CARE COMPASS

State of Connecticut

Medical Plan

2026 Plan Document



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State of Connecticut Medical Benefit Plan Document

The State of Connecticut is pleased to offer the following covered medical benefit services to eligible Employees and their eligible Dependents.

The State of Connecticut is self-insured with respect to payment of medical claims. The benefits described in this Plan document or any rider or amendments attached hereto are funded by the State of Connecticut.

Administered by: Anthem Health Plans, Inc. (Referred to as Anthem.) Anthem through its Third Party Administrator (TPA), AmeriBen conducts prior authorizations and coordinates clinical reviews for medical services. Anthem through its partnership with Carelon conducts prior authorizations and coordinates clinical reviews for behavioral health services and PRESCRIPTION DRUGS administered by the medical Plan.

Anthem provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

Member Services provided by: Quantum Health, Inc. (Referred to as Quantum or Member Services.) Quantum provides customer service via telephone and email, administers the Health Enhancement Program (HEP), and does not assume any financial risk or obligation with respect to claims.

For questions about the Plan, please call the telephone number on the back of your Anthem ID card. Also be sure to check the State of Connecticut benefits website, **carecompass.ct.gov**, for information on how to find a Provider, for answers to questions, and to access health and wellness tips.

For Spanish speakers: Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente que aparece en el reverso de su Tarjeta de Identificación.

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Introduction

Medical Plan for State of Connecticut Members

This document describes the Medical PLAN (referred to as the "Plan") that is offered by the State of Connecticut. It provides a clear description of how to access health care, what services are covered, and what costs are involved. Many sections of this document are interrelated, so reading only one or two sections may not provide a comprehensive understanding of your coverage. It is advisable to read the entire document to become familiar with the terms of your coverage.

The State of Connecticut has contracted with Anthem to administer the benefits under the Plan. The state adheres to Anthem's agreements, which may include coordination of benefits, timely filing limits, and other administrative requirements. The Plan benefits described here are exclusively for State of Connecticut EMPLOYEES and RETIREES and their eligible DEPENDENTS (referred to as "MEMBERS"). The medical services are subject to specific limitations and exclusions, copayments, deductibles, and coinsurance rules outlined in this document.

Other documents determine the details of the medical coverage you are eligible to receive, such as the contract between the state and Anthem (referred to as the Administrative Services Organization), the contracts between Anthem and medical PROVIDERS, and this document, including any amendments, endorsements, or riders. Together, these documents form the entire legal contract under which medical coverage (referred to as "COVERED SERVICES") is available. Any previous coverage will be replaced by the most current version of the Plan.

Benefits described in this document are available to all Members meeting MEDICAL NECESSITY guidelines, irrespective of race, color, religious creed, sex, actual or perceived gender identity or expression, sexual orientation, marital status, age, national origin, ancestry, intellectual disability, mental disability, learning disability, physical disability, status as a veteran, status as a victim of domestic violence, or HIV status.

Many terms used in the Plan have specific meanings and are defined in *Definitions* on page 85. The first occurrence of these defined terms appears in ALL CAPS, and subsequent occurrences appear in Initial Caps.

How to get language assistance

Call the phone number on the back of your ID Card, and a Member Services representative will be able to help you. TTY/TDD services also are available by dialing 711.

Eligibility

Eligibility requirements are described in general terms below. For more specific information, please visit carecompass.ct.gov.

Eligible Employees/Retirees

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 their position** (0.5 full-time equivalent) to be eligible to participate in the Plan (unless the Employee's coverage is otherwise required pursuant to the Affordable Care Act). Special rules apply to Employees not in classified service, to 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, 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
- An Employee in the classified service who is hired provisionally (and whose service is extended because of delays in the examination process), on the first day of the month following the completion of 60 days of continuous service.

Variable-hour Employees

If at the time of hire the state 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 state 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 Plan during the following 12 months, as long as they remain employed, regardless of the number of hours actually worked during that period.

Retired non-Medicare-eligible Members

Eligibility for retiree health benefits is determined by statute, collective bargaining agreements, and the Healthcare Policy & Benefits Division Policy issued by the Office of the State Comptroller.

The Non-Medicare-Eligible Retiree Plan will provide benefits to a retired Employee (and their eligible enrolled dependents, 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, they will be covered under the 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.

Eligible Dependents include:

- **Spouse or recognized non-Connecticut 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 State of Connecticut.[1] Except as set forth in this section, an individual from whom a covered Member is divorced or legally separated is not eligible for coverage. Exceptions:
  - An individual from whom the covered Member is **legally separated** may continue coverage under the 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 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 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 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,[2] spouse of the covered Member, or recognized civil union partner of the covered Member.** The covered Member's spouse, or the covered Member's recognized civil union partner, a child of the covered Member, including a stepchild; a child legally placed for adoption; a legally adopted child; or a legal ward. Children are eligible for continued coverage until the last day of the calendar year in which the child reaches age 26.

[1] 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 may not be eligible for continued coverage.

[2] Retirees of the Probate Court Judge Retirement pension system (PJRS) may not enroll children on coverage. For this population, dependent coverage is limited to a spouse or recognized civil union partner.

- **Newborn child.** Coverage under the 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 form to their employing agency within 91 days after the date of birth to maintain coverage for the newborn.
- **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 91 days immediately following birth. The newborn child of a covered Dependent child is not eligible for coverage under the Plan beyond the 91-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 Plan, provided they:
  - Are incapable of sustaining employment by reason of physical or mental handicap as certified by a PHYSICIAN/Provider and for whom the covered Member (or their 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, are unmarried.

  You and your Dependent child's treating Physician/Provider must complete the "Certification for a Mentally or Physically Impaired Dependent Child Over Maximum Age" form provided by Anthem. This form requires documentation that the Dependent is financially reliant on your or your spouse's support. Typically, documentation is provided in the form of your federal tax return showing the child claimed as a dependent. Proof of continued disability and dependency must be provided 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 their 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 Plan immediately before reaching the age of 18 continues to be Dependent upon them (either as a "qualifying child" or a "qualifying relative" for federal income tax purposes), coverage may be available beyond the legal guardianship age until the last day of the calendar year in which the child reaches 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 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 Order (QMCSO).** A Dependent child may be covered as a consequence of a domestic relations order issued by a state court to a 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 Plan.

No pre-existing condition limitation

We will not refuse to cover the treatment of a condition you had before you enrolled in this Plan solely because you had the condition before you enrolled.

Changes affecting eligibility

It is the covered Member's responsibility to notify the state 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:

- Termination of a legal guardianship for an enrolled child as a 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.

These 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 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 state 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 Plan is not obligated to provide COBRA continuation coverage.

See page 11 for more information.

Children of a covered Member's former spouse (stepchildren of the covered Member) are ineligible for continued coverage after divorce or legal separation. You must contact the state to let us know the date of the divorce or annulment and have us remove your ex-spouse and your stepchildren.

Failure to provide notice of status change

Continued dependent status may be audited following initial enrollment. 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 state of an event or occurrence that renders an enrolled individual ineligible for continued coverage under the 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 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 on a prospective basis only;
- Suspension from eligibility for coverage under the Plan; or
- Prosecution for fraud.

Losing coverage

Except as otherwise provided, your coverage may terminate in the following situations:

- When the ADMINISTRATIVE SERVICES AGREEMENT between the state and Anthem terminates. If your coverage is through an association, your coverage will terminate when the Administrative Services Agreement between the association and the state terminates, or when the state leaves the association. It will be the state's responsibility to notify you of the termination of coverage.
- If you choose to terminate your coverage.
- If you or your Dependents cease to meet the eligibility requirements of the Plan, subject to any applicable continuation requirements. If you cease to be eligible, you must notify the state immediately. You shall be responsible for payment for any services incurred by you after you cease to meet eligibility requirements.
- If you elect coverage under another carrier's health benefit plan, which is offered by the state as an option instead of this Plan, subject to the consent of the state.
- If you perform an act, practice, or omission that constitutes fraud or make an intentional misrepresentation of material fact, as prohibited by the terms of the Plan, your coverage and the coverage of your Dependents can be retroactively terminated or rescinded. A rescission of coverage means that the coverage may be legally voided back to the start of your coverage under the Plan, just as if you never had coverage under the Plan. You will be provided with a 30-calendar-day advance notice with appeal rights before your coverage is retroactively terminated or rescinded. You are responsible for paying the state for the cost of previously received services based on the MAXIMUM ALLOWED AMOUNT for such services, less any copayments made or fees paid for such services.
- If you fail to pay or fail to make satisfactory arrangements to pay your portion of the fees, your coverage and the coverage of your Dependents may terminate.
- If you permit the use of your or any other Member's Plan ID Card by any other person; use another person's ID Card; or use an invalid ID Card to obtain services, your coverage will

terminate immediately upon Anthem's written notice to the state. Anyone involved in the misuse of a Plan ID CARD will be liable to and must reimburse the Plan for the Maximum Allowed Amount for services received through such misuse.

Either Anthem or the state will notify you in writing of the date your coverage ends.

Continuation of coverage under federal law (COBRA)

The following applies if you are covered by the state that is subject to the requirements of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, as amended.

COBRA continuation coverage can become available to you when you would otherwise lose coverage under the Plan. It can also become available to other Members of your family who are covered under the Plan, when they would otherwise lose their health coverage.

COBRA coverage will begin retroactive to the date you lose coverage due to a qualifying event (see below). The start date of COBRA coverage cannot be delayed.

For additional information about your rights and duties under federal law, contact Member Services.

Qualifying events for COBRA

COBRA continuation coverage is available when your coverage would otherwise end because of certain qualifying events. After a qualifying event, COBRA continuation coverage must be offered to each person who is a qualified beneficiary. You, your spouse, and your Dependent children could become qualified beneficiaries if you were covered on the day before the qualifying event and your coverage would be lost because of the qualifying event. Qualified beneficiaries who elect COBRA must pay for this COBRA continuation coverage.

This benefit entitles each Member of your family who is enrolled in the Plan to elect continuation independently. Each qualified beneficiary has the right to make independent benefit elections at the time of annual enrollment. Covered subscribers may elect COBRA continuation coverage on behalf of their spouses, and parents or legal guardians may elect COBRA continuation coverage on behalf of their children. A child born to, or placed for adoption with, a covered subscriber during the period of continuation coverage is also eligible for election of continuation coverage.

Qualifying event	Length of availability of coverage
For subscribers: voluntary or involuntary termination (other than gross misconduct) or loss of coverage under the Plan due to reduction in hours worked	30 months
For Dependents:	30 months

Qualifying event	Length of availability of coverage
• A covered subscriber's voluntary or involuntary termination (other than gross misconduct) or loss of coverage under the Plan due to reduction in hours worked	
• Divorce or legal separation	36 months
• Death of a covered subscriber	36 months
For Dependent children: loss of Dependent child status	36 months

COBRA coverage will end before the end of the maximum continuation period listed above if you become entitled to Medicare benefits. In that case, a qualified beneficiary—other than the Medicare beneficiary—is entitled to continuation coverage for no more than a total of 36 months. (For example, if you become entitled to Medicare prior to termination of employment or reduction in hours, COBRA continuation coverage for your spouse and children can last up to 36 months after the date of Medicare entitlement.)

Second qualifying event

If your family has another qualifying event (such as a legal separation, divorce, etc.) during the initial 18 months of COBRA continuation coverage, your Dependents can receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months from the original qualifying event. Such additional coverage is only available if the second qualifying event would have caused your Dependents to lose coverage under the Plan had the first qualifying event not occurred.

Notification requirements

The state will offer COBRA continuation coverage to qualified beneficiaries only after the state has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, or the death of the subscriber, the state will notify you of the qualifying event.

For other qualifying events (e.g., divorce or legal separation of the subscriber and spouse or a Dependent child's losing eligibility for coverage as a Dependent child), you must notify the state within 60 days after the qualifying event occurs.

Electing COBRA continuation coverage

To continue your coverage, you or an eligible family Member must make an election within 60 days of the date your coverage would otherwise end, or the date Member Services notifies you or your family Member of this right, whichever is later. You must pay the total fees appropriate for the type of benefit coverage you choose to continue. The fees you must pay cannot be more

than 102% of the fees charged for Employees with similar coverage, and they must be paid to Anthem within 30 days of the date due, except that the initial fee payment must be made before 45 days after the initial election for continuation coverage, or your continuation rights will be forfeited.

