mail, up to 30-day supply. Specialty Pharmacies have the same member cost share as all other participating pharmacies and are not part of the ConnectiCare's Voluntary Mail Order program.
- Many services require that you obtain our Pre-Certification or Pre-Authorization prior to obtaining care prescribed or rendered by Non-Participating providers or a benefit reduction may apply. Without pre-authorization you may be responsible for the total cost of the service or benefits may be reduced by the lesser of $500 or 50%. Refer to the "Pre-Authorization and Pre-Certification Addendum" in your policy for more details.
- 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 for 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.

Broker Compensation Disclosure

Premiums for all individual policies include the cost of using a licensed insurance broker to assist individuals in selecting a plan. Insurance brokers are paid a monthly per member per month fee of $15 up to a maximum of $45 per application.

2022

CONNECTICARE INSURANCE COMPANY, INC.

FLEXPOS

INDIVIDUAL EXCHANGE POLICY

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

WELCOME TO CONNECTICARE!

Thank you for choosing ConnectiCare. We look forward to providing you with the responsive customer service that our Members have come to expect from us and working 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.

RIGHT OF POLICY EXAMINATION

You are permitted to return this Policy by delivering or mailing it to the agent or broker through whom it was purchased, or to us at the mailing address noted above within ten days after the date of delivery if, after examination of this Policy, you are not satisfied with it for any reason. If you return this Policy, it will be deemed void from the beginning and any and all claims paid will be retracted and any Premiums paid will be refunded.

GUARANTEED RENEWABLE

This Policy is guaranteed renewable provided the following requirements are satisfied:

- You continue to meet the eligibility requirements described in the "Eligibility And Enrollment" section of this Policy,
- You continue to pay the Premium due, as described in the "Premium Payment" section of this Policy, and
- Your membership has not been terminated, as described in the "Termination And Amendment" section of this Policy.

We may make changes to the benefits and/or Premium rates while this Policy is in effect:

- As described in the "Termination And Amendment" section of this Policy, or
- When renewed.

If we make any changes to the benefits, the changes apply to services that start on or after the Effective Date of this Policy. These changes (including any decrease in benefits or removal of benefits) apply to:

- Any claims or expenses,
- Incurred services, or
- Supplies furnished.

There are no vested rights to receive any benefits described in this Policy after the date this Policy changes or terminates. This applies even if the claim or expense took place after this Policy changes or ends but before you received the changed or new plan documents.

Policy Form CBI-CICI/FlexPOS IND 01 (1/2022) Policy Product Option Form: HIX CICI/FlexPOS IND 01 (1/2022)
Approved for use beginning 2022
s:/gmas2022 member documents main folder/cbi - cici exchange/2022/individual exchange/2022 cici flexpos ind exchange policy.doc

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 Or Determining Your Eligibility Or Premium Assistance And Cost-Share Reductions

Connecticut Health Insurance Exchange (access health CT)
(855) 805-4325

or

Connecticut Health Insurance Exchange
450 Capitol Avenue, MS#52HIE
Hartford, CT 06106-1379, 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

Post-Acute Care Services (Skilled Nursing Facility Admissions And Home Health Care Services)
844-359-5388

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 (general questions and complaints except for the Behavioral Health Program or the Connecticut Health Insurance Exchange)
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

Premium Payment Address
ConnectiCare, Inc.
PO Box 21849
New York, New York 10087-1849

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.

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.

Hindi

ध्यान द: य□द आप हदी बोलते ह तो आपके िलए मुफ्त म भाषा सहायता सेवाएं उपलब्ध ह। 1-800-251-7722 and TTY number 1-800-833-8134 पर कॉल कर।

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

ប្រយ័ត្ន៖ បើអ្នកនិយាយភាសា ខ្មែរ, សេវាជំនួយភាសា សេវាមិនគិតថ្លៃ មានសម្រាប់អ្នក។ ចូរ ទូរស័ព្ទ1-800-251-7722 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 the 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.

TABLE OF CONTENTS

IMPORTANT TELEPHONE NUMBERS AND ADDRESSES 2
INTRODUCTION 3
MEMBERS' RIGHTS AND RESPONSIBILITIES 5
YOUR RIGHTS 5
YOUR RESPONSIBILITIES 5
POLICY 10
ACCEPTANCE OF AGREEMENT 10
CONNECTICARE ID CARD 10
COVERAGE 10
ELIGIBILITY AND ENROLLMENT 11
ELIGIBILITY RULES 11
General Rules About You (The Subscriber) 11
General Rules About Your Eligible Dependents 11
ADDING ELIGIBLE DEPENDENTS 12
Adding A New Spouse 12
Adding A Domestic Partner 12
Adding New Children 13
EFFECTIVE DATE OF COVERAGE 13
GENERAL RULE 13
OPEN ENROLLMENT PERIODS 13
Annual Open Enrollment 13
Special Enrollment Period 13
Effective Date Of Special Open Enrollment Period 15
Special Effective Date Rules 16
WHEN A MEMBER IS AN INPATIENT AT THE TIME OF ELIGIBILITY 16
APPLICATION OF POLICY TO HEALTH SERVICES 16
CHANGES AFFECTING ELIGIBILITY 16
ELIGIBILITY FOR ADVANCE PAYMENTS OF PREMIUM TAX CREDIT OR REDETERMINATIONS OF ELIGIBILITY 16
MANAGED CARE RULES AND GUIDELINES 17
SELECTION OF A PRIMARY CARE PROVIDER (PCP) 17
WHEN YOU NEED SPECIALIZED CARE 17
CONTINUITY OF CARE 17
SERVICES REQUIRING PRE-AUTHORIZATION OR PRE-CERTIFICATION 18
The Pre-Authorization Or Pre-Certification Process 18
When Being Treated By A Preferred Participating Provider Or Participating Provider 18
When Being Treated By A Non-Participating Provider 18
Changes To The Pre-Authorization Or Pre-Certification Lists 18
When Pre-Authorization Or Pre-Certification Is Denied 18
Benefit Reduction 18
Benefit Reduction Amounts 18
Benefit Reduction Exception 18
PROVIDER NETWORKS 19
Participating Provider Network 19
In-Network Level Of Benefits 19
Using A Participating Provider 19
Out-Of-Network Level Of Benefits 19
Using A Non-Participating Provider 19
Other Network Providers 19
Exceptions When You Still Receive The In-Network Level Of Benefits 19
Preferred Participating Provider, Participating Provider And Network Provider General Rules 20
BENEFITS FOR STUDENTS, WHILE TRAVELING AND AFTER-HOURS CARE 21
Students 21
While Traveling 21
After-Hours Care 21
COST-SHARES YOU ARE REQUIRED TO PAY 22
Amount Of In-Network Level Of Benefits 22
Amount Of Out-Of-Network Level Of Benefits 22
Deductibles 22
Plan Deductibles 22
In-Network Level Of Benefits Plan Deductible 22
Out-Of-Network Level Of Benefits Plan Deductible 22
Combination In-Network and Out-Of-Network Level Of Benefits Plan Deductible 23
How Plan Deductibles Are Met 23
Benefit Deductible 23
More About Deductibles 23
Copayments 24
Coinsurance 24
More Information About Deductibles And Coinsurance 24
Maximums 24
Benefit Maximums 24
Coinsurance Maximum 24
In-Network Level Of Benefits Coinsurance Maximum 24
Out-Of-Network Level Of Benefits Coinsurance Maximum 25
Combination In-Network And Out-Of-Network Level Of Benefits Coinsurance Maximum 25
Cost-Share Maximums 26
In-Network Level Of Benefits Cost-Share Maximum 26
Out-Of-Network Level Of Benefits Cost-Share Maximum 26
Combination In-Network And Out-Of-Network Level Of Benefits Cost-Share Maximum 27
Out-Of-Pocket Maximum 27
In-Network Level Of Benefits Out-Of-Pocket Maximum 27
Out-Of-Network Level Of Benefits Out-Of-Pocket Maximum 28
Combination In-Network and Out-Of-Network Level Of Benefits Out-Of-Pocket Maximum 28
MEDICAL NECESSITY AND APPROPRIATE SETTING FOR CARE 29
UTILIZATION MANAGEMENT 29
QUALITY ASSURANCE 29
NEW TREATMENTS 30

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.

EXPERIMENTAL OR INVESTIGATIONAL....30
Certain Investigational Items Outside Of Clinical Trials....31
INSUFFICIENT EVIDENCE OF THERAPEUTIC VALUE....31
DELEGATED PROGRAMS....31
BENEFITS....32
PREVENTIVE SERVICES....32
Routine Medical Exams And Preventive Care....32
Infants/Children....32
Preventive Care Medical Services....32
Routine Eye Care....32
Adults....32
Preventive Care Medical Services....32
Gynecological Preventive Exam Office Services32
Routine Dental Care (Over Age 26)....32
Routine Eye Care....33
Preventive Exams And Preventive Care Limitations....33
Pediatric Dental Care (Under Age 26)....33
Diagnostic Services....33
X-Rays....33
Preventive....33
Restorative....33
Restorative-Crowns....33
Endodontics....33
Periodontics....33
Prosthodontics -Removable....33
Prosthodontics Adjustment....33
Prosthodontics Fixed....33
Dental Implants....33
Extractions....33
Bony Impactions....33
Orthodontics....33
General Services....34
Routine Cancer Screenings....34
Blood Lead Screening Exams And Risk Assessments....34
Lead Screening Exams....34
Risk Assessments....34
Cervical Cancer Screening (Pap Tests)....34
Colorectal Cancer Screenings....34
Mammogram Screenings....34
Prostate Screening....35
Routine Cancer Screening Limitations....35
Other Preventive Services....35
Hearing Screenings....35
Immunizations....35
Newborn Care....35
AMBULATORY SERVICES (OUTPATIENT)....35
BEHAVIORAL HEALTH (MENTAL HEALTH SERVICES)....35
Inpatient Mental Health Services....35
Inpatient Alcohol And Substance Abuse Disorder Services....35
Outpatient Mental Health And Alcohol And Substance Abuse Disorder Treatment....36
EMERGENT/URGENT CARE....36
Ambulance/Medical Transport Services....36
Emergency Services....36
Non-Emergency Services....36
Emergency Services....36
Urgent Care/Walk-In Care....36
Urgent Care....36
Walk-In Care....36
INPATIENT SERVICES....37
Dental Anesthesia....37
Hospital Services....37
Pre-Certification Rules For Non-Emergencies....37
General Hospitalizations....37
Mastectomy Services....37
Maternity Services....37
Inpatient Services....37
Post-Discharge Benefits....37
Optional Early Discharge Programs....38
Skilled Nursing And Rehabilitation Facilities....38
Skilled Nursing And Rehabilitation Facilities Limitations....38
Solid Organ Transplants And Bone Marrow Transplants....38
Transplant Pre-Authorization Rules....38
Donor Benefits....38
Testing for Bone Marrow....39
Transportation, Lodging And Meal Expenses For Transplants....39
OTHER SERVICES....39
Artificial Limbs....39
Disposable Medical Supplies And Durable Medical Equipment (DME), Including Prosthetics....39
Disposable Medical Supplies....39
Durable Medical Equipment (DME), Including Prosthetics....40
Disposable Medical Supplies And Durable Medical Equipment (DME), Including Prosthetics Exclusions And Limitations....40
Home Health Services....41
Ostomy Supplies And Equipment....41
Ostomy Supplies Limitations....41
OUTPATIENT SERVICES....41
Allergy Testing....41
Chiropractic Services....42
Gynecological Office Services....42
Laboratory Services....42
Maternity Care Office Services....42
Outpatient Habilitative Therapy And Rehabilitative Therapy, Including Physical, Occupational and Speech Therapy....42
Primary Care Provider Office Services....42
Radiological Services....43
Specialist Office Services....43
PRESCRIPTION DRUGS....43
Benefits....43
Additional Benefits....44
Over-The-Counter (OTC) Medications....44
Specialty Drugs....44
Guidelines....45
Certain Prescription Drugs/Supplies Require Pre-Authorization....45
When A Participating Provider Writes A Prescription....45

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 45
Always Use Your ID Card 45
Pharmacy Network 46
Using A Participating Pharmacy 46
Using A Non-Participating Pharmacy 46
Prescription Drug Programs 46
Advanced Opioid Management Program 46
Generic Substitution Program 47
Tiered Cost-Share Program 47
Mandatory Drug Substitution Program 48
Mandatory Drug Limitations Program 48
Voluntary Mail Order Program 48
Clinically Equivalent Alternative Drugs Or Supplies Program 49
Cost-Share Waiver Programs 49
Member Cost-Sharing 49
Benefit Limits 50
Fill Or Refill Limit 50
Fills For Contraceptive Drugs 50
Lyme Disease Treatment Limit 50
Exception Review For A Non-Covered Clinically Appropriate Drug 50
Expedited Review (Exigent Circumstances) 50
Standard Review (Non-Exigent Circumstances) 51
External Exception Request Review 51
Prescription Drug General Conditions 51
ADDITIONAL SERVICES 51
Autism Services 51
Birth To Three Program (Early Intervention Services) 52
Cardiac Rehabilitation 52
Casts And Dressing Application 52
Clinical Trials 52
Corneal Pachymetry 52
Craniofacial Disorders 53
Diabetes Services 53
Education 53
Prescription Drugs And Supplies 53
Drug Ingestion Treatment (Accidental) 53
Drug Therapy (Outpatient/Home) 53
Eye Care 54
Diseases And Abnormal Conditions Of The Eye 54
Eyeglasses And Contact Lenses 54
Genetic Testing 54
Health Management And Incentive Programs 55
Health Management Programs 55
Incentive Programs 55
Hospice Care 55
Hospital Care 55
Infertility Services 55
Benefits 55
Rules 56
Lyme Disease Services 56
Neuropsychological Testing 56
Nutritional Counseling 56
Nutritional Supplements And Food Products 56
Enteral Or Intravenous Nutritional Therapy 56
Modified Food Products For Inherited Metabolic Diseases 57
Other Specialized Formulas 57
Observation Beds 57
Pain Management Services 57
Renal Dialysis 57
Sleep Studies 57
Surgery And Other Care Related To Surgery 57
Anesthesia Services 57
Breast Implants 57
Oral Surgery Services 57
Reconstructive Surgery 58
Sterilization 58
Termination Of Pregnancy 58
Telemedicine Services 58
Wound Care Supplies 58
Wound Care Supplies for Epidermolysis Bullosa 58
EXCLUSIONS AND LIMITATIONS 59
OTHER INSURANCE, RIGHTS OF RECOVERY, SUBROGATION AND REIMBURSEMENT AND MEDICARE ELIGIBILITY 67
OTHER INSURANCE 67
Automobile Insurance Policies 67
Workers' Compensation 67
Rights To Receive And Release Necessary Information 68
Facility Of Payment 68
RIGHTS OF RECOVERY 68
SUBROGATION AND REIMBURSEMENT 68
MEDICARE ELIGIBILITY 68
TERMINATION AND AMENDMENT 69
WHEN A MEMBER TERMINATES COVERAGE 69
Effective Dates Of Termination 69
TERMINATION OF COVERAGE FOR OTHER REASONS 69
AMENDMENT 70
CLAIMS FILING, QUESTIONS AND COMPLAINTS, AND APPEAL PROCESS 70
CLAIMS FILING 70
Claims From A Participating Provider 70
Claims From A Non-Participating Provider 70
Payment To Custodial Parent 71
Claims For Emergency Services 71
If You Are Covered By Another Insurance Plan 71
Refund To Us Of Overpayments 71
Assignment Of Benefits 71
QUESTIONS AND COMPLAINTS 72
APPEAL PROCESS 72
Medical Necessity Appeal 73
Internal Appeal Process 73
Urgent Care Appeals 73
Behavioral Health Urgent Requests 73
All Other Urgent Requests 74
Bypassing The Internal Appeal Process 74
External Review And Expedited External Review 74
Administrative (Non-Medical Necessity) Appeal 75
PREMIUM PAYMENT 75

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.

