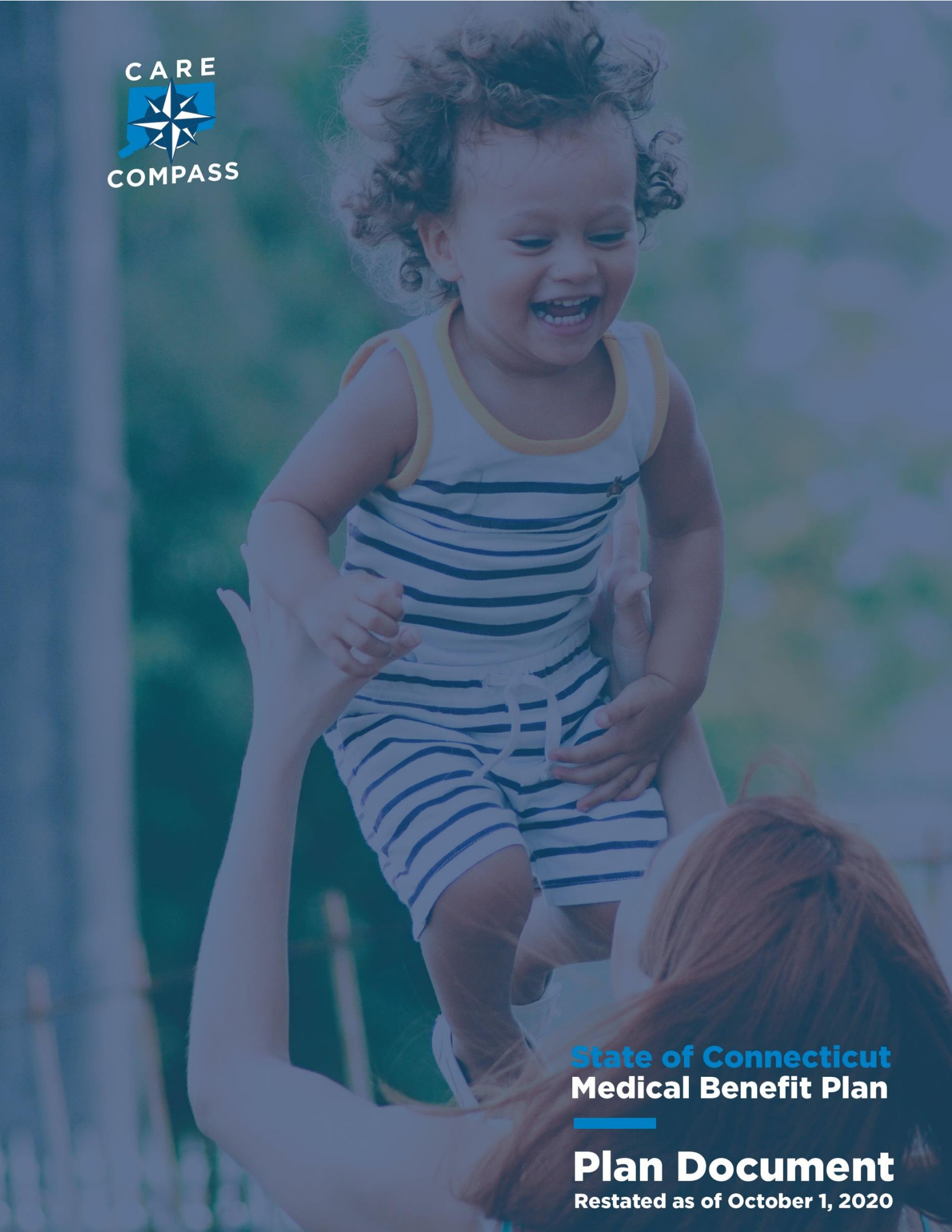

CARE COMPASS

State of Connecticut
Medical Benefit Plan

Plan Document

Restated as of October 1, 2020

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Introduction

This document describes the State of Connecticut Medical Benefit Plan ("Medical Benefit Plan") for employees, non-Medicare-eligible retirees and eligible DEPENDENTS (that are not eligible for MEDICARE). The Medical Benefit Plan is a self-funded governmental health benefit PLAN that is not subject to the Employee Retirement Income Security Act ("ERISA"). This PLAN DOCUMENT explains the benefits, exclusions, limitations, terms and conditions for coverage, and the guidelines that must be followed to obtain benefits for COVERED SERVICES. All the defined terms used in this Plan Doc, LOPD due to 2 weeks paid administrative leave and 6 weeks paid of layoff bumping in 2016ument are capitalized the first time they are used. Definitions can be found in the Glossary.

The terms of this Plan Document shall govern and supersede any previous versions thereof and any outlines or other summaries distributed by the State of Connecticut.

The State has contracted Anthem Blue Cross and Blue Shield (Anthem BCBS), as the sole CARRIER, to provide claims processing, disease management and other administrative services. Subject to collective bargaining, the State has the right to change the benefits under the Medical Benefit Plan and to interpret the meaning of the Plan Document.

The State of Connecticut is the PLAN SPONSOR of this Medical Benefit Plan. All notices to the Plan Sponsor should be directed as follows:

Office of the State Comptroller
Healthcare Policy & Benefit Services Division
165 Capital Avenue
Hartford, CT 06106

Know the Difference

- **Covered Member:** A person who is eligible and enrolled for covered services by virtue of past or present employment with the Participating Employer.
- **Covered Person:** A dependent of a covered member who is enrolled in this Medical Benefit Plan and eligible for benefits for covered services.

Carrier Contact Information

Contact Anthem Blue Cross and Blue Shield for information about IN-NETWORK PHYSICIANS and PROVIDERS. Call the telephone number printed on the COVERED PERSON'S I.D. CARD or as follows:

Carrier Contact Information
Anthem Blue Cross and Blue Shield Member Services 108 Leigus Road Wallingford, CT 06492 1-800-922-2232 www.anthem.com/statect

Eligibility

Eligible Employees

Active Employees

Unless otherwise specified in an applicable collective bargaining agreement or by the terms of employment, an employee must work at least half the hours per pay period of a full-time employee in his/her position (0.5 full time equivalent—FTE) to be eligible to participate in the Medical Benefit Plan (unless the employee's coverage is otherwise required pursuant to the AFFORDABLE CARE ACT). Special rules apply to employees not in classified service, part-time professional employees in higher education agencies, and to non-employee groups participating in the State's employee plans under Section 5-259 of the general statutes.

In addition to the provisions set forth above, to enroll in the Medical Benefit Plan an active employee must also be:

- A PERMANENT EMPLOYEE; or
- An employee in a full-time position that requires or is expected to require the services of the incumbent for a period in excess of six months (even if such position is designated as "temporary"), on the first day of the month following completion of 60 days of continuous service; or

"Variable Hour" Employees

If at the time of hire the employer cannot reasonably determine whether a new employee will work an average of 30 hours per week, the employee is considered a "VARIABLE HOUR EMPLOYEE." For such employees, the employer will use a 12-month initial measurement period to determine whether that individual worked, on average, 30 hours per week. If at the end of the initial measurement period it is determined that the employee has worked, on average, 30 hours per week, the employee will be eligible for participation in the Medical Benefit Plan during the following 12 months as long as he/she remains employed, regardless of the number of hours actually worked during that period.

Retired Non-Medicare-Eligible Employees

Eligibility for retiree health benefits is determined by statute, collective bargaining agreements and memoranda issued by the Office of the State Comptroller.

The Non-Medicare-Eligible Retiree Plan will provide benefits to a retired employee (and his/her enrolled spouse, if applicable) only to the extent that they:

- Are not eligible to participate in Medicare Parts A and B; or
- If eligible for Medicare, do not live in the geographic service area that is covered by Medicare. For example, if a Medicare-eligible retiree lives outside Medicare's geographic service area, which includes the 50 U.S. states, the District of Columbia and U.S. territories, he/she will be covered under the Medical Benefit Plan.

Eligible Dependents

For eligible dependents to be enrolled for coverage, the COVERED MEMBER and all eligible dependents must be enrolled in the same plan. The State of Connecticut reserves the right to request PROOF of dependent status at any time.

The following are eligible to be enrolled as a dependent:

- **Spouse or recognized civil union partner.** The lawful spouse of the covered member under a legally valid, existing marriage or the covered member's recognized civil union partner as defined by the Plan Sponsor. Except as set forth in this section, an individual from whom a covered member is divorced or legally separated is not eligible for coverage.

  Note: If a covered member dies before retirement, a spouse who was not married to the deceased employee for at least 12 months before the date of death is not eligible for continued coverage.

  Exceptions:

  - An individual from whom the covered member is legally separated may continue coverage under the Medical Benefit Plan for up to three years following the date of the judgment or until the remarriage of either party, whichever occurs first, provided the former spouse was covered by the Medical Benefit Plan immediately before entry of the legal separation judgment and the covered member pays 100% of the cost of individual coverage (employee plus state share) for the former spouse on a post-tax basis. This will be in addition to the covered member's cost of coverage; or
  - An individual from whom the covered member is divorced may continue coverage under the Medical Benefit Plan for up to three years following the date of the judgment or until the remarriage of either party, whichever occurs first, provided the ex-spouse was covered by the Medical Benefit Plan immediately before the divorce and the judgment requires the covered member to provide health insurance coverage for the ex-spouse. The covered member pays 100% of the cost of individual coverage (employee plus State share) for the former spouse on a post-tax basis. This will be in addition to the covered member's cost of coverage.

- **Child of the** covered member **or spouse of the** covered member**.** A child of the covered member or covered member's spouse, including a stepchild; a child legally placed for adoption; or a legally adopted child.
- **Newborn child.** Coverage under the Medical Benefit Plan shall be provided for a newborn child of the covered member from the moment of birth.
- The covered member must submit a completed enrollment application within 31 days after the date of birth to maintain coverage for the newborn. Eligibility requirements must be met, and the enrollment application must be accepted by the carrier.
- **Newborn of a covered dependent child.** A newborn child of an enrolled female dependent child is eligible for coverage from the moment of birth up to and including 31 days immediately following birth. The newborn child of a covered dependent child is not eligible for coverage under the Medical Benefit Plan beyond the 31-day period.
- **TOTALLY DISABLED child.** A totally disabled child who is incapable of sustaining employment by reason of physical or mental handicap may continue coverage beyond the age limit set forth in the Medical Benefit Plan, provided he/she:

- Is incapable of sustaining employment by reason of physical or mental handicap as certified by a physician and for whom the covered member (or his/her spouse or civil union partner) is chiefly responsible for support and maintenance; and
- Became disabled before the limiting age for a dependent child and had comparable coverage as a dependent at the time of enrollment; and
- If over the age of 26, is unmarried.
- Proof of such incapacity and dependency must be received by the carrier within 31 days of the date upon which the child's coverage would have terminated in the absence of such incapacity. The disability must be certified at that time or at the time of enrollment by a physician and then no more than annually thereafter.
- **Minor child for whom a covered member is legal guardian.** A minor child who resides with a covered member and for whom the covered member (or his/her spouse) has been named the legal guardian of the person by a court of competent jurisdiction may be enrolled as a dependent. Coverage will end when the child attains 18 years of age or upon the termination of the guardianship, whichever first occurs.
- **Continuation of coverage for former ward after termination of legal guardianship.** If the covered person demonstrates that a former ward who was enrolled under the Medical Benefit Plan immediately before reaching the age of 18 continues to be dependent upon him/her (either as a "qualifying child" or a "qualifying relative" for federal income tax purposes), coverage may be available beyond the legal guardianship age to age 26. Proof of continued dependency must be provided annually. If the covered person continues in a parental/supportive relationship to a former ward who was enrolled in the Medical Benefit Plan immediately before reaching the age of 18, but is not eligible to claim the child as a dependent for federal income tax purposes, the fair market value of such coverage will be imputed as income to the covered person.

Qualified Medical Child Support Orders (QMSCO). A dependent child may be covered as a consequence of a domestic relations order issued by a state court to a divorced parent who is a covered person or the covered member's spouse, as long as the child is under the age of 26. Enrollment may be required even in circumstances where the child was not previously covered under the Medical Benefit Plan.

Changes Effecting Eligibility

It is the covered member's responsibility to notify the Plan Sponsor of any change in status that makes an enrolled individual ineligible for continued coverage as a dependent. Notice must be made within 31 days of the qualifying event, and coverage for the ineligible person will be terminated effective the first day of the following month.

Active employees must provide written notice of the qualifying event to the personnel/payroll office of their employing agency. Retirees should notify the Retiree Health Insurance Unit, Healthcare Policy & Benefit Services Division, Office of the State Comptroller.

Examples of qualifying events that must be reported within 31 days include:

- The end of a calendar year in which a covered child reaches age 26;

- Termination of a legal guardianship for an enrolled child as result of court order, expiration of temporary guardianship, operation of law or the child's attainment of age 18, whichever first occurs; or
- Divorce or entry of a judgment of legal separation. Note: Children of a covered member's former spouse (stepchildren of the covered member) are ineligible for continued coverage because of divorce or legal separation.

The above status changes are events that provide former dependents with the right to continue medical coverage at their own expense for a limited period under a federal law known as COBRA. Although the Medical Benefit Plan requires notification and termination of coverage for ineligible individuals within 31 days of the status change, federal regulations give the ineligible dependent up to 60 days to notify the Plan Sponsor of the change in status in order to obtain COBRA continuation coverage. If notice of the change in status is not provided within the 60-day period after the qualifying event, the Medical Benefit Plan is not obligated to provide COBRA continuation coverage.

Failure to Provide Notice of Status Change

Any covered member who knowingly enrolls an ineligible individual or misrepresents (or withholds) facts regarding an enrolled individual's status, or fails to notify the Plan Sponsor of an event or occurrence that renders an enrolled individual ineligible for continued coverage under the Medical Benefit Plan, may be subject to one or more of the following:

- Disciplinary action, including termination of employment, for enrolling or maintaining the enrollment for a person who is not eligible for coverage as a dependent or failing to notify the State of any change in status (divorce, legal separation, leaving State service, etc.) that makes a covered member ineligible for the Family Less Employed Spouse (FLES) rate;
- Taxation on the fair market value of health benefit coverage provided to an ineligible individual (reported to the Internal Revenue Service as income of the employee or retiree);
- Liability for the value of claims paid on behalf of an ineligible former spouse or dependent;
- Restitution for the State share of any premiums advanced for the ineligible dependent;
- Rescission of coverage;
- Suspension from eligibility for coverage under the Medical Benefit Plan; or
- Prosecution for fraud.

Coverage During Leaves of Absence

- **Paid leave:** Health benefits will continue unchanged during the period an active employee is on active payroll status.
- **Unpaid leave:**
  - **Family and medical leave:** The State will continue to contribute the employer share of applicable premiums to maintain Medical Benefit Plan coverage for an employee on leave under the Family and Medical Leave Act (FMLA) for up to 24 weeks (12 pay periods) in any two-year period,

provided that the employee premium share for such coverage, if any, is made directly to the employing agency on a timely basis. An employee who is eligible for Federal but not State FMLA is entitled to up to 12 weeks of continued coverage for health benefits in any 12-month period, provided that employee premium share, if any, is made directly to the employing agency on a timely basis.

- **Employee medical leave:** The State will continue to contribute the employer share of applicable premiums to maintain Medical Benefit Plan coverage for an employee on personal medical leave for the length of the illness, up to 12 calendar months, provided the employee premium share, if any, is paid directly to the employing agency on a timely basis.
- Leave other than illness or injury:
    - **Less than four months duration:** If the duration of leave is expected to be less than four months, the employee may stay enrolled in the Medical Benefit Plan by paying the full amount of the premium (employee and State share) directly to the agency.
    - **Four months or more.** If the duration of leave is expected to be, or extends for four months or longer, the employee will be offered continuation coverage under COBRA procedures.
- **Other medical leave**: In addition to any leave under FMLA or personal medical leave in excess of 12 months, an additional period of coverage may be allowed if provided for in a specific collective bargaining agreement.
- **Workers' Compensation:** An employee who is on leave while receiving Workers' Compensation benefits attributable to State of Connecticut employment may continue to participate in the Medical Benefit Plan. As required by statute, the State will continue to contribute the employer share of applicable premiums to maintain Medical Benefit Plan coverage while the employee is receiving Workers' Compensation benefits. The employee must continue to pay the employee premium share, if any. The affected employee must make arrangements for either direct payment to the agency, or if leave benefits are used to supplement Workers' Compensation, by payroll deduction of the employee's premium share.

An employee on leave status of any kind has the right to change coverage during OPEN ENROLLMENT.

Enrollment

Newly Hired Employees

In order to become a covered member, enrollment must be within 31 days of commencing employment (or within 31 days of completion of any required waiting period for healthcare eligibility). If enrollment is not completed during that period, the employee may be required to wait until the next Open Enrollment, unless there is a QUALIFYING STATUS CHANGE that results in a loss of healthcare coverage. To enroll, submit the Health Insurance Enrollment Application, specifying medical plan choice, to the payroll/personnel office of the covered member's employing agency.

Retirees

Coverage for eligible retirees will take effect the first day of the month after the month in which retirement occurs, or the first day of the month after the date an affected individual satisfies the RULE OF 75. Enrollment must be completed at the time of retirement or within 31 days of satisfying the Rule of 75, or the eligible retiree may be required to wait until the next Open Enrollment, unless there is a qualifying status change that results in a loss of healthcare coverage. Retirees follow the same Open Enrollment period as active employees; plan changes should be submitted to the Office of the State Comptroller, Retiree Health Insurance Unit of the Healthcare Policy & Benefit Services Division.

Open Enrollment

Each year there is an Open Enrollment period for approximately one month, during which all Medical Benefit Plan covered members may make changes to their plan enrollment. The annual Open Enrollment period is normally the only time covered members may change carriers, change plans, or change dependent coverage. Changes made during Open Enrollment are effective July 1, unless Open Enrollment has been delayed due to the collective bargaining process. For active employees, enrollment and change forms must be submitted to the employing agency payroll/personnel office.

Proof of Dependent Status

Proof of each dependent's relationship to the employee/retiree must be presented at the time of the initial application for coverage of that individual or upon request for confirmation of continued eligibility for coverage. The original document(s) (or certified copies), as specified below, must be presented to the agency for verification of dependent status:

- **Marriage:** Marriage Certificate and the first two pages of a covered member's most recent federal income tax return confirming claimed marital status.
- **Civil union:** Civil Union Certificate and the first two pages of a covered member's most recent state income tax return confirming claimed status (where applicable).
- **Biological child:** Long-form Birth Certificate.

- **Stepchild:** Long-form Birth Certificate showing parent/child relationship between the covered member's spouse and child to be added.
- **Adoption:** Notification of Placement for Adoption from the adoption agency or a certified copy of the adoption decree.
- **QMCSO:** A valid Support Enforcement Order from the State Department of Social Services or a court of competent jurisdiction. In such case, the child must be added to the covered member's coverage, as ordered, with or without the consent of the covered member.
- **Custody of a minor child:** Proof of guardianship or custody from a court of competent jurisdiction. **The minor child must reside with the covered member to be eligible for enrollment and coverage under the Medical Benefit Plan.** A custody agreement from another state will not be honored unless it has been approved by a State of Connecticut Court or the State of Connecticut Department of Children and Families.

Special Enrollment Periods

Under certain conditions, an employee or retiree may make coverage elections that correspond to a change in family or work status outside of Open Enrollment. For active employees, all requests for change of election due to a qualifying status change must be submitted to the employing agency payroll/personnel office. Retirees should submit all requests for change to the Office of the State Comptroller, Retiree Health Insurance Unit of the Healthcare Policy & Benefit Services Division within 31 days of the event. The change must be consistent with the change in status. All coverage changes are effective the 1st of the month following the date of the event.

Examples of qualifying status changes:

- **Legal marital/civil union status**. Any event that changes the covered member's legal marital/civil union status, including marriage, civil union, divorce, death of a spouse and judgment of legal separation.
- **Number of dependents**. Any event that changes the covered member's number of dependents, including birth, death, adoption and legal guardianship.
- **Employment status**. Any event that changes the covered member's, or the covered member's dependent's, employment status, resulting in gaining or losing eligibility for coverage such as:
  - Beginning or ending employment
  - Starting or returning from an unpaid leave of absence
  - Changing from part time to full time or vice versa.
- **Dependent status**. Any event that causes a covered member's dependent to become eligible or ineligible for coverage. Note: Children of a covered member's former spouse (stepchildren of the covered member) are ineligible for continued coverage as a result of divorce or judgment of legal separation.
- **Residence**. A significant change in a covered member's place of residence that affects his/her ability to access network providers.

- **Loss of coverage**. Any event that causes a covered person to lose coverage from another source.

Prohibition of Dual Coverage

No individual is permitted to maintain dual coverage as a covered member or covered person under the Medical Benefit Plan, the Non-Medicare-Eligible Retiree Benefit Plan, or the Medicare Advantage Plan. It is also prohibited for the same individual to be simultaneously enrolled as dependent or beneficiary of more than one State of Connecticut retiree or as the dependent or beneficiary of a member of the Medical Benefit Plan and the Non-Medicare-Eligible Retiree Benefit Plan or the Medicare Advantage Plan.

A covered member who is dually enrolled in violation of this provision will have 31 days to choose a single plan in which to participate. Anyone who fails to make an election within that time will remain in the plan with the earlier enrollment date (for which they remain eligible), and their duplicate, later coverage will be terminated. If such person subsequently becomes ineligible for coverage as a dependent of a retiree, such person shall be enrolled in the plan for which he/she remains qualified.

Effective Date of Coverage

All periods of coverage start on the first day of a month and end on the last day of a month.

- **Newly hired employees:** Coverage for the employee and any eligible dependents will commence as of the first day of the month following enrollment. For example, an employee whose first day of work is in January is eligible for coverage as of February 1, if he/she enrolls on time.
- **Retirees:** Coverage for retirees will commence on the first day of the month after the month in which retirement occurs. For example, an employee who retires effective October 1 will be covered under the Retiree Benefit Plan effective November 1. In the case of individuals subject to a waiting period for commencement of retiree health benefits under the Rule of 75, coverage will commence on the first day of the month following enrollment, which must take place within 31 days of the individual's retirement date or his/her attainment of the requisite qualifying age—whichever last occurs.
- **New spouse:** Coverage for a new spouse will be effective on the first day of the month following enrollment, which must take place within 31 days of marriage or at Open Enrollment.

  Children: A newborn child of a covered member is automatically covered for 31 days following birth but will not be covered after that period unless an enrollment application is submitted within 31 days of the birth. A child who is newly adopted or placed for adoption with a covered member must be enrolled within 31 days of the DATE OF PLACEMENT for adoption or the date of adoption. Coverage will be effective on the first day of the month following the month in which the qualifying event occurs.