When COBRA coverage ends

COBRA benefits are available without proof of insurability, and coverage will end on the earliest of the following:

- A covered individual reaches the end of the maximum coverage period;
- A covered individual fails to pay a required fee on time; or
- A covered individual becomes entitled to Medicare after electing COBRA.

Other coverage options besides COBRA

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **healthcare.gov**.

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 state's share of applicable Premiums to maintain 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 the Employee Premium share, if any, is made directly to the employing agency on a timely basis.

  FMLA also provides certain military family leave entitlements. Eligible Employees may take FMLA leave for specified reasons related to certain military deployments of their family Members. Additionally, they may take up to 26 weeks of FMLA leave in a single 12-month period to care for a Covered Service Member with a serious injury or illness.

- **Employee medical leave:** The state will continue to contribute the state's share of applicable Premiums to maintain 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 Plan by paying the full amount of the Premium (Employee and state share) directly to the agency.
- **Leave other than illness or injury (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.
- **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.
- **Military leave:** If a covered Member leaves to perform military service, the Member may elect to remain on existing medical coverage for up to 24 months while serving by paying the Employee share of the Premium.
- **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 Plan. As required by statute, the state will continue to contribute the state's share of applicable Premiums to maintain 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 benefits, by payroll deduction of the Employee's Premium share.

An Employee on an authorized 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 health care 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 health care coverage.

For enrollment instructions, visit **carecompass.ct.gov**.

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, if required, as outlined in the 2011 SEBAC agreement.

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 health care coverage.

Retirees follow the same Open Enrollment period as active Employees. For Plan change instructions, visit **carecompass.ct.gov**.

Enrollment types

Employee Only coverage is only for the enrollee. Employee + 1 coverage is for the enrollee and one eligible family Member. Family coverage is for the enrollee and two or more eligible family Members.

Family Less Employed Spouse (FLES) coverage is for two Employees who have at least one Dependent. Coverage must be coordinated with the two employing agencies, both Employees must be enrolled in the same Plan with one Employee electing Employee-only coverage and the other Employee electing FLES coverage and adding the eligible Dependent(s).

Open Enrollment

Each year there is an Open Enrollment period in May for approximately one month, during which all Plan Members may make changes to their Plan enrollment. The annual Open Enrollment period is normally the only time covered Members may 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 enrollment instructions, visit **carecompass.ct.gov**.

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 instructions on changing your enrollment, visit carecompass.ct.gov. The change must be consistent with the change in status. All coverage changes are effective the first 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; or
  - 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.
- **Residence.** A significant change in a covered Member's place of residence that affects their ability to access network Providers.
- **Loss of coverage.** Any event that causes a covered person to lose coverage from another source.

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 Employee's agency for verification of Dependent status:

- **Marriage:** Marriage certificate.
- **Civil union:** Civil union certificate
- **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 Plan.

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.
- **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 attainment of the requisite qualifying age. All requests for enrollment must take place within 31 days of the individual's qualifying enrollment date.
- **New spouse:** Coverage for a new spouse will be effective on the first day of the month following the date of marriage. Enrollment must take place within 31 days of marriage or at Open Enrollment.
- **Children:** A newborn child of a covered Member is automatically covered for 91 days following birth but will not be covered after that period unless an enrollment application is submitted within 91 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 retroactive to the date of placement for adoption or the date of adoption.

A stepchild may be enrolled within 31 days of the date when eligibility requirements are first met. For example, as the result of marriage, a covered Member may enroll the child of their new spouse within 31 days of the marriage. Coverage will be effective on the first day of the month following the date of marriage.

Maintaining other State of Connecticut 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, a Partnership Plan, or the Medicare Advantage Plan. It is also prohibited for the same individual to be simultaneously enrolled as a 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, Non-Medicare-Eligible Retiree Benefit Plan, a Partnership 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 they remain qualified.

How This Plan Works

Medical plans

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.

Quality First Select Access Plan

The Quality First Select Access Plan is for Members who reside in Connecticut. It offers health care services from a defined network of quality-based Providers whose practices are based in Connecticut.

Members receiving treatment from PRIMARY CARE PHYSICIANS (PCP) and SPECIALISTS identified as **Value Tier 1 Providers** have no copays. Members receiving care from PCPs and Specialists that are identified as **In-Network Tier 2 Providers** pay $50 for PCPs and $100 for Specialists.

Members receiving care from PCPs and Specialists that do not have a tier will pay the copay shown in the *Schedule of Benefits* (page 96) for their medical plan.

Members can receive Covered Services from out-of-network Providers; however, out-of-network care will generally cost more than the same services received in-network.

Primary Care Access Plan

The Primary Care Access Plan offers health care services from a defined network of Providers. Out-of-network care is covered only in the case of emergencies.

Members must select an in-network PCP to coordinate all care. If you do not select a PCP, one will be selected for you based on your geographic area.

Referral requirements

Generally, PCP referrals are required for specialty care. PCP's can refer to any in-network Specialist. Under special circumstances, they can refer to an out-of-network Provider.

In some instances, a PCP referral is not required, such as:

- Covered Physician in the same practice/same tax identification number (TIN)
- OB/GYN (applies to BlueCare nurse midwives and advance practice registered nurses); includes visits for exam, pregnancy-related care, primary or preventive OB/GYN services resulting from gynecological exam or condition
- EMERGENCY room/URGENT CARE FACILITY
- LiveHealth Online, including behavioral health virtual visits

- HOSPITAL-based Physician for services related to INPATIENT care (i.e., radiologist, anesthesiologist, and pathologist)
- Diagnostic scans, including CAT scans and MRIs, performed by radiologists, MDs with a specialty in nuclear medicine or nuclear radiology, or Physicians with a specialty in maternal and fetal medicine for a pelvic ultrasound
- Lab tests performed by an independent clinical lab
- Behavioral health, psychiatric, and substance use disorder
- Routine eye exams

Standard Access Plan

The Standard Access Plan offers health care 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.

Expanded Access Plan

The Expanded Access Plan offers health care services within and outside a defined network of Providers. No referrals are necessary to receive care from in-network Providers.

Members can receive Covered Services from out-of-network Providers; however, out-of-network care will generally cost more than the same services received in-network.

State Preferred POS Plan

This State Preferred POS Plan is closed to new enrollment.

The State Preferred POS Plan offers health care services within and outside a defined network of Providers. No referrals are necessary to receive care from in-network Providers.

Members can receive Covered Services from out-of-network Providers; however, out-of-network care will generally cost more than the same services received in-network.

The State Preferred POS Plan has a slightly different Provider network than the other Anthem plans.

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

The Out-of-Area POS Plan is only available to Members who reside outside the State of Connecticut.

The Out-of-Area POS Plan offers health care services within and outside a defined network of Providers. No referrals are necessary to receive care from in-network Providers.

Members can receive Covered Services from out-of-network Providers; however, out-of-network care will generally cost more than the same services received in-network.

The Out-of-Area POS Plan has a slightly different Provider network than the other Anthem plans.

Minimum essential coverage (MEC)

Coverage under these plans qualifies as minimum essential coverage. Please visit the Internal Revenue Service (IRS) website at irs.gov/uac/questions-and-answers-on-the-individual-shared-responsibility-provision for more information on the individual requirement for MEC.

Providers and services

The Plan has different levels of coverage depending on the Providers used. Regardless of Medical Necessity, benefits will be denied for care that is not a Covered Service.

In-network Providers

In-network Providers have agreed to accept a specific negotiated amount as payment in full for Covered Services provided to you. Your out-of-pocket costs are generally less when you receive Covered Services from in-network Providers, and are limited to your deductible, coinsurance, or copayments.

There is no need to file claims. In-network Providers will file claims for Covered Services for Members. (Members pay any coinsurance, copayments, and/or deductibles that apply.) Members may be billed by in-network Provider(s) for any non-Covered Services received.

If PRECERTIFICATION is required, it will be done by the in-network Provider (see 26).

If care is needed when your Provider's office is closed, please call the office for instructions. If you have an Emergency, call 911 or go to the nearest Emergency room immediately.

Designation of PRIMARY CARE PROVIDER

PCPs include internists, family/general practitioners, pediatricians, geriatricians, and advanced practice registered nurses.

For information on how to select a PCP, and for a list of PCPs, please contact Member Services.

IDENTIFICATION CARDS

You will be sent an Identification (ID) Card when you enroll. You should carry your ID Card with you at all times. You will need it whenever you receive services from a covered Provider.

If you do not receive your ID Card within 30 days after the Effective Date of your enrollment, or if you need replacement cards, contact Member Services.

Provider of Distinction Program

The state has identified Providers in Connecticut that meet the highest patient care standards for specific procedures and conditions as "Providers of Distinction." By completing your care for certain common procedures with a designated Provider of Distinction, you will receive a reward. Visit carecompass.ct.gov/providersofdistinction for more information.

Transitional care

If an in-network Provider leaves the Plan's network for any reason other than termination for cause, retirement or death, and a Member is in active treatment, the Member may be able to continue seeing that Provider until treatment is complete, or for 90 days, whichever is shorter, and still get in-network benefits.

Active treatment includes an ongoing course of treatment for:

- A life-threatening condition,
- A serious acute condition (e.g., chemotherapy, radiation therapy, and postoperative visits),
- MENTAL HEALTH AND SUBSTANCE USE DISORDERS,
- Pregnancy and through the postpartum period, or
- A health condition for which the Physician or health care Provider attests that discontinuing care by the current Physician or Provider would worsen your condition or interfere with anticipated outcomes.

Contact Member Services for details. Decisions made regarding requests for continuity of care are subject to the grievance and external review process (see page 30).

Out-of-network Providers

Under the Primary Care Access and Standard Access plans, you must use in-network Providers to receive benefits, except in an emergency.

Out-of-network Providers do not have contracts with Anthem. They may or may not accept Anthem's reimbursement. When an out-of-network Provider is used, Covered Services are covered at the out-of-network level, unless otherwise indicated. You must meet a deductible; then, you will pay coinsurance for services rendered by an out-of-network Provider.

You may need to file your claim with Anthem directly when you use an out-of-network Provider. Before starting treatment, confirm with Member Services that any necessary Precertification steps have been completed. It is the Member's responsibility to obtain Precertification for out-of-network services.

Maximum Allowed Amount

Benefits for Covered Services are based on the Maximum Allowed Amount, which is the most the Plan will allow for a Covered Service. Except for surprise billing claims (see *Balance billing protection* on page 23), when you use an out-of-network Provider you may have to pay the difference in cost between the out-of-network Provider's billed charge and the Maximum Allowed Amount, in addition to any coinsurance, copayments, deductibles, and non-covered charges. This amount can be substantial.[3]

[3] This example is for illustrative purposes only; the amounts shown may be different from this document's cost-share amounts.

Out-of-network billing example – For illustrative purposes only

The out-of-network surgeon's charge for the service is $2,500. The Maximum Allowed Amount for the surgery is $1,500; your coinsurance responsibility for an out-of-network surgeon is 20% (after you meet your out-of-network deductible). You pay 20% of $1,500, which is $300. The state pays the remaining 80% of $1,500, or $1,200. In addition, the out-of-network surgeon can bill you the difference between their billed charge ($2,500) and the Maximum Allowed Amount ($1,500), so your total out-of-pocket charge would be $1,300 ($300 plus $1,000).

Balance billing protection

The No Surprises Act (NSA) is a federal law that provides you with protections against "surprise billing" and "balance billing" for out-of-network Emergency services, for out-of-network nonemergency services provided when you visit an in-network health care FACILITY, and for out-of-network air ambulance services.

Balance billing happens when you receive a bill from the out-of-network Provider, facility, or air ambulance service for the difference between the out-of-network Provider's charge and the amount payable by the Plan.

The Plan must comply with the NSA protections that hold you harmless from bills. Patients are responsible for cost-sharing no greater than what they pay for in-network care, and their cost-sharing applies to their in-network deductible and out-of-pocket limit.

A surprise bill does not include a bill for Covered Services received by a Member when an in-network Provider was available to render such services and the Member knowingly elected to obtain such services from an out-of-network Provider.

In certain situations, an out-of-network Provider must provide you with notice of their status as out-of-network. Should you agree in advance to accept services from an out-of-network Provider, you will be responsible for the out-of-network cost-shares and any difference between the Maximum Allowed Amount and the out-of-network Provider's billed charges. This is also referred to as the "notice and consent requirement."