GRACE PERIODS....76
Standard Grace Period....76
Advance Payment Of The Premium Tax Credit (APTC) Grace Period....76
GENERAL PROVISIONS....76
DEFINITIONS....77
NON-DISCRIMINATION DISCLOSURE ADDENDUM....89
PATIENT PROTECTION AND AFFORDABLE CARE ACT (PPACA) ADDENDUM....90
PRIMARY CARE PROVIDERS (PCP)S....90
PLAN DESCRIPTION ADDENDUM....90
PRE-AUTHORIZATION AND PRE-CERTIFICATION ADDENDUM....91

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.

POLICY

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

This Policy includes this document and the following documents.

- Exchange enrollment form.
- Benefit Summary.
- Riders and supplementary inserts, if any.

No statement by you in your application shall void this Policy or be used in any legal proceeding unless such application or an exact copy thereof is included in or attached to this Policy.

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 Policy 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 Policy. It is written according to the laws of the State of Connecticut, including rules, regulations or other standards set forth by the Exchange and/or the State of Connecticut Insurance Department (Department). We have the discretion to define and interpret the terms of this Policy and determine eligibility for plan benefits in accordance with our policies and procedures and in accordance with applicable state and federal law.

ACCEPTANCE OF AGREEMENT

This means that you agree to all the provisions of this Policy, including any Riders, when you receive Plan benefits, when you pay Premium to us for coverage under this Plan, and maintain this Policy more than ten days after it is delivered to you.

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 or pharmacy. 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

The Exchange enrollment form and any other forms we request must be received by us before a Qualified Individual can be considered a Member under this Plan.

You are responsible for providing to us information about yourself and your dependents that is complete, accurate and true to the best of your knowledge and belief. Coverage is being provided to you under this Plan on the basis that you are a Qualified Individual and the information that you have provided to us is truthful. If you make a fraudulent or intentional misrepresentation of a material fact, coverage may be cancelled. In the event that there is a change in the name(s), address, telephone number(s) or email address(es) that you have provided to us, you are responsible for telling us as soon as possible about the change(s).

The Exchange enrollment form and any other forms or statements that we request, must be received and accepted by us before the Qualified Individual will be considered for membership under this Plan. We reserve the right to accept or deny requested coverage based on the completion of an Exchange enrollment form by the Qualified Individual. A proof of insurability statement must be completed by the Qualified Individual. If additional information is requested and is not received by us within 45 days of the request, the Qualified Individual may be asked to reapply. If a Qualified Individual is denied coverage under this Plan, he/she cannot re-apply for coverage for up to 12 months, as determined by us.

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 AND ENROLLMENT

ELIGIBILITY RULES

Your eligibility and the eligibility of your family members for coverage in this Plan as Qualified Individuals are determined by the Exchange.

The Exchange will determine if you and your dependents can enroll in this Plan as a Qualified Individual. The Exchange uses the following eligibility rules to make that determination.

If you have any questions about enrollment, you may contact the Exchange at the telephone number listed in the "Important Telephone Numbers And Addresses" section.

Citizenship

A Qualified Individual must be:

- A citizen of the United States, or
- A national of the United States, or
- A non-citizen who is lawfully present in the United States, and reasonably expected to be a citizen, national, or a non-citizen who is lawfully present for the entire benefit period.

Incarceration

A Qualified Individual must not be incarcerated (in prison), other than in prison pending the completion of charges.

Residency

The person applying for coverage must reside or intend to reside in the Exchange Service Area of this Plan.

General Rules About You (The Subscriber)

You (the Subscriber) are eligible for coverage under this Plan as a Qualified Individual because you are:

1. A resident of the Exchange Service Area of this Plan.
2. Not eligible for or enrolled in Medicare at the time of the application, or

   Are not renewing in a different policy or contract of insurance which would duplicate benefits of Medicare Part A or Medicare Part B.
3. Listed as the applicant on the application.
4. Approved by the Exchange.

General Rules About Your Eligible Dependents

Your Eligible Dependents are eligible for coverage under this Plan as Qualified Individuals if they are:

1. Your **spouse** – Your spouse must have a legally valid existing marriage license or valid existing civil union as accepted by the State of Connecticut, and your spouse must live with you or in the Exchange Service Area of this Plan. Your spouse must not be eligible for or enrolled in Medicare.
2. 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 in the Exchange Service Area 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.
   - Your domestic partner must not be eligible for or enrolled in Medicare.

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

In addition, we require that a signed "Affidavit of Domestic Partnership" or other satisfactory certification as we determine, be returned to us with the Application/Change Form as a condition of enrollment. "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 Policy.

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. Your **child** – Your child may be eligible for coverage under this Plan until the end of the last day of this Plan's Renewal Date that is after his/her 26th birthday as long as his/her birthday is not the same day as the first day of the Renewal Date. If you child's 26th birthday is the first day of this Plan's Renewal Date, 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, or children for whom your spouse is appointed legal guardian, can be covered.
   - **Guardianship**. Children for whom you are appointed the legal guardian can be covered.
   - **Handicapped Children**. To continue to be covered beyond the allowable age for dependent children, the child must:
     - ♦ Live in the Exchange Service Area of this Plan; and
     - ♦ 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; and
     - ♦ Be dependent on you or your spouse for support and care because he/she has a mental or physical handicap; and
     - ♦ Have become handicapped and must have always been handicapped while he/she would have been able to be signed up for dependent children coverage if he/she were not disabled.

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

   Qualified Medical Child Support Orders. Special rules apply when a court issues a QMCSO requiring you to provide health insurance for your child. Enrollment may be required even in circumstances in which the child was not previously enrolled in this Plan and might not otherwise be eligible for coverage. We will not require the children to live with you, but they must live in the State of Connecticut in order to be covered.

ADDING ELIGIBLE DEPENDENTS

Adding A New Spouse

1. If you get married, you must apply for coverage to add your new spouse to this Plan within 60 days of the date of marriage. Your spouse's eligibility for coverage is subject to him/her being a Qualified Individual and our acceptance based on review of the information on your new spouse's Exchange enrollment form and his/her meeting the Plan's eligibility requirements and our underwriting criteria.
2. Coverage for your new spouse will begin on his/her Effective Date. You are not required to wait until the next open enrollment period to apply for coverage for your new spouse.

Adding A Domestic Partner

1. If your domestic partner meets all of the conditions described in the "Eligibility Rules" subsection of the "Eligibility And Enrollment" section, you must apply for coverage to add him/her to this Plan. Your partner's eligibility for coverage is subject to him/her being a Qualified Individual and our acceptance based on review of the information on your new domestic partner's Exchange enrollment form and his/her meeting the Plan's eligibility requirements and our underwriting criteria.
2. Coverage for your domestic partner will begin on his/her Effective Date. You are not required to wait until the next open enrollment period to apply for coverage for your domestic partner.

Adding New Children

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. 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.

EFFECTIVE DATE OF COVERAGE

GENERAL RULE

The payment of Premium and the Exchange enrollment form, and any other forms or statements the Exchange or we need, must be received and accepted by the Exchange or us before a Qualified Individual will be considered for membership under this Plan.

Your right to coverage for you and your dependents is subject to the condition that all of the information you provide is true, correct and complete to the best of your knowledge and belief. In addition, you are responsible for providing notification of all name and address changes.

This Policy will take effect on the Effective Date, subject to the payment of Premium and the completion and acceptance of the Exchange enrollment form. If not received, this Policy will be deemed void, and we will not have any responsibility for all claims incurred by you or your dependents after that date. Premiums received by us after the last day of the grace period will not be accepted. You must meet our eligibility rules.

OPEN ENROLLMENT PERIODS

Annual Open Enrollment

An annual open enrollment period, as established by the rules of the Exchange, is provided for Qualified Individuals and enrollees.

During an open enrollment, Qualified Individuals may enroll in a Qualified Health Plan (QHP), and enrollees may change QHPs according to rules established by the Exchange.

Qualified Individuals are only permitted to enroll in a QHP, or as an enrollee to change QHPs, during the annual open enrollment period or a special enrollment period when the Qualified Individual has experienced a qualifying event.

American Indians may move from one QHP to another QHP once per month.

Special Enrollment Period

A special enrollment period is a period during which a Qualified Individual or enrollee who experiences certain qualifying events or changes in eligibility may enroll in, or change enrollment in, a QHP through the Exchange, or another individual plan outside of the Exchange.

Unless otherwise specified, a Qualified Individual or enrollee has 60 days from the date of one of the following triggering events to select this Plan.

The Exchange will allow individuals to enroll in or change from one QHP to another as a result of the following triggering events:

1. A Qualified Individual or dependent loses Minimum Essential Coverage.

   Loss of Minimum Essential Coverage includes loss of eligibility for coverage as a result of:

   - Legal separation or divorce,
   - Cessation of dependent status, such as attaining the maximum age,
   - Death of a Subscriber, or
   - Any loss of eligibility for coverage after a period that is measured by reference to any of the following:
     - ♦ Individual who no longer resides in the Exchange Service Area for this Plan, and
     - ♦ A situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual.

   Loss of Minimum Essential Coverage **does not** include termination or loss due to:

   - Failure to pay Premiums on a timely basis, or
   - Voluntarily ending prior Minimum Essential Coverage, or
   - Situations allowing for a rescission such as fraud or intentional misrepresentation of material fact.

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.

2. A Qualified Individual gains a dependent or becomes a dependent through:
   - Birth,
   - Adoption,
   - Placement for adoption,
   - Placement for foster care,
   - Marriage,
   - Child support order, or
   - Other court order
3. An individual, who was not previously a citizen, national, or lawfully present individual gains such status.
4. A Qualified Individual's enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Exchange or HHS, or its instrumentalities as determined by the Exchange. When this occurs, the Exchange may take action, as may be necessary, to correct or eliminate the effects of the error, misrepresentation or inaction.
5. An enrollee adequately demonstrates to the Exchange that the QHP in which he/she is enrolled substantially violated a material provision of its contract in relation to the enrollee.
6. An individual is determined newly eligible for Advance Payments Of Premium The Tax Credit or has a change in eligibility for Cost-Sharing reductions, regardless of whether the individual is already enrolled in a QHP.

   The Exchange will permit individuals whose existing coverage through an eligible employer-sponsored plan will no longer be affordable or provide minimum value for his/her employer's upcoming plan year to access this special enrollment period prior to the end of his/her coverage through such eligible employer-sponsored plan.
7. An individual is determined newly eligible for Advance Payments Of The Premium Tax Credit due to a decrease in income.

   The special enrollment period will only be available to a Qualified Individual and dependents if:
   - The household combined income decreased,
   - Both the Qualified Individual and dependents are determined new eligible by the Exchange, and
   - The Qualified Individual and dependents had Minimum Essential Coverage for at least one day in the 60 days prior to the change in income.

   The Exchange may require proof of both a decrease in household income and prior health coverage.
8. An individual is determined newly *ineligible* for Advance Payments Of The Premium Tax Credit.

   The special enrollment period will only be available to a Qualified Individual and dependents if:
   - The Qualified Individual is enrolled in a silver metal level Qualified Health Plan (QHP).
   - He or she wishes to change to a QHP one metal level higher or lower.
9. A Qualified Individual or enrollee gains access to a new QHP as a result of a permanent move or becoming or gaining a dependent through marriage, where the Qualified Individual or enrollee was enrolled in Minimum Essential Coverage for at least one day in the 60 days preceding the date of the permanent move or marriage. Individuals previously living outside the United States (U.S.) or in a U.S. territory, individuals who are released from incarceration and individuals living in a service area where no QHP was available are not required to have any previously enrolled in Minimum Essential Coverage.
10. An American Indian, as defined by federal regulation, may enroll in a QHP or change from one QHP to another one time per month.
11. An American Indian, as defined by federal regulation, who is a dependent of an American Indian, as defined by federal regulation, and is enrolled or is enrolling in a QHP through the Exchange on the same application as the Indian, may change from one QHP to another QHP one time per month, at the same time as the Indian.
12. A Qualified Individual or enrollee demonstrates to the Exchange that he/she meets other exceptional circumstances as the Exchange may provide.
13. A Qualified Individual or enrollee experiences any COBRA qualifying event.
14. An individual has a non-calendar year plan and that plan ends.
15. A Qualified Individual who is the victim of domestic abuse or spousal abandonment as defined by federal regulations, including a dependent on the same application, or unmarried victim within a household, who is enrolled in Minimum Essential Coverage and seeks to enroll in coverage separate from the person who caused the abuse or abandonment.
16. A Qualified Individual or enrollee who applies for coverage on the Exchange during the annual open enrollment period or due to a qualifying event and is assessed by the Exchange as potentially eligible for Medicaid or the Children's Health Insurance Program (CHIP) but is determined ineligible for Medicaid or CHIP by the state Medicaid or CHIP agency either after the open enrollment period has ended or more than 60 days after the qualifying event.

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.

17. A Qualified Individual who applies for coverage at the state Medicaid or CHIP agency during the open enrollment period and demonstrates that they have been determined to be ineligible for Medicaid or CHIP after the open enrollment period has ended.
18. A Qualified Individual or enrollee, or his or her dependent, adequately demonstrates to the Exchange that a material error related to plan benefits, Service Area or Premium influenced the Qualified Individual's or enrollee's decision to purchase a QHP through the Exchange.
19. At the option of the Exchange, the Qualified Individual provides evidence to verify his or her eligibility for an insurance affordability program or enrollment in a QHP through the Exchange following termination of Exchange enrollment due to a failure to verify such status within the time period specified in the federal regulations, or who is under 100% of the federal poverty level and did not enroll in coverage while waiting for the U.S. Department of Health and Human Services to verify his or her citizenship, status as a national, or lawful presence.
20. A Qualified Individual who becomes pregnant and is certified by a licensed health care provider acting within the scope of his or her provider's practice not more than 30 days after the date of the pregnancy. This special enrollment period is limited to Qualified Individuals who do not have, at a minimum, essential health benefits as determined under the federal Patient Protection and Affordable Care Act (PPACA).
21. A Qualified Individual gains access to an Individual Coverage Health Reimbursement Arrangement (ICHRA). This special enrollment period is limited to a situation when his or her employer eliminates its group health plan and provides the Qualified Individual or enrollee with an ICHRA, as a funding vehicle for purchasing coverage in the individual market.
22. A Qualified Individual gains access to a Qualified Small Employer Health Reimbursement Arrangement (QSEHRA). This special enrollment period is limited to Qualified Individuals who are covered under a non-calendar year plan.
23. A Qualified Individual who is not currently enrolled in coverage through the Exchange and qualifies for a special enrollment period and has a dependent enrolled in the Exchange may be added to a dependent's current Qualified Health Plan (QHP) or if the QHP's business rules do not allow the Qualified Individual to enroll in the dependent's QHP, the Qualified Individual may enroll into another QHP within the same metal level.
24. Complete cessation of a Qualified Individual's employer contributions to Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage.

    In this case, the qualifying event would be the last day of the period for which COBRA coverage was paid for, in whole or in part, by the employer.
25. A Qualified Individual did not receive timely notice of a triggering event and was otherwise reasonably unaware that a qualifying event to select a QHP occurred.

    In this case, the Qualified Individual will be able to select a new QHP within 60 days of the date the Qualified Individual knew of the occurrence of the triggering event and also be permitted to select the earliest effective date for which the enrollee would have been eligible for coverage had the Qualified Individual received timely notice of the qualifying event.

Effective Date Of Special Open Enrollment Period

When the Exchange receives the Qualified Individual's selection to enroll in this Plan between the 1st and the 15th of the month, the Effective Date for coverage is the 1st day of the month following the date the Exchange receives a Qualified Individual's selection to enroll in this Plan.

For example, when a completed Exchange enrollment form is received and accepted by the Exchange on May 14th, the Qualified Individual's Effective Date will be June 1st.

Generally, when the Exchange receives the Qualified Individual's selection to enroll in this Plan between the 16th and the last day of the month, the Effective Date for coverage is the 1st day of the 2nd month following the date the Exchange receives a Qualified Individual's selection to enroll in this Plan.

For example, when a completed Exchange enrollment form is received and accepted by the Exchange on May 16th, the Qualified Individual's Effective Date will be July 1st.