  A stepchild may be enrolled within 31 days of the date when eligibility requirements are first met. Coverage will be effective on the first day of the month following the date of enrollment. For example, as the result of marriage, a covered member may enroll the child of his/her new spouse within 31 days of the marriage.
- **Effect of hospitalization on coverage:** If a covered person is confined in a HOSPITAL on the date when that person would otherwise become eligible for coverage, that person will not be eligible for coverage under the Medical Benefit Plan until the confinement ends, provided that the person is not totally disabled on that date.

Medical Coverage

Subject to the terms and conditions of the Medical Benefit Plan, a covered person is eligible for benefits for covered services for MEDICALLY NECESSARY care when prescribed or ordered by a physician and when in accordance with the provisions of this section.

A covered person's right to benefits for covered services provided under this Medical Benefit Plan is subject to certain policies or guidelines and limitations, including, but not limited to PRIOR AUTHORIZATION, CONCURRENT REVIEW, and CASE MANAGEMENT. Failure to follow the managed care guidelines for obtaining covered services from Anthem BCBS may result in a reduction or denial of benefits.

Members with questions regarding managed care guidelines and services for which prior authorization is required should call the telephone number on the back of the I.D. card consult the carrier's website:

- Anthem BCBS: www.anthem.com/statect

The covered person should consult his/her physician concerning courses of treatment and care. Notwithstanding any benefit determination, the covered person and the covered person's physician must determine what care and/or treatment is received.

Medical Benefit Plan Options

The State of Connecticut offers several plan types, which are described below. With minor exceptions to the plan type selected, the covered benefits for all plans are intended to be the same.

Point of Enrollment-Gatekeeper (POE-G) Plans

The POE-G Plans offer healthcare services from a defined network of providers. OUT-OF-NETWORK care is covered **only** in the case of emergencies. Covered persons must select a PRIMARY CARE physician (PCP) to coordinate all care, and referrals are required for all specialist services. Healthcare services obtained outside the network may not be covered.

Point of Enrollment (POE) Plans

The POE Plans offer healthcare services from a defined network of providers. Out-of-network care is only covered in the case of emergency. No referrals are necessary to receive care from in-network providers.

Point of Service (POS) Plans

The POS Plans offer healthcare services within and outside a defined network of providers. No referrals are necessary to receive care from in-network providers. Healthcare services obtained outside the network may require precertification and are generally reimbursed at 80% of the allowable cost (after payment of the annual DEDUCTIBLE). Covered persons will also pay 100% of the amount that out-of-network providers bill above the MAXIMUM ALLOWABLE AMOUNT. Out-of-network providers will charge more out-of-pocket for most services. Out-of-network services may also be subject to service limits that

are not applicable to covered persons receiving in-network care. Using an out-of-network provider will result in higher costs to the covered person.

State Preferred POS Plan. This plan is closed to new enrollment. The State Preferred POS Plan offers healthcare services within and outside a defined network of providers. No referrals are necessary to receive care from in-network providers. Healthcare services obtained outside the network may require precertification and are reimbursed at 80% of the allowable cost (after payment of the annual deductible). Covered persons will also pay 100% of the amount that out-of-network providers bill above the maximum allowable amount. Out-of-network providers will charge more for most services. Out-of-network services may also be subject to service limits that are not applicable to in-network care. The State Preferred POS Plan is only offered through Anthem BCBS and has a slightly different provider network than the other Anthem BCBS plans.

State BlueCare Prime Plus POS Plan

The State BlueCare Prime Plus POS Plan offers healthcare services from a defined network of quality-based providers. Covered persons must select a PRIMARY CARE physician (PCP) to coordinate all care, and referrals are required for all specialist services. Healthcare services obtained outside the network or without a PCP referral will be subject to a deductible and coinsurance. Healthcare services obtained without a referral [even if in network] or outside the network are generally reimbursed at 70% of the allowable cost (after payment of the annual DEDUCTIBLE). Using out-of-network services or obtaining services without a referral from the PCP will result in higher costs to the covered person.

Out-of-Area Point of Service (POS) Plans

The Out-of-Area POS Plans offer healthcare services within and outside a defined network of providers. These plans are only available to covered persons who reside outside the State of Connecticut. No referrals are necessary to receive care from in-network providers. Healthcare services obtained outside the network may require precertification and will be reimbursed at 80% of the allowable cost (after payment of the annual deductible). Covered persons will also pay 100% of the amount that out-of-network providers bill above the maximum allowable amount. Out-of-network providers will charge more for most services. Out-of-network services may also be subject to service limits that are not applicable to in-network care. Using an out-of-network provider will result in higher costs to the covered person.

Covered Primary and Preventive Care

Primary care consists of office visits, house calls and hospital visits provided by a primary care physician (PCP) (in the POE and POE-G Plans) or other provider for consultations, diagnosis and treatment of injury and disease.

PREVENTIVE CARE consists of services provided on an OUTPATIENT basis at a physician's office, an alternate facility or a hospital. Preventive care services encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and, as required under applicable law, include the following:

- Evidence-based items or services that have, in effect, a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force;

- Immunizations that have, in effect, a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the HRSA.

Preventive care consists of the services described below for the purpose of promoting good health and early detection of disease.

- **Well-baby and well-childcare.** The Medical Benefit Plan covers well-baby and well-child care, which consist of routine physical examinations, including vision and hearing screenings, developmental assessment, anticipatory guidance and laboratory tests ordered at the time of the visit, as recommended by the American Academy of Pediatrics. Immunizations and boosters as recommended by the State of Connecticut are also covered. HPV immunization is covered for males and females between the ages of nine and 26.
- **Adult physical examinations.** Periodic adult physical examinations are covered. The Medical Benefit Plan will cover one physical exam per CALENDAR YEAR for every covered person age 19 or older. The Medical Benefit Plan will cover an annual prostate screening for males age 50 and older, symptomatic males at any age, and males whose biological father or brother has been diagnosed with prostate cancer at any age.
- **Well-woman routine gynecological examinations.** Including a routine gynecological examination, breast examination and Pap smear.
  - Covered persons in a POE-G Plan or State BlueCare Prime Plus POS Plan may receive their well-woman examinations and any necessary follow-up care, services for acute care and care related to pregnancy from their selected primary provider of OB/GYN care without a referral.
- **Mammograms.** Including mammograms provided by Breast Tomosynthesis.
  - Comprehensive Ultrasound screening of an entire breast or breasts 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, or
  - positive genetic testing, or
  - Other indications as is recommended by a woman's treating physician or advanced practice registered nurse, for
  - a woman who is forty years of age or older, who has a
  - Family history or prior personal history of breast cancer, or
  - Prior personal history of breast disease diagnosed through biopsy as benign.

- Magnetic resonance imaging of an entire breast or breasts in accordance with guidelines established by the American Cancer Society.

- **Family planning.** Including counseling on the use of contraceptives and related topics, the insertion (or removal) of a birth control implant, the measuring or fitting of a contraceptive device, including a diaphragm cervical cap or intrauterine device.
  - Covered persons in a POE-G Plan State BlueCare Prime Plus POS Plan may receive these services from his/her selected primary provider of OB/GYN care without a referral.
- **Breast Pumps:** Preventive care benefits include the cost of renting or purchasing one breast pump per pregnancy in conjunction with childbirth. Benefits are only available if breast pumps are obtained from a DME provider, hospital or physician.
- **Immunizations**. Adult or childhood immunizations as recommended by the U.S. Department of Health and Human Services or as required for foreign travel are covered. Meningitis vaccinations are covered as part of a covered person's routine annual or age-appropriate physical.
- **Colorectal cancer screenings.** The Medical Benefit Plan will cover an annual fecal occult blood test, fecal immunochemical test, fecal DNA test, colonoscopy, flexible sigmoidoscopy or radiologic imaging. Coverage will be in accordance with the recommendations established by the American College of Gastroenterology, after consultation with the American Cancer Society as to the type and frequency with which such test should be performed (e.g., age intervals, family history, etc.).
- **Diabetes management (equipment, supplies and education).** These services are covered as follows:
  - **Supplies.** Equipment and related supplies for insulin dependent and non-insulin dependent diabetic covered persons are covered when medically necessary, as determined by a physician. Covered equipment and supplies include, but are not limited to, the following list:

Covered Supplies	
Acetone reagent strips	Drawing-up devices for visually impaired
Acetone reagent tablets	Equipment for use of the pump
Alcohol or peroxide by the pint	Glucose acetone reagent strips
Alcohol wipes	Glucose reagent strips
All insulin preparations	Glucose reagent tape
Automatic blood lance kit	Injection aides
Blood glucose kit	Injector (busher) automatic
Blood glucose strips (test or reagent)	Insulin cartridge delivery
Blood glucose monitor and strips	Insulin infusion devices
Cartridges for the visually impaired	Insulin pump
Diabetes data management systems	Lancets
Disposable insulin and pen cartridges	

  - **Diabetes self-management and education.** Outpatient self-management training for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-

insulin-using diabetes. "Outpatient self-management training" includes, but is not limited to, education and medical nutrition therapy.

- Upon initial diagnosis, the Medical Benefit Plan will cover up to ten hours of medically necessary self-management training for the care and treatment of diabetes. Such training includes, but is not limited to, counseling in nutrition and proper use of equipment and supplies for diabetes. An additional four hours of training will be covered for any subsequent diagnosis that results in a significant change in an individual's symptoms or condition, which requires modification of the individual's program of self-management of diabetes. An additional four hours of medically necessary training and education will also be covered for newly developed techniques and treatment of diabetes.
  - Diabetes self-management training shall be provided by a certified, registered or licensed healthcare professional trained in the care and management of diabetes and authorized to provide such care within the scope of his/her license.
- **Vision exams.** One vision exam, including refraction, per covered person per Calendar Year. The Medical Benefit Plan will pay 100% of the cost of the exam for covered persons who use an in-network Preferred ophthalmologist. The Medical Benefit Plan will pay 100% of the cost of an in-network exam every other year for HEP-compliant covered persons.
- **Hearing exams.** One exam per covered person per Calendar Year. Coverage includes screening to determine the medical necessity for hearing correction when performed by a physician certified as an otolaryngologist or a legally qualified audiologist holding a Certificate of Clinical Competence in Audiology from the American Speech and Hearing Association in the absence of any applicable licensing requirements.
  - Covered persons in a POE-G Plan or State BlueCare Prime Plus POS Plan must obtain a referral for hearing examinations.
- **Naturopathic physicians.** The Medical Benefit Plan will cover services performed by a naturopathic physician for the treatment of illness or injury otherwise covered under the Medical Benefit Plan.
  - Covered persons in a POE-G Plan or the Prime Plus POS Plan must obtain a referral to see a naturopath.
- **Laboratory tests.** Medically necessary laboratory tests will be covered in accordance with the terms and conditions of the Plan Document. Tests may be subject to the SITE OF SERVICE requirements, with higher COINSURANCE for using Non-Preferred and/or out-of-network providers.

Covered Specialty Care

Specialty care consists of medical care and services, including office visits, house calls, hospital visits and consultations for the diagnosis and treatment of disease or injury that cannot generally be treated by a primary care physician.

- **Surgical services.** Prior authorization is required for all surgical procedures (both INPATIENT and outpatient) in a hospital or a licensed ambulatory surgical center not located in a hospital. Covered services include the services of the surgeon or specialist assistant and anesthetist or anesthesiologist together with preoperative and post-operative care.

Pre-admission testing procedures must be rendered on an outpatient basis before the scheduled surgery. The covered person will be responsible for pre-admission testing charges if he/she cancels or postpones the scheduled surgery.

- **Reconstructive and corrective surgery.** Reconstructive and corrective surgery is covered only when:

  It is performed to correct a covered child's congenital birth defect, which has resulted in a functional defect;

  It is incidental to surgery or follows surgery that was necessitated by trauma, infection or disease of the involved part, and the reconstructive or corrective surgery must be performed within two years of the surgery that was necessitated by the trauma, infection or disease; or

  It is breast reconstruction following a mastectomy (including surgery on the healthy breast to restore and achieve symmetry of implanted breast prostheses).

- **Dental services.** The following are covered services, as determined by the carrier:
  - An initial visit for the prompt immediate repair of trauma due to an accident or injury to the jaw, natural teeth, cheeks, lips, tongue and/or the roof of the mouth. Benefits for services provided during the initial visit include, but are not limited to, the following:
    - Evaluation;
    - Radiology to evaluate extent of injury; or
    - Treatment of the wound, tooth fracture or evulsion.
  - Surgical treatment of temporomandibular joint (TMJ) syndrome and craniomandibular disorder;
  - Anesthesia, nursing and related charges for inpatient dental services, outpatient dental services, or one-day dental services are covered if deemed medically necessary by the treating dentist or oral surgeon and the patient's physician per the prior authorization requirements and:
  - The patient has been determined by a licensed dentist and a licensed primary care physician to have a dental condition complex enough that it requires inpatient services, outpatient dental services, or one-day dental services; or
    - Oral surgical services for treatment of lesions, tumors and cysts on or in the mouth; or
    - Oral surgery services for treatment related to tumors of the oral cavity, treatment of fractures of the jaw and/or facial bones, and dislocation of the jaw; or
    - Excision of unerupted or impacted tooth or tooth root and related anesthesia; or
    - Cutting procedures on gums (osseous surgery) including related anesthesia; or
    - The patient has a developmental disability, as determined by a licensed primary care physician that places him/her at serious risk.
- **Allergy testing and treatment.** The Medical Benefit Plan covers testing and evaluations to determine the existence of an allergy, allergy injections or other immunotherapy services. Patients of a Preferred allergist will not be subject to a COPAY.

- **Obstetrical/maternity care.** Services and supplies for maternity care provided by a physician, certified nurse midwife, hospital or birthing center will be covered for prenatal care (including one visit for genetic testing), postnatal care, delivery and complications of pregnancy. The Medical Benefit Plan provides a minimum inpatient stay of 48 hours following a vaginal delivery and 96 hours following a cesarean delivery for both the mother and the newly born child or children. While in the hospital, maternity care also includes, at a minimum, parent education, assistance and training in breast or bottle-feeding, and performance of any necessary maternal and newborn clinical assessments.

  In-network birthing center services are covered at 100% in the same manner as services rendered at an acute care facility. Out-of-network coverage is subject to deductible and coinsurance.

  The mother has the option to leave the hospital sooner than as described above. If she and the newborn child are discharged early, she will be provided with two home visits. The first home visit will be provided within 48 hours following discharge. The second follow-up visit will be provided within seven days of discharge.

  The home visits will be provided by a qualified healthcare professional trained in post-partum maternal and newborn pediatric care to provide such services as post-delivery care, an assessment of the mother and child, instruction on breastfeeding, cleaning and caring for child, parent education, assessment of home support systems and any required medically necessary and appropriate clinical tests.

  Covered care related to complications of pregnancy includes surgery and interruptions of pregnancy. Therapeutic abortions are covered as an unlimited benefit. Non-therapeutic abortions in cases of rape, incest or fetal malformation are also covered as an unlimited benefit. One elective abortion per covered person per Calendar Year is covered, subject to the benefit limits listed in the *Summary of Medical Coverage*.

  The Medical Benefit Plan covers vasectomies and tubal ligations.

- **Newborn care.** Covered care for newborns includes preventive healthcare services, routine nursery care, and treatment of disease and injury. Treatment of disease and injury includes treatment of prematurity and medically diagnosed congenital defects and birth abnormalities that cause anatomical functional impairment. The Medical Benefit Plan also covers necessary transportation costs from the place of birth to the nearest specialized treatment center.

  Routine nursery and preventive newborn care do not require prior authorization. Circumcision performed by a licensed medical practitioner during the inpatient delivery stay does not require prior authorization. Prior authorization must be obtained for surgery or circumcision that is performed after the inpatient stay for delivery.

- **INFERTILITY services.** Covered services include medically necessary care for the diagnosis and treatment of infertility including, but not limited to, ovulation induction, intrauterine insemination, in-vitro fertilization (IVF), uterine embryo lavage, embryo transfer, gamete intra-fallopian transfer (GIFT), zygote intra-fallopian transfer (ZIFT) and low tubal ovum transfer. Prior authorization is required for all services. Covered infertility treatment or procedures must be performed at facilities that conform to the standards and guidelines developed by the American Society of Reproductive Medicine or the Society of Reproductive Endocrinology and Infertility.

- **Nutritional counseling.** Up to three visits per covered person per Calendar Year for individualized nutritional evaluation and counseling by a registered dietitian.

- **Mental health services.** Outpatient services for the treatment of "mental or nervous conditions" as defined in the most recent edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders. Conditions that meet such definition will be covered to the same extent as the medical/surgical coverage described in the Plan Document. To the "same extent" means that the same number of visits, days and copays that apply to other outpatient specialty treatments and/or inpatient hospital stays will also apply to the treatment of mental or nervous conditions.

  Outpatient care for mental health includes services rendered in the following locations:

  - A non-profit community mental health center;
  - A non-profit licensed adult mental health center; or
  - A non-profit licensed adult psychiatric clinic operated by an accredited hospital or in a RESIDENTIAL TREATMENT FACILITY when provided by or under the SUPERVISION of a physician practicing as a psychiatrist, licensed psychologist, certified independent social worker, certified marriage and family therapist or a licensed or certified alcohol and drug counselor, or appropriately licensed professional counselor.

  Outpatient care for mental illness includes services by a person with a master's degree in social work when such person renders service in a child guidance clinic or in a residential treatment facility under the supervision of a physician practicing as a psychiatrist, licensed psychologist, certified independent social worker, certified marriage and family therapist, or a licensed or certified alcohol and drug counselor, or appropriately licensed professional counselor.

  Inpatient hospital services for mental health in a hospital, or residential treatment center facility are subject to medical necessity and prior authorization. Such inpatient rehabilitation services may include hospitals, residential treatment facilities or other facilities that are accredited by the Joint Commission on the Accreditation of Health Care Organizations as mental health treatment facilities and approved in advance by the carrier. Inpatient covered services for eligible covered persons upon confinement in a residential treatment facility must be based on an INDIVIDUAL TREATMENT PLAN prescribed by the attending physician and approved by the carrier's medical director. Services must be provided by providers who are certified by the appropriate state agency to provide such services and whose programs for such services have been approved by the carrier. For the purpose of this benefit, the eligible covered person must:

  - Have a serious mental illness which substantially impairs the person's thought, perception of reality, emotional process, or judgment or grossly impairs behavior as manifested by recent disturbed behavior;
  - Have been confined in a hospital for such illness for a period of at least three days immediately preceding such confinement in a residential treatment facility; and
  - Have an illness that would otherwise necessitate continued confinement in a hospital if such care and treatment were not available through a residential treatment facility for children and adolescents.

- **Substance abuse.** Coverage is provided for outpatient visits for SUBSTANCE ABUSE CARE services in both POE and POS Plans. Inpatient hospital services for alcohol and substance abuse in a hospital, residential treatment center, or substance abuse treatment facility are subject to medical necessity and prior authorization. Such inpatient rehabilitation services may include hospitals, residential treatment facilities or other facilities that are accredited by the Joint Commission on the Accreditation of Health Care Organizations as substance abuse disorder treatment facilities and

approved in advance by the carrier. Services must be provided by providers who are certified by the appropriate state agency to provide such services and whose programs for such services have been approved by the carrier.

- **Diagnostic procedures.**

  - X-ray and laboratory procedures, services and materials, including diagnostic X-rays, X-ray therapy, fluoroscopy, electrocardiograms, laboratory tests, and therapeutic radiology services are covered. If the services are performed within the carrier's immediate service area, they will be subject to the Site of Service Program and the covered person's copay or coinsurance will depend upon whether or not services are obtained at a Preferred facility. The coinsurance requirement under the Site of Service Program may be waived if there is a medically necessary reason why a covered person cannot use a Preferred facility for outpatient laboratory or diagnostic imaging. **Note**: The waiver is not available for services at out-of-network facilities.
  - High cost diagnostic imaging procedures, such as MRI, MRA, CAT, CTA, PET and SPECT scans, require prior authorization. An in-network provider is responsible for obtaining prior authorization. If a covered person obtains HIGH COST DIAGNOSTIC IMAGING SERVICES from an out-of-network provider without prior authorization, he/she will be assessed a penalty of $500 or 20% of the cost of such service, whichever is less.
  - If the services are performed within the carrier's immediate service area, they will be subject to the Site of Service Program. The copay or coinsurance amount will depend upon whether or not services are received at a Preferred facility. The coinsurance requirement under the Site of Service Program may be waived if there is a medically necessary reason why a covered person cannot use a Preferred in-network facility for outpatient laboratory or diagnostic imaging. **Note**: The waiver is not available for services at out-of-network facilities.
  - For the POE and POE-G Plans, all tests and procedures must be performed by an in-network provider. Unless the covered person is receiving pre-admission testing, in-network hospitals are not considered in-network providers for laboratory procedures and tests.
  - The Medical Benefit Plan does not cover laboratory procedures or any other procedure if the covered person has not obtained the required referral.

- **Acupuncture.**
  - Acupuncture is covered up to 20 visits per Calendar Year

- **GENDER IDENTITY DISORDER treatment.** Services are covered for the treatment of "gender dysphoria" or gender identity disorder as defined in the most recent edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders. Covered services include psychotherapy and gender reassignment surgery. Coverage is subject to prior authorization pursuant to the carrier's medical necessity guidelines. The patient is subject to the following general criteria for transsexual surgical benefits:
  - Must be 18 years of age or older;
  - Must have completed 12 months of successful continuous full-time real-life experience in the desired gender;

- May be required to complete continuous hormonal therapy if ordered and not contraindicated; and
- May be required to undergo psychotherapy, if recommended.

- **Bariatric surgery.** Medically necessary gastric bypass and gastric restrictive procedures are covered for the treatment of clinically severe obesity for selected adults (18 years and older). Coverage is subject to prior authorization pursuant to the carrier's medical necessity guidelines.
- **Snoring (sleep studies).** Medically necessary treatment for snoring is covered if that treatment is determined to be part of a proven treatment for documented obstructive sleep apnea (OSA). Refer to the carrier's applicable medical policy to determine if the treatment proposed is proven for OSA.

Covered Hospital and Other Facility-Based Services

- **Inpatient ADMISSIONS.** Non-emergency admissions to a hospital, SKILLED NURSING FACILITY, or SPECIALTY HOSPITAL require prior authorization from the carrier. All pre-admission testing must be rendered on an outpatient basis before the scheduled admission and not repeated upon admission for surgery. The covered person will be responsible for the pre-admission testing charges if he/she cancels or postpones the scheduled admission.