If you feel you have had a service that is covered under these protections, you have the right to appeal those claims. Members can find information regarding these protections, including information on how to contact state and federal agencies if you believe a Provider has violated these protections, on Anthem's website (**anthem.com/no-surprise-billing**).

You may also obtain information on the topics listed below by contacting Member Services.

- Cost-sharing information for covered items, services, and drugs, as required by the Centers for Medicare & Medicaid Services (CMS); and
- A listing/directory of all in-network Providers.

In addition, we will provide access through the above websites to the following information:

- In-network negotiated rates; and

- Historical out-of-network rates. To access historical out-of-network rates, visit anthem.com/machine-readable-file/search/ and search by name for "State Of Connecticut." Rates are listed under the section titled *Out-of-Network Allowed Amounts Files*.

Inter-Plan Arrangements

Anthem has a variety of relationships with other Blue Cross and/or Blue Shield licensees. Generally, these relationships are called "Inter-Plan Arrangements." Whenever you access health care services outside of the Anthem BCBS of Connecticut LOCAL NETWORK AREA, the claim for those services may be processed through one of these Inter-Plan Arrangements.

- **BlueCard® Program.** Under the BlueCard® Program, when you receive Covered Services within the geographic area served by a Host Blue, the Host Blue is responsible for (a) contracting with its Providers, and (b) handling its interactions with those Providers.
- **Negotiated (non-BlueCard Program) arrangements.** Anthem may process your claims for Covered Services through negotiated arrangements for national accounts.
- **Out-of-network Providers outside Anthem's Local Network Area.** When Covered Services are provided outside of Anthem's Local Network Area by out-of-network Providers, Anthem may determine benefits and make payment based on pricing from either the Host Blue or the pricing arrangements required by applicable state or federal law. In these situations, the amount you pay for such services as deductible, copayment or coinsurance will be based on the Maximum Allowed Amount. You will be responsible for the difference between the amount that the out-of-network Provider bills and the payment that was made for the Covered Services.

Blue Cross Blue Shield Global Core®

If you plan to travel outside the United States, call Member Services to find out your Blue Cross Blue Shield Global Core benefits. Benefits for services received outside the United States may be different from services received in the United States. Remember to take your ID Card with you.

When you are traveling abroad and need medical care, you can call Member Services to discuss your global benefits. Keep in mind, if you need Emergency medical care, go to the nearest Hospital. There is no need to call before you receive emergent care.

How claims are paid

In most cases, when you arrange Inpatient Hospital care with Blue Cross Blue Shield Global Core, claims will be filed for you. The only amounts that you may need to pay up front are any copayment, coinsurance, or deductible amounts that may apply.

You will typically need to pay up front for the following services:

- Physicians services;

- Inpatient Hospital care not arranged through Blue Cross Blue Shield Global Core; and
- Outpatient services.

You will need to file a claim form for any payments made up front.

When you need Blue Cross Blue Shield Global Core® claim forms, you can get international claims forms in the following ways:

- Call the Blue Cross Blue Shield Global Core Service Center at the numbers above; or
- Online at **bcbsglobalcore.com**.

You will find the claim mailing address on the form.

Finding an in-network Provider or Facility

There are several ways to find an in-network Provider or Facility.

- Go to the Plan's online directory for Physicians, Providers, and Facilities that participate in the network: **carecompass.quantum-health.com**.[4] The directory is an interactive tool that identifies Providers based on Provider type, specialty, and location. It will also identify if the Provider is a SITE-OF-SERVICE PROVIDER.
- Contact Member Services by calling the telephone number listed on the back of your ID Card and a representative will be able to provide a list of Physicians and Providers that participate in this Plan's network, based on specialty and geographic area.
- Check with your Physician or Provider.

In most cases, there will be an in-network Provider to treat your specific illness or injury. If there is no in-network Provider who is qualified to perform the required treatment, contact Member Services for assistance.

For details about a Provider's license or training, or to get help choosing the right Physician, call Member Services. TTY/TDD services also are available by dialing 711. A special operator will get in touch with Member Services to help with your needs.

Anthem is required to confirm the accuracy of the list of in-network Providers in the Provider directory every 90 days. If a Member shows that they received inaccurate information from the Provider directory, (i.e., that a Provider was in-network on the date of a particular claim), then the Member will only be liable for in-network cost-shares including any necessary deductible, copayments, and/or coinsurance for that claim. In-network cost-shares will be calculated based upon the Maximum Allowed Amount.

[4] If you are not registered to the Quantum Health Benefits Portal, you can use the non-login Provider search tool.

Prior approval is required for certain services

Precertification

Certain services require Anthem to provide Precertification to confirm that selected medical services meet Medical Necessity criteria under the Plan. Precertification includes a review of the medical service, the setting, and, if applicable, the number of days precertified.

Services that require precertification are as follows:

- Inpatient pre-admission certification and continued stay reviews (all ages, all diagnoses)
  - Surgical and non-surgical (excluding routine vaginal or cesarean deliveries). The attending physician does not have to obtain pre-certification from the Plan for prescribing a maternity length of stay that is forty-eight (48) hours or less for a vaginal delivery or ninety-six (96) hours or less for a cesarean delivery.
  - Long term acute care facility (LTAC), not custodial care
  - Skilled nursing facility/rehabilitation facility
  - Inpatient mental health/substance use disorder treatment (includes residential treatment facility services)
- Outpatient Surgery: Certain services within this category require pre-certification.
- Adoptive cell therapy
- Durable medical equipment (DME) and medical devices: Certain services within this category require pre-certification.
- Gene Therapy
- Genetic/genomic testing (excluding amniocentesis): Certain services within this category require pre-certification.
- Hyperbaric oxygen therapy
- Network outpatient physical therapy and occupational therapy in excess of twenty-four (24) visits per plan year per therapy type
  - Mental health diagnoses do not require pre-certification. Non-network outpatient physical therapy and occupational therapy do not require pre-certification and are subject to benefit maximum.
- Non-emergent air ambulance
- Outpatient advanced imaging (excluding services rendered in an emergency room setting)
  - MRI/MRA
  - PET scans

  Certain services within this category require pre-certification.

- Partial hospitalization and intensive outpatient program in excess of twenty-four (24) visits per plan year per therapy type, for mental health and substance use disorder treatment
- Private Duty Nursing provided in the home
- For oncology diagnoses ONLY: certain medications which are covered under the medical benefits and not obtained through the Prescription Drug Benefits (i.e. provided in an outpatient facility, physician's office, or home infusion)
- Note: Certain other non-oncology specialty medications may require precertification through CarelonRx
- Services rendered in an emergency room or urgent care setting do not require pre-certification.

Anthem may utilize subcontractors to administer precertification, but those subcontractors follow Anthem's medical policies and clinical coverage guidelines to make Medical Necessity determinations. This is also called utilization management. Medical policies and clinical guidelines reflect the standards of practice and medical interventions identified as proper medical practice. Anthem reviews and updates medical policies and clinical guidelines on a regular basis.

For any questions about the utilization review process, the medical policies, or clinical guidelines, contact Member Services. You are entitled to ask for and get, free of charge, reasonable access to any records concerning your request. To request this information, call the phone number on the back of your ID Card.

Types of reviews

Based on time of service

- **Precertification:** A required pre-service review for a benefit coverage determination for a service or treatment. If you do not obtain Precertification, there may be a reduction or denial of benefits. The benefit coverage review will include a review to decide whether the service meets the definition of Medical Necessity or is EXPERIMENTAL/INVESTIGATIONAL as defined under the Plan.
  - **For admissions following EMERGENCY CARE,** the Member, the Member's authorized representative, or the Member's Physician must inform Member Services of the admission as soon as possible.
  - **For childbirth admissions,** Precertification is not needed unless there is a problem and/or the mother and baby are not sent home (discharged) at the same time. Precertification is not required for the first 48 hours of a stay for a vaginal delivery or for the first 96 hours of a stay for a cesarean section (C-section). Admissions for longer than the 48- or 96-hour stays require Precertification.
- **Continued stay/concurrent review:** A review of a service, treatment, or admission for a benefit coverage determination, which is done during an ongoing stay in a Facility or course of treatment.

- **Urgent review:** Pre-service reviews and continued stay/concurrent reviews may be considered urgent when, in the view of the treating Provider or Physician with knowledge of the Member's medical condition, without such care or treatment, the Member's life or health or ability to regain maximum function could be seriously threatened or the Member could be subjected to severe pain that cannot be adequately managed without such care or treatment. Urgent reviews are conducted under a shorter time frame than standard reviews (see page 29).
- **Post-service review:** A review of a service, treatment, or admission for a benefit coverage determination that is conducted after the service has been provided.

Based on location of service

A service must be MEDICALLY NECESSARY to be a Covered Service. When level of care, setting or place of service is reviewed, services that can be safely given in a lower level of care or lower-cost setting/place of care will not be considered Medically Necessary if they are given in a higher level of care or higher-cost setting/place of care. This means that a request for a service may be denied because it is not Medically Necessary for the service to be provided where it is being requested. When this happens, the service can be requested again in another place and will be reviewed again for Medical Necessity.

Examples include, but are not limited to:

- A service may be denied on an Inpatient basis at a Hospital but may be approved if provided on an outpatient basis at a Hospital.
- A service may be denied on an outpatient basis at a Hospital but may be approved at a free-standing imaging center, infusion center, ambulatory surgery center (surgical center), or in a Physician's office.
- A service may be denied at a SKILLED NURSING FACILITY but may be approved in a home setting.

Utilization review criteria will be based on many sources, including medical policy and clinical guidelines. Anthem may decide that a treatment is not Medically Necessary if a clinically equivalent treatment that is more cost effective is available and appropriate. "Clinically equivalent" means treatments that, for most Members, will give similar results for a disease or condition.

How to request Precertification

In-network Providers know which services need Precertification and are responsible for obtaining Precertification when required. It is the Member's responsibility to get Precertification when using an out-of-network Provider.

The table below outlines who is responsible for Precertification and under what circumstances.

Provider network status	Responsibility to get Precertification
In-network	Provider

Provider network status	Responsibility to get Precertification
Out-of-network	Member Note: Member may be financially responsible for charges/costs related to the service and/or setting in whole or in part if the service and/or setting is found to not be Medically Necessary.
BlueCard Provider	Provider

Decision and notice requirements

Anthem will review requests for benefits according to the time frames listed below, which are based on federal and state laws.

Request for medical services, behavioral services and oncology drugs – Anthem

Type of review	Time frame requirement for decision and notification
Urgent pre-service review	48 hours from the receipt of request or 72 hours from receipt of request if any portion of the 48-hour period falls on a weekend
Nonurgent pre-service review	15 calendar days from the receipt of the request
Urgent continued stay/concurrent review when request is received more than 24 hours before the end of the previous authorization	24 hours from the receipt of the request
Urgent continued stay/concurrent review when request is received less than 24 hours before the end of the previous authorization or no previous authorization exists	48 hours from the receipt of the request or 72 hours from receipt of request if any portion of the 48-hour period falls on a weekend
Nonurgent continued stay/concurrent review for ongoing outpatient treatment	15 calendar days from the receipt of the request
Post-service review	30 calendar days from the receipt of the request

Request for Prescription Drugs through the medical Plan – Anthem

Type of review	Time frame requirement for decision and notification
Urgent pre-service review Levels of care include: Inpatient services, residential treatment, PARTIAL HOSPITALIZATION, or INTENSIVE OUTPATIENT PROGRAMS	24 hours from the receipt of the request
Nonurgent pre-service review: outpatient services	15 calendar days from the receipt of the request
Urgent continued stay/concurrent review	24 hours from the receipt of the request
Nonurgent continued stay/concurrent review for ongoing outpatient treatment	15 calendar days from the receipt of the request
Post-service review	30 calendar days from the receipt of the request

You and your Provider will be notified of the decision as required by state and federal law. Notice may be given by one or more of the following methods: verbal, written, and/or electronic.

Grievance and Appeal Rights

We want your experience to be positive; however, there may be times when you have a complaint, problem, or question about your medical Plan or a service you have received. In those cases, contact Member Services to assist you in resolution.

If you are not satisfied with the resolution of your complaint, you have the right to appeal the adverse decision. The appeal/grievance process may be pursued by the covered person, the covered person's agent of record (AOR), the Provider of record, or the Provider of record's duly authorized representative. In most cases, covered persons must comply with the internal appeals process before seeking external review of adverse determinations.