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 Effective Date Rules

In the case of birth, adoption, placement for adoption, placement for foster care, a child support order or other court order, the individual may select an Effective Date as of the date as of the birth, adoption, placement for adoption placement for foster care, a child support order or other court order or the 1st of the month following the date of the plan selection for adoption, placement for adoption, placement for foster care, child support order or other court order, or a regular Effective Date as described in the "Effective Date Of Special Open Enrollment Period" subsection, above.

Where a Qualified Individual loses Minimum Essential Coverage, as described in paragraph 1 of this "Special Enrollment Period" subsection, the Effective Date will be on the 1st day of the month following loss of coverage if plan selection is on or before loss of coverage. If plan selection is after loss of coverage, the Effective Date is the 1st day of the month after plan selection.

In the case of marriage, the Effective Date is the 1st day of the month following plan selection.

In the case of pregnancy, the Effective Date is the 1st day of the month in which the Member receives certification not more than 30 days after commencement of the pregnancy from a licensed health care provider that she is pregnant.

In the case of a permanent move, the Effective Date is the 1st day of the month following the move if Plan selection is made on or before the day of the move.

Where the death of a Subscriber or Eligible Dependent results in a special enrollment period, the Effective Date is the 1st of the month following Plan selection or a regular Effective Date as described in the "Effective Date Of Special Open Enrollment Period" subsection, above.

When A Member Is An Inpatient At The Time Of Eligibility

If you or your covered dependents become eligible for coverage under this Plan while an inpatient at a Hospital, Hospice, Skilled Nursing Facility, Rehabilitation Facility or Residential Treatment Facility, the coverage under this Plan will be effective, but this Plan will not cover the costs of that Hospitalization or inpatient stay or any medical care relating to that Hospitalization or inpatient stay if these costs are the responsibility of a previous carrier. You should notify us when an inpatient stay under these circumstances occurs.

Application Of Policy To Health Services

This Policy replaces the prior policy or agreement, if any, between you and us. This Policy applies to health care services rendered on and after the Effective Date of this Policy. Medically Necessary health services and supplies are not covered if the patient is not enrolled as a Member under this Plan at the time the service or supply is rendered or received.

Changes Affecting Eligibility

You, or your authorized representative, must tell us or the Exchange about any change that may affect you or your dependents covered under this Plan within 31 days of the date of that change. 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.
- Change of home address.
- Loss of eligibility for other reasons specified in this document.

Changes should be indicated on an Exchange enrollment form at www.accesshealthct.com. You must return the Exchange enrollment form to your broker or to the Exchange.

Eligibility For Advance Payments Of Premium Tax Credit Or Redeterminations Of Eligibility

You should contact the Exchange for information about your eligibility for Advance Payments Of Premium Tax Credit or Redeterminations of your eligibility and that of your Eligible Dependents.

The Exchange telephone number is listed in the "Important Telephone Numbers And Addresses" 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.

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 Preferred Participating Providers or 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 Preferred Participating Provider or 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 Preferred Participating Provider or Participating Provider. In this circumstance, we will notify each "continuing care patient" with respect to the Preferred Participating Provider or Participating Provider at the time of termination, notice of termination and your right to elect transitional care from such Preferred Participating Provider or Participating Provider.

For the purpose of this provision, a "**continuing care patient**" means a Member who, with respect to a Preferred Participating Provider or 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 Preferred Participating Provider or 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 Preferred Participating Providers or 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 Preferred Participating Provider or 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 Preferred Participating Provider or 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 Preferred Participating Provider Or Participating Provider

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

When Being Treated By A Non-Participating Provider

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

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

You can find the list of Health Services, including prescription drugs that need Pre-Certification or Pre-Authorization 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 under this Plan if you or your Eligible Dependents receive services or supplies after Pre-Authorization or Pre-Certification has been denied.

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

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

Benefit Reduction

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

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

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.

PROVIDER NETWORKS

Some Plan options include a network of Participating Providers and other Plan options include a network of Preferred Participating Providers and Participating Providers.

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

Participating Provider Network

If your Plan has the Participating Provider network, you are free to use either Participating Providers or Non-Participating Providers to obtain covered Health Services; however, you will pay different levels of Cost-Shares (Copayments, Coinsurance, and/or Deductibles) depending on the practitioner or facility that provides covered Health Services.

This table highlights the way the Participating Provider 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 Provider	Lower Member Cost
Non-Participating Provider	Highest Member Cost

In-Network Level Of Benefits

Using A Participating Provider

When you and your Eligible Dependents use a Participating Provider benefits are covered at the In-Network Level Of Benefits and the out-of-pocket Cost-Share amount you pay is lower than what you would have to pay if you were to use a Non-Participating Provider.

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

To locate a Participating Provider, you can refer to our Provider Directory, visit us at our web site at https://secured.connecticare.com/providerdirectory/, or call us.

Out-Of-Network Level Of Benefits

Using A Non-Participating Provider

When you use a Non-Participating Provider for covered Health Services benefits are covered at the Out-Of-Network Level Of Benefits and the out-of-pocket costs will be higher than they would be if you were to use a Participating Provider.

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

Other Network Providers

When a Member is out of the Network Access Area, that Member will be eligible for a higher level of benefits under this Plan, as long as he or she obtains covered Health Services from Network Providers.

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

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

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

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

In addition, in very limited circumstances, if we determine Medically Necessary services are not available from a Preferred Participating Provider, Participating Provider (or a Network Provider when you are outside of the Network Access Area) without unreasonable travel or delay for the Member, you can obtain the In-Network Level Of Benefits for care received from a Non-Participating Provider. But to do that, **you will need written Pre-Authorization BEFORE you obtain the care from the Non-Participating Provider**. Pre-Authorization to obtain care from a Non-Participating Provider at the In-Network Level Of Benefits will be given only if **both** of the following conditions are met:

- 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 Preferred Participating Provider, Participating Provider (or a Network Provider when you are outside of the Network Access Area).
- We or, as appropriate, our Delegated Program have determined, at our discretion, Medically Necessary services are not available from a Preferred Participating Provider, Participating Provider or a Network 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.

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

By telephone: 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.

Preferred Participating Provider, Participating Provider And Network Provider General Rules

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

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

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

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

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

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

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

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

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

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 FOR STUDENTS, WHILE TRAVELING AND AFTER-HOURS CARE

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

Students

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

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

In those instances, covered Health Services include:

- **Allergy shots**

  Your child can arrange to have allergy shots while at school. When a Preferred Participating Provider or 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.

- **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.

While Traveling

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

- Emergency Services.
- Urgent Care.

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

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

After-Hours Care

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

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

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.

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 Preferred Participating Provider, Participating Providers (or Network Providers when you are out of the Network Access Area) render Medically Necessary care. In general, you are required to pay a Copayment for the In-Network Level Of Benefits before the In-Network Level Of Benefits is paid, but some benefits require you to pay a Benefit Deductible first.

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

Amount Of Out-Of-Network Level Of Benefits

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

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

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

Deductibles

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

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

Plan Deductibles

In-Network Level Of Benefits Plan Deductible

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

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

Out-Of-Network Level Of Benefits Plan Deductible

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

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

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

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

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

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

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

How Plan Deductibles Are Met

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

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

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

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

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

An applicable family (when you and at least two other persons are covered under your Plan) In-Network Level Of Benefits Plan Deductible and the family (three or more Members) Out-Of-Network Level Of Benefits Plan Deductible are met by **combining the total expenses for Health Services incurred by each family member**, up to the applicable family Plan Deductible amount as specified on your Benefit Summary. There may be an individual maximum on this amount. Please refer to your Benefit Summary for any maximums.

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

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

Benefit Deductible

This Plan may have a specific Benefit Deductible that applies separately to certain benefits. For example, this Plan may have a prescription drug Benefit Deductible. When this Plan does have a Benefit Deductible, that Benefit Deductible must be individually met by you or your Eligible Dependents each year before we will begin paying for those benefits. Anything paid by Members towards a Benefit Deductible does not count towards meeting any Plan Deductible amounts.

More About Deductibles

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

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

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

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.

Copayments

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

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

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.

More Information About Deductibles And Coinsurance

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

Maximums

Benefit Maximums

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

Coinsurance Maximum

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

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

In-Network Level Of Benefits Coinsurance Maximum

If this Plan has an In-Network Level Of Benefits Coinsurance Maximum, that Coinsurance Maximum includes all Coinsurance amounts paid by the Member in a year for benefits to Preferred Participating Providers, Participating Providers (or by Network Providers when out of the Network Access Area), 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 the Coinsurance amounts he/she paid for services to Preferred Participating Providers, Participating Providers (or by Network Providers when out of the Network Access Area) add up to the individual In-Network Level Of Benefits Coinsurance Maximum.

The family In-Network Level Of Benefits Coinsurance Maximum is met if the Coinsurance amounts that Member and all of the Members in the family who are covered by the Plan paid for services to Preferred Participating Providers, Participating Providers (or by Network Providers when out of the Network Access Area) add up to the family In-Network Level Of Benefits Coinsurance Maximum. 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.

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-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 to Non-Participating Providers (or by Network Providers when in the Network Access Area), 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 the Coinsurance amounts paid by that Member for services paid to Non-Participating Providers (or by Network Providers when in the Network Access Area) add up to the individual Out-Of-Network Level Of Benefits Coinsurance Maximum.

The family Out-Of-Network Level Of Benefits Coinsurance Maximum is met by the total Coinsurance amounts that Member and all of the Members in the family who are covered by the Plan paid to Non-Participating Providers (or by Network Providers when in the Network Access Area) add up to the family Out-Of-Network Level Of Benefits Coinsurance Maximum.

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, 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.

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. 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.

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

In-Network Level Of Benefits Cost-Share Maximum

If this Plan has an In-Network Level Of Benefits Cost-Share Maximum, that Cost-Share Maximum includes all Copayment and Coinsurance amounts paid by the Member in a year for benefits to Preferred Participating Providers, Participating Providers (or by Network Providers when out of the Network Access Area), 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 the Copayment and Coinsurance amounts he/she paid to Preferred Participating Providers, Participating Providers (or by Network Providers when out of the Network Access Area) add 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 the Members in the family who are covered by the Plan to Preferred Participating Providers, Participating Providers (or by Network Providers when out of the Network Access Area) add 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.

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 to Non-Participating Providers (or by Network Providers when in the Network Access Area), 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 the Copayment and Coinsurance amounts paid by that Member for services paid to Non-Participating Providers (or by Network Providers when in the Network Access Area) add up to the per Member Out-Of-Network Level Of Benefits Cost-Share Maximum.

The family 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 paid to Non-Participating Providers (or by Network Providers when in the Network Access Area) add 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.

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.

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, 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 add 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 for a Member and all of the Members in the family who are covered by the Plan if the Copayment and Coinsurance amounts add up to the 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.

Out-Of-Pocket Maximum

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

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

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

The In-Network Level Of Benefits Out-Of-Pocket Maximum is the Member's maximum payment liability per year for services (**including prescription drug coverage**) covered at the In-Network Level Of Benefits.

The In-Network Level Of Benefits Out-Of-Pocket Maximum is met for a Member if his or her individual In-Network Level Of Benefits Out-Of-Pocket Maximum is met by the eligible amounts paid by that Member for services paid at the In-Network Level Of Benefits or if the family In-Network Level Of Benefits Out-Of-Pocket Maximum is met by the total eligible amounts paid by that Member and all of the members in his or her family who are covered by the Plan. There may be an individual maximum on this amount. Please refer to your Benefit Summary for any maximums.

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

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

- Amounts a Member pays toward any non-covered Health Services, or
- Amounts a Member pays toward any Out-Of-Network Level Of Benefits, or
- 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 (**including prescription drug coverage**) covered at the Out-Of-Network Level Of Benefits.

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

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

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

- Amounts a Member pays toward any non-covered Health Services, or
- Amounts a Member pays toward any In-Network Level Of Benefits, or
- 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.

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

The combination In-Network Level Of Benefits and Out-Of-Network Level Of Benefits Out-Of-Pocket Maximum is the Member's maximum payment liability per year for covered Health Services, (**including prescription drug coverage**).

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

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

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

- Amounts a Member pays toward any non-covered Health Services, or
- 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. At our discretion, development of alternative individual plans may include coverage of otherwise non-covered services or supplies.

UTILIZATION MANAGEMENT

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

QUALITY ASSURANCE

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

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

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

Take a look at the "Managed Care Rules And Guidelines" section to see if you 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 and in our discretion, cover a New Treatment for Members in the same or similar circumstances before our determination is made. Once we complete our review, if we determine the New Treatment should be covered, those New Treatments rendered **AFTER** our determination will be covered. There will be no retroactive coverage of a New Treatment.

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

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

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

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

EXPERIMENTAL OR INVESTIGATIONAL

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

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

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

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

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

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, in our sole discretion, that either:

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

There may be Insufficient Evidence Of Therapeutic Value for a Treatment even when it has been approved by a regulatory body or recommended by a health care practitioner.

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

Delegated Programs

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

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

BENEFITS

Benefits for Medically Necessary Health Services provided under this Plan are subject to all the rules of this document, 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 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 in a 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 infants/children 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 Dental Care (Over Age 26)

Some Plan options provide adults over age 26 with coverage for the following routine dental care when provided in the office of Dentist:

- Preventive examinations that help stop oral disease from occurring, including:
  - Visits (two times per year).
  - Consultations (one within a six-month consecutive period) and only after primary teeth erupt.
  - Routine cleanings (two times per year).
- X-rays, including:
  - Full mouth x-rays, or
  - Panoramic x-rays at 36-month intervals,
  - Bitewing x-rays at six-month intervals, and
  - Other x-rays, if Medically Necessary and only after primary teeth erupt.

To determine whether your Plan provides these adult preventive dental benefits and the Cost-Shares amounts you are required to pay for those benefits, consult 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.

Routine Eye Care

Routine eye care for adults 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:

- Any dental service, procedure, or treatment modality not specifically listed in the "Routine Dental (Over Age 26)" subsection.
- Services which are covered to any extent under any other part of this Policy.
- 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.

Pediatric Dental Care (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.

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.

General Services

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

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, and
- 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, and
- At any time in accordance with state guidelines for a child age 36 months or younger.

Cervical Cancer Screening (Pap Tests)

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

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

Colorectal Cancer Screenings

Colorectal cancer screenings, using fecal occult blood testing, sigmoidoscopy, colonoscopy, or radiological imaging, are **covered** in accordance with the recommendations established by the American Cancer Society, based on the ages, family histories and frequencies provided in the recommendations.

- 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).

Mammogram Screenings

Mammogram screenings are **covered**.

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

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

In addition to the mammogram screenings noted above, a comprehensive ultrasound screening and magnetic resonance imaging (MRI) screening of an entire breast or breasts are also **covered and exempt from Cost-Sharing.**

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

- A mammogram demonstrates heterogeneous or dense breast tissue based on the Breast Imaging Reporting and Data System established by the American College of Radiology, or
- A woman is believed to be at increased risk for breast cancer due to family history or prior personal history of breast cancer, positive genetic testing or other indications as determined by her physician or advanced practice registered nurse, or
- The screening is recommended by a woman's treating physician for a woman who is forty years of age or older, has a family history or prior personal history of breast cancer, or has a prior personal history of breast disease diagnosed through biopsy as benign.

Any breast ultrasounds during the year that do not comply with the above requirements **may be subject to the applicable mammography ultrasound Cost-Share as shown on your Benefit Summary.**

MRI of an entire breast or breasts is **covered** in accordance with guidelines established by the American Cancer Society:

Any breast MRIs during the year that do not comply with the above requirements **may be subject to the applicable advanced radiology Cost-Share as shown 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.

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.

Routine Cancer Screening Limitations

Unless specified in this "Routine Cancer Screenings" subsection, **there is no coverage under this subsection** for other services that are covered to any extent under any other part of this Policy.

Other Preventive Services

Hearing Screenings

Hearing screenings are **covered**:

- As a part of a physical examination if a Member is under age 21.
- 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 New Children" 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.