  For mastectomy or lymph node dissection, covered services will include at least a 48-hour stay after the procedure unless both the covered person and physician agree to a shorter stay.

  Admission to a specialty hospital is subject to prior authorization. For covered persons enrolled in a POS Plan**,** inpatient care at in-network specialty hospitals is an unlimited benefit; care received at out-of-network specialty hospitals has a benefit limit of 60 days per covered person per Calendar Year.

  The Medical Benefit Plan covers non-custodial services provided in a skilled nursing facility, including care and treatment in a semi-private room. Custodial, convalescent or domiciliary care is not covered. In addition to prior authorization, admission to a skilled nursing facility must be supported by a treatment plan prepared by the carrier.
  - Covered persons in a POE Plan are restricted to in-network skilled nursing facilities.
  - Covered persons in a POS Plan have an unlimited benefit for inpatient care at an in-network skilled nursing facility. Covered persons using an out-of-network skilled nursing facility are limited to 60 days per covered person per Calendar Year.

  The following services will be covered:
  - Room and board for a semi-private hospital room. If a private room is used, this Medical Benefit Plan shall only provide benefits for covered services up to the cost of the semi-private room rate, unless the carrier decides that a private room is medically necessary;
  - Administration of blood and blood processing;
  - Anesthesia, anesthesia supplies and services;
  - Chemotherapy for treatment of cancer;
  - Diagnostic services;
  - Electroshock therapy;
  - Inpatient hospital services and supplies;
  - Laboratory tests;

- Medical and surgical dressing, supplies, casts and splints;
- Operating, delivery and treatment room usage and equipment (including intensive care);
- Pre-admission testing for surgery (to be performed on an outpatient basis);
- Prescribed drugs;
- Rehabilitative and restorative physical and occupational therapy, and speech therapy for treatment expected to result in the sound improvement of a covered person's condition;
- Radiation therapy;
- Services for hemodialysis, or peritoneal dialysis for chronic renal disease, including equipment, - training and medical supplies until the covered person is eligible for Medicare;
- Services connected with accidental consumption, or ingestion of a controlled drug or other substance; and
- X-ray or imaging studies.

- **Outpatient surgery.** Prior authorization may be required for outpatient surgery, whether rendered in a hospital setting on an outpatient basis or in a licensed ambulatory surgical center not located in a hospital.

  Pre-admission testing procedures must be rendered to a covered person as an outpatient before the scheduled surgery. The covered person will be responsible for pre-admission testing charges if he/she cancels or postpones the scheduled surgery.

- **Walk-in medical centers or clinics.** Services provided at a WALK-IN CLINIC or center are deemed not to be emergency medical services and will be covered only if treatment of the covered person is determined to be medically necessary, based on the signs and symptoms at the time of treatment.
  - Covered persons in a POE or POE-G Plan do not need a referral from a primary care physician to obtain services at an in-network walk-in center. Non-emergency treatment obtained at an out-of-network walk-in center or clinic is not covered.

- **URGENT CARE centers.** Medically necessary treatment at an URGENT CARE FACILITY (either free-standing or located in a hospital) will be covered. Covered persons in a POE-G or POE Plan do not need to obtain a referral to go to an in-network urgent care facility when a covered person's primary care physician or covering physician is not available to treat the covered person. Urgent care services obtained outside the United States have a $15 copay.

- **Hospital emergency rooms (medical emergencies).** Services are covered if the care is found to be for a MEDICAL EMERGENCY. If the emergency calls for the covered person to be taken to the nearest hospital, coverage will be provided whether or not the nearest hospital is in-network or out-of-network.
  - Active employees and non-Medicare-eligible retirees with a retirement date on or after October 2, 2017, and covered dependents are subject to a $250 copay.
  - Retirees with a retirement date from October 2, 2011 to October 1, 2017, and covered dependents, are subject to a $35 copay.
  - The copay will be waived if the covered person is admitted to the hospital or if the covered person had no reasonable medical alternative.

The determination of whether or not a reasonable medical alternative exists shall depend upon:

- The facts and circumstances existing at the time of treatment, including without limitation:
- The time of day;
- Day of the week;
- The nature of the symptoms or injury;
- Whether or not the covered person telephoned the carrier's 24-hour helpline for assistance in finding appropriate care before seeking emergency medical services; and
- The number of times the covered person has sought emergency care for conditions not deemed to be a medical emergency.

All admissions due to a medical emergency must be reported to and approved by the carrier within 48 hours of the diagnosis, care or treatment of the medical emergency.

Claims for services rendered to the covered person shall be reviewed by the carrier; the covered person may be liable for COST SHARE or the full cost of all services rendered if the carrier determines that the services provided were not for a medical emergency. Medical emergency covered services are limited to the treatment rendered during the first visit only.

For covered persons in a POE or POE-G Plan or the Prime Plus POS Plan, a referral is not required for emergency care.

Coverage for medical emergencies and urgent care is provided when a covered person is traveling internationally. The covered person may be required to pay applicable cost share at the time of discharge or may be required to pay a physician in full at the time of service and to seek reimbursement for emergency and urgent care from the carrier for treatment rendered outside the United States.

- **Ambulance services.** Medically necessary medical transport services are covered as follows:
  - From the place where the covered person is injured by an accident or taken ill to a GENERAL HOSPITAL where treatment is to be given;
  - From a general hospital where a covered person is an inpatient to another general hospital, or a free-standing facility to receive specialized diagnostic or therapeutic services not available at the first general hospital, and the return to the first general hospital (if that payment is only made for one such transport during the period between the day of admission to the general hospital) and the day-of discharge from the general hospital;
  - From a general hospital to another general hospital when the discharging general hospital does not have the proper facilities for treatment, and the receiving general hospital has the proper treatment facilities; and
  - To provide in the course of such transport, such care as may be reasonably necessary to maintain the life of or stabilize the condition of such covered person.

  Medical transportation service provided through a home health agency in conjunction with home health services is covered as follows:
  - From a hospital to a provider to home;
  - To and from a hospital or a provider for treatment; or

- From home to a hospital or provider, if readmission is required.

Therapy Services

- **Autism services.** Coverage shall be provided for the medically necessary diagnosis and treatment of AUTISM SPECTRUM DISORDERS based on an approved treatment plan. A treatment plan will be reviewed not more than once every six months unless the covered person's licensed physician, licensed psychologist, or licensed clinical social worker agrees that a more frequent review is necessary or as a result of changes in the covered person's treatment plan. Covered services include:
  - Behavioral therapy rendered by an AUTISM BEHAVIORAL THERAPY provider and ordered by a licensed physician, psychologist or clinical social worker in accordance with a treatment plan developed by a licensed physician, psychologist or licensed clinical social worker provided to children less than 21 years of age;
  - Direct psychiatric or consultative services provided by a licensed psychiatrist or psychologist;
  - Physical therapy provided by a licensed physical therapist;
  - Speech therapy provided by a licensed speech and language pathologist; and
  - Occupational therapy provided by a licensed occupational therapist.

  Visit limits for physical, speech and occupational therapy will not apply to autism spectrum disorder services on any basis other than lack of medical necessity.
- **Chemotherapy for the treatment of cancer.**
- **Chiropractic therapy.**
- **Early intervention services.** For an eligible enrolled child from birth to age three (36 months) who is not eligible for special education and related services pursuant to Connecticut law. Services under this section are limited to children who:
  - Are experiencing a significant developmental delay as measured by standardized diagnostic instruments and procedures, including informed clinical opinion, in one or more of the following areas:
    - Cognitive development;
    - Physical development, including vision or hearing;
    - Communication development;
    - Social or emotional development;
    - Adaptive skills; or
    - Are diagnosed as having a physical or mental condition that has a high probability of resulting in a developmental delay.

  For the purpose of this benefit, early intervention services are services:
  - Designed to meet the developmental needs of a covered person and the needs of his/her family related to enhancing the child's development; and
  - Selected in collaboration with the parents of the covered person.
- **Electroshock therapy.**

- **Infusion therapy.** Benefits will be provided for infusion therapy administered in an outpatient hospital, physician's office or home under the following conditions:
  - A plan of care for such services is prescribed in writing by a physician (M.D.);
  - The plan of care is reviewed and certified by the physician (M.D.) and, in the case of covered persons in a POE Plan, approved by the carrier.

  Infusion therapy is limited to:
  - Chemotherapy (including gamma globulin);
  - Intravenous antibiotic therapy;
  - Total parenteral nutrition;
  - Enteral therapy when nutrients are only available by a physician's prescription; and
  - Intravenous pain management.

  Covered services include supplies, solutions and pharmaceuticals.
- **Kidney dialysis.** Covered when received in a hospital or free-standing dialysis center.
- **Outpatient cardiac rehabilitation therapy.**
- **Outpatient physical and occupational therapy.** Physical and occupational therapy is covered only when reasonable and necessary to correct a condition that is the result of a disease, injury or congenital physical deformity that inhibits normal function. To be considered reasonable and necessary, the following conditions must be met:
  - The services must be considered under accepted standards of medical practice to be a specific, safe and effective treatment for the covered person's condition.
  - The services must be of such a level of complexity and sophistication or the condition of the covered person must be such that the services required can safely and effectively be performed only by a qualified physical therapist or assistant under the supervision of a qualified physical therapist, by a qualified speech-language pathologist, or by a qualified occupational therapist or assistant under the supervision of a qualified occupational therapist. Services that do not require the performance or supervision of a physical therapist or an occupational therapist are not considered reasonable or necessary physical therapy or occupational therapy services, even if they are performed by or supervised by a physical therapist or occupational therapist.
  - There must be an expectation that the covered person's condition will improve materially in a reasonable (and generally predictable) period of time based on the physician's assessment of the covered person's restoration potential and unique medical condition, or the services must be necessary to establish a safe and effective maintenance program required in connection with a specific disease, or the skills of a therapist must be necessary to perform a safe and effective maintenance program. If the services are for the establishment of a maintenance program, they may include the design of the program, the instruction of the covered person, family or home health aides, and the necessary infrequent reevaluations of the covered person and the program to the degree that the specialized knowledge and judgment of a physical therapist, or occupational therapist is required.
  - The amount, frequency and duration of the services must be reasonable.

For out-of-network services, coverage is limited to 30 outpatient days of service per Calendar Year.

Retirees with a retirement date from October 2, 2011 to October 1, 2017, and covered dependents must receive prior authorization.

- **Short-term inpatient physical therapy and rehabilitation services.** Covered when reasonable and necessary to correct a condition that is the result of a disease, injury or congenital physical deformity that inhibits normal function. Prior authorization is required. For out-of-network services, inpatient coverage is limited to 60 days per Calendar Year.
- **Radiation therapy.**
- **Speech therapy.** When prescribed by a physician (M.D.) and provided by a licensed speech pathologist for treatment resulting from autism, stroke, tumor removal, injury or congenital anomalies of the oropharynx. Coverage for services provided by an in-network provider is not subject to benefit limits. For out-of-network providers, there is a benefit limit of 30 visits per Calendar Year.
- **Expanded speech therapy.** When prescribed by a physician (M.D.) and provided by a licensed speech pathologist for treatment resulting from causes other than those specified is a covered service and is subject to a benefit limit of 30 visits per covered person per Calendar Year in-network or out-of-network, subject to prior authorization.

Covered Hospice Care (Inpatient or Home Based) Services

HOSPICE care is available to covered persons who have a prognosis of six months or less to live. Prior authorization is required for inpatient hospice care. Coverage consists of palliative care rather than curative treatment. Hospice care will be covered only when provided as part of a hospice care program certified by the state where such services are provided. Such certified programs may include hospice care delivered by a hospital (inpatient or outpatient), home healthcare agency, skilled nursing facility or a licensed hospice facility.

The copay will correspond to the place of treatment**.** If a covered person receives care in a hospice unit in a hospital or a skilled nursing facility, the copay is for inpatient admissions. If care is received in the home, there is a home healthcare copay.

Home-Based Hospice

Covered services include hospice care provided by a home healthcare agency and the following:

- Psychological and dietary counseling;
- Consultation or case management services by a physician;
- Medical supplies and drugs prescribed by a physician;
- Part-time nursing care by a registered nurse, or licensed practical nurse, and services of a home health aide for patient care up to eight hours per day; and
- Medical/social services for patient and patient's covered family members, up to the maximum shown in the *Schedule of Medical Benefits*.

When certified as part of the hospice program, the Medical Benefit Plan will cover supportive care and guidance to the covered person's family members for the purpose of helping them cope with emotional and social issues related to the covered person's impending death. The maximum benefit for this service cannot exceed $420 per Calendar Year.

Covered Home Healthcare Services

Home healthcare will be covered when at least one of the following is received:

- Skilled nursing care by a registered nurse (RN), or a licensed practical nurse (LPN) under the supervision of a RN when the services of a RN are not on hand;
- Skilled, progressive and rehabilitative services of a licensed physical therapist;
- Occupational, speech and respiratory therapy;
- Medical and surgical supplies, and prescribed DURABLE MEDICAL EQUIPMENT;
- Oxygen and its administration;
- Home health aide services that consist of patient care of a medical or therapeutic nature;
- Laboratory services;
- Services with regard to diet and nutritional services;
- Transport to and from a hospital for treatment, re-admission or discharge by the most safe and cost-effective means available.

A benefit period for home healthcare begins:

- After an admission, commencing within seven days after discharge from the hospital;
- In lieu of an admission, upon receipt of prior authorization; or
- For a terminal illness upon diagnosis by a physician.

With regard to post-discharge services, the covered person must be confined at home and home healthcare services must be rendered to treat the same illness or injury for which the covered person was hospitalized.

Every four hours of covered services rendered by a home health aide will be charged as one visit. This benefit is limited to 200 visits per Calendar Year.

Covered Human Organ Transplant Services

Subject to prior authorization, coverage is provided for transplants of the heart, lung, heart-lung, pancreas, liver (adult or child), kidney, bone marrow, and peripheral stem cell procedures when performed along with the administration of high dose chemotherapy.

Benefits for blood transfusion, cornea transplant, bone and cartilage grafting, and/or skin grafting are provided without prior authorization when used in connection with human organ and tissue transplant services.

The following services are covered with prior authorization from the carrier:

- Room and board for a semi-private room (if a private room is used, this Medical Benefit Plan will only provide benefits for covered services up to the cost of the semi-private room rate, unless the carrier decides that a private room is medically necessary);
- Services and supplies furnished by the hospital;
- Care given in a special care unit that has all the facilities, equipment and supportive services needed to provide an intensive level of care for critically ill patients;
- Use of operating and treatment rooms;
- Diagnostic services;
- Rehabilitative and restorative physical therapy services;
- Hospital supplies;
- Prescribed drugs;
- Whole blood, administration of blood and blood processing;
- Anesthesia, anesthesia supplies and services; and
- Medical and surgical dressings and supplies.

The following surgical services are covered when used with covered human organ and tissue transplants with prior authorization from the carrier:

- Surgery, including diagnostic services related to a surgery (separate payment will not be made for preoperative and post-operative services or for more than one surgery done during one operative session);
- Services of a physician who actively assists the operating surgeon; and
- Meting out of anesthesia ordered by the attending physician and rendered by a physician or provider other than the surgeon or assistant at surgery.

The following medical services related to human organ and tissue transplants with prior authorization are covered:

- Inpatient medical care visits;
- Intensive medical care rendered to a covered person whose condition needs a physician's constant attendance, and treatment for a prolonged length of time;
- Medical care given at the same time with surgery during the hospital stay by a physician, other than the operating surgeon for treatment of a medical condition, and separate from the condition for which the surgery was performed;
- Medical care by two or more physicians during the same hospital stay when the nature or severity of the covered person's condition requires the skills of separate physicians;
- Consultation services given by another physician at the request of the attending physician, other than staff consultations, which are needed per hospital rules and regulations;

- Home, office and other outpatient medical care visits for exam, and treatment of the covered person; and
- Diagnostic services, which include a referral for evaluation.

The following rehabilitative and restorative therapy services are covered:

- Services provided in a skilled nursing facility, with prior authorization from the carrier, which are neither custodial, nor for the ease of the covered person or the physician, and only until the covered person has reached the maximum level of recovery possible for the given condition, and no longer needs skilled nursing care, or definitive treatment other than routine supportive care;
- Home healthcare covered services to a homebound covered person when prescribed by the covered person's attending physician in lieu of hospitalization, and arranged before discharge from the hospital;
- Medically necessary immunosuppressants prescribed with covered human organ and tissue transplants, and which, under federal law, may only be dispensed by prescription, and which are approved for general use by the Food and Drug Administration;
- Benefits for transport and lodging for the transplant recipient and companion(s) limited to a maximum of $10,000 per transplant, except as otherwise stated in *Exclusions and Limitations*;
- Transport costs spent for travel to and from the site of surgery for covered services for a transplant recipient, and one other person traveling with the patient, or if the transplant recipient is a minor child, transport costs for two other persons traveling with the patient, as follows:
  - Lodging, not to exceed $150 total per day ($200 total if two persons are traveling with a minor child) will be paid for the person traveling with the patient; and
  - Lodging for the covered person while receiving medically necessary post-operative outpatient care at the hospital.

Benefits for the following services when provided with covered human organ and tissue transplants:

- Transport of the surgical harvesting team, and DONOR organ or tissue; and
- Evaluation and surgical removal of the donor organ or tissue, and related supplies.

If a human organ or tissue transplant is provided from a donor to a transplant recipient, the following apply:

- When both the recipient and the donor are covered persons, each is entitled to the covered services.
- When only the recipient is a covered person, both the donor and the recipient are entitled to the covered services:
- Donor benefits are limited to only those not provided or available to the donor from any other source. This includes, but is not limited to, other insurance coverage, grants, foundations, government programs, etc.
- Benefits provided to the donor will be charged against the covered person's Medical Benefit Plan.
- When the recipient is uninsured and the donor is a covered person, this Medical Benefit Plan will only provide benefits related to the procurement of the organ up to the Medical Benefit Plan maximums.

No benefits will be provided for procurement of a donor organ or organ tissue that is not used in a covered transplant procedure, unless the transplant is cancelled due to the covered person's medical condition or death, and the organ cannot be transplanted to another person. No benefits will be provided for procurement of a donor organ or organ tissue that has been sold rather than donated. These covered services for procurement of a donor organ, including hospital, surgical, medical, storage and transport costs, will be subject to a maximum of $15,000 per transplant.

This Medical Benefit Plan shall provide benefits for human organ and tissue transplant services only with prior authorization from the carrier. The hospital must be designated and approved by the carrier to perform the covered services. In addition, the covered person must follow all provisions in this Medical Benefit Plan.

It should be noted that not every designated hospital performs each of the covered services.

Only those organ and tissue transplants and related procedures described are covered services under this Medical Benefit Plan. As shown in the *Schedule of Medical Benefits*, the benefits for covered services are unlimited.

Other Covered Medical Services and Supplies

- Blood and blood plasma, which are not replaced or will not be replaced by blood donors or a blood bank.
- Blood derivatives when purchased through a blood derivative supplier.
- Blood lead screenings and clinically indicated risk assessments.
- Intravenous and oral antibiotic therapy for the treatment of Lyme Disease. Coverage is provided for up to 30 days of intravenous antibiotic therapy, or 60 days of oral antibiotic therapy, or both. More treatment is covered if recommended by a board-certified rheumatologist, infectious disease specialist or neurologist.
- Medically necessary pain management procedures when ordered by a pain management specialist.
- **ROUTINE PATIENT CARE COSTS in connection with CANCER CLINICAL TRIAL.** A cancer clinical trial must be conducted under the auspices of an independent peer-reviewed protocol that has been reviewed and approved by:
  - One of the National Institutes of Health;
  - A National Cancer Institute affiliated cooperative group;
  - The Federal Food and Drug Administration as part of an investigational new drug or device exemption; or
  - The Federal Department of Defense or Veterans Affairs.

  Hospitalization for routine patient care costs in connection with cancer clinical trials shall include treatment at an out-of-network facility if such treatment is not available in-network and not eligible for reimbursement by the sponsors of such clinical trial. Out-of-network hospitalization will be rendered at no greater cost to the covered person than if such treatment was available in-network; all applicable in-network cost shares will apply.

- **Private duty nursing.** Coverage is provided for medically necessary intermittent and temporary, complex skilled nursing care on an hourly basis in the home by a Registered Nurse (RN) or a Licensed Practical Nurse (LPN) and performed under the direction of a physician. Private duty nursing care includes assessment, monitoring, skilled nursing care and caregiver/family training to assist with transition of care from a more acute setting to home. This benefit is subject to prior authorization.
- **Durable medical equipment.** Durable medical equipment (DME) is:
  - Designed and intended for repeated use;
  - Primarily and customarily used to serve a medical purpose;
  - Generally, not useful to a person in the absence of disease or injury; and
  - Is appropriate for use in the home.

  Coverage is for standard equipment only. The Medical Benefit Plan does not cover customization of any item of DME or brace (including an orthotic used with a brace) unless the Medical Benefit Plan specifically allows for coverage in certain instances. All maintenance and repairs that result from a covered person's misuse are the covered person's responsibility. The decision to rent or purchase such equipment will be made solely at the carrier's discretion.

  Replacements are covered when growth or a change in the covered person's medical condition make replacement medically necessary. The Medical Benefit Plan does not otherwise cover the cost of repairs or replacement (e.g., the Medical Benefit Plan does not cover repairs or replacements that result from misuse or abuse by the covered person).

- **PROSTHETIC DEVICES and appliances.** Whether surgically implanted or worn as an anatomic supplement, when prescribed subject to the following:
  - Repair, replacement, fitting and adjustments are covered when made necessary by normal wear and tear or by body growth or change;
  - The Medical Benefit Plan covers penile implants when medically necessary for those suffering from erectile dysfunction resulting from disease or traumatic injury, or those having undergone radical prostatectomy;
  - Removal of a penile implant will be covered when medically necessary due to infection, intractable pain, mechanical failure or urinary obstruction.
  - Appliances such as a leg, arm, back or neck brace or artificial legs, arms or eyes or any prosthesis with supports, are covered, including replacement, if a covered person's physical condition changes;
  - The Medical Benefit Plan covers braces (and some orthotic devises that are used with braces) that are worn externally. The brace must temporarily or permanently assist all or part of an external body part function that has been lost or damaged because of an injury, disease or defect;
  - In cases of a tumor of the oral cavity, non-dental prosthetic devices, including maxillo-facial prosthetic devices used to replace anatomic structures removed during treatment of head or neck tumors, and additional appliances essential for the support of such prosthetic devices;
  - Surgically implanted internal breast prostheses will be covered to improve or restore the function of a breast that has been removed or damaged due to injury or disease. The Medical

Benefit Plan does not cover surgical implantation of a breast prostheses for cosmetic reasons except following a mastectomy;

- Removal of an internal breast prosthesis will be covered when medically necessary due to recurring infection, overlying contracture or ruptured or leaking silicone implants or where implant removal is necessary to restore symmetry post-prophylactic/therapeutic mastectomy or there is a personal history of breast cancer and family history of malignant neoplasm of breast; and
- Removal of an internal breast prosthesis is not covered for non-specific systemic symptoms in patients who have silicone implants.