The Connecticut Department of Insurance is available to decide appeals of adverse utilization review determinations where Medical Necessity or clinical judgments are at 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 applicable internal appeals process administered by Anthem 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.

Types of Appeals, Timetable for Issuing a Decision

- **To reconsider a nonurgent care claim.** You may ask for a standard grievance (a grievance that is not urgent) for a coverage decision you don't agree with. You can also ask for a standard grievance for a rescission (ending or canceling) of coverage. Your request must be in writing. In your request, please let Anthem know that you are asking for a grievance. Include any additional information you have to support your request. Anthem will respond in writing within 30 calendar days from the date they receive the request.
- **To reconsider an urgent care claim.** An urgent grievance is available if you have not had or are currently receiving services and the time frame of a standard grievance review could:
  - Seriously jeopardize (harm) your life or health;
  - Jeopardize your ability to regain maximum function; or
  - In the opinion of a health care professional with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without the health care service or treatment being requested.

Anthem will let you know their decision within 48 hours of receiving a request or within 72 hours from receipt of request if any portion of the 48-hour period falls on a weekend. Anthem will let you know their decision by phone, fax, or any other available means.

While you may file an urgent grievance in writing, we encourage you to call Member Services with this type of request. This will help them handle the review quickly.

Include the following details with your grievance if you have them:

- The Member's name and ID number;
- The name of the Provider who will or has provided care;
- The date(s) of service;
- The claim or reference number for the specific decision with which you don't agree;
- The specific reason(s) why you don't agree with the decision; and
- Any written comments, documents, or other relevant information to support the request. At any time, you can name someone to act for you. You must do this in writing.

To file a grievance, you, your Physician, or any person you choose (your authorized representative) can request a grievance in writing or by calling Member Services. Your grievance should be sent to the following address.

For medical issues, mental health and substance use disorders, and oncology drugs covered under the Medical Plan:

Anthem Blue Cross Blue Shield

Appeals Department

P.O. Box 9758

Boise, ID 83707

Fax number: 1-208-514-0974

For non-oncology Prescription Drugs covered under the medical Plan:

Anthem Blue Cross and Blue Shield

Grievances and Appeals

P.O. Box 2100

North Haven, CT 06473-4201

External review

Review by the State of Connecticut Department of Insurance is available to a covered person who has completed the Plan's internal clinical appeals process applicable to the treatment, procedure or service involved. Only one internal appeal is required.

The covered person or the covered person's designee has the right to request an external review 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 internal appeals 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 review.

Expedited appeals. In an emergency or life-threatening situation, a covered person may use the external appeal process directly, without exhausting the internal appeal process 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 four months after the receipt of a notice of an adverse benefit determination or final internal adverse benefit determination 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 the covered person's designee (and provider, if applicable) must release all pertinent medical information concerning the medical condition and request for services.

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 Review" form.
- An authorization form allowing Anthem 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 ID card issued by Anthem BCBS).
- Copies of all correspondence from Anthem.
- A copy of the final determination letter indicating that the internal appeal mechanism has been exhausted.
- A copy of the Plan Document or explanation of benefits.

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

Notification of External Appeal

Following receipt of the request for external appeal or expedited external appeal, the Insurance Commissioner will forward the appeal to Anthem who will notify the member of the request's eligibility and acceptance for external review and, if requested, for expedited external review.

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 initial adverse determination by Anthem, 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 an internal appeal process, the covered person may resume the internal appeal process until it has been exhausted. A standard external appeal may then be filed within four months after the receipt of a notice of an adverse benefit determination or final internal adverse benefit determination.

If the internal appeal was previously exhausted, a rejected expedited appeal will automatically be eligible for consideration for a 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).

Time Frames 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.

Anthem will forward to the independent review organization the medical and treatment plan records relied upon in making its determination. If the documentation represents a material change from the documentation upon which the adverse determination or denial was based, Anthem 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 time frames:

- **External reviews:** Within 45 days after assignment from the Commissioner.
- **External reviews 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, their representative (if applicable), the Commissioner and to Anthem. If the decision is to reverse or revise the 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.

Rights available to Members

You may ask for and get copies of all documents, including the actual benefit provision, guidelines, protocol, or other similar criterion on which an adverse coverage decision was based. If you prefer, any other person you choose may ask for this information.

Anthem will send this information within five business days after receiving your request. They will send this information within one calendar day after receiving your request about a final adverse coverage decision for:

- An admission, availability of care, continued stay, or health care service for which you received Emergency services but haven't been discharged from a Facility; or
- A denial of coverage based on a decision that the recommended or requested health care service or treatment is Experimental or Investigational and your treating Provider certifies in writing that this care service or treatment would be significantly less effective if not promptly initiated.

Anthem will send the information by fax, electronic means, or any other fast method.

If you don't agree with the coverage decision, you have the right to ask for a grievance. The review of your grievance may change our previous coverage decision.

Other helpful resources

Whether or not you use the grievance rights available to you, you may contact the Consumer Affairs Division of the Connecticut Department of Insurance or the Connecticut Office of the Health Care Advocate at any time. You may also benefit from free assistance with filing a grievance.

Consumer Affairs Division of the Connecticut Department of Insurance

Address: P.O. Box 816
Hartford, CT 06142-0816

Phone: 860-297-3900 (local)
800-203-3447 (toll-free)

Email: cid.ca@ct.gov

Connecticut Office of the Health Care Advocate

Address: P.O. Box 1543
Hartford, CT 06144

Phone: 866-466-4446 (toll-free)

Email: healthcare.advocate@ct.gov

What You Pay for Covered Services

Cost-share

Cost-share is your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive. You are responsible for the full cost of non-Covered Services.

Deductible

A deductible is a fixed amount you have to pay for Covered Services before the Plan starts paying for them. The deductible excludes Premiums, copays, coinsurance, balance-billed charges, and payments for services the Plan does not cover.

The **in-network upfront deductible** is the amount a Member must pay before the Plan begins to pay for in-network Covered 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 does not apply if a Member is enrolled in and compliant with the Health Enhancement Plan.**

The in-network, out-of-network, and upfront deductibles are separate and do not accumulate toward each other. The Plan features two types of deductibles: individual and family. If only one person is covered by the Plan, the individual deductible applies. If multiple individuals are covered (such as family Members), both deductibles may be relevant. When a Member incurs a health care expense, payments toward the deductible are credited to both the individual and family deductibles. The individual deductible is considered satisfied ("met") when any one Member satisfies ("meets") their individual deductible amount, allowing them to receive benefits, subject to the deductible. Similarly, the Plan begins to pay benefits for the entire family once the collective payments made by all Members meet the family deductible, regardless of whether any single Member has met their individual deductible.

The deductible starts to accrue as of July 1 each year.

Copayment

A copayment is the fixed amount you pay to the covered Provider, Facility, pharmacy, etc., when you receive certain services. The copayment amount can vary by the type of Covered Service. For details, see the *Schedule of Benefits* on page 96.

Coinsurance

Coinsurance is the percentage of the Plan allowance that you must pay for your care. Your coinsurance is based on the Plan allowance or billed amount, whichever is less. Under plans with deductibles, coinsurance does not begin until you have met your calendar year deductible. Example: After meeting your $300 deductible under the Expanded Access Plan, you pay 20%

coinsurance for durable medical equipment obtained from an out-of-network Provider. For details, see the *Schedule of Benefits* on page 96.

Coinsurance will not be reduced by any refunds, rebates, or any other form of negotiated post-payment adjustments.

Coinsurance for out-of-network services will be based on the Maximum Allowed Amount. If an out-of-network Provider is used, there may be a coinsurance charge plus the difference between the out-of-network Provider's billed charge and the Maximum Allowed Amount. See page 22 for more information on Maximum Allowed Amounts.

Out-of-pocket limit

To protect you from unexpected health care costs, the annual out-of-pocket limit "caps" (limits) your expenses for the Covered Services you receive. When your eligible out-of-pocket expenses reach this maximum, you no longer have to pay the associated cost-sharing amounts for the rest of the Plan year.

The out-of-pocket limit includes all deductibles, coinsurance, and copayments paid during a BENEFIT PERIOD, except:

- Charges over the Maximum Allowed Amount.
- Amounts paid for non-Covered Services.
- Services listed under out-of-network human organ and tissue transplant (bone marrow/stem cell, cord blood), cellular, and gene therapy services.

The in-network and out-of-network out-of-pocket limits are separate and do not accumulate toward each other.

The Plan includes two types of out-of-pocket limits: individual and family. If the Plan covers only one person, the individual out-of-pocket limit applies. If more than one person is covered (e.g., family Members), both types of limits may apply. When any covered person incurs a health care expense, the amount paid counts toward both the individual and family out-of-pocket limits. A Member's individual out-of-pocket limit is considered met when their personal expenses meet the individual limit. The family out-of-pocket limit is considered met when the combined expenses paid by all family Members reach the family limit. Each family Member can contribute to the family limit, but no single Member will contribute more than their individual limit, and some family Members may not need to contribute at all toward the family out-of-pocket limit.

Covered Services

Covered Services are subject to all the terms and conditions listed in this document, including, but not limited to, benefit maximums, deductibles, copayments, coinsurance, exclusions, and Medical Necessity requirements. For details, please read the *Schedule of Benefits* on page 96.

Many Covered Services can be received in several settings, including a Physician's office or your home, a walk-in center, an Urgent Care Facility, an outpatient Facility, or an Inpatient Facility. Benefits will often vary depending on where you receive services and who provides the services.

Medical services and supplies provided by Physicians and other health care professionals

Acupuncture

Treatment of neuromusculoskeletal pain by an acupuncturist who acts within the scope of their license. Treatment involves using needles along specific nerve pathways to ease pain.

Acupuncture is covered up to 20 visits per calendar year.

Allergy care

Benefits for Medically Necessary allergy testing and treatment, including allergy serum and allergy shots.

Diabetes equipment, education, and supplies

Coverage for diabetic drugs, supplies, and equipment. Generally, these services are covered under your Prescription Drug benefit. However, insulin pumps and supplies are covered under durable medical equipment (DME).

Outpatient self-management training for the treatment of diabetes is covered if:

- Prescribed by a licensed health care professional; and
- Performed by:
  - A certified, licensed, or registered health care professional trained in diabetes care, and
  - Operating within the scope of their license.

Benefits are provided for 10 hours of initial training, 4 hours of extra training because of changes in the person's condition, and 4 hours of training required by new developments in the treatment of diabetes.

Covered supplies

Supplies include, but are not limited to:

- 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

Diagnostic and treatment services

Outpatient professional services

Outpatient professional services of Physicians and other health care professionals:

- Consultations
- Genetic counseling
- Second surgical opinions
- Clinic visits
- Office visits
- Home visits
- Initial examination of a newborn needing definitive treatment
- Virtual visits

Inpatient professional services

Covered Services include:

- Medical care visits.
- Intensive medical care when your condition requires it.
- Treatment for a health problem by a Physician who is not your surgeon while you are in the Hospital for surgery. Benefits include treatment by two or more Physicians during one Hospital stay when the nature or severity of your health problem calls for the skill of separate Physicians.
- A personal bedside exam by another Physician when asked for by your Physician. Benefits are not available for staff consultations required by the Hospital, consultations asked for by the patient, routine consultations, phone consultations, or EKG transmittals by phone.
- Surgery and general anesthesia.
- Newborn exam. A Physician other than the one who delivered the child must do the exam.
- Professional charges to interpret diagnostic tests such as imaging, pathology reports, and cardiology.

Telehealth professional services

Covered Services include virtual telemedicine/telehealth visits that are appropriately provided by a telehealth Provider in accordance with applicable legal requirements, including:

- Live (synchronous) secure videoconferencing
- Secure instant messaging through a mobile app
- Interactive store and forward (asynchronous) technology
- Remote patient monitoring technology, including monitoring of clinical patient data such as weight, blood pressure, pulse, pulse oximetry, blood glucose, and other condition-specific data; medication adherence monitoring; and interactive video conferencing with or without digital image upload.

Covered Services are provided to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's physical and/or behavioral health. In-person contact between a health care Provider and the patient is not required for these services, and the type of setting where these services are provided is not limited.

> Not all services can be delivered through virtual visits. Certain services require equipment and/or direct physical hands-on care that cannot be provided remotely. Services that Anthem determines require in-person contact and/or equipment that cannot be provided remotely are not covered by the Plan if received through telehealth.