BEHAVIORAL HEALTH (MENTAL HEALTH SERVICES)

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

Inpatient Mental Health Services

Medically Necessary inpatient mental Health Services, as defined in the most recent edition of the 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.

EMERGENT/URGENT CARE

Ambulance/Medical Transport Services

Emergency Services

Emergency land or air ambulance/medical transport services are **covered after the Cost-Share amount as shown on your Benefit Summary** 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 or chair car 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 a Non-Participating Provider. You may be responsible to pay a bill submitted to you by Non-Participating Providers for their charges over and above the amount paid by us.

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

- The closest emergency room, or
- A Participating Hospital emergency room.

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

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 Providers. However, the removal of stitches is covered, if the same Urgent Care Center used to obtain the stitches is used to take them out.

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

Walk-In Care

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

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

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

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

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.

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), and
- A licensed dentist and a doctor specializing in primary care decide the Member has a complicated dental condition that requires treatment be done in a Hospital, or

  A licensed doctor specializing in primary care decides the Member has a developmental disability that puts the Member at serious risk.

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

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.

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.

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 maximum benefit as shown in your Benefit Summary** if such care is provided:

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

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.

There is no coverage for long term care or Custodial Care.

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, and
- 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**.
- 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 Policy.

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 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 Services or Walk-In/Urgent Care Centers benefit.
- 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.
- We reserve the right to limit the payment of charges up to the most cost efficient and least restrictive level of service or item which can be safely and effectively provided.
- 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 Services or Walk-In/Urgent Care Centers benefit.
- 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 are **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.

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

There is no coverage for medical supplies, equipment or prosthetics that are not durable or that are not on our list of covered equipment. Examples of excluded supplies and equipment include, but are not limited to:

- Any item not primarily medical in nature.
- Any item or service which is not covered by the Medicare or Medicaid programs.
- Artificial Limbs, except as described in the "Artificial Limbs" subsection.
- Assistive technology and adaptive equipment, including but not limited to:
  - Communication boards, computers, equipment or devices.
  - Gait trainers.
  - Prone standers.
  - Supine boards.
  - Other equipment not intended for use in the home.
- Beds, bedding and bed-related item.,
- Bone growth (osteogenic) stimulators (spinal, non-spinal and ultrasonic).
- Clothing or bodywear, except as otherwise covered in the "Benefits" section.
- Comfort or convenience items, including but not limited to:
  - Furniture or modifications to furniture.
  - Home climate control devices.
  - Tubs, spas or saunas.
- Compression and cold therapy devices.
- Compression or anti-embolism stockings, except when a Member has lymphedema, lymphedema related to cancer or a cancer related procedure.
- Cryotherapy; polar packs.
- Exercise equipment,
- Foot orthotics, except if the Member is a diabetic.
- Hearing aids, except as otherwise described in this subsection.
- Home or automobile equipment or modifications.
- Items used to perform or assist with personal hygiene.
- Lifts of any type.
- Mechanical stretch devices for treatment of joint stiffness (pre- or post-surgery) or joint contractures.

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.

- Pneumatic compression devices for the treatment of lymphedema or the prevention of deep vein thrombosis.
- Power mobility devices, such as wheelchairs or scooters.
- TENS units or other neuromuscular stimulators and related supplies, either internal or external, for the treatment of pain or other medical conditions.
- Wigs, hair prosthetics, scalp hair prosthetics or cranial prosthetics, except as otherwise described in this 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 and 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,
- Long term 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 durable medical equipment for ostomy care are **covered after the applicable Cost-Share amount described in your Benefit Summary**.

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

Ostomy Supplies Limitations

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.
- 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 Services 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 Services or Walk-In/Urgent Care Centers benefit.

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 maximum benefit 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 maximum benefit 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 maximum benefit 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**.

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

Medically Necessary outpatient diagnostic x-rays and therapeutic procedures are **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 as shown on your Benefit Summary.** 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 Policy, 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 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 Policy 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 Policy 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.

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 Policy. 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.

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.

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 this Policy. 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.

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.

Pharmacy Network

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

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

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

Using A Participating Pharmacy

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

Prescription Drug Programs

The following provisions apply to our Prescription Drug Programs.

Advanced Opioid Management Program

1. This Plan has an "Advanced Opioid Management Program."

   This program applies to prescriptions written for certain controlled substances, including, but not limited to, stimulants, opioid analgesics, and benzodiazepines, as well as muscle relaxants for Members who have been identified as demonstrating potentially unsafe or abusive behaviors.

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

2. Under this program, certain prescriptions written for a controlled substance and/or muscle relaxant will only be covered if a certain treating provider writes the prescription for you and when it is filled at a pharmacy, we advise you of.

   We will notify you which controlled substance and/or muscle relaxant applies, the name of the provider who can write the prescription, and the pharmacy where the prescription can be filled.

3. You can request a different provider who can write the prescription for the controlled substance and/or muscle relaxant or the pharmacy where that prescription can be filled.

To request such a change, you should call our Member Services Department at the telephone number listed in the "Important Telephone Numbers And Addresses" section and explain why you need a different provider or pharmacy.

If you fill or refill a prescription for a controlled substance and/or muscle relaxant from any provider other than the original treating provider or at any pharmacy other than the original dispensing pharmacy, the medicine will not be covered under this Plan and you will be responsible to pay the full cost of the controlled substance and/or muscle relaxant.

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.

Generic Substitution Program

1. This Plan has a "Generic Substitution Program." This program applies to prescriptions filled at 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 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.

Tiered Cost-Share Program

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

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

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

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

We have the right to change the drugs (including certain OTC medications) or supplies in each tier, 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, (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 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 that, because of your or your covered dependent's adverse reaction to the covered drug or the covered drug's ineffectiveness for the Member, the excluded drug is Medically Necessary. We will make this determination based on clinical evidence presented by your physician to us.
5. We will also cover excluded drugs which are added to the "Mandatory Drug Substitution" list, if the following conditions are met:
   - You were obtaining, through your coverage under the Plan, the excluded drug for the treatment of a chronic illness prior to it being added to the "Mandatory Drug Substitution" list, and
   - Your doctor provides to us a written statement that the excluded drug is Medically Necessary and includes the reasons why the excluded drug is more medically beneficial in treating your chronic illness than the drugs that are covered under the Plan.

The drugs on the "Mandatory Drug Substitution" list are published from time to time in our member 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.

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, 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, 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, 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.

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.

Clinically Equivalent Alternative Drugs Or Supplies Program

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

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

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

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

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

The covered drugs and supplies are displayed on our web site. You should call our Member Services Department at the telephone number listed in the "Important Telephone Numbers And Addresses" section (or visit us at our web site at 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.

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.
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

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

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 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.

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 do not generally coordinate benefits under this Plan. However, If you or your covered dependent have the Medicare Part D Drug program or a Medicare Advantage plan with drug coverage, Medicare is the primary plan over this Plan.
8. We reserve the right to designate that certain prescriptions be filled or refilled for no more than a 30-day supply at a time. When coverage is limited to a 30-day supply at a time for a drug, you will not be able to purchase that drug through our Voluntary Mail Order Program.

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, are **covered** as described in the under our "Prescription Drugs" subsection of the "Benefits" section.

There is no coverage for special education and related services, except as otherwise 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 the law, or
- Negatively affect the eligibility of coverage under this Plan to the child, the child's parent or the child's family members who are Members under this Plan, or
- Constitute a reason for us to rescind or cancel the Member's coverage under this Plan.

Cardiac Rehabilitation

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

Phase I cardiac rehabilitation is **covered**.

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

Coverage for Phase III cardiac rehabilitation is only available for Members who 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.

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

Prescription drugs and supplies for the treatment of diabetes are **covered** as described in the "Prescription Drugs" subsection of the "Benefits" section, including its Cost-Share provisions. 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 Drugs" 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.

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.

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, up to the limits described below**.

- Ovulation induction (to a maximum of four cycles).
- Intrauterine insemination (to a maximum of three cycles per recipient, regardless of source).
- Uterine embryo lavage, in-vitro fertilization (IVF), gamete intra-fallopian transfer (GIFT), zygote intra-fallopian transfer (ZIFT) or low tubal ovum transfer (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 need not be tried first if the Member's treating Board Eligible or Board Certified Reproductive Endocrinologist certifies that such treatment or procedure is unlikely to be successful.

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-implantation genetic testing is covered 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 (medications) to treat Infertility.

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

Rules

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

1. For certain Infertility services, a Member must be treated by a board eligible or board certified reproductive endocrinologist at a facility that meets the standards and rules of the American Society of Reproductive Medicine or the Society of Reproductive Endocrinology and Infertility.

   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 otherwise described above or in the "Genetic Testing" section.
- Medicines for sexual dysfunction,
- 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 treatment if it is recommended by a board-certified rheumatologist, by an infectious disease specialist, or by a neurologist.

Antibiotic drugs are **covered** as described in the "Prescription Drugs" subsection of the "Benefits" section.

Neuropsychological Testing

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

Nutritional Counseling

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

Nutritional Supplements And Food Products

Enteral Or Intravenous Nutritional Therapy

Medically Necessary enteral (tube feeding) or intravenous nutritional products are **covered at the applicable Cost-Share amount** 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.

Modified Food Products For Inherited Metabolic Diseases

Medically Necessary modified food products (low protein) and amino acid modified preparations are **covered at the non-preferred Brand Name Drug Cost-Share amount listed in 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 non-preferred Brand Name Drug Cost-Share amount listed in 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 in 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.

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**.

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.

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

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.
- 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

Termination of pregnancy due to rape or incest, or for a pregnancy which, as certified by a physician, places the woman in danger of death unless termination of pregnancy is performed (i.e., abortions for which Federal funding is allowed) is **covered**.

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.

The federal Patient Protection and Affordable Care Act prohibits the use of federal funds to pay for elective termination of pregnancy services. A portion of the total Premium amount owed is a separate payment for these services.

Telemedicine Services

Pursuant to Public Act 21-9, 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.

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 will exclude or limit it.

1. All assistive communication devices.
2. Ambulance services that are non-Emergency medical transport services or chair car 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. Behavioral conditions with the following diagnoses:
   - Caffeine-related disorders,
   - Communication disorders,
   - Gambling disorders,
   - Learning disorders,
   - Mental retardation,
   - Motor skills disorders,
   - Relational disorders,
   - Sexual deviation, or
   - Other conditions that may be a focus of clinical attention not defined as mental disorders in the most recent edition of the "Diagnostic and Statistical Manual of Mental Disorders."
8. Benefits for services rendered before the Member's Effective Date under this Plan or after the Plan has been rescinded, suspended, canceled, interrupted or terminated, except as otherwise required by the law.
9. Blood, blood products and related expenses.
10. Body piercing.
11. Cardiac rehabilitation for Phase III, unless the Member:
    - Is being actively case managed and
    - The rehabilitation is approved by us.

    Phase III Cardiac Rehabilitation may be covered as part of a health management program value-added service or benefit. Phase IV cardiac rehabilitation is excluded.
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 the 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:
    - Cost 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.

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.

15. Complementary or alternative medicine that is not considered standard medical treatment by the traditional United States medical community.

    Examples of non-standard treatments include, but are not limited to:

    - Acupressure.
    - Acupuncture, except when acupuncture is provided as part of pain management.
    - Animal-related therapies.
    - Ayurveda.
    - Biofeedback.
    - Bioidentical hormones.
    - Colonic irrigation.
    - Craniosacral therapy.
    - Essential metabolics analysis.
    - Live blood cell analysis.
    - Massage therapy.
    - Megavitamin therapy.
    - Mind-Body therapies.
    - Music or artistic therapies.
    - Reiki.
    - Reflexology.
    - Rolfing.
    - Therapeutic touch.
16. Concierge services (which means the fees a provider charges as a condition of selecting or using his/her services).
17. 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.
    - 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.
18. 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.

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.

19. Dental services, including, but not limited to the following:
    - Any service, procedure, or treatment modality not specifically listed in the "Pediatric Dental Care (Under Age 26)" subsection of the "Benefits" section as a covered Dental Service.
    - For adults (Members age 26 and over), except as noted in the "Routine Dental Care (Over Age 26)" subsection of the "Benefits" section.
    - 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 persons 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.
    - 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.

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.

- 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 therapy.
- 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.

20. 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.
21. Extracorporeal shock wave therapy for the treatment of musculoskeletal conditions.
22. Experimental Or Investigational treatment, except as described in the "Bypassing The Internal Appeal Process" subsection of the "Claims Filing, Questions And Complaints, And Appeal Process" section.
23. Facelift surgery, or rhytidectomy
24. Family planning and Infertility services, including but not limited to:
    - Contraceptive drugs and devices, except to the extent 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, including but not limited to:
        - ♦ 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.
        - ♦ 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.
25. Genetic analysis and testing, except as described in the "Infertility Services" or "Genetic Testing" subsections of the "Benefits" section including, but not limited to:
    - Genetic testing kits available either direct to the consumer or via a physician prescription.
    - Genetic testing only for the benefit of another family member.
26. Gynecomastia surgery.
27. Health club membership and exercise equipment.
28. Home health aide care that is not patient care of a medical or therapeutic nature.
29. Homeopathic and holistic treatments.
30. Hypnosis, biofeedback, and acupuncture, except when acupuncture is provided as part of pain management.
31. Injection of collagen or other fillers or bulking agents to enhance appearance.

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.

32. Medical supplies, equipment or prosthetics that are not durable or that are not on our list of covered equipment.

    Examples of excluded equipment including, but not limited to:

    - Any item not primarily medical in nature
    - Any item or service which is not covered by the Medicare or Medicaid programs
    - Assistive technology and adaptive equipment, including but not limited to:
        - ♦ Communication boards, computers, equipment or devices.
        - ♦ Gait trainers.
        - ♦ Prone standers.
        - ♦ Supine boards.
        - ♦ Other equipment not intended for use in the home.
    - Beds, bedding and bed-related items.
    - Bone growth (osteogenic) stimulators (spinal, non-spinal and ultrasonic).
    - Clothing or bodywear, except as otherwise covered in the "Benefits" section.
    - Comfort or convenience items, including but not limited to:
        - ♦ Furniture or modifications to furniture.
        - ♦ Home climate control devices.
        - ♦ Tubs, spas or saunas.
    - Compression and cold therapy devices.
    - Compression or anti-embolism stockings, except when a Member has lymphedema, lymphedema related to cancer or a cancer related procedure.
    - Cryotherapy; polar packs.
    - Exercise equipment.
    - Foot orthotics, except if the Member is diabetic.
    - Hearing aids, except as described in the "Benefits" section.
    - Home or automobile equipment or modifications.
    - Items used to perform or assist with personal hygiene.
    - Lifts of any type.
    - Mechanical stretch devices for treatment of joint stiffness (pre- or post-surgery) or joint contractures.
    - Pneumatic compression devices for the treatment of lymphedema or the prevention of deep vein thrombosis.
    - Power mobility devices, such as wheelchairs or scooters.
    - TENS units or other neuromuscular stimulators and related supplies, either internal or external, for the treatment of pain or other medical conditions.
    - Wigs, hair prosthetics, scalp hair prosthetics or cranial prosthetics, except as described in the "Benefits" section.
33. Neuropsychological and neurobehavioral testing, except to assess the extent of any cognitive or developmental delays due to chemotherapy or radiation treatment in a child diagnosed with cancer.
34. 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.
35. Non-licensed professionals.
36. 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 policy, or benefit policy guidelines.
37. Non-medical supportive counseling services (individual or group) for alcohol or substance abuse (e.g., Alcoholics Anonymous).
38. Non-surgical treatment of temporomandibular joint (TMJ) dysfunction or temporomandibular disease (TMD) syndrome, including but not limited to:
    - Appliances.
    - Behavior modification.
    - Physiotherapy.
    - Prosthodontic therapy.
39. Otoplasty.
40. Overnight or day camps focused on illness or disability.
41. 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.
42. Pain management procedures and services, except as provided in the "Pain Management" subsection of the "Benefits' section, as follows:
    - Automated percutaneous lumbar discectomy (APLD)/automated percutaneous nucleotomy.
    - Coblation Nucleoplasty ™, disc nucleoplasty, decompression nucleoplasty plasma disc decompression.
    - Endoscopic anterior spinal surgery/Yeung endoscopic spinal system (YESS)/percutaneous endoscopic diskectomy (PELD)/arthoroscopic microdiscectomy, selective endoscopic discectomy (SED).
    - Endoscopic disc decompression, ablation or annular modulation using the DiscFX ™ System.