- **Hearing aid coverage.** Limited to a maximum benefit of one set of hearing aids per 36-month period. Prior authorization may be required for certain bone-anchored devices.
- **Foot orthotics**. Medically necessary shoe inserts prescribed by a physician for the following conditions:
  - Diabetes with neurological manifestations;
  - Diabetes with peripheral circulatory disorders;
  - Lesion of plantar nerve;
  - Ulcer of lower limb except pressure ulcer;
  - Tibialis tendinitis;
  - Calcaneal spur;
  - Other bursitis disorders; or
  - Plantar fascial fibromatosis.
- **Ostomy related services.** Ostomy bags, catheters and supplies required for their use, and any other medically necessary ostomy-related appliances including, but not limited to, collection devices, irrigation equipment and supplies, and skin barriers and protectors.
- **SPECIALIZED FORMULA.** Coverage includes AMINO ACID MODIFIED PREPARATIONS and LOW PROTEIN MODIFIED FOOD PRODUCTs for the treatment of an inherited metabolic disease for covered persons who are or will become malnourished or suffer from disorders, which if left untreated, will cause chronic disability, mental retardation or death. These products must be prescribed and administered under the direction of a physician. Coverage requires prior authorization.

  Inherited metabolic disease includes a disease for which newborn screening is required and cystic fibrosis.
- **Medically necessary SPECIALIZED INFANT FORMULA.** For children up to the age of 12. Coverage is provided for formulas that are exempt from the general requirements for nutritional labeling (under the statutory and regulatory guidelines of the Federal Food and Drug Administration) and intended for use solely under medical supervision in the dietary management of specific diseases. Such formulas will be covered when they are medically necessary for the treatment of a disease or condition and are administered under the direction of a physician. Coverage is subject to prior authorization.

  Prior authorization is not required in the case of a child diagnosed with metabolic syndrome.

- **Wigs.** If prescribed by a licensed oncologist for a patient who suffers hair loss as a result of chemotherapy for the treatment of leukemia and outpatient chemotherapy following surgical procedures in connection with the treatment of tumors. Coverage is subject to a limit of one wig per covered person per Calendar Year.

Schedule of Medical Benefits

Point of Enrollment (POE) and Point of Enrollment – Gatekeeper (POE-G) Plans

	In-Network ONLY
Upfront deductible *Waived for HEP-compliant members and pre-October 2, 2011 retirees*	$350 per person, $1,400 family maximum
OUT-OF-POCKET MAXIMUM limit	$2,000 individual, $4,000 family
Lifetime maximum	None
Person responsible for obtaining prior authorization	Primary care physician or participating provider
Medical Services	
Preventive care	Plan pays 100%
Primary care physician Includes in-office procedures	**Preferred provider:** Plan pays 100% **Non-Preferred provider:** $15 copay; $5 copay for pre-1999 retirees
Specialist physician Includes in-office procedures; Preferred provider eligible specialties: Allergy, Cardiology, ENT, Endocrinology, Gastroenterology, OB/GYN, Ophthalmology, Orthopedic Surgery, Rheumatology, and Urology	**Preferred provider:** Plan pays 100% **Non-Preferred provider:** $15 copay; $5 copay for pre-1999 retirees
Vision exam and refraction One per Calendar Year	**Preferred provider:** Plan pays 100% **Non-Preferred provider:** $15 copay *Copay waived for HEP members every other year*
Routine hearing screening One per Calendar Year when performed as part of an exam	$15 copay
Outpatient surgery Performed in hospital or licensed ambulatory surgery center, includes colonoscopy; prior authorization may be required	Plan pays 100%*
Non-surgical services of a physician or surgeon Other than medical office visit, may include after care/attending medical care	Plan pays 100%*
Maternity First visit only	**Preferred provider:** Plan pays 100% **Non-Preferred provider:** $15 copay; $5 copay for pre-1999 retirees
Infertility services	$15 copay; $5 copay for pre-1999 retirees

* Plan pays 100% for HEP-compliant covered persons. Non-HEP covered persons must satisfy the deductible to obtain services at no copay.

	In-Network ONLY
Gender identity disorder services	$15 copay; $5 copay for pre-1999 retirees
Bariatric surgery	Plan pays 100%*
Allergy office visit/testing	**Preferred provider:** Plan pays 100% **Non-Preferred provider:** $15 copay; $5 copay for pre-1999 retirees
Allergy injection	Plan pays 100%*
Surgical removal of breast implant	Plan pays 100%*
Emergency/Urgent Care Services	
Emergency room treatment Waived if admitted	$250 copay; $35 copay for retirees with a retirement date from October 2, 2011 to October 1, 2017; Plan pays 100% for retirees with a retirement date before October 1, 2011
Urgent care/walk-in clinic	$15 copay; $5 copay for pre-1999 retirees
Emergency ambulance	Plan pays 100%*
Hospital Service	
Inpatient admissions Prior authorization required, including childbirth	Plan pays 100%*
Ancillary services Prior authorization required	Plan pays 100%*
Skilled nursing facility Prior authorization required	Plan pays 100%*
Inpatient hospice care Prior authorization required	Plan pays 100%*
Other Healthcare Services	
Radiological and high cost diagnostic tests MRI, MRA, CAT, CTA, PET and SPECT scans; Prior authorization required	**Within carrier's immediate service area** **Preferred provider:** Plan pays 100%* **Non-Preferred provider:** 20% coinsurance **Outside carrier's immediate service area** Plan pays 100%*
Diagnostic, laboratory and X-ray services Excludes mammography and breast ultrasound	**Within carrier's immediate service area** **Preferred provider:** Plan pays 100%* **Non-Preferred provider:** 20% coinsurance **Outside carrier's immediate service area** Plan pays 100%
Nutritional counseling Limit: Three visits per covered person per Calendar Year	Plan pays 100%*
Private duty nursing - Prior authorization required	Plan pays 100%*

* Plan pays 100% for HEP-compliant covered persons. Non-HEP covered persons must satisfy the deductible to obtain services at no copay.

	In-Network ONLY
Home healthcare Limit: 200 visits per Calendar Year	Plan pays 100%*
In-home hospice	Plan pays 100%*
Acupuncture Limit 20 visits per Calendar Year	$15 copay
Infusion therapy	Plan pays 100%*
Other Therapy Services Radiation, chemotherapy, electroshock, kidney dialysis in hospital or free-standing dialysis center	Plan pays 100%*
Outpatient Rehabilitation Services	
Physical or occupational therapy Prior authorization required; no prior authorization for pre-October 2, 2011 retirees	Plan pays 100%*
Chiropractic therapy	Plan pays 100%*
Speech therapy Coverage for treatment resulting from autism, stroke, tumor removal, injury or congenital anomalies of the oropharynx	Plan pays 100%*
Speech therapy for other conditions Prior authorization required; must be medically necessary - Limit: 30 visits per Calendar Year	Plan pays 100%*
Autism services BEHAVIORAL THERAPY/outpatient rehabilitation	Plan pays 100%*
Cardiac rehabilitative therapy	Plan pays 100%*
Medical Devices/Supplies	
Durable medical equipment and prosthetic devices Prior authorization may be required	Plan pays 100%
Home oxygen, diabetic equipment, ostomy related supplies	Plan pays 100%
Hearing aids Limit: One set of hearing aids within a 36-month period	Plan pays 100%
Specialized formula Prior authorization required	Plan pays 100%
Penile implant For those suffering from erectile dysfunction as a result of disease or traumatic injury, or those having undergone radical prostatectomy	Plan pays 100%
Foot orthotics	Plan pays 100%

* Plan pays 100% for HEP-compliant covered persons. Non-HEP covered persons must satisfy the deductible to obtain services at no copay.

	In-Network ONLY
Wig For patient suffering hair loss due to chemotherapy Limit: One per Calendar Year	Plan pays 100%
Mental Health & Substance Abuse	
Outpatient treatment for mental healthcare	$15 copay; $5 copay for pre-1999 retirees
Inpatient treatment in a hospital or mental health residential treatment center Prior authorization required	Plan pays 100%*
Outpatient substance abuse treatment	$15 copay; $5 copay for pre-1999 retirees
Inpatient substance abuse treatment In a hospital or substance abuse treatment facility; prior authorization required	Plan pays 100%*

* Plan pays 100% for HEP-compliant covered persons. Non-HEP covered persons must satisfy the deductible to obtain services at no copay.

Point of Service (POS) Plans

	In Network	Out-of-Network
UPFRONT DEDUCTIBLE *Waived for HEP-compliant members and pre-October 2, 2011 retirees*	$350 per person, $1,400 family maximum	Not Applicable
OUT-OF-NETWORK DEDUCTIBLE	Not Applicable	Individual: $300 Two persons: $600 Family: $900
Out-of-network cost share	Not Applicable	20% of allowable charges plus 100% of billed charges in excess of allowable charges (unless otherwise indicated)
Out-of-pocket maximum limit	$2,000 individual, $4,000 family	$2,000 individual, $4,000 family plus out-of-network deductible
Lifetime maximum	None	None
Person responsible for obtaining prior authorization	Participating provider or physician	Covered person
Penalty for failing to obtain prior authorization	Not Applicable	20% of allowable charges or $500, whichever is less

* Plan pays 100% for HEP-compliant covered persons. Non-HEP covered persons must satisfy the deductible to obtain services at no copay.

	In Network	Out-of-Network
Medical Services		
Preventive care	Plan pays 100%	20% coinsurance, after deductible
Primary care physician Includes in-office procedures	**Preferred provider:** Plan pays 100% **Non-Preferred provider:** $15 copay; $5 copay for pre-1999 retirees	20% coinsurance, after deductible
Specialist physician Includes in-office procedures; Preferred provider eligible specialties: Allergy, Cardiology, ENT, Endocrinology, Gastroenterology, OB/GYN, Ophthalmology, Orthopedic Surgery, Rheumatology, and Urology	**Preferred provider:** Plan pays 100% **Non-Preferred provider:** $15 copay; $5 copay for pre-1999 retirees	20% coinsurance, after deductible
Vision exam and refraction One per Calendar Year	**Preferred provider:** Plan pays 100% **Non-Preferred provider:** $15 copay* *Copay waived for HEP members every other year*	50% coinsurance, after deductible
Routine hearing screening One per Calendar Year when performed as part of an exam	$15 copay	20% coinsurance, after deductible
Outpatient surgery Performed in hospital or licensed ambulatory surgery center, includes colonoscopy; prior authorization may be required	Plan pays 100%*	20% coinsurance, after deductible
Non-surgical services of a physician or surgeon Other than medical office visit, may include after care/attending medical care	Plan pays 100%*	20% coinsurance, after deductible
Maternity First visit only	**Preferred provider:** Plan pays 100% **Non-Preferred provider:** $15 copay; $5 copay for pre-1999 retirees	20% coinsurance, after deductible
Infertility services	$15 copay; $5 copay for pre-1999 retirees	20% coinsurance, after deductible

* Plan pays 100% for HEP-compliant covered persons. Non-HEP covered persons must satisfy the deductible to obtain services at no copay.

	In Network	Out-of-Network
Gender identity disorder services	$15 copay; $5 copay for pre-1999 retirees	20% coinsurance, after deductible
Bariatric surgery	Plan pays 100%*	20% coinsurance, after deductible
Allergy office visit/testing	**Preferred provider:** Plan pays 100% **Non-Preferred provider:** $15 copay; $5 copay for pre-1999 retirees	20% coinsurance, after deductible
Allergy injection	Plan pays 100%*	20% coinsurance, after deductible
Surgical removal of breast implant	Plan pays 100%*	20% coinsurance, after deductible
Emergency/Urgent Care Services		
Emergency room treatment Waived if admitted	$250 copay; $35 copay for retirees with a retirement date from October 2, 2011 to October 1, 2017; Plan pays 100% for retirees with a retirement date before October 1, 2011	
Urgent care/walk-in clinic	$15 copay; $5 copay for pre-1999 retirees	20% coinsurance, after deductible
Emergency ambulance	Plan pays 100%*	
Hospital Services		
Inpatient admissions Including childbirth; prior authorization required	Plan pays 100%*	20% coinsurance, after deductible
Ancillary services Prior authorization required	Plan pays 100%*	20% coinsurance, after deductible
Specialty hospital Prior authorization required	Plan pays 100%*	20% coinsurance, after deductible Limit: 60 days per covered person per Calendar Year
Skilled nursing facility Prior authorization required	Plan pays 100%*	20% coinsurance, after deductible Limit: 60 days per covered person per Calendar Year
Inpatient hospice care Prior authorization required	Plan pays 100%*	20% coinsurance, after deductible Limit: 60 days per covered person per Calendar Year

* Plan pays 100% for HEP-compliant covered persons. Non-HEP covered persons must satisfy the deductible to obtain services at no copay.

	In Network	Out-of-Network
Other Healthcare Services		
Radiological and high cost diagnostic tests MRI, MRA, CAT, CTA, PET and SPECT scans; Prior authorization required	**Within carrier's immediate service area** **Preferred provider:** Plan pays 100%* **Non-Preferred provider:** 20% coinsurance **Outside carrier's immediate service area** Plan pays 100%*	**Within carrier's immediate service area** 40% coinsurance, after deductible **Outside carrier's immediate service area** 20% coinsurance, after deductible
Diagnostic, laboratory and X-ray services Excludes mammography and breast ultrasound	**Within carrier's immediate service area** **Preferred provider:** Plan pays 100%* **Non-Preferred provider:** 20% coinsurance **Outside carrier's immediate service area** Plan pays 100%	**Within carrier's immediate service area** 40% coinsurance, after deductible **Outside carrier's immediate service area** 20% coinsurance, after deductible
Nutritional counseling Limit: Three visits per covered person per Calendar Year	Plan pays 100%*	20% coinsurance, after deductible
Private duty nursing Prior authorization required	Plan pays 100%*	20% coinsurance, after deductible
Home healthcare Limit: 200 visits per Calendar Year	Plan pays 100%*	20% coinsurance, after deductible
In-home hospice	Plan pays 100%*	20% coinsurance, after deductible Limit: 200 visits per Calendar Year
Acupuncture Limit 20 visits per Calendar Year	$15 copay	20% coinsurance, after deductible
Infusion therapy	Plan pays 100%*	20% coinsurance, after deductible
Other Therapy Services Radiation, chemotherapy, electroshock, kidney dialysis in hospital or free-standing dialysis center	Plan pays 100%*	20% coinsurance, after deductible

* Plan pays 100% for HEP-compliant covered persons. Non-HEP covered persons must satisfy the deductible to obtain services at no copay.

	In Network	Out-of-Network
Outpatient Rehabilitation Services		
Physical or occupational therapy Prior authorization required; no prior authorization for pre-October 2, 2011 retirees	Plan pays 100%*	20% coinsurance, after deductible Limit: 30 visits per Calendar Year
Chiropractic therapy	Plan pays 100%*	20% coinsurance, after deductible Limit: 30 visits per Calendar Year
Speech therapy Coverage for treatment resulting from autism, stroke, tumor removal, injury or congenital anomalies of the oropharynx	Plan pays 100%*	20% coinsurance, after deductible Limit: 30 visits per condition per Calendar Year
Speech therapy for other conditions Prior authorization required; must be medically necessary Limit: 30 visits per Calendar Year	Plan pays 100%*	20% coinsurance, after deductible
Autism services Behavioral therapy, outpatient, rehabilitation, physical, occupational & speech therapy	Plan pays 100%*	20% coinsurance, after deductible
Cardiac Rehabilitation Therapy	Plan pays 100%*	20% coinsurance, after deductible
Medical Devices/Supplies		
Durable medical equipment and prosthetic devices Prior authorization may be required	Plan pays 100%	20% coinsurance, after deductible
Home oxygen, diabetic equipment, ostomy related supplies	Plan pays 100%	20% coinsurance, after deductible
Hearing aids - Limit: One set of hearing aids within a 36-month period; prior authorization may be required	Plan pays 100%	20% coinsurance, after deductible
Specialized formula Prior authorization required	Plan pays 100%	20% coinsurance, after deductible
Penile implant For those suffering from erectile dysfunction as a result of disease or traumatic injury, or those having undergone radical prostatectomy	Plan pays 100%	20% coinsurance, after deductible
Foot orthotics Prior authorization may be required	Plan pays 100%	20% coinsurance, after deductible
Wig - For patient suffering hair loss due to chemotherapy Limit: One per Calendar Year	Plan pays 100%	

* Plan pays 100% for HEP-compliant covered persons. Non-HEP covered persons must satisfy the deductible to obtain services at no copay.

	In Network	Out-of-Network
Mental Health & Substance Abuse		
Outpatient treatment for mental healthcare	$15 copay; $5 copay for pre-1999 retirees	20% coinsurance, after deductible
Inpatient treatment in a hospital or mental health residential treatment center Prior authorization required	Plan pays 100%*	20% coinsurance, after deductible
Outpatient substance abuse treatment	$15 copay; $5 copay for pre-1999 retirees	20% coinsurance, after deductible
Inpatient substance abuse treatment In a hospital or substance abuse treatment facility; prior authorization required	Plan pays 100%*	20% coinsurance, after deductible

* Plan pays 100% for HEP-compliant covered persons. Non-HEP covered persons must satisfy the deductible to obtain services at no copay.

State BlueCare Prime Plus POS Plan

BlueCare Prime Plus POS is a point-of-service (POS) plan. PCP referrals are required to receive care from a specialist provider.

	In-Network with PCP Referral	In-Network without PCP Referral	Out of Network
COST SHARE PROVISIONS	**Member pays:**	**Member pays:**	**Member pays:**
Office Visit (OV) Copayment1	**$0 Copayment**	**Deductible and 30% Coinsurance**	**Deductible and 30%Coinsurance**
Specialist Visit (SV) Copayment1	**$0 Copayment**	**Deductible and 30% Coinsurance**	**Deductible and 30%Coinsurance**
Hospital (HSP) Copayment – prior authorization required	**$0 Copayment**	**Deductible and 30% Coinsurance**	**Deductible and 30%Coinsurance**
Urgent Care (UR) (no referral required)	**$15 Copayment**	**$15 Copayment**	**Deductible and 30%Coinsurance**
Walk-in Clinic Copayment	**$15 Copayment**	**$15 Copayment**	**Deductible and 30%Coinsurance**
Emergency Room (ER) Copayment – waived if admitted (no referral required)	**$250 Copayment**	**$250 Copayment**	**$250 Copayment**
Outpatient Surgery (OS) Copayment – Prior authorization may be required Performed in hospital or licensed ambulatory surgery center	**$0 Copayment**	**Deductible and 30% Coinsurance**	**Deductible and 30%Coinsurance**
Self-Referral and Out of Network Deductible (Cross applies)	**Not Applicable**	**OPTION 2: $1000 individual $4000 family**	
Out of Pocket Maximum (cross applies between Self- Referral and Out of Network. With PCP Referral is separate)	**$3000 individual, $6000 family**	**$5000 individual, $10000 family**	
Coinsurance (Lab, X-ray, and HCD apply different Coinsurance levels INN & OON)	**Not Applicable**	**30%**	**30%**
Lifetime Maximum	**Unlimited**		

PREVENTIVE CARE

(Included are the preventive care services that meet the requirements of federal and state law, including certain screenings, immunizations, and physician visits. No referral required.)

	In-Network with PCP Referral	In-Network without PCP Referral	Out of Network
	Member pays:	Member pays:	Member pays:
Well childcare	$0 Copayment	$0 Copayment	Deductible and 30%Coinsurance
Adult physical examinations	$0 Copayment	$0 Copayment	Deductible and30% Coinsurance
Routine OB/GYN visits	$0 Copayment	$0 Copayment	Deductible and 30%Coinsurance
Mammography	$0 Copayment	$0 Copayment	Deductible and 30%Coinsurance
Immunizations and vaccinations – including those needed for travel	$0 Copayment	$0 Copayment	Deductible and Coinsurance

MEDICAL CARE	In-Network with PCP Referral	In-Network without PCP Referral	Out of Network
	Member pays:	Member pays:	Member pays:
Office visits PCP1and Specialist1	$0 Copayment	Deductible and Coinsurance	Deductible and 30%Coinsurance
Outpatient mental health & substance abuse - prior authorization required. (no referral required)	$0 Copayment	$0 Copayment	Deductible and 30%Coinsurance
OB/GYN care (no referral required)	$0 Copayment	$0 Copayment	Deductible and 30%Coinsurance
Maternity care – initial visit subject to copayment, no charge thereafter (no referral required)	$0 Copayment	$0 Copayment	Deductible and 30%Coinsurance
Surgical Fees of a Physician or Surgeon Other than office visit; may include after care or attending medical care	$0 Copayment	Deductible and 30% Coinsurance	Deductible and 30%Coinsurance
Diagnostic lab (no referral required)	$0 copay- Site of Service Provider	$0 copay- Site of Service Provider	Deductible and 40% Coinsurance
	20% Coinsurance non-Site of Service Provider	20% Coinsurance non-Site of Service Provider	
Diagnostic x-ray (no referral required)	$0 copay- Site of Service Provider	$0 copay- Site of Service Provider	Deductible and 40% Coinsurance
	20% Coinsurance non-Site of Service Provider	20% Coinsurance non-Site of Service Provider	
High-cost outpatient diagnostic – prior authorization required. The following are subject to copayments: MRI, MRA, CAT, CTA, PET, SPECT scans (no referral required)	$0 copay- Site of Service Provider	$0 copay- Site of Service Provider	Deductible and 40% Coinsurance
	20% Coinsurance non-Site of Service Provider	20% Coinsurance non-Site of Service Provider	
Allergy services Office visits/testing Injections	$0 Copayment	Deductible and Coinsurance	Deductible and Coinsurance

EMERGENCY CARE	In-Network with PCP Referral	In-Network without PCP Referral	Out of Network
	Member pays:	Member pays:	Out of Network Member pays:
Urgent care – at participating centers only (no referral required)	$15 Copayment	$15 Copayment	Deductible and Coinsurance
Emergency care – (no referral required)	$250 Copayment	$250 Copayment	$250 Copayment
Ambulance	$0 Copayment	$0 Copayment	$0 Copayment

HOSPITAL CARE – Prior authorization required	In-Network with PCP Referral	In-Network without PCP Referral	Out of Network
Semi-private room (General/Medical/Surgical/Maternity)	$0 Copayment	Deductible and Coinsurance	Deductible and 30% Coinsurance
Inpatient mental health & substance abuse	$0 Copayment	$0 Copayment	Deductible and 30% Coinsurance
Skilled nursing facility - unlimited; 60 day limit Out of Network	$0 Copayment	Deductible and 30% Coinsurance	Deductible and 30%Coinsurance
Outpatient surgery – in a hospital or licensed ambulatory surgery center	$0 Copayment	Deductible and 30% Coinsurance	Deductible and 30% Coinsurance

OTHER HEALTH CARE	In-Network with PCP Referral	In-Network without PCP Referral	Out of Network
Outpatient rehabilitative services Includes physical, occupational, speech, chiropractic, cardiac rehabilitation and other therapy services	$0 Copayment	Deductible and 30%Coinsurance	Deductible and Coinsurance
Durable medical equipment / Prosthetic devices / Foot orthotics - Prior authorization may be required	$0 Copayment	Deductible and 30% Coinsurance	Deductible and Coinsurance
Diabetic supplies & equipment	$0 Copayment	Deductible and Coinsurance	Deductible and Coinsurance
Infertility services	$0 Copayment	Deductible and Coinsurance	Deductible and Coinsurance
Home health care – 200 visits per year	$0 Copayment	Deductible and Coinsurance	Deductible and Coinsurance
LiveHealth Online (no referral required)	$5 Copayment	$5 Copayment	Deductible and Coinsurance

Medical Coverage Programs and Rules

Except as required by applicable law, the benefits and rights granted under this Medical Benefit Plan shall not be assigned or encumbered, directly or indirectly, at any time by contract or by operation of law or otherwise absent the express written consent of the Plan Administrator.