Benefits do not include the use of facsimile, audio-only telephone, texting (outside of secure health care-specific mobile apps), electronic mail, or nonsecure instant messaging, unless

compliant with applicable Connecticut law pertaining to telehealth services. Benefits also do not include reporting test results; requesting office visits; getting answers to billing, insurance coverage, or payment questions; asking for referrals to Providers outside Anthem's network; benefit Precertification; or Provider-to-Provider discussions except as approved in this document.

Durable medical equipment (DME)

Benefits for durable medical equipment and medical devices when the equipment:

- Is prescribed by a licensed health care provider;
- Is primarily and customarily used for a medical purpose;
- Is not useful to a person in the absence of illness or injury;
- Can withstand repeated use; and
- Is appropriate for use in the home.

Examples of covered DME include, but are not limited to:

- Wheelchairs (manual and power)
- Hospital beds
- Oxygen and respiratory equipment
- Continuous Positive Airway Pressure (CPAP) devices
- Walkers, canes, and crutches
- Diabetic equipment and related supplies
- The Plan will determine whether DME is provided on a rental or purchase basis, whichever is more cost-effective and clinically appropriate. In many instances:
- Equipment may initially be rented.
- Ownership may transfer to the member after a specified rental period.
- Maintenance and repairs of covered equipment are included when medically necessary.

The Plan will not cover deluxe or luxury features when a standard model meets the member's medical needs. The Plan does not cover customization of any item of DME or brace (including an orthotic used with a brace) unless the Plan specifically allows for coverage in certain instances.

Benefits include repair and replacement costs as well as supplies and equipment needed for the use of the equipment or device; for example, a battery for a powered wheelchair.

Replacements are covered when growth or a change in the covered person's medical condition makes replacement Medically Necessary.

The cost-shares listed in the *Schedule of Benefits* (page 96) only apply when you get the equipment or supplies from a third-party supplier. If you receive the equipment or supplies as part of an office or outpatient visit, or during a Hospital stay, benefits will be based on the setting in which the covered equipment or supplies are received.

This benefit is subject to Precertification.

Family planning

Contraceptive benefits

Benefits include contraceptive devices such as diaphragms, intrauterine devices (IUDs), implants, and injectable contraceptive drugs and patches. Oral contraceptive drugs are covered under the pharmacy plan.

Certain contraceptives are covered under *Preventive care*. See page 48 for details.

Sterilization services

Benefits include sterilization services and services to reverse a nonelective sterilization that resulted from an illness or injury. Reversals of elective sterilizations are not covered.

Sterilizations for women are covered under *Preventive Care*. See page 48 for details.

Abortion services

Benefits include services for a therapeutic abortion, which is an abortion recommended by a Provider, performed to save the life or health of the mother, or as a result of incest or rape. The Plan will also cover elective abortions.

Hearing services (testing, treatment, and supplies)

Limited to a maximum benefit of one set of hearing aids per 36-month period. Precertification may be required for certain bone-anchored devices.

Home health services

Benefits are available for Medically Necessary Covered Services performed in your home by a HOME HEALTH CARE AGENCY or other home health care Provider. To be eligible for benefits, you must essentially be confined to the home, as an alternative to a Hospital stay, and be physically unable to get needed medical services on an outpatient basis. Services must be prescribed by a Physician, Physician assistant, or an advanced practice registered nurse (APRN), and the services must be so inherently complex that they can be safely and effectively performed only by qualified, technical, or professional health staff.

Covered Services by a licensed health care professional include, but are not limited to:

- Intermittent skilled nursing services by an R.N. or L.P.N.
- Medical/social services up to $420 per Benefit Period
- Diagnostic services
- Nutritional guidance
- Training of the patient and/or family/caregiver

- Home health aide services. You must be receiving skilled nursing or therapy. Services must be given by appropriately trained staff working for the home health care Provider. Other organizations may give services only when approved by Anthem, and their duties must be assigned and supervised by a professional nurse on the staff of the home health care Provider or other Provider as approved by Anthem.
- Therapy services (except for manipulation therapy, which will not be covered when given in the home). The home health care services limit includes therapy services given as part of the home health care services benefit. Dialysis and infusion therapy visits are not included in the home health care services visit maximum.
- Medical supplies
- Durable medical equipment
- Private duty nursing services

Benefits are also available for intensive in-home behavioral health services. These do not require confinement to the home. These services are described under *Mental Health and Substance Use Disorder Benefits* on page 63.

Covered Services do **not** include:

- CUSTODIAL CARE, convalescent care, domiciliary care, and rest home care.
- Services given by registered nurses and other health workers who are not Employees of or working under an approved arrangement with a home health care Provider.
- Food, housing, homemaker services, and home-delivered meals.

Lab, x-ray, and other diagnostic tests

Diagnostic services

Tests or procedures to find or check a condition when specific symptoms exist. Tests must be ordered by a Provider and include diagnostic services ordered before a surgery or Hospital admission.

Covered Services include:

- Diagnostic laboratory and pathology services
  - Laboratory and pathology tests, such as blood tests.
  - Genetic tests, when the test meets Medical Necessity criteria.
- Non-advanced radiology, including:
  - X-rays/regular imaging services
  - Ultrasounds
  - Electrocardiograms (EKGs)
  - Electroencephalograms (EEGs)

  - Echocardiograms
  - Breast tomosynthesis
  - Hearing and vision tests for a medical condition or injury (not for screenings or preventive care)
  - Tests ordered before a surgery or admission.
- Advanced radiology, including:
  - CT scan
  - CTA scan
  - Magnetic resonance imaging (MRI)
  - Magnetic resonance angiography (MRA)
  - Magnetic resonance spectroscopy (MRS)
  - Nuclear cardiology
  - PET scans
  - PET/CT fusion scans
  - QCT bone densitometry
  - Diagnostic CT colonography
  - The list of advanced imaging services may change as medical technologies change.
- Other diagnostic services, including:
  - Blood lead screenings and clinically indicated risk assessments.
  - Sleep studies.
  - Neuropsychological testing — psychological, neuropsychological, and neurobehavioral testing are covered as prescribed by state law.

Manipulative treatment

Covered Services include therapy to treat problems of the bones, joints, and back.

Maternity care

Covered Services include services needed during a normal or complicated pregnancy and for services needed for a miscarriage, including:

- Professional and Facility services for childbirth in a Facility or the home, including the services of an appropriately licensed nurse-midwife;
- Routine nursery care for the newborn during the mother's normal Hospital stay, including circumcision of a covered male Dependent;

- Prenatal, postnatal, and postpartum services. Benefits for services for Members who have current symptoms or a diagnosed health problem may be billed in addition to the global fee (e.g., for additional ultrasounds during a high-risk pregnancy) under *Diagnostic and Treatment Services*, and may be subject to additional cost-shares, based on the setting in which Covered Services are received; and
- Fetal screenings, which are genetic or chromosomal tests of the fetus, that meet Medical Necessity guidelines.

If you are pregnant on your Effective Date and in the first trimester of the pregnancy, you must change to an in-network Provider to have services covered at the in-network level. If you are pregnant on your Effective Date and in your second or third trimester of pregnancy (13 weeks or later) as of the Effective Date, benefits for obstetrical care will be available at the in-network level even if an out-of-network Provider is used, if you fill out a continuation of care request form and send it to Member Services. Covered Services will include the obstetrical care given by that Provider through the end of the pregnancy and the immediate postpartum period.

Under federal law, the Plan may not limit benefits for any Hospital length of stay for childbirth for the mother or newborn to less than 48 hours after a vaginal birth, or less than 96 hours after a cesarean section (C-section). However, federal law as a rule does not stop the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours, or 96 hours, as applicable. Should a mother and newborn be discharged earlier than the 48 hours, or 96 hours, as applicable, coverage will include a follow-up visit within 48 hours of discharge and an additional follow-up visit within 7 days of discharge. In any case, as provided by federal law, the Plan may not require a Provider to get authorization from Anthem before prescribing a length of stay which is not more than 48 hours for a vaginal birth or 96 hours after a C-section.

If the newborn needs services other than routine nursery care or stays in the Hospital after the mother is discharged (sent home), benefits for the newborn will be treated as a separate admission (stay).

Medical supplies

Medical and surgical supplies

Coverage for medical and surgical supplies that serve only a medical purpose, are used once, and are purchased (not rented). Covered supplies include syringes, needles, surgical dressings, splints, and other similar items that serve only a medical purpose.

Benefits include wound-care supplies that are Medically Necessary and are administered under the direction of a Physician.

Covered Services do **not** include items often stocked in the home for general use (e.g., Band-Aids, thermometers, and petroleum jelly) and multipurpose items that could be used for nonmedical reasons (e.g., tape, surgical gloves, batteries, battery chargers, and cleansing agents).

Blood and blood products

Coverage for the administration of blood products unless they are received from a community source, such as blood donated through a blood bank.

Compression stockings

Coverage is limited to four pairs of compression stockings/socks per 12-month period.

Orthopedic and prosthetic devices

Orthotics

Benefits are available for certain types of orthotics (braces, boots, splints). Covered Services include the initial purchase, fitting, and repair of a custom-made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part.

Prosthetics

Benefits are available for prosthetics, which are artificial substitutes for body parts for functional or therapeutic purposes, when they are Medically Necessary for activities of daily living.

Benefits include the purchase, fitting, adjustments, repairs, and replacements. Covered Services may include, but are not limited to:

- One pair of glasses or contact lenses used after surgical removal of the lens(es) of the eyes.
- Breast prosthesis (whether internal or external) and surgical bras after a mastectomy, as required by the Women's Health and Cancer Rights Act.
- Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
- Restoration prosthesis (composite facial prosthesis).
- Wigs needed after cancer treatment. Coverage is available up to one wig for hair loss after cancer treatment per calendar year.
- Cochlear implants.
- Hearing aids to aid or compensate Members who are certified as deaf or hearing impaired by either a Physician or licensed audiologist. This includes bone-anchored hearing aids as well as

FDA-approved over-the-counter hearing aids. Limited to a maximum benefit of one set of hearing aids per 36-month period. Precertification may be required for certain bone-anchored devices and other prosthetics.

Foot care

Foot orthotics — Medically Necessary shoe inserts — prescribed by a Physician to treat or maintain the following conditions:

- Diabetes with neurological manifestations;
- Diabetes with peripheral circulatory disorders;
- Lesion of plantar nerve;
- Ulcer of lower limb except pressure ulcer;
- Tibialis tendonitis;
- Calcaneal spur;
- Other bursitis disorders; or
- Plantar fascial fibromatosis

Certain foot care services are **not** covered, including foot care only to improve comfort or appearance, routine care of corns, calluses, toenails (except surgical removal or care rendered as treatment of the diabetic foot, impaired circulatory conditions, or ingrown toenail), flat feet, fallen arches, weak feet, chronic foot strain, or asymptomatic complaints related to the feet.

Artificial limbs

Artificial limbs and accessories, including a Medically Necessary device that contains a microprocessor and repairs and replacements. Artificial limbs are devices to replace, in whole or in part, an arm or a leg when they are Medically Necessary for activities of daily living. Precertification may be required.

Covered Services do **not** include:

- Artificial limbs designed exclusively for athletic purposes.
- Repair or replacement due to misuse or loss.
- Back-up items or items that serve a duplicate purpose.

Physical therapy, occupational therapy, speech therapy, and cognitive rehabilitation therapy

Benefits include services in a Hospital, freestanding Facility, Skilled Nursing Facility, or outpatient day REHABILITATION program. To be a Covered Service, the therapy must improve your level of function within a reasonable period of time. Precertification required for in-network therapies in excess of 24 visits per plan year per therapy type.

Covered Services include:

- **Physical therapy.** The treatment by physical therapy means to ease pain, to restore health, and to avoid disability after an illness, injury, or loss of an arm or a leg. It includes hydrotherapy, heat, physical agents, biomechanical and neurophysiological principles and devices. It does not include massage therapy services.

- **Speech therapy and speech-language pathology (SLP) services.** Services to identify, assess, and treat speech, language, and swallowing disorders in children and adults. Therapy will develop or treat communication or swallowing skills to correct a speech impairment.
- **Occupational therapy.** Treatment to restore a person's ability to do activities of daily living, such as walking, eating, drinking, dressing, using the toilet, moving from a wheelchair to a bed, and bathing. It also includes therapy for tasks needed for the person's job. Occupational therapy does not include recreational or vocational therapies, such as hobbies, or arts and crafts.
- **Cognitive Rehabilitation therapy.** Only when Medically Necessary following a post-traumatic brain injury or cerebral vascular accident.