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.

- Endoscopic epidural adhesiolysis.
- Epiduroscopy, epidural myeloscopy, epidural spinal endoscopy.
- Intradiscal and/or paravertebral oxygen/ozone injections.
- Intervertebral disc biacuplasty/cooled radiofrequency.
- Interdiscal electrothermal annuloplasty/Interdiscal electrothermal therapy (IDET).
- Intralesional Anesthesia or Postoperative Disposable Ambulatory Regional Anesthesia.
- Percutaneous laminotomy/laminectomy, percutaneous spinal decompression.
- Percutaneous laser discectomy/decompression, laser-assisted disc decompression (LADD).
- Percutaneous epidural adhesiolysis, percutaneous epidural lysis of adhesions, Racz procedure.
- Percutaneous intradiscal radiofrequency thermocoagulation (PIRFT), intradiscal radiofrequency thermomodulation or percutaneous radiofrequency thermomodulation.
- Prolotherapy.
- Spinal Distraction Systems.

43. 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.

44. Personal convenience or comfort items of any kind.
45. Platelet-rich-plasma for bone, wound or tendon healing.
46. 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 Policy.

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.

- Infant formulas, dietary or food supplements, prescription medical foods and nutritional supplies, except as described in the "Nutritional Supplements And Food Products" and "Prescription Drug" 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.
  - ♦ 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 this Policy, 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 in 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.
- Vitamins, minerals, hematinics and supplements, except prescription pre-natal vitamins or as otherwise described in this Policy.

47. Private room accommodations or private duty nursing in a facility.
48. 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.
49. Routine foot care (except when the Member is a diabetic), including, but not limited to: the evaluation or treatment of subluxations (structural misalignments of the joints) of the feet, and the elevation or treatment of flattened arches and the prescription of supportive devices.
50. Routine physical exams or immunizations at an Urgent Care Center.
51. Screening and/or testing required for public health surveillance, travel, education, employment, or returning to employment, except as required by law.
52. Sensory and auditory integration therapy, unless covered under the "Autism Services" or "Birth To Three Program (Early Intervention Services)" subsections of the "Benefits" section.
53. Services and supplies exceeding the benefit 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.

54. Services and supplies not specifically included in this document.
55. Services, drugs, medications or supplies obtained outside of the United States, except for Emergency Services.
56. 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.
57. Services required by or received at a Wilderness Camp or a boarding school, including:
    - Medications, including prophylactic.
    - Physical examinations, blood tests.
    - Supplies.
    - Vaccinations/immunizations.
58. 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.
59. Services obtained for foreign or domestic travel, including:
    - Camp.
    - Employment.
    - Insurance.
    - Licensing.
    - Pursuant to a court order.
    - School.
60. Solid organ transplant and bone marrow transplant transportation costs, including, but not limited to:
    - 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.
61. Speech therapy for stuttering, lisp correction, or any speech impediment, except as described in the "Benefits" section.
62. Sports medicine clinic services and treatments and the services of a personal trainer. In addition, there is also no coverage for any diagnostic services related to any of these programs, services or procedures.
63. Surgical procedures using an artificial disc.
64. 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 question.
    - Costs for provider to provider discussions.
    - Costs for Referrals to providers outside the online care panel.
    - 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 fees for technical costs or facility fees for the provision of Telemedicine services.
    - Telemedicine services involving electronic-mail, facsimile, texting, or audio-only telephone, except as required by Public Act 21--9.
65. Thigh, leg, hip, or buttock lift procedures.
66. Third party coverage, such as other primary insurance, workers' compensation and Medicare will not be duplicated.

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.

67. Transportation, accommodation cost, and other non-medical expenses related to Health Services (whether they are recommended by a physician or not), except as described in the "Benefits" section.
68. Treatment of melasma.
69. Treatment of snoring, including, but not limited to:
    - Laser-assisted uvulopalatoplasty.
    - Snore guards.
    - Somnoplasty, and any other snoring-related appliances.
70. Ventricular assist devices, except for bridge to heart transplantation.
71. 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 keratomy.
    - 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.
72. War related treatment or supplies, whether the war is declared or undeclared.
73. Weight loss/control services, equipment and treatment, including, but not limited to:
    - Bariatric surgery.
    - Commercial diet plans and any clinics and services in connection with such plans or programs.
    - Exercise equipment.
    - Weight loss or weight control programs.

OTHER INSURANCE, RIGHTS OF RECOVERY, SUBROGATION AND REIMBURSEMENT AND MEDICARE ELIGIBILITY

OTHER INSURANCE

Automobile Insurance Policies

To the extent permissible by law, benefits shall not be provided by this Plan for covered Health Services paid, payable or required to be provided as basic reparations benefits under any no-fault or other automobile insurance policy.

We shall be entitled:

- To charge the insurer obligated under such law for the dollar value of those benefits to which a Member is entitled.
- To charge the Member for such dollar value, to the extent that the Member has received payment from any and all sources, including but not limited to, first party payment.
- To reduce any sum owing to the Member by the amount that the Member has received payment from any and all sources, including but not limited to, first party payment.

A Member who fails to secure no-fault insurance required by law shall be deemed to be his or her own insurer and we shall reduce his or her benefits for covered Health Services by the amount of basic reparations benefits or other benefits provided for injury if such a no-fault policy had been obtained.

If a Member is entitled to benefits under a no-fault or other automobile insurance policy, benefits for covered Health Services will only be provided when a Member follows all of the guidelines stated in the "Managed Care Rules And Guidelines" section. It is necessary to follow all the guidelines in the "Managed Care Rules And Guidelines" section in order for us to continue to provide benefits for covered Health Services when the no-fault or other automobile insurance policy benefits are exhausted.

Workers' Compensation

As required by law, we will not exclude coverage under this Plan for a sole proprietor who is eligible for, but who does not elect, workers' compensation.

In addition, to the extent permissible by law, no benefits shall be provided for covered Health Services paid, payable or eligible for coverage under any workers' compensation law, employer's liability or occupational disease law, denied under a managed workers' compensation program as Out-of-Network services or which, by law, were rendered without expense to the Member.

We shall be entitled to the following:

1. To charge the entity obligated under such law for the dollar value of those benefits to which the Member is entitled.
2. To charge the Member for such dollar value, to the extent that the Member has been paid for the covered Health Services.
3. To reduce any sum owing to the Member by the amount that the Member has received payment.
4. To place a lien on any sum owing to the Member for the amount we have paid for covered Health Services rendered to the Member, in the event that there is a disputed and/or controverted claim between the Member's employer and the designated workers' compensation insurer as to whether or not the Member is entitled to receive workers' compensation benefits payments.
5. To recover any such sum owing as described above, in the event that the disputed and/or controverted claim is resolved by monetary settlement to the full extent of such settlement.
6. If a Member is entitled to benefits under workers' compensation, employer's liability or occupational disease law, it is necessary to follow all of the guidelines in the "Managed Care Rules And Guidelines" section in order for this Plan to continue to provide benefits for covered Health Services when the workers' compensation benefits are exhausted.

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 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 pay to that plan any amounts we determine to be warranted in order to satisfy the intent of this section. Amounts paid will be deemed to be services or 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 right to do that will be limited to the amount that you have received from another plan.

SUBROGATION AND REIMBURSEMENT

You or your covered 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, the third person, organization or governmental entity may have primary payment responsibility and not by way of limitation, may include the following sources: a third party tortfeasor or his insurer, payments under an uninsured or underinsured motorist policy, a worker's compensation award or settlement, a recovery made pursuant to a no-fault insurance policy, and any medical payment coverage in any automobile or homeowner's insurance policy. For claims we paid in relation to that 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 covered dependents agree to reimburse us, in full, without any offset or reduction under any theory of attorney or common fund, made-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 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, his or her guardian, personal representative, estate, dependents or survivors, as appropriate, to assign his or her 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 those instruments and to take such other reasonable actions as may be necessary to secure our rights.

MEDICARE ELIGIBILITY

If you become enrolled in Medicare after this Policy became effective for you, you can still remain eligible for coverage under this Plan. If you or your covered dependents have both Medicare Part A and Part B, Medicare is the primary Plan over this Plan.

You or your covered dependents who have coverage receive our same Plan Benefits, but Medicare will be the primary 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.

TERMINATION AND AMENDMENT

This Plan will terminate and your coverage under this Plan will terminate as follows.

WHEN A MEMBER TERMINATES COVERAGE

The Exchange will permit a Member to terminate coverage under this Plan, as long as the Member provides the Exchange with notice.

Effective Dates Of Termination

When a Member's coverage terminates under this Plan at his/her request, the last day of coverage is as follows:

1. The termination date requested by the Member or another prospective date selected by the Member, as long as the Member provides notice of at least 14 days in writing,
2. If the Member has not given reasonable notice of at least 14 days, the termination date will be 14 days after the Member provides notice,
3. On a date determined by the Exchange or us, if we are able to terminate in less than 14 days and the Member requests an earlier termination date, or
4. The day before coverage begins when the Member is newly eligible for Medicaid, the Children's Health Insurance Program or a Basic Health Plan.

TERMINATION OF COVERAGE FOR OTHER REASONS

Termination of coverage may occur for other reasons besides the Member's request.

When termination occurs for any of the reasons that follow, we will provide the Member with notice that includes the reason why coverage was ended. That notice will be sent to the Member as least 30 days before the last day of coverage. In addition, we will also notify the Exchange of the termination effective date and the reason for the termination.

We will make reasonable accommodations for all Qualified Individuals with disabilities, as required by federal law, before we terminate his/her coverage.

Termination of a Member's coverage occurs in the following circumstances:

1. The Member is no longer eligible for coverage in this Plan, including the Member moving outside of the State of Connecticut.

   Coverage will end on the last day of the month following the month in which the Exchange notifies us (unless the Member requests an earlier termination date with appropriate notice).

2. Non-payment of Premium, and
   - The three-month grace period required for Members receiving Advance Payments Of The Premium Tax Credit has been exhausted, or
   - The standard one-month grace period has been exhausted.

   Coverage will end the last day of the first month of the three-month grace period, if termination is because the three-month grace period has been exhausted.

   Coverage will end on the last day of the standard grace period, if termination is because the standard grace period has been exhausted.

3. The Member's coverage is rescinded.
4. We no longer participate as a Qualified Health Plan Issuer (QHP Issuer).
5. The Member switches from this Plan to another QHP during an open enrollment period or special enrollment period.

   Coverage will end the day before the Member becomes effective in the new QHP.

6. Your death.

   Coverage will end the date of your death.

7. In the event a Member has committed fraud (as determined by a court of competent jurisdiction) or has willfully concealed or misrepresented any material fact or circumstance in applying for enrollment or in obtaining Plan Benefits.

   Coverage will end, as we determine.

   However, we may not contest the Member's coverage under this subsection beyond two years from the Member's Effective Date of coverage under this Policy.

8. Upon a Member's commission of acts of physical or verbal abuse (which are unrelated to his or her physical or mental condition), which pose a threat to or create an intimidating, hostile or offensive working environment for:
   - Providers,
   - Other Members, or
   - Our employees, our affiliates or our subcontractors.

   Coverage will end, as we determine.

9. For a Member's persistent refusal to comply with treatment that is prescribed and Medically Necessary.

   Coverage will end, as we determine.

10. For a Member's failure to take such reasonable actions as may be necessary to secure our rights under this Plan.

    Coverage will end, as we determine.

11. In the event the Member has repeatedly failed to make the required Cost-Sharing payments to providers.

    Coverage will end, as we determine.

AMENDMENT

We may amend the Policy with approval from the Connecticut Insurance Department. The effective date of any changes will be designated by us, and notification to you will be provided. No agent or representative of ours, other than an officer of ours, is authorized to change this Policy or to waive any of its provisions. Any changes or waivers must be in writing.

We have the right to develop medical and managed care policies and procedures and to amend such policies and procedures from time to time. The effective date of any changes shall be designated by us.

CLAIMS FILING, QUESTIONS AND COMPLAINTS, AND APPEAL PROCESS

We have the right to review any claims and 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, 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 provider.

Special Rules If You Are Enrolled In Our *POS Deductible Open Access Plans Or Our POS Open Access HDHP Plan*

An explanation of benefits (EOB) will be sent to you, which will indicate:

- The Participating Provider's charges.
- What charges in what amounts were applied to the Plan Deductible.
- What charges in what amounts were paid by us.
- The reasons for any adjustments to those billed charges.
- The amount you are required to pay to the Participating Providers, if any.

Any amount owed to the Participating Providers must be paid directly to the 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.

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.

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.

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 "Other Insurance, Rights Of Recovery, Subrogation And Reimbursement" section for a description of how to determine if this Plan is the primary or secondary insurance company and any requirements that apply 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.

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.

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.

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.

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

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 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.

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.

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.

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.

4. The review will require a fee of $25 payable to the State of Connecticut Insurance Department. There is a maximum fee of $75 per Member per year. This fee may be waived if you are poor or unable to pay by the State of Connecticut Insurance Commissioner. The fee is refunded if the Adverse Determination is reversed or revised.
5. If you request an external review or an expedited external review, you will receive additional information including instructions on how to supply additional comments or materials related to your benefit request.
6. You or your authorized representative will be provided with a written decision 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 and the Exchange.

Please be aware that when you apply for a new Plan from us, we will check to see if you owe any Premium for a Plan you ended within the past year. If you do, we reserve the right to apply any payment first to your outstanding balance. That means you would need to pay both the past amount due and the first month's Premium for the new Plan with us to go into effect.

1. All Premiums must be sent to us in accordance with our payment instructions, and according to the rates in force on behalf of the number of Members covered under this Plan, even if Premium is being made in the aggregate for Members of a tribe, tribal organization, or urban tribal organization.
2. All Premiums are due and payable on the first day of the month for which coverage applies and the first day of each calendar month after that. If a grace period is allowed, it means that if payment is not made on or before the date it is due, it may be paid during the grace period. Please refer to the "Grace Periods" subsection below.
3. 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. Membership changes received and processed afterward will be reflected on the next bill.
4. The amount, time and manner of payment of Premium shall be determined by us and shall be subject to the approval of the State of Connecticut Insurance Department and the Exchange.

   In the event of any increase change in Premium, the Subscriber will be given notice at least 30 days prior to such change. Payment of the Premium by the Subscriber shall serve as the Subscriber's acceptance of the Premium change.
5. You must notify the Exchange and us at least 14 days prior to the date on which a Member's coverage is to terminate under this Plan in order for termination to be effective on that date. This notification must be sent to us in writing.
6. You must tell the Exchange and us when your address changes right away. If the change in your new address results in a change in Premium, that change in Premium will be effective the first day of the month after you move. You are responsible for any increase in Premium because of an address change, even if you do not tell us about the change until after you move.
7. We have the right to decline any Premium payments made on your behalf by a third party.

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.

GRACE PERIODS

If you do not pay the full amount of the Premium by the Premium due date, a grace period is triggered. A grace period is an additional period of time during which coverage remains in effect. If you do not pay the required premium by the end of the grace period, your Policy is cancelled.

We will provide you with notice when the Premium is past due.

Standard Grace Period

This Policy has a standard grace period of one month. This means if you do not make payment during the standard grace period, this Policy will terminate on the last day of the grace period. You will be liable to us for the payment due including those for the grace period.

Payment must reach us in time for us to complete our posting process in order for it to be considered paid by the end of the grace period.

If Premium is not paid as described above, coverage under this Plan will end.

Advance Payment Of The Premium Tax Credit (APTC) Grace Period

1. If a Member is receiving Advance Payment Of The Premium Tax Credit (APTC) and has previously paid at least one month's Premium, we will provide a grace period of at least three consecutive months.
2. During this grace period:
   - We will pay all incurred claims during the first month of this grace period, and
   - Any claims that were incurred in the second and third months may be pended, subject to our right to cancel your Policy.