Health Enhancement Program

The Health Enhancement Program ("HEP") is an incentive program that rewards covered people who commit to taking an active role in managing their health. Covered people who sign up for HEP will qualify for lower premiums, reduced copays for certain services and medications, and no upfront deductibles on in-network services. All family members enrolled in HEP must obtain age-appropriate preventive care and screenings; those with one or more chronic conditions (diabetes, asthma and COPD, heart failure or heart disease, hyperlipidemia, and hypertension) may be required to participate in counseling or condition management program services.

Details about HEP are contained in a separate document. WellSpark, an affiliate of ConnectiCare Insurance Company, has been engaged to assist with monitoring covered people's compliance with their HEP requirements and to provide disease and care management services to covered people with chronic conditions.

WellSpark
175 Scott Swamp Road
Farmington, CT 06034
877-687-1448
www.cthep.com

Site of Service Program: Active Members and Post-October 2, 2017 Retirees ONLY

This program applies only to active members, post-October 2, 2017 retirees, and their dependents for services obtained within the carrier's immediate service area.

Outpatient laboratory, diagnostic X-ray and high cost imaging services are subject to a Site of Service Program that impacts the amount a covered person must pay for using Non-Preferred facilities.

The Medical Benefit Plan provides 100% coverage for diagnostic laboratory and high cost imaging services performed at Preferred facilities, as designated by the member's carrier. Breast ultrasounds and mammograms of all types are excluded from this program.

A list of Preferred facilities is posted on the carrier's website. The Site of Service Program applies to services performed within the carrier's immediate service area, which includes Connecticut and counties in New York, Massachusetts and Rhode Island that are immediately adjacent to the State of Connecticut.

Typically, Non-Preferred facilities are those located within hospitals or hospital-affiliated services that may impose facility fees in addition to the cost of care. Covered persons who obtain laboratory, X-ray and diagnostic high cost imaging services at in-network, Non-Preferred facilities have a 20% coinsurance, based on the carrier's allowed amount. Covered persons obtaining laboratory, X-ray and

high cost imaging services at out-of-network facilities are subject to a deductible and 40% coinsurance. (Covered persons enrolled in the POE or POE-G Plans do not have out-of-network benefits.)

The following are considered high cost imaging services: MRI, MRA, CAT, CTA, PET and SPECT scans. In addition to being subject to Site of Service requirements, certain high cost imaging services are subject to prior authorization. If a covered person obtains diagnostic high cost imaging services at an out-of-network facility without obtaining Prior Authorization that covered person may also be assessed a penalty of 20% or $500, whichever is less.

There is a waiver process that allows a covered person subject to Site of Service requirements to have services performed at a Non-Preferred in-network facility without assessment of additional coinsurance where there is a medically necessary reason to do so.

Note: The Site of Service Program does not apply to covered members (or their dependents) who retired on or before October 2, 2017. It also does not apply to those obtaining outpatient laboratory, X-ray and diagnostic high cost imaging services outside the carrier's immediate service area.

Network of Distinction

The State of Connecticut has contracted with the highest quality doctors, hospitals and medical groups in the state for some of the most common procedures and designated them Networks of Distinction. Incentives will be provided to reward covered people when they select high-value, lower-cost providers or settings for designated services. The Network of Distinction program provides cash incentives for those who use Health Navigator to research and select a Preferred provider for one of the eligible services (the list of services for which rewards will be offered may be modified from time to time).

To qualify for an incentive, the covered person must comply with all program requirements. These include:

- Obtaining any necessary prior authorization for the service;
- Contacting Health Navigator to research an eligible procedure at least 24 hours before receiving the service;
- Selecting a high-value, lower cost provider as identified by Health Navigator; and
- Obtaining the covered service from that provider.

Payment of the incentive will be made when Health Navigator obtains confirmation (through claims data) that the covered person has received the service. Contact Health Navigator at 866-611-8005 for complete details.

Healthcare Requiring Prior Authorization

Prior authorization, also known as precertification, of certain services is required so that the carrier can review the service to verify that it is medically necessary, and that the treatment provided is the proper level of care. Prior authorization may be obtained by contacting the carrier at the telephone number located on the back of the covered person's I.D. card. If care is received in-network, it is the provider's responsibility to obtain prior authorization. If care is received out-of-network, it is the covered person's responsibility to obtain prior authorization from the carrier before receiving services. The covered person and provider will receive written notification regarding approval or denial of a prior authorization request.

Issuance of prior authorization indicates that the carrier has determined that the services are medically necessary and will pay for such approved services, if they are otherwise covered under the Medical Benefit Plan, the coinsurance/copay/deductible requirements are met, and the patient is covered on the date care is received. The prior authorization will indicate a period within which the service must be performed. Any service that is not performed within the specified period will need to be re-authorized.

Non-medically necessary treatment or services for which the required prior authorization has not been obtained will be subject to review and will not be eligible for coverage if they are determined not to have been medically necessary. Penalties may also apply for obtaining services for which prior authorization is required from an out-of-network provider.

Medical Services Requiring Prior Authorization	
Air ambulance	Oral surgery
Bariatric surgery	Organ transplant
Chemotherapy	Orthoptic exercises
	Outpatient occupational therapy
High cost diagnostic imaging (MRI, MRA, CAT, CTA, PET, SPECT scans)	Outpatient physical therapy
Gender reassignment surgery	Outpatient surgery
Hearing aids (bone-anchored)	PARTIAL HOSPITALIZATION (under 12 hours) mental health/substance abuse
Infertility treatments	Private duty nursing
Inpatient non-emergency care	Skilled nursing facility admission
Inpatient hospice	Speech therapy (expanded benefits)
Inpatient mental health/intensive outpatient (IOP) mental health	Specialized formula
Inpatient substance abuse treatment	Specialized infant formula
Internal & external prosthetic devices	Substance abuse residential treatment

Obtaining Prior Authorization

Participating providers in the carrier's network know which services require prior authorization and will obtain the prior authorization when required. Participating providers have detailed information regarding the carrier's managed care guidelines procedures and are responsible for assuring that those requirements are met.

Covered persons in a POS Plan who are using an out-of-network provider should advise that provider to contact the carrier for information on obtaining prior authorization. A penalty of 20% of the cost of the service or $500, whichever is less, will be imposed for failure to obtain prior authorization for an out-of-network service where it is required.

Note: The covered person will be financially responsible for the cost of obtaining services and/or care in settings that are not covered under the Medical Benefit Plan if the carrier makes an adverse determination that such services are not medically necessary or are EXPERIMENTAL OR INVESTIGATIONAL.

Medical Emergency Admissions

This Medical Benefit Plan provides benefits for medical emergency admissions. It is the in-network provider's responsibility to notify the carrier within 48 hours of an inpatient admission due to a medical emergency. If the covered person receives services from an out-of-network provider, the covered person must notify the carrier within 48 hours of an inpatient admission due to a medical emergency.

Upon receiving proper notification of the medical emergency admission, the carrier must AUTHORIZE and manage continued inpatient or outpatient care related to the medical emergency in order for such care to be covered under this Medical Benefit Plan.

If the covered person has an inpatient admission due to a medical emergency and the carrier is not notified within two business days, benefits for covered services shall only be provided if the covered person's condition at the time of diagnosis, care or treatment is confirmed to have been a medical emergency.

After the cessation of the medical emergency any follow-up diagnosis, care or treatment performed must be provided by an in-network provider in order for benefits to be considered as in-network. Follow-up diagnosis, care or treatment provided by an out-of-network provider will be subject to the cost shares specified in the *Schedule of Medical Benefits*.

Prior Authorization for Inpatient Admissions

Prior authorization is required for hospital admissions, INPATIENT FACILITY admissions, or admission to a partial hospitalization or DAY/NIGHT PROGRAM.

When a covered person is scheduled for an in-network admission to a hospital, skilled nursing facility, or inpatient hospice care, the in-network provider is responsible for obtaining the prior authorization from the carrier, unless the admission is due to a medical emergency.

When a covered person is scheduled for an admission to an out-of-network hospital, skilled nursing facility, or inpatient hospice care, it is the responsibility of the covered person or his/her representative to obtain prior authorization from the carrier, unless the admission is due to a medical emergency.

Concurrent Review

The provision of benefits for inpatient services will be subject to concurrent review conducted by the carrier, which will determine whether:

- Additional inpatient days will be prior authorized;
- There will be a change in the services, supplies, treatment or setting; or
- No additional inpatient days will be authorized as of a specific date.

No benefits will be provided for inpatient services that are billed by a hospital and/or the admitting physician after the specific date indicated in the carrier's authorization notice.

Notice for Admission Following Outpatient Surgery

If a covered person is admitted as an inpatient as result of outpatient surgery, the covered person must notify his/her carrier within two business days of the admission in accordance with this Plan Document.

Exclusions and Limitations

Medical Policy

The carrier's medical policy sets forth the standards of practice and medical interventions that have been identified as reflecting appropriate medical practice. The purpose of the carrier's medical policy is to assist in the determination of medical necessity. Medical technology is constantly changing, and the carrier has the right to review and update its medical policy periodically.

The benefits, exclusions and limitations in the Plan Document take precedence over the carrier's medical policy.

Exclusions and Limitations

Except as required by applicable law, the benefits and rights granted under this Medical Benefit Plan shall not be assigned or encumbered, directly or indirectly, at any time by contract, by operation of law, or otherwise absent the express written consent of the administrator.

In addition to the other limitations, conditions and exclusions set forth elsewhere in this Plan Document, no benefits will be provided for expenses related to the services, supplies, conditions or situations that are described in this section. These items and services are not covered even if received from a provider or according to a provider's referral.

If a service is not covered, then all services performed in conjunction with that service are not covered. The carrier is responsible for determining whether services or supplies are medically necessary, subject to the appeals process.

This Medical Benefit Plan does not cover any services or supply benefits that are not specifically listed as a covered service in this Plan Document. The following list of exclusions is not a complete list of all services, supplies, conditions or situations that are not covered services:

- Benefits for services which are not:
  - Described in the Plan Document;
  - Rendered or ordered by a physician;
  - Within the scope of a physician's, provider's or hospital's license; and
  - Medically necessary care for the proper diagnosis or treatment of the covered person.
- Benefits for services rendered before the covered person's EFFECTIVE DATE under this Medical Benefit Plan.
- Benefits for services rendered after the covered person's Medical Benefit Plan has been rescinded, suspended, cancelled, interrupted or terminated. Any person getting services after his/her Medical Benefit Plan is rescinded, suspended, cancelled, interrupted or terminated for any reason will be liable for payment of such services.
- Benefits that are reduced under the managed care guidelines. Any reduced or denied benefits paid by the covered person do not count towards any applicable COST SHARE MAXIMUMS shown in the *Schedule of Medical Benefits*.

- Any reduction in benefits, including, but not limited to, penalties imposed by another plan, will not be paid as a covered service under this Medical Benefit Plan.
- Care for conditions that are required by state or local law to be treated in a public facility.
- Services and care in a veteran's hospital or any federal hospital, except as may be required by law.
- Services covered in whole, or in part by public or private grants.
- Studies related to pregnancy, except for major medical reasons.
- Simplified or self-administered tests and multiphasic screening.
- Prenatal medical conferences with a pediatrician regarding an unborn child, unless the visit is the result of a medical referral.
- Charges for the covered person's room and board when the covered person has a leave of absence from a hospital, substance abuse treatment facility or other inpatient facility.
- Vaccines (other than adult or childhood immunizations recommended by the U.S. Department of Health and Human Services for the covered person or immunizations required for foreign travel).
- Services, medical supplies or supplies not listed as covered services. These include, but are not limited to educational therapy, marital counseling, sex therapy, weight control programs, nutritional programs and exercise programs.
- Experimental or investigational treatment, procedure, facility, equipment, drugs, devices or supplies and any services associated with, or as follow-up to any of the above is not a covered service.
- Any treatment, procedure, facility, equipment, drug, device or supply which requires federal or other governmental agency approval that has not been granted at the time services are rendered. Any service associated with, or as follow-up to, any of the previous is not a covered service.
- Any services by a physician or provider to himself/herself, or for services rendered to his/her parent, spouse, children, grandchildren or any other close family member or relation, even if an in-network physician or provider.
- Services that the covered person or the carrier is not legally required to pay.
- Wigs and other cranial prostheses, except as noted as a covered service.
- Inpatient services which can be properly rendered as outpatient services.
- Cosmetic, reconstructive or plastic surgery that is performed for a condition that does not meet the specific criteria of a covered service, including but not limited to cosmetic, plastic or reconstructive surgery performed primarily to improve the appearance of any portion of the body including, but not limited to surgery for sagging skin or extra skin, any augmentation or reduction procedure (e.g., mammoplasty), liposuction, rhinoplasty and rhinoplasty done in conjunction with a covered nasal or covered sinus surgery.
    - Complications of such cosmetic, reconstructive or plastic surgeries are covered only if they are medically necessary and are otherwise covered.
- Court ordered services or services that have been ordered as a condition of probation or parole. However, these services may be covered if the carrier agrees that they are medically necessary, are otherwise covered, the covered person has not exhausted any applicable benefit for the Calendar Year, and the treatment is provided in accordance with the carrier's policies and procedures.

- Except as specifically covered under this Plan Document, the Medical Benefit Plan does not cover non-medical services and long-term rehabilitation for treatment of alcoholism or drug abuse, including rehabilitation services in a specialized inpatient or residential facility.
- Nutritional programs or meal replacement programs.
- Funeral arrangements, pastoral, bereavement counseling, financial or legal counseling, homemaker, caretaker or respite care.
- CUSTODIAL CARE, convalescent care, domiciliary care, long-term care, MAINTENANCE CARE, adult day care or rest cures. The Medical Benefit Plan does not cover room, board, nursing care or personal care which is rendered to assist a covered person who, in the carrier's opinion, has reached the maximum level of physical or mental function possible and will not make further significant clinical improvement.
- Transport solely for the convenience of the covered person, family, or physician or provider, except when medically necessary, or in the case of a medical emergency.
- Remedial work, including any medical procedure to correct undesired results of an unsuccessful procedure connected to a prior non-covered cosmetic surgery/procedure.
- Examinations for the purpose of obtaining or maintaining any license issued by a municipality, state or federal government, obtaining insurance coverage, school admission or attendance, including examinations required for participation in athletic activities.
- Court ordered psychological or behavioral evaluations or counseling related to marital disputes, divorce proceedings, or child custody proceedings.
- Diseases contracted or injuries resulting from war.
- Transport for elective hospital admissions.
- Private or special duty nursing services during an inpatient admission.
- Rehabilitation services or physical therapy on a long-term basis.
- Services or supplies furnished by a non-eligible institution, which is defined as other than a hospital or skilled nursing facility, and which is primarily a place of rest, a place for the aged or any similar institution, regardless of how denominated.
- Adult routine physicals and well childcare exams in excess of the guidelines if performed at a walk-in medical clinic or center.
- Charges after the provider's or hospital's regular discharge hour on the day indicated for the covered person's discharge by his/her physician.
- Eyeglasses and contact lenses.
- Travel, whether, or not recommended by a physician.
- Birth control pills, condoms, foams or contraceptive jellies and ointments even if they are being prescribed or recommended for a medical condition other than birth control.
- Breast pumps that are not obtained from a DME provider, hospital or physician.
- An adopted newly born infant's initial hospital stay is not covered if the natural parent has coverage available for the infant's care.

- Services for the evaluation or treatment (including remedial education) of learning disabilities or minimal brain dysfunction, mental retardation, developmental and learning disorders or behavioral problems are not covered except as noted in this Plan Document. The Medical Benefit Plan also does not cover behavioral training or cognitive rehabilitation.
- The following surgeries are considered cosmetic when used to improve the gender specific appearance of an individual who has undergone or is planning to undergo gender reassignment surgery and are not covered:
    - Liposuction/body contouring
    - Rhinoplasty
    - Facial bone reconstruction
    - Voice modification surgery
    - Hair removal
    - Face lift
    - Blepharoplasty
    - Reversal of genital surgery
    - Sperm preservation in advance of hormone treatment or surgery
    - Cryopreservation in advance of hormone treatment or surgery
    - Surgical treatment of anyone under the age of 18.
- Non-medical services and long-term rehabilitation for the treatment of mental illness, including rehabilitation services in a specialized inpatient or residential facility.
- Meals, personal comfort items and housekeeping services.
- Nursing services rendered in the home by a relative, even if that person is a registered nurse or a licensed practical nurse.
- Certain pulmonary function tests which, in the opinion of the carrier, do not meet the definition of a covered diagnostic laboratory test.
- Services or procedures rendered without regard for specific clinical indications or performed solely for research purposes.
- Services or procedures that have become obsolete or are no longer medically justified as determined by appropriate medical fields.
- Radiation therapy as a treatment for acne vulgaris.
- Services required by third parties for employment, membership, enrollment or insurance, such as school or employment physicals, physicals for summer camp, enrollment in health, athletic or similar clubs, premarital blood work or physicals, or physicals required by insurance companies or court-ordered alcohol or drug abuse courses.
- Durable medical equipment and other items for home or personal use, except as provided in the Plan Document.
- Membership in health clubs, diet plans or other organizations, even if recommended by a physician or a qualified health provider for the purpose of losing weight.
- Any counseling or courses in diabetes management other than as described in the Plan Document.
- Stays at special facilities or spas for the purpose of diabetes education/management.

- Special foods, diet aids and supplements related to dieting.
- Any item that is not both medically necessary and prescribed by the covered person's physician or qualified health provider.
- Prosthetic devices, except as provided in the Plan Document. Examples of non-covered items include, but are not limited to:
    - Bite plates/dental prosthetics, except for maxillo-facial prosthetic devices used to replace anatomic structures lost during treatment of tumors;
    - Optical or visual aids, including eyeglasses or contact lenses, except for the treatment of congenital aphakia or for aphakia following cataract surgery when an intraocular lens is not medically possible;
    - Penile implants (except as medically necessary for those suffering from erectile dysfunction resulting from disease or traumatic injury, or who have undergone radical prostatectomy);
    - Xomed audient bone conductors;
    - Foot orthotics (except as medically necessary and subject to prior authorization); or experimental or research prostheses.
- Treatment of pattern baldness.
- Injectable infertility drugs.
- Cost for an ovum donor or donor sperm.
- Sperm storage costs.
- Cryopreservation and storage of embryos.
- Ovulation predictor kits.
- In-vitro services for women who have undergone tubal ligation.
- Reversal of tubal ligations.
- Any infertility services if the male has undergone a vasectomy.
- All costs for and relating to surrogate motherhood (maternity services are covered for covered persons acting as surrogate mothers).
- Services to reverse voluntary sterilizations.
- Self-administration of allergy serums or the administration of allergy serums in a location where emergency resuscitative equipment and trained personnel are not present.
- Serums delivered orally, sublingually or bronchially.
- General dental services are not covered.
    - Dental diagnosis, care, treatment or diagnostic imaging studies, except as provided in the Plan Document. Examples of non-covered services include correction of malposition of the teeth and jaw, treatment of dental caries, dental implants, periodontics, endodontics, orthodontics, replacement of teeth, bonding, gold foil restorations, application of sealants, bitewing X-rays, crown or tooth preparations, fillings, crowns, bridges, dentures, inlays and onlays, and services with respect to congenital malformations. Anesthesia, X-ray, laboratory or facility fees for non-covered dental services shall also not be covered.

- In the case of injury to the oral cavity, non-covered prosthetic devices include, but are not limited to, plates, bridges, dentures, implants or caps/crowns.
- Injury to teeth or soft tissue as a result of chewing or biting shall not be considered an accidental injury.
- No additional benefits will be provided for any services rendered after the initial visit due to accident, injury or trauma, including but not limited to, follow-up care, replacement of sound natural teeth, crowns, bridges, implants and prosthetic devices.