The limits for therapy services (physical, occupational, and speech therapy) will not apply if care is received as part of the hospice benefit or the mental health and substance use disorder benefit. When therapy services (physical, occupational, or speech therapy) are provided in the home, the home health care services limit will apply instead of the applicable therapy services visit limit.

Preventive care

Preventive care includes screenings and other services for adults and children. All recommended preventive services will be covered as required by the Affordable Care Act (ACA) and applicable state law. This means many preventive care services are covered with no deductible, copayments, or coinsurance when you use an in-network Provider.

Certain benefits for Members who have current symptoms or a diagnosed health problem may be covered under *Diagnostic and Treatment Services* if the coverage does not fall within the state or ACA recommended preventive services.

Covered Services fall under the following broad groups:

- Services with an "A" or "B" rating from the United States Preventive Services Task Force, including screenings for:
  - Breast cancer,
  - Cervical cancer,
  - Colorectal cancer,
  - High blood pressure,
  - Type 2 diabetes mellitus,
  - Cholesterol,
  - Child and adult obesity.
- Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- Preventive care and screenings for infants, children, and adolescents as listed in the guidelines supported by the Health Resources and Services Administration;

- Preventive care and screenings for women as listed in the guidelines supported by the Health Resources and Services Administration, including:
  - Women's contraceptives, sterilization treatments, and counseling. This includes contraceptive devices such as diaphragms, intrauterine devices (IUDs), and implants.
  - Breastfeeding support, supplies, and counseling. Benefits for breast pumps are limited to one pump per pregnancy.
  - Screenings and/or counseling, including gestational diabetes, human papillomavirus (HPV), sexually transmitted infections (STIs), human immunodeficiency virus (HIV), and interpersonal and domestic violence.
- Preventive counseling services for smoking cessation and tobacco cessation for Members age 18 and older as recommended by the United States Preventive Services Task Force;
- Additional screenings and services to monitor for breast cancer and other gynecological cancers may be considered preventive care services under state law. These may be available to you if you are believed to be at an increased risk due to:
  - A family history.
  - A prior personal history of breast, ovarian, or certain related cancers.
  - If the treatment of a childhood cancer has increased your risk of breast cancer.
  - A positive genetic test for gene variants that increase your risk of certain cancers.
  - Other indications as determined by the insured's Physician, advanced practice registered nurse, Physician assistant, certified nurse-midwife, or other medical Provider.

  Requirements for each screening or service may vary and may be subject to Medical Necessity review. Diagnostic and screening services may include:
  - Mammograms, including mammograms provided by breast tomosynthesis (3D).
  - 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.
  - Magnetic resonance imaging of an entire breast or breasts in accordance with guidelines established by the American Cancer Society.
  - Mastectomies intended to prevent disease (prophylactic mastectomy).
  - Genetic testing.
  - Routine screening procedures and surveillance tests for ovarian cancer.

You may call Member Services for more details about these services or view the federal government's websites: **healthcare.gov/what-are-my-preventive-care-benefits**, **ahrq.gov**, and **cdc.gov/acip**.

Reproductive services

Fertility services are covered for Plan Members who are:

- Experiencing infertility; or
- Unable to achieve a pregnancy as an individual or with a partner because the individual or couple does not have the necessary gametes to achieve a pregnancy; or
- When at least one partner has been confirmed to have an autosomal dominant gene for a genetic disorder or both partners have been confirmed to have the same autosomal recessive gene for a genetic disorder.

Covered Services include:

- Procedures, products, medications, and services intended to provide information and counseling about an individual's fertility, including laboratory assessments and imaging studies;
- Procedures, products, testing, medications, and services that are intended to achieve pregnancy, that are provided in a manner consistent with established medical practice and professional guidelines published by the American Society for Reproductive Medicine or the Society of Reproductive Endocrinology and Infertility, and that result in a live birth. Covered Services include inseminations, ova, and embryo transfers to a Plan Member's covered designee in the case of surrogacy.
- Extraction of ova or sperm for future use in cases where patients will undergo treatment that has the potential to render them infertile.

Precertification is required.

Except as outlined above, charges associated with the cryopreservation of eggs, embryos, or sperm, including freezing, and thawing are not covered by the Plan.

Specialized formula and modified foods

Specialized formula is a nutritional formula for children that is exempt from the general requirements for nutritional labeling under the statutory and regulatory guidelines of the U.S. Food and Drug Administration.

Coverage for specialized formula is intended for use of dietary management of specific diseases when under the medical direction and supervision of a Physician and when such specialized formulas are Medically Necessary for the treatment of that disease or condition.

Benefits also include amino acid modified preparations and low-protein modified food products for the treatment of inherited metabolic diseases and cystic fibrosis.

Treatment therapies

For benefit limits, please see the *Schedule of Benefits* starting on page 96.

Early intervention services

For eligible children from birth to age three or as required by law, Medically Necessary services are available for early intervention. Covered Services for a Member and their family Members are provided as part of an individualized family service plan.

Autism services

Coverage shall be provided for the Medically Necessary diagnosis and treatment of autism spectrum disorders (ASDs).

Covered Services include:

- Behavior therapy rendered by an autism behavioral therapy Provider and ordered by a licensed Physician, psychologist, or clinical social worker;
- Direct psychiatric or consultative services provided by a licensed psychiatrist or psychologist; and
- Occupational, physical, and speech therapy provided by a licensed therapist.

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

Autism spectrum disorders are those disorders that meet the criteria set forth in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders (DSM)."

An **autism behavioral therapy Provider** is a person certified to provide autism behavioral therapy or a person who provides autism behavioral therapy under the supervision of a behavior analyst certified by the Behavior Analyst Certification Board; a licensed Physician; or a licensed psychologist. Supervision means at least 1 hour of face-to-face supervision of the autism behavioral therapy Provider for each 10 hours of autism behavioral therapy provided by the supervised certified assistant behavior analyst or behavior therapist.

Other therapy services

Benefits are also available for:

- **Cardiac Rehabilitation.** Medical evaluation, training, supervised exercise, and psychosocial support to care for you after a cardiac event (heart problem). Benefits do not include home programs, ongoing conditioning, or maintenance care.
- **Chemotherapy.** Treatment of an illness by chemical or biological antineoplastic agents. For details, see *Prescription Drugs Covered Under the Medical Plan* on page 64.
- **Dialysis.** Services for acute renal failure and chronic (end-stage) renal disease, including hemodialysis, home intermittent peritoneal dialysis (IPD), home continuous cycling peritoneal dialysis (CCPD), and home continuous ambulatory peritoneal dialysis (CAPD). Covered Services include dialysis treatments in an outpatient dialysis Facility. Covered Services also include home dialysis and training for you and the person who will help you with home self-dialysis.

- **Infusion therapy.** Nursing, durable medical equipment, and drug services that are delivered and administered to you through an intravenous line (IV) in your home. Also includes total parenteral nutrition (TPN), enteral nutrition therapy, antibiotic therapy, pain care, and chemotherapy. May include injections (intramuscular, subcutaneous, continuous subcutaneous). For details, see *Prescription Drugs Covered Under the Medical Plan* on page 64.
- **Pulmonary Rehabilitation.** Includes outpatient short-term respiratory care to restore your health after an illness or injury.
- **Radiation therapy.** Treatment of an illness by x-ray, radium, or radioactive isotopes. Covered Services include treatment (teletherapy, brachytherapy, and intraoperative radiation therapy, including photons or high-energy particle sources), materials and supplies needed, and treatment planning.
- **Respiratory therapy.** Includes the use of dry or moist gases in the lungs, nonpressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication, continuous positive pressure ventilation (CPAP); continuous negative pressure ventilation (CNP); chest percussion; therapeutic use of medical gases or drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers; bronchopulmonary drainage and breathing exercises.
- **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, for the treatment of Lyme disease. Further treatment is covered if recommended by a board-certified rheumatologist, infectious disease Specialist, or neurologist.
- **Post-cochlear implant aural therapy.** Services to help a person understand the new sounds they hear after getting a cochlear implant.

Vision services (testing, treatment, and supplies)

Coverage is available for one routine vision exam every calendar year.

Benefits include medical and surgical treatment of injuries and illnesses of the eye, including surgery for cataracts. Certain vision screenings required by federal law are covered under *Preventive care*.

Certain vision services are **not** covered, including:

- **Eyeglasses and contact lenses.** Eyeglasses and contact lenses to correct your eyesight unless listed as covered in this document. This exclusion does not apply to lenses needed after a covered eye surgery.
- **Eye surgery.** Eye surgery to fix errors of refraction, such as nearsightedness. This includes, but is not limited to, LASIK, radial keratotomy or keratomileusis, and excimer laser refractive keratectomy.

Surgical and anesthesia services provided by Physicians and other health care professionals

Oral and maxillofacial surgery

Benefits are limited to certain oral surgeries, including:

- Treatment of medically diagnosed cleft lip, cleft palate, ectodermal dysplasia, or other complex craniofacial disorder.
- Orthognathic surgery for a physical abnormality that prevents normal function of the upper and/or lower jaw and is Medically Necessary to attain functional capacity of the affected part.
- Oral/surgical correction of ACCIDENTAL INJURIES as indicated under *Dental benefits* on page 65.
- Treatment of non-dental lesions, such as removal of tumors and biopsies.
- Incision and drainage of infection of soft tissue not including odontogenic cysts or abscesses.
- Treatment of fractures of the jaw and/or facial bones, and dislocation of the jaw.
- Surgical treatment of temporomandibular joint (TMJ) syndrome and craniomandibular disorder.

Organ and tissue transplants

Coverage for Medically Necessary human organ and tissue transplants as well as certain cellular and gene therapies. Cost-shares will be based on the setting in which Covered Services are received. **For you to be eligible for coverage, Anthem must approve the benefits in advance through Precertification.**

As soon as you think you may need a transplant, please call Member Services to talk about your benefit options. You must do this before you have an evaluation and/or workup for a transplant.

Covered procedures include Medically Necessary:

- Human solid organ, tissue, and bone marrow/stem cell/cord blood transplants and infusions,
- Cellular or other gene therapies,
- Acquisition procedures, mobilization, collection, and storage,
- Myeloablative or reduced-intensity preparative chemotherapy, radiation therapy, or a combination of these therapies.

Certain transplants and services (e.g., cornea) are covered, like any other surgery, under the regular Inpatient and outpatient benefits described elsewhere in this document. This includes any Covered Services related to a covered procedure that you get before or after the covered procedure Benefit Period.

Centers of Excellence (COE) Provider

For procedures to be covered, the Hospital must be designated as an Anthem Blue Distinction Center for Transplant or Anthem Center of Medical Excellence. It should be noted that not every designated Hospital performs each of the Covered Services.

If a designated Center of Medical Excellence or Blue Distinction Center is unable to perform a Medically Necessary transplant, the Plan will cover Medically Necessary services provided at an in-network Facility with Precertification from Anthem and in accordance with the applicable schedule of benefits.

The following services are covered:

- Room and board;
- 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:

- Surgery, including diagnostic services related to a surgery (separate payment will not be made for preoperative and postoperative 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 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, that is 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, 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 health care Covered Services to a 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 U.S. 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*;
- 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 postoperative 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 Plan.
- When the recipient is uninsured and the donor is a covered person, this Plan will only provide benefits related to the procurement of the organ, up to the 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 canceled 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.

Reconstructive surgery

Note: This section does not apply to orthognathic surgery. See *Dental benefits* on page 65.

Benefits are available for Medically Necessary reconstructive surgeries, procedures, and services only if at least one of the following criteria is met. Reconstructive surgeries, procedures and services must be Medically Necessary:

- Due to ACCIDENTAL INJURY; or
- For reconstruction or restoration of a functional part of the body following a covered surgical procedure for disease or injury; or
- To restore or improve a bodily function; or
- To correct a birth defect for covered Dependent children who have functional physical deficits due to a birth defect. Corrective surgery for children who do not have functional physical deficits due to a birth defect is not covered under any portion of this document; or
- Due to a mastectomy in accordance with the Women's Health and Cancer Rights Act of 1998 (see page 113).

Reconstructive surgeries, procedures, and services that do not meet at least one of the above criteria are not covered under any portion of this Plan.