     When this occurs, we will notify providers that claims may be denied.

   The application of this grace period to claims is based on the date of service and not on the date the claim was submitted.

   - We will notify the United States Department of Health and Human Services of the non-payment of Premium.
   - We will apply any payment received to the first billing cycle in which payment was delinquent.

GENERAL PROVISIONS

1. You agree to cooperate with us and to follow our rules and instructions in all administrative matters required for the administration of this Plan.
2. You must meet the eligibility requirements of the Exchange. It is your responsibility to notify the Exchange and us within 31 days if you change your residence.

   If you move within the Exchange Service Area of this Plan, Premium rates will be adjusted, if necessary, to adjust to your new address and the current ages of your Eligible Dependents, effective at the beginning of the Premium Period following the change of residence.
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 all of the 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 "Other Insurance, Rights Of Recovery, Subrogation And Reimbursement" section to find out your responsibilities.
4. By being covered under this Plan, you and your Eligible Dependents accept all of the rules of this Plan.
5. We, upon receipt of a notice of claim, shall furnish to the Member such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within 15 days after the giving of such notice, the Member shall be deemed to have complied with the requirements of this Policy as to proof of loss, upon submitting, within the time fixed in this Policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.
6. No legal action may be taken to recover benefits within 60 days after notice of claim has been given as specified above, nor may any action be brought after three years from the date covered Health Services are received. No liability shall be imposed upon us other than for benefits provided herein.
7. We will have no liability for benefits other than as provided 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.

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, other than termination for non-payment of Premium, this Policy may be reinstated if we received your request for reinstatement within 10 days of the termination date and all outstanding Premiums are paid in full.
10. This document, including the Exchange enrollment form, Benefit Summary, Riders and supplemental inserts is the entire contract and understanding between you and us. It replaces all prior agreements and understandings relating to the subject matter. Except as 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.
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 and the rules, regulations or other standards set forth by the Exchange and/or the. State of Connecticut Insurance Department.
13. Participating Providers are not our employees or agents. They are independent contractors with the responsibility for determining and providing health care for their patients.
14. 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.
15. 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.
16. This Plan does not limit coverage for conditions just because you had the condition before you became covered under the Plan.
17. This Policy shall be incontestable, except for nonpayment of premium, after it has been in force for two years from its date of issue.
18. This Plan calculates benefits on a Contract Year basis. This means that benefit changes to your benefit plan become effective upon the Renewal Date (when a new Policy or amendatory Rider may be issued to you).
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.

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).

ADVANCE PAYMENTS OF THE PREMIUM TAX CREDIT (APTC)

Payment of the tax credits which are provided on an advance basis to an eligible individual enrolled in a Qualified Health Plan (QHP) through an Exchange.

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.

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.

AMERICAN INDIAN

An individual who is a member of a Federally Recognized Indian tribe. A tribe is defined as any Indian tribe, band, nation, or other organized group or community, including any Alaska native village or regional or village corporation which is recognized as eligible for the special programs and services provided by the United States because of their status as Indians.

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 DISORDER (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.

BEHAVIORAL THERAPY

Any interactive Behavioral Therapy derived from evidence-based research and consistent with the services and interventions designated by the Commissioner of Social 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.

BENEFIT REDUCTION

A Benefit Reduction is a reduction in benefits, which applies when a Member 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.

BRAND NAME DRUG OR SUPPLY

A drug or supply manufactured and approved by federal FDA standards that has a proprietary trade name selected by the manufacturer used to describe and identify it.

CASE MANAGEMENT

The process for identifying Members with specific health care needs in order to help in the development and implementation of a plan that efficiently uses health care resources to help the Member manage his/her health.

CASE MANAGER

An individual, usually a registered nurse, who is responsible for developing and implementing a plan of care that takes into account benefit structure, accepted industry and internal standards, and cost effectiveness in order to help the Member mange his/her health.

CLINICALLY EQUIVALENT ALTERNATIVE DRUG OR SUPPLY

A drug or supply in the same category as an excluded drug or supply and determined by us to be an effective alternative.

CLINICAL PEER

A physician or other health care professional who:

- Holds a non-restricted license in a state of the United States and in the same or similar specialty as typically manages the medical condition, procedure or treatment under review, and
- For a review concerning a child or adolescent substance use disorder or mental disorder, holds a national board certification in child and adolescent psychiatry, or 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.

COINSURANCE

Coinsurance means the percentage of the Maximum Allowable Amount that you are legally responsible to pay after any applicable Deductible is met.

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

- The physician's or provider's charge for the Health Service at the time it is provided, or
- The contracted rate with the physician or provider for the Health Service.

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

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

COINSURANCE MAXIMUM

Generally, the Member's maximum payment liability per year for Coinsurance for Health Services covered at the In-Network Level Of Benefits or separately at the Out-Of-Network Level Of Benefits, as listed in the Member's Benefit Summary.

CONNECTICARE, WE, US OR OUR

ConnectiCare Insurance Company, Inc., the company insuring this Plan.

CONTRACT YEAR

January 1st through December 31st.

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.

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.

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.

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 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.

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.

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.

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 any prosthetic denture, bridge appliance or of 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.

EFFECTIVE DATE

The date that coverage under this Policy became effective. The Effective Date is subject to the payment of Premium and our receipt and approval of a completed Exchange enrollment form.

ELIGIBLE DEPENDENTS

Persons, other than you (the Subscriber), who are eligible to be enrolled as Members under this Policy and as described in the "Eligibility And Enrollment" section of this Policy.

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.

EMERGENCY SERVICES

Evaluation of an emergency medical condition and treatment to keep the condition from getting worse.

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, beginning in October 2014.

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

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

GENERIC DRUG OR SUPPLY (GENERICS)

A drug or supply manufactured and approved by federal FDA standards that has the same active ingredients as the original Brand Name Drug Or Supply and is classified as a generic by a nationally recognized source and recognized by us as a Generic Drug Or Supply.

GENERIC EQUIVALENT

A Generic Drug Or Supply that is therapeutically equivalent to the Brand Name Drug Or Supply and that meets the composition, safety, strength, purity, and quality standards of the federal FDA and that we require be substituted for a Brand Name Drug Or Supply. Not all Brand Name Drugs with Generic Equivalents are required to be substituted.

HEALTH SERVICES

Those diagnostic and therapeutic, medical, surgical, and mental health services and supplies that are Medically Necessary and available to you and your Eligible Dependents under this Plan. Health Services must be provided or rendered by a licensed health care provider within the scope of his/her its license or authorization in accordance with the laws and regulations of the governmental authority having jurisdiction.

HOME HEALTH AGENCY

A duly licensed agency where:

1. Nursing care is provided by a registered nurse or licensed practical nurse.
2. Home health aide services consisting of patient care of a medical or therapeutic nature are provided by someone other than a registered or licensed practical nurse.
3. Physical, occupational or speech therapy is provided.
4. Certain medical supplies, drugs and medicines prescribed by a physician and laboratory services to the extent such services would be covered if Medically Necessary, as we determine, are provided.
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 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.

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.

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.

INSUFFICIENT EVIDENCE OF THERAPEUTIC VALUE

Insufficient Evidence Of Therapeutic Value occurs when we determine 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 Deductibles(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.

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.

MEDICAID

A government program, sponsored by the federal government and the individual states, including Connecticut, which provides coverage for people with lower incomes, older people, people with disabilities, and some families and children. Beginning in 2014, most adults under age 65 with individual incomes up to about $15,000 per year will qualify for Medicaid in every state.

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.

MEDICALLY NECESSARY OR MEDICAL NECESSITY

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

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

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

When used with Dental Services, Medically Necessary means a necessary dental procedure or service as determined by a Dentist to either establish or maintain a patient's oral health. Such determinations are based on the professional diagnostic judgment of the Dentist and the standards of care that prevail in the professional community. The practitioner determines the care, but coverage of the care under this Plan is subject to Dental Necessity as determined by us. We use input from local Dentists, including specialists, to approve, and in some cases develop our Dental Necessity protocols.

To be Medically Necessary, dental treatment must be:

For illness or injury: This means the treatment must be for a diagnosis that is commonly recognized as a disease or injury,

Therapeutic: This means there must be a reasonable expectation the treatment will directly result in the restoration of health or function,

Required: This means there must be no reasonable alternative treatment which is less intensive or invasive, or which costs less and is at least equally effective,

Not Experimental Or Investigational: and

Not elective and not for Cosmetic Treatment purposes.

MEDICARE

Title XVIII of the Social Security Act, including amendments.

MEMBER, YOU, AND YOUR ELIGIBLE DEPENDENTS

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

MINIMUM ESSENTIAL COVERAGE

Any of the following government sponsored programs:

- Medicare,
- Medicaid,
- CHIP,
- TRICARE for Life, veteran's health care program),
- Coverage under an eligible employer-sponsored plan,
- Coverage under a health plan offered in the individual market within a State, or
- Coverage under a grandfathered health plan, and such other health benefits coverage, such as a State health benefits risk pool, or as the Secretary of HHS recognizes.

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.

NETWORK PROVIDER

A provider or facility that has a contract to provide health care services through a designated network vendor outside the Network Access Area. These providers or facilities are not listed in our Provider Directory. To locate a Network Provider, you can refer to the back of your ID Card to identify the Network Provider vendor and for instructions on obtaining a list of Network Providers, or visit our web site at https://secured.connecticare.com/providerdirectory/, or call us.

Note: Network Providers may NOT be used at the In-Network Level Of Benefits inside the Network Access Area, unless the Network Provider is also a Participating Provider.

NEW TREATMENTS

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

NON-PARTICIPATING HOSPITAL

A Hospital that is not a Participating Hospital.

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.

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. You may pay more to see a Non-Participating Provider.

OUT-OF-NETWORK LEVEL OF BENEFITS

Generally, a lesser level of benefits than the In-Network Level Of Benefits under this Plan available for Health Services provided to a Member when the Health Services are not eligible for benefit coverage at the In-Network Level Of Benefits. 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 select 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.

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

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 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 PROVIDER

A select 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 Dental Services or 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 Health Services to you and your Eligible Dependents.

A Participating Provider is a provider who when used by a Member typically provides a higher level of benefits, because out-of-pocket Cost-Shares are lower.

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.

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.

A Participating Physician is a provider who when used by a Member typically provides a higher level of benefits, because out-of-pocket Cost-Shares are lower.

PLAN

The program, which is operated by us providing coverage for Health Services to Members.

PLAN BENEFITS

Health Services covered as specified in this document.

POLICY

This document, and including the Benefit Summary, Riders, insert pages, Exchange enrollment form.

PRE-AUTHORIZATION OR PRE-AUTHORIZED

The authorization, based on Medical Necessity, needed from us, or the applicable Delegated Program, in advance of the Member's receipt of certain specified Health Services.

Pre-Authorization also includes the written authorization from us, or the applicable Delegated Program, needed in advance of the Member's receipt of Health Services from a Non-Participating Provider in order to have those services or supplies covered at the highest level of benefits under the Plan and prescription drugs and supplies.

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.

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 HOSPITAL

A select 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.

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

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.

PREFERRED PARTICIPATING PROVIDER

A select health care practitioner or facility, including a Preferred Participating Physician, Preferred Participating Pharmacy, Preferred 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 Health Services to you and your Eligible Dependents.

A Preferred Participating Provider is a provider who when used by a Member typically provides a higher level of benefits, because out-of-pocket Cost-Shares are lower.

Preferred Participating Providers do not include Hospital-based clinics, even if the Hospital is a Preferred Participating Hospital or a Participating Hospital, unless the Hospital clinic is specifically contracted with us.

PREFERRED PARTICIPATING PHYSICIAN

A select 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.

A Preferred Participating Physician is a provider who when used by a Member typically provides a higher level of benefits, because out-of-pocket Cost-Shares are lower.

PREMIUM

The regular payments required to be made to us by you under this Plan for coverage to remain in effect.

PREMIUM PERIOD

The span of time which begins at either the first of the month based on your Effective Date and ends one month later.

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.

QUALIFIED HEALTH PLAN ISSUER OR QHP ISSUER

A health plan insurance issuer that offers a QHP in accordance with the certification from an Exchange.

QUALIFIED INDIVIDUAL

With respect to an Exchange, an individual who has been determined eligible to enroll through the Exchange in a QHP in the individual market.

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.

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.

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.

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.

RENEWAL DATE

January 1st of each year whereby coverage under this Policy is continued subject to the terms of this Policy, as long as the Subscriber pays the Premium due.

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.

You will also be considered the Subscriber in the case of child only coverage, where this Policy has been issued in your name. When that child only Policy has been issued to you, it is your responsibility to assure a child complies with any and all the terms and conditions outlined in this Policy.

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 21-9, 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 or a provider enrolled in the Connecticut medical assistance program providing such health care or other health services to a Connecticut medical assistance program recipient.

URGENT CARE 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.

WALK-IN CARE CLINIC

A facility designed to treat common ailments. Examples of common ailments include, but are not limited to:

- 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.

Walk-In Care Clinic provide basic primary health care and are typically staffed by a nurse practitioner or at the most physician's assistant.

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.

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 sex. ConnectiCare does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

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 this document, any 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 2020 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 includes review data for benefits managed or administered by an outside company under its own Connecticut utilization review license.

Utilization Review Data

	ConnectiCare Insurance Company, Inc.
Requests for Certification	36,322
Certification Denials	4,063 (11.19%)
Number of Appeals of Denials	402 (9.89%)
Number of Denials Reversed Upon Appeal	209 (5.14%)

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.

Below are the medical loss ratios for 2020.

Medical Loss Ratios

State Medical Loss Ratio

	ConnectiCare Insurance Company, Inc.
	85.8.%

Federal Medical Loss Ratio

	ConnectiCare Insurance Company, Inc.
	86.6%

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 2020, 59.8% 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 State of Connecticut Insurance Department to develop and distribute a consumer report card, which compares:
   - All licensed managed care organizations, and
   - The 15 largest licensed health insurers that use provider networks not included above.

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

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.