- Items generally used for personal comfort and/or useful to the covered person's household, including but not limited to:
  - Air conditioners, humidifiers, air cleaners, filtration units and related apparatus;
  - Whirlpools, saunas and related apparatus;
  - Vans and van lifts;
  - Stair and chair lifts;
  - Exercise bicycles and other types of exercise equipment.
- Physical therapy, chiropractic care, occupational therapy, speech therapy and cardiac rehabilitative therapy, except as provided in the Plan Document.
- Testing for or treatment of a LEARNING DISABILITY, except as provided in the Plan Document.
- Testing, training or rehabilitation for educational or developmental purposes, except as provided in the Plan Document.
- Special foods and diets, supplements, vitamins and enteral feedings are not covered except as noted in this Plan Document.
- Services for the evaluation or treatment (including remedial education) of learning disabilities or minimal brain dysfunction, mental retardation, developmental and learning disorders or behavioral problems, except as noted in the Plan Document are not covered. The Medical Benefit Plan also does not cover behavioral training, visual perceptual or visual motor training related to learning disabilities or cognitive rehabilitation. Behavioral and learning disorders related to congenital abnormalities, such as Down Syndrome, are not covered.
- Oral surgery, except as provided in the Plan Document. An example of a non-covered service includes but is not limited to the correction of malposition of the teeth or jaw.
- Except for the initial visit, all services related to the non-surgical treatments of temporomandibular joint dysfunction or syndrome, also called myofascial pain dysfunction or craniomandibular pain syndrome. Examples of non-covered services include but are not limited to physiotherapy, such as therapeutic muscle exercises, galvanic or transcutaneous nerve stimulation, vapocoolant sprays, ultrasound, or diathermy, behavior modification such as biofeedback, psychotherapy, appliance therapy and/or dental orthotic devices such as occlusal appliances (splints) or other oral prosthetic devices and their adjustments, orthodontic therapy such as braces, prosthodontic therapy such as crowns, bridgework, and occlusal adjustments.
- Routine foot care rendered:
  - In the exam, treatment or removal of all or part of corns, callosities, hypertrophy, or hyperplasia of the skin, or subcutaneous tissues of the foot, except when medically necessary in the treatment of those diagnosed with Type 1 or Type 2 diabetes; or

- In the cutting, trimming, or other non-operative partial removal of toenails, except when medically necessary in the treatment of neuro-circulatory conditions or of those diagnosed with Type 1 or Type 2 diabetes.

- Emergency room services that are not related to a medical emergency.
- Private room accommodations, except as noted in the Plan Document.
- Prescription drugs or over-the-counter medications prescribed for use as an outpatient, except as otherwise stated in the Plan Document.
- Whole blood, blood plasma and other blood derivatives, and donor services that are provided by the American Red Cross.
- Sperm collection and preservation, all services related to surrogate parenting arrangements and preparatory treatment.
- Marriage counseling other than for the treatment of a diagnosed mental illness, stress management, parent-child management and pain control.
- Psychiatric and other treatment for sexual dysfunction, including sex therapy, unless documented by a medical condition and with prior authorization from the carrier.
- Special nutritional formulas for the treatment of Crohn's disease.
- Hypnosis.
- Human organ and tissue transplants, or associated donor costs, except as stated in the Plan Document.
- Care, treatment, service or supplies to the extent that the covered person has obtained benefits under any applicable law, government program, or public or private grant.
- Routine eye exams or refractions, except as provided in the Plan Document.
- Radial keratotomy.
- Human growth hormone therapy, except when medically necessary for cases of hypopituitarism, and with prior authorization from the carrier.
- Hospital outpatient clinic services.
- Penalties imposed on a covered person by the primary payer.
- Inpatient private duty nursing or outpatient private duty nursing for the convenience of the member or member’s family.
- Any medication or drug, which has a biotechnical application, is a genetically engineered biological product, or is listed in the formulary as such.
- Hypodermic needles or syringes prescribed by a physician, except for the purpose of administering medicine for medical conditions, provided such medicines are covered services.
- No benefits will be available for maintenance care which is:
  - Treatment provided for the covered person's continued well-being by preventing deterioration of a chronic clinical condition; and
  - Maintenance of an achieved stationary status, which is a point where little or no improvement in musculo-skeletal function can be made despite therapy.

- Benefits for services caused by or resulting from the covered person's participation in a riot or civil disorder act of or attempt to commit an assault or felony.
- Services for CHRONIC CARE.
- Allogeneic or syngeneic bone marrow transplant, or other forms of stem cell rescue, and stem cell infusion (with or without high dose chemotherapy and/or radiation) with a donor other than the patient. They are not covered, unless:
  - At least five out of six histocompatibility complex antigens match between the patient and the donor;
  - The mixed leukocyte culture is non-reactive; and
  - One of the following conditions is being treated:
  - Severe aplastic anemia;
  - Acute nonlymphocytic leukemia in first or subsequent remission or early first relapse;
  - Myelodysplastic syndrome;
  - Secondary acute nonlymphocytic leukemia as initial therapy;
  - Acute lymphocytic leukemia in second or subsequent remission;
  - Acute lymphocytic leukemia in first remission;
  - Chronic myelogenous leukemia in chronic and accelerate phase;
  - Non-Hodgkin’s lymphoma, high grade, in first or subsequent remission;
  - Hodgkin’s lymphoma low grade, which has undergone conversion to high grade;
  - Neuroblastoma, stage 3 or relapsed stage 4;
  - Ewing’s sarcoma;
  - Severe combined immunodeficiency syndrome;
  - Wiskott-Aldrich syndrome;
  - Osteopetrosis, infantile malignant;
  - Chediak-Higashi syndrome;
  - Congenital life-threatening neutrophil disorders to include Kostmann’s syndrome, chronic granulomatous disease, and cartilage hair hypoplasia;
  - Diamond Blackfan syndrome;
  - Thalassemia;
  - Sickle cell anemia;
  - Primary thrombocytopathy including Glanzmann’s syndrome;
  - Gaucher disease; or
  - Mucopolysaccharidoses and lipidoses to include Hurler’s syndrome, Sanfilippo’s syndrome, Maroteaux-Lamy syndrome, Morquio’s syndrome, Hunter’s syndrome, and metachromatic leukodystrophy.

- All other uses of allogeneic or syngeneic bone marrow transplants, or other forms of stem cell rescue, and stem cell infusion (with or without high dose chemotherapy or radiation) are not covered.
- Autologous bone marrow transplantation or other forms of stem cell rescue, and stem cell infusion (in which the patient is the donor) with high dose chemotherapy or radiation are not covered except for the following:
- Non-Hodgkin's lymphoma, high grade, first or subsequent remission. No morphological evidence of bone marrow involvement should be evident;
- Hodgkin's disease as defined above with an absence of bone marrow involvement;
- Acute nonlymphocytic leukemia in second remission, in which no HLA matched donor exists, or an allogeneic transplant is inappropriate;
- Acute lymphocytic leukemia in second remission, in which no HLA matched donor exists, or an allogeneic transplant is inappropriate;
- Retinoblastoma, adjuvant setting after successful induction (consolidation); or
- Neuroblastoma, adjuvant setting after successful induction (consolidation).

- No-show charges assessed by a provider for a missed appointment.
- Services for the evaluation or treatment (including remedial education) of learning disabilities or minimal brain dysfunction, mental retardation, developmental and learning disorders or behavioral problems except as noted in the Plan Document are not covered. The Medical Benefit Plan also does not cover behavioral training, visual perceptual or visual motor training related to learning disabilities or cognitive rehabilitation. Behavioral and learning disorders related to congenital abnormalities, such as Down Syndrome, are not covered.
- Court ordered psychological or behavioral evaluations or counseling related to marital disputes, divorce proceedings or child custody proceedings.
- Besides what is included in this Plan Document, coverage is not provided for transplants related to:
  - The covered person is not a suitable candidate as determined by the hospital and approved by the carrier to provide such services.
  - Services for donor searches or tissue matching, or personal living expenses related to donor searches or tissue matching, for the recipient or donor, or their respective family or friends.
  - Any human organ and tissue transplant service that is determined to be experimental or investigational.
  - Benefits for transportation and lodging for the transplant recipient and companion(s), when the human organ or tissue transplant is provided in a hospital or other facility not designated and approved by the carrier.
- Care, treatment, procedures, services or supplies which are primarily for dietary control including, but not limited to weight reduction programs, except as stated in the Plan Document.

Exclusion of Workers' Compensation

To the extent permitted by law, no benefits shall be provided for covered services that are 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 non-participating retail pharmacy services or which, by law, were rendered without expense to the covered person.

The Medical Benefit Plan shall be entitled to the following:

- To charge the entity obligated under such law for the dollar value of those benefits to which the covered person is entitled.
- To charge the covered person for such dollar value, to the extent that the covered person has been paid for the covered services.
- To reduce any sum owed to the covered person by the amount that the covered person has received in payment.
- To place a lien on any sum owed to the covered person for the amount the Medical Benefit Plan has paid for covered services rendered to the covered person, in the event that there is a disputed and/or controverted claim between the Medical Benefit Plan and the designated Workers' Compensation carrier as to whether or not the covered person is entitled to receive Workers' Compensation benefit payments.
- To recover any such sum owed as described, in the event that the disputed and/or controverted claim is resolved by monetary settlement to the full extent of such settlement.
- If a covered person is entitled to benefits under Workers' Compensation, employer's liability or occupational disease law, it is necessary to follow all of the guidelines for coverage under such program in order for this Medical Benefit Plan to continue to provide benefits for covered services when the Workers' Compensation benefits are exhausted.

Exclusion of Automobile Insurance

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

The Medical Benefit Plan shall be entitled:

- To charge the insurer obligated under such law for the dollar value of those benefits to which a covered person is entitled;
- To charge the covered person for such dollar value, to the extent that the covered person has received payment from any and all sources, including but not limited to, first party payment.
- To reduce any sum owed to the covered person by the amount the covered person has received from any and all sources, including but not limited to, first party payment.
- Benefits shall be subject to the *Coordination of Benefits* section for covered services a covered person receives under an automobile insurance policy, which provides benefits without regard to fault.
- If a covered person is entitled to benefits under a no-fault or other automobile insurance policy, benefits for covered services will only be provided when a covered person follows all the guidelines for coverage under that policy. It is necessary to follow all the guidelines under that policy in order for the Medical Benefit Plan to continue to provide benefits for covered services when the no-fault or other automobile insurance policy benefits are exhausted.

Coordination of Benefits

All benefits provided under this Medical Benefit Plan are subject to the Coordination of Benefits (COB) process. Penalties imposed on a covered person by the primary plan are not subject to COB.

COB applies to this Medical Benefit Plan when a covered person has healthcare coverage under more than one plan.

If the covered person is covered by this Medical Benefit Plan and another plan, the "order of benefit determination rules" shall determine which plan is the primary plan. The benefits of this Medical Benefit Plan:

- Shall not be reduced when, under the order of benefit determination rules, this Medical Benefit Plan is the primary plan; but
- May be reduced (or the reasonable cash value of any covered service provided under this Medical Benefit Plan may be recovered from the primary plan) when, under the order of benefit determination rules another plan is the primary plan.

The covered person must submit the explanation of benefits from the primary plan to his/her carrier in order to be eligible for payment under COB.

Order of Benefit Determination Rules

When a covered person receives covered services by or through this Medical Benefit Plan or is otherwise entitled to claim benefits under this Medical Benefit Plan and has followed the carrier's guidelines and procedures, including prior authorization requirements, and the covered services are a basis for a claim under another plan, this Medical Benefit Plan is a SECONDARY PLAN which has its benefits determined after those of the other plan (expect when the carrier is secondary payor), unless:

- The other plan has rules coordinating its benefits with those described in this Plan Document; and
- Both the other plan's rules and this Medical Benefit Plan's coordination rules require that this Medical Benefit Plan's benefits be determined before those of the other plan.

Coordination Rules

The carrier decides its order of benefits using the following rules:

- **Other than a dependent.** The plan which covers the person as a covered member, (that is, other than as a dependent), is primary to the plan which covers the person as a dependent;
- **Dependent child/parents not separated or divorced.** When this Medical Benefit Plan and another plan cover the same child as a dependent of different persons, called "parents," the plan of the parent whose birthday falls earlier in a year is primary to the plan of the parent whose birthday falls later in that year. If both parents have the same birthday, the plan which covered a parent longer is primary. Only the month and day of the birthday are considered.
- Dependent child/separated or divorced parents. In the case of a covered dependent child:
  - When the parents are separated or divorced and the parent with legal custody of the child has not remarried, the plan that covers the child as a dependent of the parent with legal custody of

the child shall pay benefits before the plan that covers the child as a dependent of the parent without legal custody;

- When the parents are divorced and the parent with legal custody of the child has remarried, the plan that covers the child as a dependent of the parent with custody shall pay benefits before the plan that covers that child as a dependent of the step-parent; and
- The plan that covers that child as a dependent of the stepparent shall pay benefits before the plan that covers that child as a dependent of the parent without legal custody.

However, if the specific terms of a court order state that one of the parents is financially responsible for the healthcare expenses of the child, then the plan that covers the child as a dependent of the financially responsible parent shall pay benefits before any other plan that covers the child as a dependent.

The provisions of this subsection do not apply with respect to any CLAIM DETERMINATION PERIOD or Plan Year during which any benefits are actually paid or provided before the payor has actual knowledge of the terms of the court order

- **Active/inactive employee.** A plan which covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) is primary to a plan which covers that person as laid off or retired (or as that employee's dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
- **Longer/shorter/length of coverage.** If none of the above rules determines the order of benefits, the plan that covered a covered member longer is primary to the plan that covered that person for the shorter time.

NOTE: Certain services may not require prior authorization when it is determined that this is the secondary plan. Contact customer service before any services are rendered to determine if such services require prior authorization. In the event that a later determination finds that this is the primary plan, any services that were obtained without prior authorization while this Medical Benefit Plan was administering benefits as a secondary plan will not require prior authorization as would be required under a primary plan.

Effect of this Medical Benefit Plan on Other Benefits

This subsection applies, when in accordance with the order of benefit determination rules this Medical Benefit Plan is a secondary plan to one or more other plans. In that event, the benefits of this Medical Benefit Plan may be reduced. Such other plan or plans are referred to as "the other plans."

When the Medical Benefit Plan is the secondary plan, the carrier will provide benefits under the Medical Benefit Plan so that the sum of the reasonable cash value of any covered service provided by the Medical Benefit Plan, and the benefits payable under the other plans shall not total more than the ALLOWABLE EXPENSE. Benefits will be provided by the secondary plan at the lesser of the amount that would have been paid had it been the primary plan or the balance of the bill. The carrier shall never pay more than it would have paid as the primary plan.

If another plan provides that its benefits are "excess" or "always secondary" and if this Medical Benefit Plan is determined to be secondary under the COB provisions, the amount of benefits paid under this benefit program shall be determined on the basis of this Medical Benefit Plan being secondary.

Right to Receive and Release Needed Information

Certain data is needed to apply these COB rules. The carrier has the right to decide which data it needs. By enrolling in the Medical Benefit Plan, the covered person allows the release of data needed to apply the COB rules. Any covered person claiming benefits under this Medical Benefit Plan must give data to the carrier, which is necessary for the coordination of benefits.

Facility of Payment

A payment made or a service provided under another plan may include an amount that should have been paid or provided under this Medical Benefit Plan. If it does, the carrier may pay that amount to the group which made that payment. Such amount shall then be considered as though it were a benefit paid under this Medical Benefit Plan.

Right of Recovery

If the amount of the payments made by the carrier is more than it should have paid under this COB provision or if this Medical Benefit Plan has provided services which should have been paid by the primary plan, the Plan Sponsor may recover the excess or the reasonable cash value of the covered services, from one or more of the persons it has paid, or for whom it has paid insurance companies, or other groups.

The right of the Plan Sponsor to recover from a covered person shall be limited to the allowable expense that the covered person has received from another plan. Acceptance of covered services will constitute consent by the covered person to the Plan Sponsor's right of recovery. The covered person agrees to take all further action to execute and deliver such documents as may be needed and do whatever else is needed to secure the Plan Sponsor's rights to recover excess payments. A covered person's failure to comply may result in a withdrawal of benefits already provided, or a denial of benefits requested.

Termination of Coverage

Coverage under this Medical Benefit Plan may terminate for the following reasons:

- The last day of the month in which required premiums for a covered person's coverage are not paid when due. Coverage that is canceled for non-payment will not be reinstated unless the full amount in arrears is paid. Failure to pay the employee premium share (or total premium if applicable) when due may result in cancellation of coverage, with no right to COBRA continuation coverage.
- The first day of the month following the covered member's termination from employment or the covered member's change in work status such that he/she is employed less than the equivalent of one-half of the full-time hours (0.5 FTE) for his/her position or transferred to a position not eligible for health benefits. Notwithstanding any reduction in hours, a variable hour employee who became eligible for health benefits after the initial 12-month measurement period will not lose coverage until the first day of the month following 12 months of participation in the Medical Benefit Plan or upon termination of employment, which ever first occurs.
- Coverage for dependents will automatically terminate on the first day of the month following the death of the covered member, unless the covered dependents are eligible for continued coverage or elect COBRA continuation coverage.
- Coverage will terminate on the first day of the month following the date of entry of a judgment of legal separation, divorce or annulment. Failure of the covered member to provide notice of a change in marital status within 60 days of the event will result in loss of rights to COBRA continuation coverage.
- Coverage of a child will terminate automatically:
  - On the last day of the calendar year in which the child reaches age 26, unless the child elects COBRA continuation coverage; or
  - In the case of an unmarried child over 26 years of age who has been covered by reason of physical or mental disability, on the last day of the month in which the child is no longer incapable of self-support or on the last day of the month after the child's marriage.
- Coverage as a retiree or dependent of a retiree will terminate upon eligibility for coverage and enrollment in the State of Connecticut Group Medicare Advantage plan. Each covered person's eligibility for enrollment in the Group Medicare Advantage plan will be determined independently.

Member Notification Requirements

The covered employee, spouse or other family member is responsible for informing the State of Connecticut of a divorce, legal separation or a child losing dependent status under the State sponsored group health plan. The Plan requires that notification must be made within 31 days from the date of the event or the date on which coverage would be lost under the terms of the Medical Benefit Plan because of the event. This notification must be made to the personnel or payroll office of the employing agency or in the case of a retiree to the Retiree Health Insurance Unit of the Healthcare Policy & Benefit Services Division.

In most cases a child will cease to qualify as an eligible dependent the last day of the calendar year in which he/she reaches age 26. However, coverage may be lost sooner as the result of a divorce, legal

separation or, in the case of a child who was under the legal guardianship of a covered member, upon the child's attainment of age 18 or the termination of the guardianship, whichever first occurs.

If this notification is not provided within 60 days from the date of the even or the date on which coverage would be lost under the terms of the Medical Benefit Plan because of the event, rights to continuation coverage may be forfeited.

The employing agency is responsible for notifying the COBRA administrator of termination of employment, reduction in hours or death

Notification of Address Change

It is the covered member's responsibility to ensure that all covered individuals receive COBRA continuation information properly and efficiently. It is the covered member's obligation to notify his/her personnel or payroll office of any address change as soon as possible. Failure to do so may result in delayed notification or a loss of continuation coverage options.

Continuation Options

A covered member or dependent is required to notify the covered member's employing agency (or the Retiree Health Insurance Unit, in the case of a retiree) within 31 days of the change in status that renders an enrolled dependent ineligible for coverage and may be subject to disciplinary action for failing to do so.

COBRA Continuation Coverage

In accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), covered persons have certain rights and responsibilities regarding continuation of health benefits coverage when it is terminated.

Under federal law, the State of Connecticut is required to offer covered employees and covered dependents the opportunity to elect a temporary continuation of health coverage at group rates when coverage under the Medical Benefit Plan would otherwise end due to certain qualifying events.

Qualifying Events

An active employee of the State of Connecticut covered by the Medical Benefit Plan may have the right to elect this continuation coverage due to loss of group health coverage because of a termination of employment or a reduction in hours that causes an employee to become ineligible for coverage. In the event that the termination arises from the employee's willful misconduct, there is no right to continued coverage under COBRA.

The spouse of an employee or retiree of the State of Connecticut may have the right to elect continuation coverage if he/she loses coverage for any of the following reasons:

- Termination of the covered member's employment or a reduction of the covered member's hours of employment with the State of Connecticut;
- The death of the covered member; or
- Divorce or legal separation.

A covered dependent may be entitled to elect continuation coverage if he/she loses coverage for any of the following reasons:

- Termination of the covered member's employment or reduction in the covered member's hours of employment with the State of Connecticut;
- The death of the covered member;
- Parent's divorce or legal separation; or
- Failure to meet eligibility requirements for coverage as a dependent of the covered member (e.g., reaching the age of 26).

Continuation Coverage

Election period. When the employing agency is notified of the occurrence of a qualifying event, it will notify covered persons of their right to elect continuation coverage.

Each covered person has an independent election right and will have **60 days** from the latter of the date coverage ceased under the Medical Benefit Plan or from the date of notification to elect continuation coverage. The law does not allow for an extension of this maximum period. If a covered person does not elect continuation coverage within this election period, the right to elect continuation coverage will end.

If a covered person elects continuation coverage and pays the applicable premium, the covered person will receive coverage that is identical to the coverage provided under the Medical Benefit Plan to similarly situated members or dependents. If coverage is modified for similarly situated active employees, then continuation coverage may be similarly changed and/or modified.

Length of continuation coverage. Continuation coverage will be available for a period of **30 months** if the event causing the lack of coverage is:

- Layoff;
- Reduction of hours;
- Leave of absence; or
- Termination of employment.

Continuation coverage will not apply if such reduction of hours, leave of absence or termination of employment results from the death of the employee, the employee's "gross misconduct," as that term is used in 29 U.S.C. §1163(2), or the employee's eligibility to receive Social Security income.

If the event causing lack of coverage for a covered person is divorce or anything other than an employee's termination of employment, leave of absence or reduction in hours, continuation coverage will be available for such covered persons for up to **36 months**.

Termination of continuation coverage. The law allows continuation coverage to end before the maximum continuation period for any of the following reasons:

- The State of Connecticut ceases to provide any Medical Benefit Plan to its employees;
- Any required premium for continuation coverage is not paid in a timely manner;
- A qualified beneficiary becomes covered under another plan that does not contain any exclusion or limitation with respect to any preexisting condition of such beneficiary;

- A qualified beneficiary who extended continuation coverage due to a disability is determined by Social Security to be no longer disabled;
- A qualified beneficiary notifies the COBRA administrator that he/she wants to cancel continuation coverage.

COBRA Administrator

Anthem administers the COBRA benefits for the State of Connecticut Medical Benefit Plan. Contact the Anthem COBRA Unit at 1-800-433-5436.

Continuation of Coverage Due To Military Service

If an employee is no longer actively employed due to MILITARY SERVICE in the Armed Forces of the United States, he/she may elect to continue health coverage for himself/herself and dependents (if any) under this Medical Benefit Plan in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.

Continuation of coverage for the employee and eligible dependents (if any) under this Medical Benefit Plan is contingent upon the employee's payment of any required contribution for health coverage. This may include the amount the employer normally pays on the covered person's behalf. If military service is for a period less than 31 days, the employee may not be required to pay more than the active employee contribution, if any, for continuation of health coverage. If continuation is elected under this provision, the maximum period of health coverage under this Medical Benefit Plan shall be the lesser of:

- The 24 months beginning on the first date of the employee's absence from work; or
- The day after the date on which the covered member fails to apply for or return to a position of employment.

Regardless of whether coverage is continued during military service, an employee's health coverage will be reinstated upon return to active employment.