In addition to the above criteria, benefits are available for certain reconstructive surgeries, procedures, and services subject to medical policy coverage criteria. Some examples of reconstructive surgeries, procedures, and services eligible for consideration based on medical policy coverage criteria are:

- Mastectomy for gynecomastia;
- Mandibular/maxillary orthognathic surgery;
- Adjustable band for treatment of nonsynostotic plagiocephaly and brachycephaly in infants; and

- Port-wine stain surgery.

Mastectomy notice

A Member who is getting benefits for a mastectomy or for follow-up care for a mastectomy and who chooses breast reconstruction will also get coverage for:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to give a symmetrical appearance; and
- Prostheses and treatment of physical problems at all stages of mastectomy, including lymphedema.

Members will have to pay the same deductible, coinsurance, and/or copayments that normally apply to surgeries in this Plan.

Breast implant removal notice

For breast implants that were surgically implanted as a result of a mastectomy, benefits for the Medically Necessary removal of such implants due to a medical complication of a mastectomy will be covered the same as any other illness or injury. As to all other breast implants, benefits for the Medically Necessary removal of any breast implant without regard to the reason for implantation will be provided.

Gender-affirming services

Benefits are available for gender-affirming services, including gender-affirming surgery and hormone treatments, for Members diagnosed with gender identity disorder (also known as gender dysphoria). For you to be eligible for benefits, services must be Medically Necessary, and all Inpatient Facility admissions must be approved in advance through Precertification.

Services to reverse gender-affirming services are **not** covered under the Plan.

Surgical procedures

Surgical services are available on an Inpatient or outpatient basis, including office surgeries. Covered Services include:

- Accepted operative and cutting procedures.
- Other invasive procedures, such as angiogram, arteriogram, amniocentesis, and tap or puncture of brain or spine.
- Endoscopic exams, such as arthroscopy, bronchoscopy, colonoscopy, and laparoscopy.
- Treatment of fractures and dislocations.
- Anesthesia and surgical support when Medically Necessary.
- Medically Necessary preoperative and postoperative care.

Services provided by a Hospital or other Facility, and ambulance services

Ambulance

Medically Necessary ambulance services are a Covered Service when:

- You are transported by a state-licensed vehicle that is designed, equipped, and used only to transport the sick and injured and is staffed by Emergency medical technicians (EMTs), paramedics, or other certified medical professionals. This includes ground, water, fixed wing, and rotary wing air transportation. And,
- One or more of the following criteria are met:
  - For ground ambulance, you are taken:
    - From your home or from the scene of an accident or medical Emergency to a Hospital;
    - Between Hospitals, including when required to move from an out-of-network Hospital to an in-network Hospital;
    - Between a Hospital and a Skilled Nursing Facility or other approved Facility.
  - For air or water ambulance, you are taken:
    - From the scene of an accident or medical Emergency to a Hospital;
    - Between Hospitals, including when required to move from an out-of-network Hospital to an in-network Hospital;
    - Between a Hospital and an approved Facility.

Emergency ground ambulance services do not require Precertification and are allowed regardless of whether the Provider is an in-network or out-of-network Provider. For ground or water ambulance services, out-of-network Providers may also bill you for any charges that exceed the Plan's Maximum Allowed Amount. Ambulance services are subject to Medical Necessity reviews.

You must be taken to the nearest Facility that can give care for your condition. In certain cases Anthem may approve benefits for transportation to a Facility that is not the nearest Facility.

Covered Services include Medically Necessary transportation and treatment of a sickness or injury by medical professionals from an ambulance service. The ambulance service medical professionals will transport you to the Emergency Facility best suited to provide you care at the time of services, regardless if they are in- or out-of-network. Benefit also includes onsite treatment of the sickness or injury, even if you are not taken to a Facility.

Ambulance services are **not** covered when another type of transportation can be used without endangering your health. Ambulance services for your preference or convenience, or for the preference or convenience of your family or Physician are not a Covered Service.

Other non-covered ambulance services include, but are not limited to, trips:

- To a Physician's office or clinic;

- To a morgue or funeral home;
- To elective Hospital admissions;
- In wheelchair vans, ambulettes, or medical cabs.

Air ambulance benefits

Benefits are only available for an air ambulance when it is not appropriate to use a ground or water ambulance. For example, if using a ground ambulance would endanger your health, and your medical condition requires a more rapid transport to a Facility than the ground ambulance can provide, the Plan will cover the air ambulance. An air ambulance will also be covered if you are in an area that a ground or water ambulance cannot reach.

Nonemergency ambulance services are subject to Medical Necessity review. When using an air ambulance for nonemergency transportation, Anthem reserves the right to select the air ambulance Provider. If you do not use the air ambulance Provider Anthem selects, no benefits will be available.

For air ambulance services, out-of-network Providers cannot bill you for more than your applicable in-network deductible, coinsurance, and/or copayment.

Precertification required for non-emergent air ambulance. Air ambulance will not be covered if you are taken to a Hospital that is not an acute care Hospital (such as a Skilled Nursing Facility or a Rehabilitation Facility), or if you are taken to a Physician's office or your home.

Hospital to Hospital transport

If you are moving from one Hospital to another, air ambulance will only be covered if using a ground ambulance would endanger your health and if the Hospital that first treats you cannot give you the medical services you need. Certain specialized services are not available at all Hospitals. For example, burn care, cardiac care, trauma care, and critical care are only available at certain Hospitals. To be covered, you must be taken to the closest Hospital that can treat you. Coverage is not available for air ambulance transfers simply because you, your family, or your Provider prefers a specific Hospital or Physician.

Extended care benefits/Skilled Nursing Facility care benefits

When you require Inpatient skilled nursing and related services for convalescent and Rehabilitative care, Covered Services are available if the Facility is licensed or certified under state law as a Skilled Nursing Facility.

Precertification is required. Custodial Care is **not** a Covered Service.

Hospice care

You are eligible for hospice care if your Physician or advanced practice registered nurse (APRN) and the hospice medical director certify that you are terminally ill and likely have less than 12 months to live. You may access hospice care while participating in a CLINICAL TRIAL or

continuing disease modifying therapy, as ordered by your treating Provider. Disease modifying therapy treats the underlying terminal illness.

The services and supplies listed below are Covered Services when given by a hospice for the palliative care of pain and other symptoms that are part of a terminal disease. Palliative care means care that controls pain and relieves symptoms but is not meant to cure a terminal illness. Covered Services include:

- Care from an interdisciplinary team with the development and maintenance of an appropriate plan of care.
- Short-term Inpatient Hospital care when needed in periods of crisis or as respite care.
- Skilled nursing services, home health aide services, and homemaker services given by or under the supervision of a registered nurse.
- Social services and counseling services from a licensed social worker.
- Nutritional support such as intravenous feeding and feeding tubes.
- Physical therapy, occupational therapy, speech therapy, and respiratory therapy given by a licensed therapist.
- Pharmaceuticals, medical equipment, and supplies needed for the palliative care of your condition, including oxygen and related respiratory therapy supplies.
- Bereavement (grief) services, including a review of the needs of the bereaved family and the development of a care plan to meet those needs, both before and after the Member's death. Bereavement services are available to the patient and those individuals who are closely linked to the patient, including the immediate family, the primary or designated caregiver, and individuals with significant personal ties, for one year after the Member's death.

Your Physician must agree to hospice care and must be consulted in the development of the hospice care plan. The hospice must keep a written care plan on file and give it to Anthem upon request.

Benefits for services beyond those listed above that are given for disease modification or palliation, such as but not limited to chemotherapy and radiation therapy, are available to a Member in hospice. These services are covered under other parts of this Plan.

Inpatient Hospital

Covered Services include acute care in a Hospital setting. Precertification is required.

Benefits for room, board, and nursing services include:

- A room with two or more beds.
- A private room. The most the Plan will cover for private rooms is the Hospital's average semi-private room rate unless it is Medically Necessary that you use a private room for isolation and no isolation Facilities are available.
- A room in a special care unit approved by Anthem. The unit must have Facilities, equipment, and supportive services for intensive care or critically ill patients.

- Routine nursery care for newborns during the mother's normal Hospital stay.
- Meals, special diets.
- General nursing services.

Benefits for ancillary services include:

- Operating, childbirth, and treatment rooms and equipment.
- Prescribed drugs.
- Anesthesia, anesthesia supplies, and services given by the Hospital or other Provider.
- Medical and surgical dressings and supplies, casts, and splints.
- Diagnostic services.
- Therapy services.
- Treatment for ingestion and accidental consumption of a controlled drug or other substance.

When available in your area, certain Providers have programs available that may allow you to receive Inpatient services in your home instead of staying in a Hospital. Inpatient services in the home are for acute services that require higher levels of care and monitoring and regular contact with care Providers from the Hospital staff. To be eligible, your condition and the Covered Services to be delivered must be appropriate for the home setting. Your home must also meet certain accessibility requirements. These programs are voluntary and are separate from the benefits under *Home health services*. Your Provider will contact you if you are eligible and provide you with details on how to enroll. If you choose to participate, the cost-shares listed in the *Schedule of Benefits* will apply.

Outpatient Hospital or ambulatory surgical center

Covered Services in:

- An outpatient Hospital,
- A freestanding ambulatory surgery center (surgical center),[5]
- A mental health/substance use disorder Facility, or
- Other Facilities approved by Quantum or Anthem.

Benefits include Facility and related (ancillary) charges, when proper, such as:

- Surgical rooms and equipment,

[5] A freestanding facility, such as an ambulatory surgical center, freestanding surgicenter, freestanding dialysis center, or freestanding ambulatory medical facility, that:
- Provides services in an outpatient setting;
- Contains permanent amenities and equipment primarily for the purpose of performing medical, surgical, and/or renal dialysis procedures;
- Provides treatment performed or supervised by doctors and/or nurses, and may include other professional services performed at the facility; and
- Is not, other than incidentally, an office or clinic for the private practice of a doctor or other professional.

Note: Anthem may, at its discretion, recognize any other similar facilities, such as birthing centers, as freestanding ambulatory facilities.

- Prescription drugs, including SPECIALTY DRUGS,
- Anesthesia and anesthesia supplies and services given by the Hospital or other Facility,
- Medical and surgical dressings and supplies, casts, and splints,
- Diagnostic services,
- Therapy services,
- Treatment for ingestion and/or accidental consumption of a controlled drug or other substance.

Emergency services/accidents

If you are experiencing an Emergency, please call 911 or visit the nearest Hospital for treatment.

Emergency services

Benefits are available in a Hospital Emergency room or freestanding Emergency Facility for services and supplies to treat the onset of symptoms for an Emergency. Services provided for conditions that do not meet the definition of Emergency may not be covered.

Medically Necessary services will be covered whether you get care from an in-network or out-of-network Provider. Emergency Care you get from an out-of-network Provider will be covered as an in-network service and will not require Precertification, only until your condition is stable.

This means you have been provided necessary Emergency Care such that your condition will not materially worsen, and you are able to travel to an in-network Facility. While under Emergency Care, the out-of-network Provider can only charge you any applicable cost-shares (deductible, coinsurance, and/or copayment) and cannot bill you for the difference between the Maximum Allowed Amount and their billed charges until your condition is stable, as required under surprise billing claims.

Treatment you get after your condition has stabilized is not Emergency Care. If you continue to receive services from the out-of-network Provider after you are stabilized, you may have to pay the difference between the out-of-network Provider's charge and the Maximum Allowed Amount, as well as any applicable cost-shares.

If you are admitted to the Hospital from the Emergency room, be sure that you or your Physician calls Provider Services (Anthem/AmeriBen) as soon as you are stabilized. Provider Services will review your care to decide if a Hospital stay is needed and how many days you should stay.

Urgent care services

Often an urgent rather than an Emergency health problem exists. An urgent health problem is an unexpected illness or injury that calls for care that cannot wait until a regularly scheduled office visit. When that happens, you can visit your local walk-in center or Urgent Care Facility

(Urgent Care Center). Urgent health problems are not life threatening and do not call for the use of an Emergency room. Urgent health problems include earache, sore throat, and fever.

Benefits for urgent care include:

- X-ray services;
- Care for broken bones;
- Tests such as flu, urinalysis, pregnancy test, rapid strep;
- Lab services;
- Stitches for simple cuts; and
- Draining an abscess.

Mental health and substance use disorder benefits

Inpatient Hospital or other covered Facility

Inpatient benefits include psychotherapy, psychological testing, electroconvulsive therapy, detoxification, and stabilization services. Precertification is required.