- 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**

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)*

Extended Outpatient Psychotherapy*

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 CareCentrix - 844-359-5388 when SNF admission or home health services are preceded by a hospital admission. For all other SNF and home health services, call or fax ConnectiCare Prior Authorization Department.**

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

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 Need Pre-Authorization For The Following Prescription Drugs:

Abecma
Abelcet
Abilify Maintena
Abilify Mycite
Abiraterone
Abraxane
Absorica
Abstral
Acanya
Accu-chek test strips
Accutrend test strips
Acetazolamide sodium
Aciphex
Acitretin
Actemra
Acthar Gel
Acthrel
Acticlate
Actimmune
Actiq
Actoplus Met XR
Acuvail
Acyclovir Cream/Ointment
Aczone
Acne-Brand Name Oral Agents; Doryx, Dynacin, Adoxa, Myrac, Soladyn, Minocin PAC, Minolira ER, Monodox, Seysara Ximino, CoreMino
Adasuve
Adcetris
Adcirca
Adempas
Adhansia XR
Adlyxin
Adoxa
Adriamycin (doxorubicin)
Advair Diskus
Advanced glucose test strips
Advocate
Admelog
Adrucil (Fluorouracil)
Aduhelm
Adzenys ER Susp/XR-ODT
Aemcolo
Afinitor
Afinitor Disperz
Afrezzat
Afstyla
Agamatrix AMP trest strips
Aimovig
Airduo respiclick
Ajovy
Aklief
Albuterol sulfate HFA
Alunbrig
Aldurazyme
Alcortin A
Alecensa
Alferon
Alimta
Aliqopa
Aliskiren
Alkeran
Alkeran Injection
Alkindi Sprinkle
Allopurinol sodium
Aloprim
Alocril
Alomide
Alsuma
Akynzeo
Aloquin
Aloxi
Alprostadil
Alrex
Altabax
Altoprev
Altreno
Argatrobam Intravenous Solution
Atropine syringe
Alvesco
Alyq
Ambisome
Ambrisentan
Amcinonide
Amitiza
Aminocaproic acid intravenous
Aminophylline
Amjevita
Amondys 45
Amphadase
Amphetamine
Amphotericin b
Ampicillin Sodium
Ampicillin-sulbactam injection
Ampyra (dalfampridine ER)
Amrix
Amlodipine/Olmesartan
Amlodipine/Valsartan
Amzeeq
Anastia
Android
Apexicon e
Apidra
Aplenzin
Apriso
Apokyn
Aptensio XR
Aptiom
Aralast
Aranesp (in polysorbate)
Arazlo
Arcalyst

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Aredia
Aricept
Aricept 23
Aricept ODT
Arikayce
Armodafinil
ArmonAir Respiclick
Arranon
Arthrotec
Arymo ER
Arzerra
Asacol/HD
Ascensia Test Strips
Ascor
Asenapine
Ascorbic acid (vitamin c) injection
Ammonium lactate
Assure test strips
Atacand
Atgam
Ativan inj
Atovaquone
Atovaquone-proguanil
Atropen IM pen
Aubagio
Auryxia
Austedo
Auvi-Q
Avandia
Avar/Avar Plus/Avar LS/Avar-E LS
Avastin
Aveed
Avidoxy
Avidoxy / DK
Avonex
Ayvakit
Avycaz
Azacitidine
Azactam
Azathioprine Sodium
Azedra
Azelaic acid
Azelastine/Fluticasone
Azelex
Azithromycin IV
Azopt
Azor
Aztreonam
Bacitracin IM
Bafiertam
Balversa
Bavencio
Baxdela
B Complex 100 injection
Beconase AQ
Belbuca
Beleodaq
Belsomra
Bendeka
Benicar
Benlysta
Benzefoam ultra
Benztropine injection
Benzyl Peroxide 9.8%
Berinert
Benznidazole
Bepreve
Beser
Besponsa
Betamethasone valerate foam
Betaseron
Betoptic S
Bevespi Aerosphere
Bexarotene
Bicillin C-R
BiCNU (Carmustine)
Bionime Righest
Bivigam
Blenrep
Bleomycin
Blincyto
Blood Glucose test
Blood Clotting Factors (All)
Boniva oral /Injection
Bosentan
Bosulif
Botox
Braftovi
Breyanzi
Breztri
Brineura
Briviact
Bronchitol
Brukinsa
Bryhali
Breo Ellipta
Budesonide/Formoterol Fumarate
Bumetanide Inj
Bunavail
Buphenyl
Buprenoprhine
Buproprion ER 24hr 450mg
Busulfex
Busulfan
Butrans
Bydureon
Byetta
Bynfezia
Bystolic
Byvalson
Cabenuva
Cablivi
Cabometyx
Calcipotriene Foam

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Calcipotriene/Betamethasone Susp
Calcitriol IV
Calquence
Cambia
Camptosar (Irinotecan)
Canasa
Candesartan
Candesartan HCTZ
Capastat
Capecitabine
Caplyta
Caprelsa
Carbaglu
Caresens N test strips
Caretouch test strip
Carbinoxamine 6mg
Cardizem LA
Cardura XL
Carboplatin
Carnitor Injection
Carvedilol phosphate
Carvedilol ER
Cayston
Cefepime
Cefotan
Cefotaxime
Cefotetan
Cefotoxamine
Cefoxitin
Ceftazidime
Ceftriaxone
Cefuroxime IV
Celestone Soluspan
Celexa tablet
Cellcept IV
Cellcept oral suspension
Cerdelga
Cerezyme
Cesamet
Centany
Cequa
Ceprotin
Cetrotide
Chloramphenicol
Chloroquine
Chlorpromazine Inj
Chlorzoxazone
Chlorothiazide sodium
Chenodal
Cholbam
Chorionic Gonadotropins
Cidofovir
Cimzia
Cinacalcet
Cinqair
Cinryze
Cinvanti
Ciprofloxacin in dextrose
Cisplatin
Cladribine
Claforan
Clarinex / D
Cleocin Injection
Clenpiq
Clever choice test strips
Clindagel
Clindamycin in Dextrose
Clindamycin Phosphate Injection
Clobazam
Clobetasol
Clobex
Clocortolone
Clodan/ kit
Cloderm
Clolar
Clovique
Coartem
Cogentin
Colchicine Capsule
Colcrys
Colistin
Coly-mycin M Parenteral
Cometriq
Compounded Medications
Conjupri
Consensi
Contour / next test strips
Contraceptives
Conzip
Copiktra
Cordran
Corlanor
Cortrosyn
Cosela
Cosentyx
Cosmegen (Dactinomycin)
Cosyntropin
Cotellic
Cotempla XR ODT
Cresemba
Crysvita
Cuprimine
Cutivate lotion
Cuvposa
Cyclobenzaprine oral tablet 7.5 mg
Cyclobenzaprine oral capsule,extended release 24hr
Cyclophosphamide IV
Cyclosporine IV
Cyramza
Cystadrops
Cystagon
Cystaran
Cytarabine
Dacarbazine

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Dacogen
Daklinza
Dalvance
Danyelza
Dapsone Gel Pump
Daraprim
Darifenacin ER
Darzalex
Darzalex Faspro
Daunorubicin
Daurismo
Dayvigo
Decitabine
Deferasirox
Delzicol
Demerol (PF) Inj syringe 25 ml/ml, 50 mg/ml
Demser
Depen
Depo-Estradiol
Desloratadine
Desonate
Desonide
Desowen
Desoximetasone
Desvenlafaxine Fumarate
Desvenlafaxine ER 24 hr
Dexabliss
Dexamethasone dose pack
Dexchlorpheniramine maleate
Dexilant
Dexpak
Dextenza
Dexycu
Diacomit
Diazepam Inj
Dibenzyline
D.H.E.45
Diatrue plus
Diclofenac Epolamine
Diclofenac Submicronized
Dificid
Diflorasone
Dihydroergotamine Nasal Spray
Dimenhydrinate
Dimethyl fumarate
Dipentum
Diuril IV
Diskets
Docefrez
Dojolvi
Donepezil
Doptelet
Doral
Doryx
Dovonex
Doxepin topical
Doxepin tablet
Doxercalciferol
Doxil
Doxy-100
Doxycycline 50, 75 and 150 mg
Doxycycline ER/DR
D-Penamine
Drizalma Sprinkle
Dronabinol
Droperidol
Droxidopa
Duaklir Pressair
Duetact
Duexis
Duobrii
Dupixent
Duragesic
Durezol
Dyanavel XR
Dymista
Dysport
Easy Plus II
Easy Step
Easy Talk
Easy Touch
Easy Trak / II
Easygluco
Easymax
Ecoza
Edarbi
Edarbyclor
Edluar
Egrifta
Egrifta SV
Elaprase
Elelyso
Element diabetic
Eletriptan
Elitek
Ellence
Elliotts B
Eloxatin
Elzonris
Emadine
Embrace diabetic
Embeda
Emend injection
Emflaza
Emgality
Empliciti
Emsam Patch
Enalaprilat intravenous solution
Enbrel
Enspryng
Endari
Endometrin
Enstilar
Entyvio

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Enzoclear
Epaned
Epclusa
Epidiolex
Epiduo Forte
Epinephrine hcl (PF)
Epirubicin
Equetro
Epogen
Epoprostenol
Epoprostenol (glycine)
Eprosartan
Eraxis
Erbitux
Erelzi
Erivedge
Erleada
Erlotinib Hcl
Erwinaze
Erythrocin IV
Esbriet
Ethyol
Etopophos
Eucrisa
Euflexxa
Evekeo ODT
Evkeeza
Everolimus
Evomela
Evrysdi
Exelderm
Exelon/Exelon patch
Exjade
Exondys 51
Extavia
Extina
Evencare diabetic
Evolution diabetic
Eylea
Eysuvis
Ezallor Sprinkle
EZ Smart System
Fabrazyme
Famotidine pf / IV
Fanapt
Farxiga
Farydak
Fasenra
Faslodex
Feiba
Fenofibrate 50mg, 160mg
Fenoglide
Fentora
Fetzima
Febuxostat
Fenoprofen
Fenortho oral capsule 200 mg
Fentanyl
Fentanyl citrate buccal lozenge on a handle
Feraheme
Ferrlecit
Fexmid
Fexmid
Fiasp
Fibricor
Fifty50 test strip
Finacea
Firazyr
Firdapse
Firmagon
Flarex
Flector Patch
Flolan
Flolipid
Floxuridine
Fludarabine
Fluocinonide
Fluphenazine hcl Inj
Flurandrenolide
Fluticasone
Fluticasone/Salmeterol
Fluvoxamine oral capsule,extended release 24hr
FML Forte
FML S.O.P
Focalin XR
Folic acid injection
Follistim AQ
Folotyn
Foracare test strips
Fora diabetic
Fortamet
Forfivo XL
Fortaz
Fortiscare
Fosrenol
Fotivda
Freestyle test strips
Fulphila
Fulvestrant
Furosemide injection
Fuzeon
Galafold
Galantamine
Gamifant
Ganirelix
Gattex
Gavreto
Gazyva
Ge100 Blood Glucose
Gelnique
Gel-One
Gelsyn-3
Gemcitabine
Gemtesa

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Genotropin
Genstrip test strip
Genvisc
Genvisc 850
Gilenya
Gilotrif
Gimoti
Glassia
Gleevec
Gloperba
Glucagen Hypokit
Gluco Navii
Glucocard
Glucocom
Glucogon hcl Emergency Kit
Glumetza
Glycopyrrolate 1.5mg / IV
Glyxambi
GM100
Gocovri
Gojji blood glucose test strip
Gonal-F
Gralise
Granisetron oral
Granix
Grastek
Growth Hormones (All)
Gvoke
Haegarda
Halaven
Halcinonide
Haldol
Halobetasol
Halog
Haloperidol lactate Inj
Harvoni
Harmony glucose test strip
Healthpro test strips
Hectorol
Hemady
Hepagam B
Heparin (porcine) pf
Heparin (porcine) intravenous solution
Herceptin-and biosimilars
Hetlioz
Hidex
Horizant
Humatrope
Humira
Hyalgan
Hydralazine Injection
Hycamtin (Topotecan)
Hycofenix
Hydrocodone bitartarate
Hydrocortisone Butyr
Hydromorphone oral tablet extended release 24 hr
Hydroxocobalamin
Hydroxyzine hcl intramuscular
Hylenex
Hyperhep B / Neonatal
Hyqvia
Hysingla ER
Ibrance
Icatibant
Inbrija
Iclusig
Idamycin (Idarubicin)
Idhifa
Ifex (Ifosfamide)
Ilaris
Ilumya
Iluvien
Iluvien
Imatinib
Imbruvica
Imcivree
Imipenem-cilastatin
Imlygic
Imfinzi
Impavido
Impeklo
Impoyz
Increlex
Indomethacin Submicronized
Infed
Infertility Medications (All)
Infinity diabetic
Inflectra
Infuvite Adult
Infuvite Pediatric
Ingrezza
Injectable Drugs (All): excluding insulin
Inlyta
Inqovi
Inrebic
All Insulin Lispro Products
Interferons (All)
Intron-A
Inveltys
Iodopen
Iressa
Isolyte S PH 7.4
Isolyte-S
Isoniazid Injection
Isturisa
Ivermectin Cream
IV Immune Globulin (IVIG)
Ixempra
Ixifi
Jadenua
Jakafi
Jazz Wireless 2 Meter Kit
Jelmyto
Jemperli

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Jetrea
Janumet/Janumet XR
Januiva
Jatenzo
Jevtana
Jivi
Jornay PM
Jublia
Juxtapid
Jynarque
Kadcyla
Kalbitor
Kalydeco
Kanuma
Katerzia
Kazano
Kepivance
Kerydin
Kesimpta
Ketoprofen/ER
Ketorolac Nasal Spray
Kevzara
Keveyis
Keytruda
Khapzory
Khedezla
Kineret
Kinevac
Kisqali
Klisyri
Kombiglyze XR
Korlym
Koselugo
Kovaltry
Krintafel
Krystexxa
Kuvan
Kymriah
Kynmobi
Kyprolis
Lactulose
Lamictal XR Starter Kit
Lampit
Lanoxin pediatric
Lansoprazole disintegrating
Lanthanum Carbonate
Lapatinib
Lartruvo
Lastacaft
Latuda
Lazanda
Lemtrada
Lenvima
Lexette
Letairis
Leucovorin Inection
Levalbuterol Tartrate HFA
Levetiracetam IV
Levofloxacin IV
Levoleucovorin
Levsin
Lialda
Libtayo
Licart
Lidocaine-epinephrine
Leukine Injection Recon Solution
Lexapro
Lidotopic Max
Linezeolid IV
Liothyronine IV
Lipodox
Lipofen
Livalo
Livixil
Locoid lotion
Locort
Lofibra
Lokelma
Lonsurf
Lorazepam Inj
Lorbrena
Lorzone
Lotemax
Lotemax SM
Lovaza (formerly Omacor)
Lovenox sq solution
Lubiprostone
Lucemyra
Lucentis
Luliconazole
Lumizyme
Lumoxiti
Lupkynis
Lutathera
Luxiq
Luxturna
Luzu
Lynparza
Lyrica/CR
Lyumjev
Macugen
Mannitol
Margenza
Marinol
Marqibo
Matulane
Mavenclad
Matzim LA
Maxidex
Mayzent
Mekinist
Mektovi
Mefloquine
Naglazyme

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Nalfon oral capsule 400 mg
Nalfon oral tablet
Melphalan
Menopur
Mepron
Mepsevii
Methyldopate
Meropenem
Mesalamine 800mg/1.2GM DR
Mesna
Mesnex IV
Methadone
Methadose
Metformin ER (OSM and MOD)
Metformin Solution
Methyltestosterone
Metoclopramide hcl IV
Metoprolol HCTZ
Metoprolol tartrate intravenous solution
Methitest
Methocarbamol injection
Metro IV
Metronidazole IV
Metyrosine
Micardis
Miconazole nitrate-zinc ox-pet
Micro blood glucose
Microdot
Midazolam (pf) injection cartridge
Midazolam (pf) injection solution 1 mg/ml
Midazolam (pf) injection syringe 2 mg/2 ml (1 mg/ml)
Midazolam injection
Miglustat
Minocyline ER
Miostat
Mircera
Mirvaso
Mitigare
Mitoxantrone
Modafinil
Monjuvi
Monovisc
Morphabond ER
Morphine Inj syr 2mg/ml
Morphine oral capsule, er multiphase
Morphine oral capsule,extend.release pellets
Morphine oral tablet extended release
Motegrity
Moxifloxacin
Mozobil
MS Contin
Mulpleta
Mupirocin calcium
Mutamycin (Mitomycin)
Mvasi
M.V.I. Adult
M.V.I. Pediatric
Myalept
Mycapssa
Mycophenolate
Myglucohealth
Mylotarg
Myobloc
Myrbetriq
Mytesi
Nabi-HB
Nafcillin
Naglazyme
Namenda
Namzaric
Naprelan CR
Naproxen ER
Naproxen/Esomeprazole Mag
Nasonex
Natesto
Natpara
Navelbine (Vinorelbine)
Nayzilam
Neomycin-polymyxin b gu
Nerlynx
Nesina
Neulasta
Neupogen
Neutek 2tek test strip
Nevanac
Nexavar
Nexium
Nexletol
Nexlizet
Nilandron
Nilutamide
Nimodipine
Ninlaro
Nipent
Nitisinone
Nitroglycerin intravenous
Nityr
Nivestym
Nocdurna
Noctiva
Nolix
Norditropin
Norgesic Forte
Noritate
Normosol-R
Normosol-R PH 7.4
Nourianz
Nova Max Glucose Test
Novarel
Novolin/Novolog
Novoseven
Noxafil
Nubeqa
NPlate