Payment Provisions

Right of Recovery

The purpose of the Medical Benefit Plan is to provide coverage for qualified medical expenses that are not covered by a third party. If the Medical Benefit Plan pays benefits for any claim a covered person incurs as the result of negligence, willful misconduct or other action or omission of a third party, to the extent permitted by law, the Medical Benefit Plan has a right of subrogation and right of recovery for benefits for covered services provided under the terms of this Medical Benefit.

Acceptance of covered services will constitute consent by the covered person to the Medical Benefit Plan's right of recovery. The covered person agrees to execute and deliver such additional instruments, and to take such other action as the carrier or the Medical Benefit Plan may require to implement this provision. To the extent permitted by law, the Medical Benefit Plan, or the carrier acting on its behalf, will have the right to bring suit against such third party in the name of the covered person and in its own name as subrogee. The covered person shall do nothing to prejudice the Medical Benefit Plan's rights under this provision without its consent.

If a covered person receives payment from a third party by suit or settlement for the cost of covered services, such covered person is obligated to reimburse the Medical Benefit Plan for benefits paid on his/her behalf out of the recovery from the third party or insurer, minus a pro rata share of the reasonable attorney's fees and costs the covered person sustained in obtaining the recovery. To the extent permitted by law, the Medical Benefit Plan has a lien on any amount recovered by the covered person from the responsible third party or insurer whether or not designated as payment for medical expenses. Such lien shall remain in effect until the Medical Benefit Plan is repaid in full, minus a pro rata share of the reasonable attorney's fees and costs the covered person sustained in obtaining the recovery.

The covered person must notify the Medical Benefit Plan immediately if he/she begins settlement negotiations with or obtains a judgment against a third party or insurer in connection with an accident or injury for which benefits have been paid by the Medical Benefit Plan.

Grievance and Appeal Rights

The covered person has the right to appeal a carrier's denial of benefits. The appeal/grievance process may be pursued by the covered person, the covered person's duly authorized representative, the provider of record, or the provider of record's duly authorized representative. In most cases, covered persons are required to comply with the requirements of their carrier's internal appeals process before seeking external review of adverse determinations.

The Connecticut Department of Insurance is available to decide appeals of a carrier's adverse utilization review determinations where medical necessity or clinical judgments are in issue. The Department of Insurance does not entertain appeals based on benefit exclusions, claims payment or coverage issues. Unless a matter is urgent and accepted for an expedited review, the covered person must complete the carrier's internal appeals process before filing an external appeal with the Department of Insurance. In urgent situations, the covered person may seek an external appeal directly or may seek both an internal and an external appeal simultaneously.

Adverse decisions are classified as follows:

- **Utilization management review determinations** include judgments on whether services or treatments will be covered or judgments concerning medical necessity; this includes determinations concerning cosmetic, custodial and convenience items. An appeal of a utilization review decision may be sought whether the requested services have not been rendered (prior authorization or pre-certification), are currently being rendered (concurrent care) or have already been rendered (retrospective review).
- **Non-utilization management review determinations** may include denials based on Medical Benefit Plan exclusions or limitations, claim payment disputes or administrative disputes not involving medical necessity judgments. There is no external appeal for non-utilization review determinations.

First Level Appeal

A first level appeal may be requested orally, electronically or in writing within 180 days from the date the initial adverse determination is received. The appeal should identify any issues, comments or additional evidence to support the claimant's request for review and should include the patient's medical record as it relates to this request.

Covered persons have the right to be represented by a person of their choice and can indicate this choice either verbally or in writing when starting the appeals process. The covered person will have the opportunity to present written comments, documents, medical records, photos, peer review and other information relevant to the appeal.

The grievance/appeal will be investigated by a person or persons who were not involved in the initial determination and who are not subordinate to the person involved in the original decision.

Utilization Management (Clinical) Appeals

First level appeal review requests should be submitted as follows:

By mail	**Anthem Blue Cross and Blue Shield** First Level Appeal Review 108 Leigus Road Wallingford, CT 06492
By fax	203-985-7363
Verbal appeal	Call Member Services at 800-922-2232

First level appeal review requests for Anthem behavioral health coverage should be submitted as follows:

By mail	**Anthem Blue Cross and Blue Shield** Behavioral Health Grievance Department 108 Leigus Road Wallingford, CT 06492
By fax	800-265-9866

Non-Utilization (Non-Clinical) Management Appeals

First level appeal review requests should be submitted as follows:

By mail	**Anthem Blue Cross and Blue Shield** First Level Appeal Review 108 Leigus Road Wallingford, CT 06492
By fax	203-985-7363
Verbal appeal	Call Member Services at 800-922-2232

Expedited Appeals

In the event of an emergency or a life-threatening situation, or when a claim involves urgent care, or when a covered person is denied benefits for an otherwise covered service on the grounds that it is experimental and the covered person has been diagnosed with a condition that creates a life expectancy of less than two years, an expedited first level appeal review may be requested. A determination will be issued within two business days or 72 hours, whichever is earlier, from the date the expedited appeal request is received.

Timetable for First Level Appeal Decisions

Appeal Type*	Anthem Time for Issuing Decision
Utilization review—Pre- or concurrent service	30 calendar days
Utilization review—Post Service	30 calendar days
Non-utilization review	20 calendar days
Expedited (urgent)—Following receipt of all required information	72 hours

***** The timetable for the carrier to issue a decision may be extended pending receipt of requested documentation needed to resolve the appeal from the covered person or that person's representative.

Second Level Appeal

Anthem members have an option to submit a second level appeal. A second level appeal is not required before seeking external review by the Connecticut Department of Insurance. If a member chooses to submit a second level appear, the appeal will be determined by persons who were not involved in the initial determination and will not give deference to the denial decision. When an appeal is clinical in nature the appeal will be determined by a licensed physician who did not review the issue at the first level appeal.

Utilization Management (Clinical) Appeals

For utilization management (medical necessity) second level appeals the requests should be submitted within **60 days** of the date of the first level appeal determination as follows:

By mail	**Anthem Blue Cross and Blue Shield** Grievances and Appeals Second Level Grievance 108 Leigus Road Wallingford, CT 06492
By fax	203-985-7363
Verbal appeal	Call Member Services at 800-922-2232

Non-Utilization (Non-Clinical) Management Appeals

For non-utilization (non-medical necessity) second level appeals, the requests should be submitted within **10 calendar days** from the date of the first level appeal determination, as follows:

By mail	**Anthem Blue Cross and Blue Shield** Grievances and Appeals Second Level Grievance Panel 108 Leigus Road Wallingford, CT 06492
By fax	203-985-7363
Verbal appeal	Call Member Services at 800-922-2232

Timetable for Second Level Appeal Decisions

Appeal Type*	Anthem Time for Rendering Decision
Utilization review—Pre- or concurrent service	15 calendar days
Utilization review—Post service	30 calendar days
Non-utilization review	20 calendar days
Expedited (urgent)—Following receipt of all required information	72 hours

* The timetable for the carrier to issue decision may be extended pending receipt of requested documentation needed to resolve the appeal from the covered person or that person's representative.

External Appeals

Review by the State of Connecticut Department of Insurance is available to a covered person who has completed the carrier's internal clinical appeals process. Only the first level appeal is required; the second level appeal is voluntary.

The covered person or the covered person's designee has the right to request an external appeal when:

- The service, procedure or treatment is a covered service under the Medical Benefit Plan; and
- The covered person has received a final adverse determination through the carrier's internal review process with a denial based on lack of medically necessary criteria or experimental/investigational treatment **unless** it is determined that the time frame for completion of an internal appeal may cause or exacerbate an emergency or life-threatening situation. In an emergency or life-threatening situation, a covered person does not need to complete all internal appeals in order to file for an external appeal.

Expedited appeals. In an emergency or life-threatening situation, a covered person may use the external appeal process directly, without exhausting the carrier's internal appeals if it is determined that the time frame for completion of an expedited internal appeal may cause or exacerbate an emergency or life-threatening situation.

Filing an External Appeal

To file a standard (non-expedited) external appeal, a covered person has 120 days after completion of the carrier's internal review process to initiate the appeal through the State of Connecticut Department of Insurance. The Department of Insurance does not accept appeals based on denial of services following a non-utilization review.

Requests for external appeals and expedited external appeals must be in writing on an external appeal application form, which is available from the Connecticut Insurance Commissioner. The covered person or his/her designee (and provider, if applicable) must release all pertinent medical information concerning the medical condition and request for services.

All requests for external review or expedited external review must be accompanied by a $25.00 filing fee. The Connecticut Insurance Commissioner will waive the filing fee if the fee will pose a hardship to the covered person as determined by the Commissioner. In the event the external appeal agent overturns the adverse determination, the fee will be refunded.

The appeal may be sent to the following address:

Connecticut Department of Insurance
Attn: External Review
P.O. Box 816
Hartford, CT 06142
860-297-3910

For overnight delivery only, send the application for external review to:

Connecticut Insurance Department
Attn: External Review
153 Market Street, 7th Floor
Hartford, CT 06103
860-297-3910

Contents of Appeal

The following items must be included in the appeal:

- A completed "Request for External Appeal" form.
- An authorization form allowing the carrier and the covered person's healthcare professional to release medical information to the independent review organization.
- Evidence of being enrolled in the Medical Benefit Plan (i.e., photocopy of the I.D. card issued by the carrier).
- Copies of all correspondence from the carrier.
- A copy of the final determination letter indicating that all internal appeal mechanisms have been exhausted.

- A copy of the Plan Document or explanation of benefits.
- The filing fee of $25.

In addition to the required items, the covered person may also submit any additional information relevant to his/her condition.

Carrier Confirmation

Following receipt of the request for external appeal or expedited external appeal, the Insurance Commissioner will forward the appeal to the carrier to confirm that the appeal is complete and that the conditions listed below are met:

- The person submitting the appeal is or was a covered person under the Medical Benefit Plan at the time of the event that is subject of the adverse determination;
- The service in question reasonably appears to be a covered service under the Medical Benefit Plan but was denied because it does not meet the carrier's requirements for medical necessity, appropriateness, healthcare setting, level of care or effectiveness;
- The service in question reasonably appears to be a covered service under the Medical Benefit Plan but was denied because it is experimental or investigational for a particular medical condition, is not explicitly listed as an excluded benefit under the Medical Benefit Plan and the treating healthcare professional has certified that one of the following situations is applicable:
  - Standard healthcare services or treatments have not been effective in improving the covered person's medical condition;
  - Standard healthcare services or treatments are not medically appropriate for the covered person; or
  - There is no available standard healthcare service or treatment covered by the carrier that is more beneficial than the recommended or requested healthcare service or treatment;

  In addition, the treating healthcare professional:

  - Has recommended a healthcare service or treatment that he/she certifies, in writing, is likely to be more beneficial, in his/her opinion, than any available standard healthcare services or treatments; or
  - Is a licensed, board certified or board eligible healthcare professional qualified to practice in the area of medicine appropriate to treat the covered person's condition and has certified in writing that scientifically valid studies using accepted protocols demonstrate that the denied healthcare service or treatment is likely to be more beneficial to the covered person than any available standard healthcare services or treatments;
- The covered person has completed the first level internal review;
- The covered person has provided all of the required information; and
- The covered person has paid the required filing fee.

The carrier will complete this review within five business days for an external review request or within one day for an expedited external review request. Once the carrier has completed its review, it will notify the covered person, the covered person's designee (if appropriate) and the Insurance Commissioner whether the appeal is complete and eligible for external review and will communicate

its findings in writing within one business day for an external appeal or on the day the review is completed for an expedited external appeal. If the appeal is not complete, the notice will identify what information or materials are missing. If the appeal is not eligible, the notice will include the reason(s).

Expedited External Appeals

To file an expedited external appeal, a covered person can submit an application with the Connecticut Department of Insurance immediately following receipt of the carrier's initial adverse determination or at any level of adverse appeal determination. If the external appeal is not accepted on an expedited basis, and the covered person has not previously exhausted all internal appeals, the covered person may resume the internal appeal process until all internal appeals are exhausted. A standard external appeal may then be filed within 120 days following receipt of the final denial letter.

If all internal appeals were previously exhausted, a rejected expedited appeal will be eligible automatically for consideration for standard appeal without submission of a new application.

A covered person may not file an expedited external appeal for services that have already been provided (retrospective).

Timeframes for Resolution

If an appeal is eligible for external review, the Commissioner will assign it to an Independent Review Organization and send a notice advising that (a) an external review or expedited external review has been accepted, and (b) that the covered person has five business days from receipt of the notice to submit any additional information.

The carrier will forward the medical and treatment plan records relied upon in making its determination to the Independent Review Organization. If the documentation represents a material change from the documentation upon which the adverse determination or denial was based, the carrier will have the opportunity to consider the documentation and amend or confirm its adverse determination or denial.

The Independent Review Organization will make a determination with regard to the appeal within the following timeframes:

- **External reviews:** within 45 days after assignment from the Commissioner.
- External review involving an experimental or investigational treatment: within 20 days after assignment from the Commissioner.
- **Expedited external reviews:** as expeditiously as the covered person's condition requires, but not later than 72 hours after assignment from the Commissioner.
- **Expedited external reviews involving an experimental or investigational treatment:** as expeditiously as the covered person's condition requires, but not later than five days after assignment from the Commissioner.

Binding Effect of External Appeal Decision

Upon completion of the review, the Independent Review Organization will communicate its decision in writing to the covered person, his/her representative (if applicable), the Commissioner and to the carrier. If the decision is to reverse or revise the carrier's initial or final adverse determination, the decision will be binding on the Medical Benefit Plan, subject to any party's right to seek judicial review under federal or state law.

General Provisions

This Plan Document supersedes all other agreements or descriptions of the benefits provided under the Medical Benefit Plan.

I.D. Cards

I.D. cards issued to a covered person and their covered dependents pursuant to this Medical Benefit Plan are for identification purposes only. Possession of an I.D. card confers no right to covered services or other benefits. To be entitled to such services or benefits the holder of the I.D. card must, in fact, be a covered member or covered dependent on whose behalf all applicable benefit cost contributions under this Medical Benefit Plan have been paid. Any person receiving services or other benefits to which he/she is not then entitled pursuant to the provisions of this Medical Benefit Plan will be liable for the actual cost of such services or benefits. In addition, any covered member who fails to notify the Plan Sponsor of a change in circumstances that affects a covered dependent's eligibility status (including without limitation, divorce, legal separation, end of legal guardianship, a child reaching age 26, etc.) will have the fair market value of coverage reported as income and, if actively employed, may be subject to disciplinary action, including termination.

Notice

Any notice required under this Plan Document to be given to the Plan Sponsor may be sent by U.S. Mail, first class, postage prepaid to the Office of the State Comptroller, in care of the Healthcare Policy and Benefit Services Division, 165 Capitol Avenue, Hartford, CT 06106. Notice to a covered person will be sent to the last address the Medical Benefit Plan has for that covered person. A covered person agrees to provide the Plan Sponsor with notice, within 31 days, of any change of address.

Interpretation of the Medical Benefit Plan

The laws of the State of Connecticut shall be applied to the interpretation of this Medical Benefit Plan.

Gender

The use of any gender in this Plan Document is deemed to include the other gender and, whenever appropriate, the use of the singular is deemed to include the plural (and vice versa).

Modifications

This Plan Document is subject to amendment, modification and termination in accordance with this provision and applicable collective bargaining agreements affecting healthcare coverage, benefits and services under the State of Connecticut Employee Health Plan.

Clerical Error

Clerical error, whether by the Plan Sponsor or the carrier with respect to Plan Document or any other documentation issued by the carriers in connection with the Medical Benefit Plan, or in keeping any record pertaining to the coverage hereunder, will not modify or invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated.

Policies and Procedures

The Medical Benefit Plan may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of the Medical Benefit Plan with which a covered person shall comply.

Waiver

The waiver by any party of any breach of any provision of the agreement will not be construed as a waiver of any subsequent breach of the same or any other provision. The failure to exercise any right hereunder will not operate as a waiver of such right.

Protected Health Information

Unless otherwise permitted by law and subject to obtaining written certification pursuant to this section, the Medical Benefit Plan may disclose PROTECTED HEALTH INFORMATION (PHI) to the Plan Sponsor provided the Plan Sponsor uses or discloses such PHI only for the following purposes.

- Performing Medical Benefit Plan administration functions, which the Plan Sponsor performs;
- Obtaining premium bids from carriers for providing coverage;
- Modifying, amending or terminating the group health plan.

Notwithstanding the provisions of the Medical Benefit Plan to the contrary, in no event will the Plan Sponsor use or disclose PHI in a manner that is inconsistent with 45 CFR §164.504(f).

Information regarding participation. Notwithstanding this section, the Medical Benefit Plan may disclose to the Plan Sponsor information regarding participation or enrollment.

Conditions of disclosure. With respect to any disclosure, the Plan Sponsor shall:

- Not use or further disclose the PHI other than as permitted or required by the Medical Benefit Plan or as required by law.
- Shall ensure that any agents, contractors or subcontractors to whom it provides PHI shall agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to PHI.
- Not use or disclose the PHI for employment-related actions and decisions or in connection with any other employee benefit plan of the Plan Sponsor.
- Report any use or disclosure of the information that is inconsistent with the use or disclosures provided for of which it becomes aware.
- Make available PHI in accordance with 45 CFR §164.524.
- Make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 CFR §164.526.
- Make available the information required to provide an accounting of disclosures in accordance with 45 CFR §164.528.
- Make its internal practices, books and records relating to the use and disclosure of PHI available to the Secretary of Health and Human Services for purposes of determining compliance with the Medical Benefit Plan with subpart E of 45 CFR §164.
- If feasible, return or destroy all PHI received that the Plan Sponsor still maintains in any form, and retain no copies of such information when no longer needed for the purpose for which disclosure was made. If such return or destruction is not feasible, the Plan Sponsor will limit further uses and disclosures to those purposes that make the return or destruction infeasible.
- Ensure that adequate separation between Medical Benefit Plan and the Plan Sponsor, required by 45 CFR §504(f)(2)(iii) is satisfied.
- Reasonably and appropriately safeguard electronic PHI that is created, received, maintained or transmitted to or by the Plan Sponsor on behalf of the Medical Benefit Plan.

Certification by the Plan Sponsor. A carrier shall disclose PHI to the Plan Sponsor only upon receipt of certification from the Plan Sponsor that the Plan Document incorporates the provisions of 45 CRF

§164.504(f)(2)(ii), and that the Plan Sponsor agrees to the conditions of disclosure set forth in this section. The Medical Benefit Plan shall not disclose and may not permit a carrier to disclose PHI to the Plan Sponsor as otherwise permitted herein unless the statement required by 45 CFR §164.504(b)(b1)(iii)(C) is included in the appropriate notice.

Adequate separation between the Medical Benefit Plan and the Plan Sponsor. The Plan Sponsor shall only allow employees of the Office of the State Comptroller, Healthcare Policy & Benefit Services Division access to PHI to perform the plan administration functions that the Plan Sponsor performs for the Medical Benefit Plan. In the event that any of these specified employees do not comply with the provisions of this section, that employee shall be subject to disciplinary action by the Plan Sponsor for non-compliance pursuant to the Plan Sponsor's employee discipline and termination procedures.

Permitted uses and disclosures of SUMMARY HEALTH INFORMATION. Notwithstanding anything previously mentioned in this section, a carrier may disclose summary health information to the Plan Sponsor for the purpose of:

- Obtaining premium bids for providing health benefit coverage under the Medical Benefit Plan; or
- Modifying, amending or terminating the Medical Benefit Plan.

Glossary

Admission: The period from the date the covered person enters the hospital, skilled nursing facility, substance abuse treatment facility, residential treatment facility, hospice, or other inpatient facility as an inpatient until the date of discharge. When counting days of inpatient services, the date of entry and date of discharge are combined to count together as one day.

Affordable Care Act: The Patient Protection and Affordable Care Act (P.L. 111-148) and the Health Care and Education Reconciliation Act of 2010.

Allowable expense: A medically necessary allowable expense, for an item of expense for healthcare, when the item of expense, including any copay amount, is covered at least in part by one or more plans covering the covered person for whom the claim is made. When this Medical Benefit Plan provides covered services, the reasonable cash value of each covered service is the allowable expense and is a paid benefit.

Amino acid modified preparation: A product intended for the dietary treatment of an inherited metabolic disease under the direction of a physician.

Authorize: Approval that has been obtained from the carrier for the emergency admission of a covered person to a hospital, skilled nursing facility, substance abuse treatment facility, residential treatment facility, or hospice when required under the terms of this Medical Benefit Plan.

Autism behavioral therapy: Behavioral therapy provided by or under the supervision of a behavior analyst certified by the Behavior Analyst Certification Board, a licensed physician, or a licensed psychologist.

- **Supervision:** At least one hour of face-to-face supervision of the autism services provider for each ten hours of behavioral therapy provided by the supervised certified assistant behavior analyst or behavior therapist.

Autism spectrum disorders: As set forth in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders". The results of an autism spectrum disorder diagnosis shall be valid for a period of twelve months unless the covered person's licensed physician, licensed psychologist, or licensed clinical social worker determines a shorter period is appropriate or changes the results of the covered person's diagnosis.

Behavioral therapy: Any interactive behavioral therapies derived from evidence-based research, including, but not limited to, applied behavior analysis, cognitive behavioral therapy, or other therapies supported by empirical evidence of the effective treatment of individuals diagnosed with an autism spectrum disorder, that are:

- Provided to children less than 21 years of age; and
- Provided or under the supervision of an autism behavioral therapy provider.

Calendar Year: A period beginning 12:01 a.m. on January 1 and ending midnight on December 31 of the same year**.**

Cancer clinical trial: An organized, systematic, scientific study of therapies, tests or other clinical interventions for purposes of treatment or palliation or therapeutic intervention for the prevention of cancer in human beings, except that a clinical trial for the prevention of cancer is eligible for coverage only if it involves a therapeutic intervention and is a Phase III clinical trial that is conducted at multiple institutions. A cancer clinical trial must be conducted under the auspices of an independent peer-reviewed protocol that has been reviewed and approved by:

- One of the National Institutes of Health;
- A National Cancer Institute affiliated cooperative group;
- The Federal Food and Drug Administration as part of an investigational new drug or device exemption; or
- The Federal Department of Defense or Veterans Affairs.

Carrier: Anthem Blue Cross and Blue Shield, the entity chosen by the State of Connecticut to administer benefits and process claims under the Medical Benefit Plan. With regard to administration of benefits, the term shall refer to the carrier that has issued an I.D. card to the covered person.

Case management: The process of evaluating and arranging for medically necessary treatment for patients, identified through the use of one or more managed care programs.