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Nucala
Nucynta ER
Nuedexta
Nulibry
Nulojix
Numbonex
Nuplazid
Nurtex ODT
Nutropin/AQ
Nuvigil
Nuzyra
Nymalize
Nyvepria
Ocaliva
Ocrevus
Octreotide
Odactra
Odomzo
Ofev
Ogivri
Olmesartan
Olmesartan HCTZ
Olopatadine nasal
Olumiant
Olux
Olux E
Omega-3 acid ethyl esters
Omeprazole-sodium bicarbonate
Omnaris
Omnitrope
On Call
Oncaspar
Ondansetron hcl pf / IV
Ongentys
One Touch Test Strips
One Touch Ultramini
Onexton
Onfi
Onivyde
Onglyza
Onmel
Onpattro
Onureg
Onzetra Xsail
Opdivo
Opioids (All long and short acting products)
Opsumit
Optium
Optumrx
Oracea
Oralair
Oravig
Orbactiv
Orencia
Orenitram
Orfadin
Orgovyx
Orilissa
Orkambi
Orladeyo
Orphenadrine-Aspirin-Caffeine
Orphengesic Forte
Orphenadrine citrate injection
Orthovisc
Ortikos
Oseni
Osmitrol
Osmolex ER
Otezla
Otrexup
Oxiconazole Nitrate
Ovace plus topical foam
Ovidrel
Oxacillin
Oxaliplatin
Oxandrin
Oxandrolone
Oxaydo
Oxbryta
Oxervate
Oxtellar XR
Oxycodone ER
Oxycontin
Oxymorphone oral tablet extended release 12 hr
Oxytrol
Oxytocin
Ozempic
Ozobax
Ozurdex
Paclitaxel
Padcev
Palforzia
Palynziq
Pamidronate
Pancreaze
Pancretin
Pantoprazole IV/packet
Papaverine injection solution
Paraplatin
Paricalcitol
Parsabiv
Patanase
Paxil tablet/CR/Suspension
Pazeo
Pegasys
Peg-Intron
Pemazyre
Penicillamine
Penicillin G
Pennsaid
Pentasa
Pepaxto
Perjeta
Pertzye

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Pharmacist choice test strip
Phenoxybenzamine Hcl
Phenytoin sodium
Piqray
Pioglitazone-glimepiride
Pexeva
Pfizerpen-g
Phesgo
Photofrin
Plasma-Lyte 148
Plasma-Lyte A
Plegridy
Plenvu
Plexion
Polymyxin B Sulfate
Pomalyst
Ponvory
Portrazza
Posaconazole
Poteligeo
Pradaxa
Potaba
Praluent
Pred Mild
Pregabalin
Pregnyl
Premarin injection
Premier test strip
Premium V10 Strip
Pretomanid
Prepopik
Prestalia
Prevacid (Rx)
Prevymis oral
Prialt
Prilosec Rx
Primaxin
Proair Digihaler
Proair HFA
Probuphine
Procainamide Inj
Prochlorperazine edisylate
Procrit
Procysbi
Prograf IV
Prolastin
Prolensa
Proleukin
Prolia
Promacta
Propranolol Intravenous
Prostin VR Pediatric
Protonix (brand)
Provenge
Proventil HFA
Provigil
Prozac oral capsule
Prudoxin Cream
Psorcon
Pyrimethamine
Qbrelis
Qbrexza
Odolo
Qinlock
Qmiiz
Qnasl
Qtern
Omidria
Qelbree
Qualaquin
Quazepam
Qudexy XR
Quillichew ER
Quillivant
Quintest AC strip
Qutenza
Rabeprazole Sprinkle Cap
Radicava
Ragwitek
Rapaflo
Rapivab
Rasuvo
Ravicti
Razadyne/ ER
Rayaldee
Rayos
Rebif
Reditrex (pf)
Refuah
Regonol
Regranex
Relafen DS
All Relion Products
Relistor
Relexxii
Relpax
Relizorb
Reltone
Remicade
Remodulin
Renagel
Renflexis
Renvela
Repatha
Retacrit
Retevmo
Retisert
Revatio
Revcovi
Reveal diabetic
Revlimid
Rexulti
Reyvow
Rhofade

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Rhopressa
Riabni
Ribavirin inhalation
Rifadin
Rifampin IV
Rightest diabetic
Rinvoq ER
Riomet
Riomet ER
RiaStap
Reisperdal Consta
Rituxan
Rituxan Hycela
Rixubis
Robaxin
Rocklatan
Romidepsin
Rosula
Rozlytrek
Roszet
Rubraca
Ruconest
Ruzurgi
Rybelsus
Ryclora
Rydapt
Ryvent
Saizen
Samsca
Sancuso
Sandimmune IV
Saphris
Sapropterin
Savaysa
Savella
Scalacort DK
Secuado
Seebri Neohaler
Semglee
Sernivo
Sevelamer carbonate powder
Sevelamer Hcl
Shingrix (pf)
Siklos
Signifor/ LA
Silenor
Siliq
Silodosin
Simbrinza
Simponi/Simponi ARIA
Simulect
Simvastin Susp
Sirturo
Sitavig
Sivextro
Skyrizi
Smart sense test strip
Smartest diabetic supplies
Sodium ferric gluconat-sucrose
Sodium Edecrin
Sodium phenylbutyrate
Solesta
Solfenacin
Soliqua
Solodyn
Solosec
Soliris
Soma oral tablet 250 mg
Somatuline Depot
Somavert
Soolantra
Sorilux
Sovaldi
Spinraza
Spravato
Sprix
Sprycel
Steroids, Anabolic
Stelara
Steglatro
Steglujan
Stegluromet
Stivarga
Strensiq
Streptomycin
Striant
S SPRYCELubsys
Sulconazole Nitrate
Sulfamethoxazole DS
Sulfamethoxazole-trimethoprim intravenous
Sumatriptan-naproxen
Sucraid
Sunosi
Supartz FX
Supprelin LA
Sure-test easyplus mini strip
Sustol
Sutent
Sylatron
Sylvant
Symdeko
Symjepi
Symlin Pen
Sympazan
Synagis
Synarel
Syndros
Synercid
Synribo
Synvisc (hyaluronate sodium)
Synvisc-1
Tabrecta
Tadalafil
Tagrisso

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Takhzyro
Tafinlar
Taltz
Talzenna
Talwin
TaperDex
Tarceva
Targadox
Targretin oral
Targretin topical
Tavaborole
Tavalisse
Tasigna
Taxotere (Docetaxel)
Tazicef
Tazverik
Tecentriq
Tecfidera
Technivie
Teflaro
Tegsedi
Tekturna/ HCT
Telcare
Telmisartan
Telmisartan/Amlodipine
Telmisartan HCTZ
Temodar
Temovate
Temozolomide
Teniposide
Tepadina
Tepmetko
Tetrabenazine
Teriparatide
Testim
Test N'Go Test
Testosterone (All)
Testopel
Non-preferred diabetic test strips and meters
Testred
Thallous chloride
Thalomid
Thiola
Thiola EC
Thymoglobulin
Thyquidity
Thyrogen
Tibsovo
Tigan IM
Tiglutik
Timolol maleate (pf)
Timoptic Ocudose
Tirosint / SOL
Triostat
Tice BCG
Tivorbex
Tolsura
Topiramate oral capsule,sprinkle,er 24hr
Tobi
Tobramycin Ampul for Nebulization
Tolvaptan 30 mg
Topicort
Toposar (Etoposide)
Torisel
Tosymria
Tovet
Toviaz
Tracleer
Tramadol Biphasic
Tramadol oral tablet extended release 24 hr
Tramadol oral tablet, er multiphase 24 hr
Tranexamic acid intravenous
Travatan Z
Travel Medication: including Malarone, Larium and Aralen, Chloroquine
Tranzarel
Tremfya
Treanda
Trelstar
Treprostinil sodium
Tretin
Tretinoin 10mg Capsule
Tretten
Treximet
Triamcinolone
Trianex
Trientine
Triglide
Trikafta
Trintellix
Triptodur
Trisenox (Arsenic Trioxide)
Trodelvy
Trogarza
Trokendi XR
Trospium
True Metrix test strip
Trueresult Blood Glucose System
Truetest test strip
Truetrack
Trulicity
Tudorza Pressair
Tukysa
Turalio
Tuzistra XR
Tykerb
Tysabri
Tymlos
Tyvaso
Ubrelvy
Udenyca
Uceris
Ukoniq
Ultima test strip

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Uloric
Ultratrak test strip
Ultomiris
Ultravate
Unasyn
Unistrip test strip
Unituxin
Upneeq (PF)
Uptravi
Utibron Neohaler
Utopic
Uvadex
Valchlor
Valptoate sodium
Valstar
Valtoco
Vanos
Vantas
Vascepa
Vectibix
Velcade
Velphoro
Veltassa
Veltin
Veletri
Vemlidy
Venclexta
Venlafaxine Hcl ER Tab
Venofer
Ventavis
Ventolin HFA
Verasens test strip
Verdeso
Verquvo
Verzenio
Vesicare
Vfend IV
Vibativ
Victoza
Vidaza
Viekira Pak/XR
Viibryd
Vimizim
Vimovo
Vimpat IV
Vinblastine
Vincasar (Vincristine)
Viokace
Virazole
Visudyne
Vistogard
Vitrakvi
Vitrase
Voriconazole IV
Vyxeos
Vyzulta
Vituz
Vivaguard ino test strip
Vivlodex
Vizimpro
Vonvendi
Voraxaze
Votrient
Vpriv
Vraylar
Vumerity
Vusion
Vyondys 53
Vyndamax
Vyndaqel
Vyzulta
Wakix
Wavesense
Weight Loss Medication (if covered by your plan), Xenical, Tenuate, etc
Winlevi
Wynzora
Xadago
Xalkori
Xatmep
Xcopri
Xeljanz/XR
Xeloda
Xelpros
Xenazine
Xenleta
Xepi
Xerese
Xermelo
Xeomin
Xhance
Xiaflex
Xifaxan
Xigduo XR
Ximino
Xofigo
Xolair
Xopenex HFA
Xospata
Xpovio
Xtampza ER
Xuriden
Xtandi
Xyntha
Xyosted
Xyrem (Sodium Oxybate)
Xywav
Yervoy
Yescarta
Yondelis
Yonsa
Zaltrap
Zanosar
Zarxio

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Zcort
Zavesca
Zegalogue
Zegerid oral packet / capsule
Zelboraf
Zelnorm
Zejula
Zemaira
Zembrace SymTouch
Zemplar IV
Zepatier
Zeposia
Zepzelca
Zerbaxa
Zerviate
Zetonna
Zevalin
Zilretta
Zileuton
Zilxi
Zinbryta
Zingo
Zinplava
Zioptan
Zipsor
Zipsor
Zithromax IV
Zocor 10 MG, 20 MG, 40 MG, 80 MG
Zohydro ER
Zokinvy
Zolinza
Zoladex
Zolgensma
Zoloft
Zolpimist
Zonalon
Zontivity
Zortress
Zorvolex
Zovirax topical
ZTlido
Zuplenz
Zydelig
Zyflo/CR
Zykadia
Zynlonta
Zypitamag
Zytiga

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:

Genotropin
Humatrope
Increlex
Norditropin
Nutropin AQ
Omnitrope
Saizen
Serostim
Zomacton
Zorbtive

Blood Clotting Factors including:

Advate
Adynovate
Afstyla
Alphanate
AlphaNine SD
Alprolix
Bebulin
Benefix
Bevyxxa
Bivalirudin
Coagadex
Cyklokapron
Eloctate
Helixate
Hemlibra
Hemofil M
Humate P
Idelvion
Iprivask
Ixinity
Jivi
Kcentra
Koate
Kogenate FS
Kovaltry
Monoclate-p
Mononine
Novoeight
NovoSeven
Nuwiq
Obizur
Profilnine
Protamine
Rebinyn
Recombinate
Rixubis
Rivastigmine
Tretten
Vonvendi
Xyntha
Xyntha Solofuse

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Hepatitis C Treatments including:

Daklinza
Epclusa
Harvon
Mavyret
Peg Intron
Pegasys
Sovaldi
Sylatron
Technivie
Viekira Pak
Viekira XR
Vosevi
Zepatier

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LHRH Agonists including;
- Trelstar
- Vantas
- Zoladex

Multiple Sclerosis Treatments including:
- Ampyra (dalfampridine ER)
- Aubagio
- Avonex
- Betaseron
- Extavia
- Gilenya
- Ocrevus
- Plegridy
- Rebif
- Tecfidera
- Tysabri

Other Drugs including:
- Acthar Gel
- Actimmune
- Aldurazyme
- Apokyn
- Aralast
- Aveed
- Benlysta
- Berinert
- Boniva injection
- Botox (botulinium toxin type A)
- Cayston
- Cerdelga
- Cerezyme
- Cinqair
- Dysport
- Cinryze
- Cuvitru
- Egrifta
- Egrifta SV
- Elaprase
- Elelyso
- Emflaza
- Esbriet
- Esomeprazole
- Ethacrynate sodium
- Exforge
- Exjade
- Exondys
- Fabrazyme
- Firazyr
- Flebogamma
- Folotyn
- Gammagard
- Gammaked
- Gammaplex
- Gamunex-C
- Gattex
- Glassia
- Hetlioz
- Hetlioz LQ
- Hizentra
- Ibandronate IV
- Ilaris
- IVIG (Immuneglobulin)
- Jakafi
- Juxtapid
- Kalbitor
- Kalydeco
- Kanuma
- Korlym
- Krystexxa
- Kuvan
- Lumizyme
- Mozobil
- Myobloc
- Naglazyme
- Northera
- Nplate
- Nucala
- Nulojix
- Ocaliva
- Octagam
- Ofev
- Oralair
- Orfadin
- Orkambi
- Ozurdex
- Panzyga
- Praluent
- Prialt
- Procysbi
- Prodigy
- Prolastin
- Prolia
- Promacta
- Ravicti
- Repatha
- Retisert
- Riastap
- Ruconest
- Qutenza
- Samsca
- Sandostatin/ LAR
- Signifor
- Soliris
- Solus
- Somavert
- Sotalol Intravenous
- Spinraza
- Strensiq
- Sucraid
- Supprelin LA
- Sylvant
- Synagis
- Testopel
- Thyrogen
- Veltassa

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Vimizim
Vistogard
Vpriv
Xenazine
Xeomin
Xiaflex
Xolair
Xuriden
Xylocaine with Epinephrine
Xyrem
Zemaira
Zavesca
Zemaira
Zortress

Oral Oncology Agents Including:

Afinitor
Alecensa
Bosulif
Cabometyx
Caprelsa
Cometriq
Cotellic
Erivedge
Erlotinib Hcl
Everolimus
Gazyva
Gilotrif
Gleevec
Hycamtin
Ibrance
Iclusig
Icosapent ethyl
Imbruvica
Inlyta
Iressa
Jakafi
Lenvima
Lonsurf
Lynparza
Mekinist
Nexavar
Ninlaro
Odomzo
Ofev
Pomalyst
Revlimid
Sprycel
Stivarga
Sutent
Sylatron
Synribo
Tafinlar
Tarceva
Tasigna
Temodar
Thalomid
Tykerb
Valchlor
Venclexta
Votrient
Xalkori
Xeloda
Xtandi
Zelboraf
Zolinza
Zolmitriptan nasal
Zortress
Zydelig
Zykadia
Zytiga

Psoriasis/Rheumatoid Arthritis/Crohn's Disease Treatments including:

Actemra
Amjevita
Arcalyst
Benlysta
Cimzia
Cosentyx
Cuvposa
Enbrel
Entyvio
Erelzi
Humira
Inflectra
Ilaris
Kineret
Krystexxa
Orencia
Otezla
Remicade
Rituxan RA
Simponi
Stelara
Taltz
Xeljanz

Pulmonary Hypertension Drugs including:

Adcirca
Adempas
Flolan
Letairis
Opsumit
Remodulin
Revatio
Sildenafil
Tracleer
Tyvaso
Uptravi
Veletri
Ventavis

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Infertility Drugs including:

Cetrotide
Chorionic Gonadotropins
Follistim AQ
Ganirelix
Gonal-F
Menopur
Ovidrel
Pregnyl

Viscosupplements including:

Durolane
Euflexxa
Gel-One
Gelsyn-3
Genvisc
Hyalgan
Hymovis
Monovisc
Orthovisc
Supartz /FX
Synvisc
Synvisc One
TriVisc
Visco-3

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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