Chronic care: Care for a condition that continues and/or recurs over a prolonged period of time and is characterized by either a slow progressive loss of function or a static/stationary loss of function in which little, or no measurable objective improvement is made despite therapeutic intervention.

Claim determination period: Claim determination period means a Calendar Year. However, it does not include any part of a Calendar Year during which a person has no coverage under this Medical Benefit Plan, or any part of a Calendar Year before the date COB provisions or a similar provision takes effect.

Coinsurance: A fixed percentage of the maximum allowed amount for covered services that the covered person is required to pay as specified in the *Schedule of Medical Benefits*.

Concurrent review: A process to monitor an inpatient admission to decide its continued medical necessity, starting from the assignment of the initial prior authorization of days and continuing to the covered person's discharge.

Copay: A fixed amount per prescription that the covered person is required to pay for covered services. This fee is in addition to premiums paid by and on behalf of the covered person and is payable by a covered person for covered services at the time that those services are rendered.

Cost share: The amount that the covered person is required to pay for covered services.

Cost share maximum: The deductible and coinsurance amount that are paid by the covered person on a Calendar Year basis. The cost share maximum does not include charges applicable to services in excess of the Medical Benefit Plan's limits for those benefits, cost shares for human organ and tissue transplants when the facility is not designated and approved by the carrier, or charges that exceed the maximum allowed amount.

Covered member: A person who is eligible and enrolled for covered services by virtue of past or present employment with the Participating Employer.

Covered person: A dependent of a covered member who is enrolled in this Medical Benefit Plan and eligible for benefits for covered services.

Covered service(s): Services, supplies or treatment as described in this Plan Document. To be a covered service, the service, supply or treatment must be:

- Medically necessary or otherwise specifically included as a benefit under this Plan Document.
- Within the scope of the license of the provider performing the service.
- Rendered while coverage under this Plan Document is in force.
- Not experimental or investigational or otherwise excluded or limited by the Plan Document.
- Authorized in advance by the carrier if such prior authorization is required under the Plan Document.

Custodial care: Care primarily for the purpose of assisting the covered person in the activities of daily living or in meeting personal rather than medical needs, and which is not specific treatment for an illness or injury. It is care that cannot be expected to substantially improve a medical condition and has minimal therapeutic value. Such care includes, but is not limited to:

- Assistance with walking, bathing or dressing;
- Transfer or positioning in bed;
- Normally self-administered medicine;
- Meal preparation;
- Feeding by utensil, tube or gastrostomy;
- Oral hygiene;
- Ordinary skin and nail care;
- Catheter care;
- Suctioning;
- Using the toilet;
- Enemas; and
- Preparation of special diets, supervision over medical equipment or exercises; or
- Self-administration of oral medications not requiring constant attention of trained medical personnel.

Care can be custodial whether, or not it is recommended or performed by a professional and whether, or not it is performed in a facility (e.g. hospital or skilled nursing facility) or at home.

Date of placement: The assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of adoption of the child.

Day/night program: Continuous treatment consisting of not less than four hours and not more than 12 hours in any 24-hour period when received in a general or specialty hospital or in a substance abuse treatment facility.

Deductible: An annual fixed dollar amount that a covered person must pay before the Medical Benefit Plan pays for covered medical services. The deductible starts to accrue as of July 1 of each year. The deductible excludes premiums, copays, coinsurance, balance billed charges and payments for services the Medical Benefit Plan does not cover. There are two deductibles under this Medical Benefit Plan, an out-of-network deductible and the upfront deductible. Both deductibles begin on July 1—the first day of the Plan Year.

- **Out-of-network deductible**: The amount a covered person must pay before the Medical Benefit Plan begins to pay for covered out-of-network services. The out-of-network deductible is $300 per individual and $900 per family per year. This deductible does not apply to in-network services.
- **Upfront deductible:** The amount a covered person has to pay before the Medical Benefit Plan begins to pay for covered services. This deductible applies to in-network services. For in-network services, the upfront deductible applies only to those services listed as "no copay" with the exception of those listed under "preventive care." The upfront deductible is $350 per individual and $350 per family member up to a maximum of $1,400 per year. The upfront deductible does not apply if a covered member is enrolled in and compliant with the Health Enhancement Plan.

Dependent: The term dependent means a covered member's lawful spouse under a legally valid existing marriage, a covered member's civil union partner under a legally valid civil union, and any child of either the covered member or his/her spouse who meets the requirements for coverage as set forth in this Plan Document, including the Addendum.

Donor: A person who provides organ tissue for transplant in a histo-compatible recipient.

Durable medical equipment: Equipment which:

- Is designated for repeated use in the medically necessary care, diagnosis or treatment of an illness or injury;
- Improves the function of a malformed body part or prevents, or retards further worsening of the covered person's medical condition; and
- Is not useful in the absence of injury or illness.

Effective date: The term effective date means the date a covered member and his/her covered dependents, if any, are accepted by the Participating Employer and are eligible to receive benefits for covered services under this Medical Benefit Plan.

Experimental or investigational: Services or supplies which include, but are not limited to, any treatment, equipment, drugs, drug usage, devices or supplies which are determined in the sole discretion of the Plan Sponsor to be experimental or investigational.

In making its determination, the Plan Sponsor will deem a service or supply to be experimental or investigational if it satisfies one or more of the following criteria:

- The service or supply does not have final approval by the appropriate government regulatory body or bodies, or such approval for marketing has not been given at the time the service or supply is furnished; or

- A written informed consent form for the specific service or supply 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
- The services or supply is the subject of a protocol, protocols or clinical trial study, or is otherwise under study in determining its maximum tolerated toxicity dose, its toxicity, its safety, its efficacy or its efficacy as compared with standard means of treatment or diagnosis.

Notwithstanding the above, services or supplies will not be considered experimental if they have successfully completed a Phase III clinical trial of FDA for the illness or condition being treated or the diagnosis for which they are being prescribed.

In addition, a service or supply may be deemed experimental or investigational based upon:

- Published reports and articles in the authoritative medical, scientific and peer review literature;
- The written protocol or protocols used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure; or
- The written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

Gender identity disorder: A condition in which a person feels a strong and persistent identification with the opposite gender accompanied with a severe sense of discomfort in their own gender.

High cost diagnostic imaging services: MRI, MRA, CAT, CTA, PET, SPECT scans.

Hospice: A facility, organization or agency that is primarily engaged in providing pain relief, symptom management, and supportive services to terminally ill people and their families.

Hospital: An institution which provides 24-hour continuous services to confined patients, and whose chief function is to provide diagnosis and therapeutic facilities for the surgical and medical diagnosis, treatment or care of injured or sick persons. A professional staff of licensed physicians and surgeons must provide or supervise the services. The institution must provide general hospital and major surgical facilities and services or specialty services.

- **General hospital:** A hospital that is licensed as such by the State of Connecticut and has appropriate accreditation from the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). If out-of-state, a general hospital must have state equivalent licensure and accreditation.
- **Specialty hospital**: A hospital which is not a general hospital, but which is licensed by the State of Connecticut as a certain type of specialty hospital and has appropriate accreditation from the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). If out-of-state, a specialty hospital must have equivalent state licensure and accreditation.
- **Participating hospital**: A hospital designated and accepted as a participating hospital by the carrier to provide covered services to covered persons under the terms of the Medical Benefit Plan.
- **Non-participating hospital**: Any appropriately licensed hospital that is not a participating hospital under the terms of the Medical Benefit Plan.
- **Mobile field hospital:** A modular, transportable facility used intermittently, deployed at the discretion of the Governor, or the Governor's designee, for the purpose of training or in the event of a public health or other emergency for isolation care purposes or triage and treatment during a mass casualty event, or for providing surge capacity for a hospital during a mass casualty event or infrastructure failure and is licensed as such by the State of Connecticut.

The following shall not be considered a hospital:

- A convalescent or extended care unit within or affiliated with the hospital;
- A non-hospital based clinic;
- A nursing, rest, or convalescent home, or extended care facility;
- An institution operated mainly for care of the aged;
- A health resort, spa or sanitarium; or
- Any facility not having appropriate state licensure and not accredited as a hospital by the Joint Commission on the Accreditation of Health Care Organizations (JCAHO), except for a hospital located outside the United States.

I.D. card: A card issued by the carrier to a covered member or dependent for identification purposes. The I.D. card must be shown by the covered person to obtain covered services.

Individual treatment plan: A treatment plan prescribed by a physician with specific attainable goals and objectives appropriate to both the patient and the treatment modality of the program.

Infertility: means the condition of a presumably healthy individual who is unable to conceive or produce conception or sustain a successful pregnancy during a one-year period.

In-network: A physician, provider or facility has a participation contract with the carrier that has issued the I.D. card to the covered person enrolled in that Medical Benefit Plan.

Inpatient: A covered person who occupies a bed in a hospital or other 24-hour care facility, receives board as well as diagnosis, care or treatment and is counted as an inpatient at the time of a hospital or 24-hour care facility census.

Inpatient facility: A facility other than a hospital that provides board as well as a diagnosis, care or treatment on a 24-hour-a-day basis to patients, such as a skilled nursing facility, hospice, substance abuse treatment facility, substance care facility or residential treatment facility.

Learning disability: A disorder in one or more of the basic psychological processes involved in understanding or in using spoken or written language. This may be manifested in disorders of learning, thinking, talking, reading, writing, spelling, arithmetic or social perception.

Low protein modified food product: A product formulated to have less than one gram of protein per serving and is intended for the dietary treatment of an inherited metabolic disease under the direction of a physician.

Maintenance care: Treatment provided for the covered person's continued well-being by preventing deterioration of the covered person's chronic clinical condition, and maintenance of an achieved stationary status that is at a point where little or no measurable objective improvement in musculo-skeletal function can be effectuated despite therapy.

Maximum allowable amount: The term maximum allowable amount means, except as otherwise required by law, either:

- An amount agreed upon by the carrier and a participating provider as full compensation for covered services provided to a covered person; or
- With respect to a non-participating provider, an amount designated by the carrier and based on the amount paid to a participating provider for a particular service.

When applicable, it is the covered person's obligation to pay cost shares as a component of this maximum allowable amount. The amount the Plan Sponsor will pay for covered services will be the maximum allowable amount or the billed charge, whichever is lower. The amount the covered person will pay for cost shares will be calculated based on the maximum allowable amount or the billed charges, whichever is lower.

Please note that the maximum allowable amount may be greater or less than the participating provider's billed charges for the covered service.

Medical emergency: A medical or behavioral condition the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect in the absence of immediate medical attention to result in:

- Placing the health of the afflicted covered person in serious jeopardy, or in the case of a behavioral condition placing the health of such covered person or others in serious jeopardy;
- Serious impairment to the covered person's bodily functions;
- Serious dysfunction of any bodily organ or part of such covered person; or
- Serious disfigurement of such covered person.

Medical emergencies include, but are not limited to, the following conditions:

- Severe chest pains
- Severe or multiple injuries
- Severe shortness of breath
- Loss of consciousness
- Sudden change in mental status (e.g., disorientation)
- Severe bleeding
- Poisonings
- Convulsions
- Acute pains or conditions requiring immediate attention (suspected heart attack or appendicitis).

The carrier shall have the right to review all appropriate medical records and make the final decision regarding the existence of a medical emergency. Regarding such retrospective reviews, the Medical Benefit Plan will cover only those services and supplies that are determined to be medically necessary and are performed to treat or stabilize a medical emergency condition.

All medical emergencies that meet the criteria of a medical emergency will be treated as an in-network service regardless of where care is received, providing notification protocols have been followed.

Medically necessary (medical necessity): A service which is prescribed by an appropriately licensed physician or provider; and, which may be a covered service which a physician, 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 is:

- In accordance with generally accepted standards of medical practice;

- Clinically appropriate, in terms of type, frequency, extent, site and duration and considered effective for the patient's illness, injury or disease; and
- Not primarily for the convenience of the patient, physician or other healthcare provider and not costlier 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 subsection, "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.

Medicare: Title XVIII of the Social Security Act of 1965, as amended.

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

Open Enrollment: The period during which employees may select or make changes to their group health coverage for themselves or their dependents.

Out-of-network: Services that have been obtained from a non-participating physician, non-participating hospital or other non-participating provider not affiliated with the carrier under the Medical Benefit Plan. Depending upon the Medical Benefit Plan, obtaining treatment or care from an out-of-network provider may result in services not being covered at all (in the case of the POE or POE-G Plans) or being covered but requiring the covered person to satisfy a deductible, pay a portion of the allowed amount (usually 20%) and remain liable for payment of billed charges that exceed the carrier's maximum allowed amount for the service obtained.

Out-of-pocket maximum: The most that a covered person would pay during a coverage period (usually one year) for his or her share of the cost of covered services. The following are **not** included in calculating the out-of-pocket maximum:

- Premiums;
- Balance-billed charges; and
- Health care services the Medical Benefit Plan does not cover.

Outpatient: The covered person receives services in a hospital emergency room, physician's office, or ambulatory surgical facility, and leaves in less than 24 hours.

Partial hospitalization: Continuous treatment in a general hospital, specialty hospital, or residential treatment facility consisting of not less than four hours and not more than 12 hours in any 24-hour period.

Permanent employee: An employee holding a position in the classified service which requires or is expected to require the services of an incumbent without interruption for a period of more than six months, except positions funded in whole or in part by the federal government as part of any public service employment program, on-the-job training program or work experience program.

Physician: Any licensed Doctor of Medicine (M.D.), osteopathic physician (D.O.), dentist (D.D.S./D.M.D.), podiatrist (Pod. D/D.S.C./D.P.M.), doctor of chiropractic (D.C.), naturopath (N.D.),

optometrist (O.D.), or psychologist (Ph.D./Ed.D/PsyD.) who is licensed to practice in the state in which services are rendered.

Plan: Any of these that provides benefits or services for, or because of, medical or dental care or treatment.

- Group insurance or group-type coverage, whether insured or self-insured. This includes prepayment, HMO, group practice or individual practice coverage, as well as insurance coverage which is not available to the general public and can be obtained and maintained only because of coverage in or connection with a particular organization or group; it does not include student accident or student accident & health coverage for which the student or parent pays the entire premium.
- Coverage under a governmental plan or required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act as amended from time to time). It also does not include any plan when, by law, its benefits are excess to those of any private insurance program or other non-governmental program. It also does not include group contracts issued by or reinsured through the Health Reinsurance Association, or subscriber contracts issued by a residual market mechanism established by hospital and medical service corporations and providing comprehensive healthcare coverage as provided in the Connecticut Health Care Act as now constituted or later amended.
- Medical benefits coverage of group, group-type and individual no-fault and traditional automobile fault contracts.

Each contract or other arrangement for coverage under the first and second bullets is a separate plan.

Plan Document: The term Plan Document means this document, (including any riders and amendments), which describes the rights, benefits, terms, conditions and limitations of the coverage available to covered members and eligible dependents.

Plan Sponsor: The term Plan Sponsor means the Office of the State Comptroller on behalf of the State of Connecticut.

Preferred Provider: The term Preferred Provider means an appropriately licensed or certified healthcare professional or facility that has been designated by the covered person's carrier as providing high value services and whose utilization may qualify for reduced copayments or incentive payments.

Preventive care: Medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and include the following as required under applicable law:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;
- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA);
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the HRSA; and

- With respect to women, include the cost of renting one breast pump per pregnancy in conjunction with childbirth. Benefits are only available if breast pumps are obtained from a DME provider, hospital or physician.

Primary plan: A plan whose benefits for a person's healthcare coverage must be determined without taking the existence of any other plan into consideration. A plan is a primary plan if:

- The plan either has no order of benefit determination rules or it has rules which differ from those stated in this Plan Document; or
- All plans which cover the person use the order of benefit determination rules as stated in this Plan Document, and under those rules the plan determines its benefits first. There may be more than one primary plan (for example, two plans which have no order of benefit determination rules).

When this Medical Benefit Plan is the primary plan, covered services are provided or covered without considering the other plan's benefits.

Prior authorization: A prior approval that must be obtained from the carrier before a covered person is entitled to receive benefits for certain covered services.

Proof: Any information that may be required by the carrier or the Participating Employer in order to satisfactorily determine a covered person's eligibility or compliance with any provision of this Medical Benefit Plan.

Prosthetic device: Any device which replaces all or part of a body organ (including contiguous tissues), or replaces all or part of the function of a permanently inoperative, absent, or malfunctioning part of the body, including leg, arm, back, or neck braces, or artificial legs, arms or eyes, and any prosthesis with supports, including replacement if a covered person's physical condition changes.

Protected Health Information (PHI): Individually identifiable health information that is:

- Received or created by a healthcare provider, carrier or health plan;
- Relates to the past, present or future physical, mental health or condition of an individual, the provision of healthcare to an individual, or the past, present or future payment for the provision of healthcare to the individual; and
- Identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

PHI excludes health information or medical information supplied to the Plan Sponsor in its role as an employer. For example, medical information submitted in support of an application for Family Medical Leave or Disability.

Provider: Any appropriately licensed or certified healthcare professional or facility providing healthcare services or supplies to covered persons.

Qualifying status change: A change affecting an individual's eligibility for coverage under the Medical Benefit Plan (resulting from a change in marital or employment status, number or age of dependents, or residency) which entitles that individual to make changes in healthcare enrollment outside of Open Enrollment or that would create a right in the affected individual(s) to obtain continuation of coverage under COBRA.

Residential treatment facility: A 24-hour mental health facility that is licensed or approved by the Department of Children and Families and that operates for the purpose of effecting positive change and

normal growth and development for behavior disorders and emotionally disturbed and socially maladjusted children.

Routine patient care costs: Costs for medically necessary healthcare services that are incurred as a result of treatment rendered to a covered person for purposes of a cancer clinical trial that would otherwise be covered if such services were not rendered in conjunction with a cancer clinical trial. Such services shall include those rendered by a physician, diagnostic or laboratory tests, hospitalization or other services provided to the covered person during the course of treatment in cancer clinical trial and coverage for routine patient care costs incurred for off-label drug prescriptions. Hospitalization for routine patient care costs shall include treatment at an out-of-network facility if such treatment is not available in-network and is not eligible for reimbursement by the sponsors of such clinical trial. Out-of-network hospitalization will be rendered at no greater cost to the insured person than if such treatment was available in-network; all applicable in-network cost shares will apply.

Routine patient care costs shall not include:

- The cost of an investigational new drug or device that has not been approved for market for any indication by the Federal Food and Drug Administration,
- The cost of a non-healthcare service that a covered person may be required to receive as a result of the treatment being provided for the purposes of the cancer clinical trial;
- Facility, ancillary, professional services and drug costs that are paid for by grants or funding for the cancer clinical trial;
- Costs of services that (a) are inconsistent with widely accepted and established regional or national standards of care for a particular diagnosis, or (b) are performed specifically to meet the requirements of the cancer clinical trial; or
- Costs that would not be covered under this Medical Benefit Plan for non-investigational treatments, including items excluded from coverage under the Medical Benefit Plan, and transportation, lodging, food or any other expenses associated with travel to or from a facility providing the cancer clinical trial, for the covered person or any family member or companion.

Rule of 75: A collectively bargained provision applicable to certain employees who leave State service in deferred, vested status that requires an individual to attain an age which, in combination with his/her years of State service, equals 75 as a condition of enrolling in health benefits as a retired State employee.

Secondary plan: A plan that is not a primary plan. If a person is covered by more than one secondary plan, the order of benefit determination rules of this Plan Document decides the order in which his/her benefits are determined in relation to each other. The benefits of the secondary plan may take into consideration the benefits of the primary plan or plans and the benefits of any other plan that, under the rules of this Plan Document, has its benefits determined before those of the secondary plan.

When this Medical Benefit Plan is the secondary plan, benefits for covered services under the Medical Benefit Plan may be reduced and the plan may recover from the primary plan, the provider of covered services, or the covered person, the reasonable cash value of the covered services provided by this Medical Benefit Plan.

Site of Service: A program whereby laboratory, X-ray services (other than mammograms) and diagnostic high cost imaging services that are performed within the carrier's primary service area will carry varying cost shares depending upon the provider selected. Covered persons using a Preferred in-network provider for a service will be covered at 100%. Those using a Non-Preferred in-network

provider will incur 20% coinsurance. Those using an out-of-network provider will be subject to 40% coinsurance.

Skilled nursing facility means any institution that:

- Accepts and charges for patients on an inpatient basis;
- Is primarily engaged in providing skilled nursing care, rehabilitative, and related services to patients requiring medical and skilled nursing care;
- Is under the supervision of a licensed physician;
- Provides 24-hour-a-day nursing service under the guidance of a registered nurse; and
- It is not a place mainly used for the treatment of nervous-mental disorders, pulmonary tuberculosis, a place of rest, custodial care, or acute inpatient level of care.

Specialized formula: Amino acid modified preparations and low protein modified food products prescribed and administered by a physician for the treatment of an inherited metabolic disease for individuals who are or will become malnourished or suffer from disorders, which, if left untreated, will cause chronic disability, mental retardation or death.

Specialized infant formula: A nutritional formula for children up to age of 12 that is exempt from the general requirements for nutritional labeling under the statutory and regulatory guidelines of the Federal Food and Drug Administration and is intended for use solely under medical supervision in dietary management of specific diseases.

Substance abuse care: Services to treat alcoholism or drug dependency.

Substance abuse treatment facility: A facility that is established primarily to provide 24-hour inpatient treatment of substance abuse and licensed for such care by the State of Connecticut Department of Public Health and Addiction Services or accredited by the Joint Commission on the Accreditation of Health Care Organizations as a substance abuse disorder treatment facility if located outside the State of Connecticut.

Summary health information: Information that summarizes the claims history, claims expenses or types of claims experience by individuals for whom a Plan Sponsor provided health benefits under a health plan and from which the information described in 45 CFR §164.514(b)(2)(i) has been deleted (except for geographic information which only needs to be aggregated to the level of a five-digit zip code).

Totally disabled: Due to an injury or disease the covered member is unable to perform the duties of any occupation for which he/she is suited by reason of education, training or experience. A dependent shall be totally disabled if because of an injury or disease he/she is unable to engage in substantially all the normal activities of persons of like age and sex in good health. The carrier will determine if a covered person is totally disabled and shall be entitled to request proof of continued disability at least annually.

Urgent care: Care for an illness or injury that is not a medical emergency but requires immediate medical attention.

Urgent care facility: A provider from whom urgent care services may be obtained when a covered person's physician or covering physician is not available to treat the covered person.

Variable hour employee: An employee for whom at the time of hire the employer is unable to reasonably determine whether he/she will work an average of 30 hours per week.

Walk-in clinic: A free-standing center providing episodic health services without appointments for diagnosis, care, and treatment of non-urgent conditions or symptoms.