Outpatient Hospital or other covered Facility

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 medical/surgical coverage. 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 illness includes services rendered at Facilities with appropriately licensed or credentialed Providers.

Professional services

Coverage is available for up to two mental health wellness examinations per Benefit Period when performed by a licensed mental health professional or Primary Care Physician. No cost-share will apply to the two visits, and Precertification is not required.

Covered Services include office visits, therapy, treatment, evidence-based maternal, infant and early childhood home visitation services, detoxification and stabilization services, chemical maintenance treatment, Partial Hospitalization/day treatment programs, Intensive Outpatient Programs, intensive in-home Behavioral Health Services, home-based or evidence-based therapeutic interventions for children and adolescents, extended day treatments, and observation beds in an acute Hospital setting.

The Facility and/or Provider must be licensed or credentialed as required by law and be approved by Anthem.

RESIDENTIAL TREATMENT CENTER

Residential treatment in a licensed Residential Treatment Center that offers individualized and intensive treatment, such as detoxification and stabilization services, and includes:

- Regular observation and assessment by a Physician or appropriately licensed clinical Provider,
- Rehabilitation and therapy.

Benefits for confinement in a Residential Treatment Center must meet Medical Necessity guidelines.

Not covered (Inpatient or outpatient)

Behavioral health care does not include conditions that are not defined as disorders in the most recent edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders.

Prescription drugs covered under the medical Plan

This Plan covers Prescription Drugs, including Specialty Drugs that must be administered to you as part of a Physician's visit, home care visit, or at an outpatient Facility when they are Covered Services. This may include drugs for infusion therapy, chemotherapy, blood products, certain injectables, and any drug that must be administered by a Provider. This section applies when a Provider orders the drug and a medical Provider administers it to you in a medical setting.

Benefits for drugs that you inject or get through your pharmacy benefits (i.e., self-administered drugs) are not covered under this section.

To be a Covered Service, Prescription Drugs must be approved by the U.S. Food and Drug Administration (FDA) and, under federal law, require a prescription. Prescription Drugs must be prescribed by a licensed Provider, and controlled substances must be prescribed by a licensed Provider with an active DEA license.

Compound ingredients within a compound drug are a Covered Service when a commercially available dosage form of a Medically Necessary medication is not available and the ingredients of the compound drug are FDA approved, require a prescription to dispense, and are not essentially the same as an FDA-approved product from a drug manufacturer. Non-FDA-approved, multisource ingredients that are vehicles essential for compound administration may be covered.

Precertification

Precertification may be required for certain Prescription Drugs to help make sure proper use and guidelines for Prescription Drug coverage are followed. Anthem will give the results of their decision to both you and your Provider.

For a list of Prescription Drugs that need Precertification, please call the phone number on the back of your ID Card. The list will be reviewed and updated from time to time. Including a Prescription Drug or related item on the list does not guarantee coverage under this Plan. Your

Provider may check with Anthem to verify Prescription Drug coverage and to find out which drugs are covered under this section.

Designated pharmacy Provider

Anthem, on behalf of the state, may establish one or more designated pharmacy Provider programs that provide specific pharmacy services to Members. An in-network Provider is not necessarily a designated pharmacy Provider. To be a designated pharmacy Provider, the in-network Provider must have signed a designated pharmacy Provider agreement with Anthem. Find a list of designated pharmacy Providers at **carecompass.ct.gov/state/pharmacy** or you or your Provider can contact Member Services.

For Prescription Drugs that are shipped to you or your Provider and administered in your Provider's office, you and your Provider are required to order from a designated pharmacy Provider. A patient care coordinator will work with you and your Provider to obtain Precertification and to assist shipment to your Provider's office.

The Plan may also require you to use a designated pharmacy Provider to obtain Prescription Drugs for treatment of certain clinical conditions, such as hemophilia. The state reserves its right to modify the list of Prescription Drugs as well as the setting and/or level of care in which the care is provided to you. Anthem may, from time to time, change with or without advance notice, the designated pharmacy Provider for a drug, if in its discretion, such change can help provide cost-effective, value-based, and/or quality services.

If you are required to use a designated pharmacy Provider and you choose not to obtain your Prescription Drug from a designated pharmacy Provider, coverage will be provided at the out-of-network level.

Therapeutic equivalents

Therapeutic equivalents is a program that tells you and your Physician about alternatives to certain prescribed drugs. Anthem may contact you and your Physician to make you aware of these choices. Only you and your Physician can determine if the therapeutic equivalent is right for you. For questions or issues about therapeutic drug equivalents, call Member Services.

Dental benefits

This Plan may coordinate with a dental benefit, if available, before services are covered under the medical benefit. Generally, the dental coverage will pay first, and this Plan will act as a supplemental dental policy. This arrangement applies if the service is considered covered under both the dental and medical plans.

Accidental Injury benefit

Benefits are also available for dental work needed to treat injuries to the jaw, sound natural teeth, mouth, or face as a result of an accident. An injury that results from chewing or biting is not considered an Accidental Injury under this Plan, unless the chewing or biting results from a medical or behavioral health condition.

Medically Necessary Hospital dental services

This Plan also includes Medically Necessary coverage for anesthesia, nursing, and other related Hospital services for Inpatient or outpatient Hospital dental services, or one-day dental services when the treating dentist, oral surgeon, and your Primary Care Physician determine the dental services to be Medically Necessary and:

- You have a dental condition complex enough that it requires Inpatient services, outpatient Hospital dental services, or one-day dental services; or
- You have a developmental disability that places you at serious risk.

Preparing the mouth for medical treatments

This Plan includes coverage for dental services to prepare the mouth for medical services and treatments, such as radiation therapy to treat cancer and prepare for transplants. Covered Services include:

- Evaluation
- Dental x-rays
- Extractions, including surgical extractions
- Anesthesia

Services that are not covered

The following services are not considered Covered Services under the Plan:

- **Dental devices for snoring.** Oral appliances for snoring.
- **Dental treatment.** General dental services are not covered.
  - Dental diagnosis, care, treatment, or diagnostic imaging studies, except as provided in the Plan. 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.
- **Oral surgery.** Except as listed in this document.

Clinical Trials

Benefits include coverage for services, such as routine patient care costs, given to you as a participant in an approved Clinical Trial if the services are Covered Services under this Plan. An "approved Clinical Trial" means a phase I, phase II, phase III, or phase IV Clinical Trial that studies the prevention, detection, or treatment of cancer or other life-threatening conditions. The term life-threatening condition means any disease or condition from which death is likely unless the disease or condition is treated.

Benefits are limited to the following trials:

- Federally funded trials approved or funded by one of the following:
  - The National Institutes of Health.
  - The Centers for Disease Control and Prevention.
  - The Agency for Health Care Research and Quality.
  - The Centers for Medicare & Medicaid Services.
  - Cooperative group or center of any of the entities described in (a) through (d) or the Department of Defense or the Department of Veterans Affairs.
  - A qualified nongovernmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
    - In any of the following below if the study or investigation has been reviewed and approved through a system of PEER review that the Secretary of Health and Human Services determines 1) to be comparable to the system of Peer review of studies and investigations used by the National Institutes of Health, and 2) ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
    - The Department of Veterans Affairs.
    - The Department of Defense.
    - The Department of Energy.
- Studies or investigations done as part of an Investigational new drug application reviewed by the U.S. Food and Drug Administration;
- Studies or investigations done for drug trials, which are exempt from the Investigational new drug application.

This Plan may require you to use an in-network Provider to maximize your benefits.

All requests for Clinical Trials services, including services that are not part of approved Clinical Trials will be reviewed according to clinical coverage guidelines, related policies, and procedures.

Routine patient care costs in connection with Clinical Trials shall include Medically Necessary health care services that are incurred as a result of treatment rendered to a Member for purposes of a Clinical Trial that would otherwise be covered if such services were not rendered in conjunction with a Clinical Trial. Such services shall include those rendered by a Physician,

diagnostic or laboratory tests, hospitalization, or other services provided to the Member during the course of treatment in a Clinical Trial, and coverage for routine patient care costs incurred for off-label drug prescriptions in accordance with Connecticut law. Hospitalization shall, for routine patient care costs, 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-share to the insured person than if such treatment was available in-network; and 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 U.S. Food and Drug Administration;
- The cost of a non-health care service that an insured person may be required to receive as a result of the treatment being provided for the purposes of the Clinical Trial;
- Facility, ancillary, professional services, and drug costs that are paid for by grants or funding for the 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 Clinical Trial;
- Costs that would not be covered under this Plan for non-Investigational treatments, including items excluded from coverage under the Plan; and
- Transportation, lodging, food, or any other expenses associated with travel to or from a Facility providing the Clinical Trial, for the insured person or any family Member or companion.

Non-Covered Services include any Investigational drugs or devices, non-health services required for you to receive the treatment, the costs of managing the research, or costs that would not be a Covered Service under this Plan for non-Investigational treatments.

This Plan is not required to provide benefits for the following services. The Plan reserves the right to exclude any of the following services:

- The Investigational item, device, or service;
- Items and services that are given only to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient;
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
- Any item or service that is paid for, or should have been paid for, by the sponsor of the trial.

Exclusions: Services, Drugs, and Supplies We Do Not Cover

Excluded items will not be covered even if the service, supply, or equipment is Medically Necessary. This section is only meant to be an aid to point out certain items that may be misunderstood as Covered Services. This section is not meant to be a complete list of all the items that are excluded by this Plan.

- **Acts of war, disasters, or nuclear accidents.** In the event of a major disaster, epidemic, war, or other event beyond our control, the state will make a good faith effort to give you Covered Services. We will not be responsible for any delay or failure to give services due to lack of available Facilities or staff. Benefits will not be given for any illness or injury that is a result of war, service in the armed forces, a nuclear explosion, nuclear accident, release of nuclear energy, participation in a riot,[6] or civil disobedience.
- Administrative charges:
  - Charges to complete claim forms,
  - Charges to get medical records or reports,
  - Membership, administrative, or access fees charged by Physicians or other Providers. Examples include, but are not limited to, fees for educational brochures or calling you to give you test results.
- **Alternative/complementary medicine.** Services or supplies given by a Provider for alternative or complementary medicine except as otherwise listed in the Plan.
- **Autopsies.** Autopsies and postmortem testing.
- **Before Effective Date or after termination date.** Charges for care you get before your Effective Date or after your coverage ends, except as written in this Plan.
- **Certain Providers.** Services you get from Providers that are not licensed by law to provide Covered Services as defined in this document. Examples include, but are not limited to, masseurs or masseuses (massage therapists), physical therapist technicians, and athletic trainers.
- **Charges not supported by medical records.** Charges for services not described in your medical records.
- **Charges over the Maximum Allowed Amount.** Charges over the Maximum Allowed Amount for Covered Services except for surprise billing claims as outlined on page 22.
- **Cosmetic services.** Treatments, services, Prescription Drugs, equipment, or supplies given for cosmetic services. Cosmetic services are meant to preserve, change, or improve how you look or are given for social reasons. No benefits are available for surgery or treatments to change the texture or look of your skin or to change the size, shape, or look of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest, or breasts). This exclusion does not apply to reconstructive surgery for breast symmetry after a mastectomy or to procedures to treat

[6] Actively taking part in a violent disturbance involving two or more persons.

gender dysphoria. Complications of such cosmetic, reconstructive or plastic surgeries are covered only if they are medically necessary.

- **Court-ordered testing.** Court-ordered testing or care unless Medically Necessary. This exclusion does not apply to mental health/substance use disorder services.
- **Crime.** Treatment of an injury or illness that results from a crime you committed or tried to commit. This exclusion does not apply if, during the time of the crime or attempted crime, you had an elevated blood alcohol content or were under the influence of an intoxicating liquor or any drug or both; or your involvement in the crime was solely the result of a medical or behavioral health condition, or where you were the victim of a crime, including domestic violence.
- **Custodial Care.** Custodial Care, unless otherwise required by federal or state law, convalescent care, or rest cures. This exclusion does not apply to hospice services.
- **Educational services.** Services, supplies, or room and board for teaching, vocational, or self-training purposes. This includes, but is not limited to, boarding schools and/or the room and board and educational components of a residential program where the primary focus of the program is educational in nature rather than treatment based.
- **Experimental or Investigational services.** 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 state to be Experimental or Investigational.
- **Family Members.** Services prescribed, ordered, referred by, or given by a Member of your immediate family, including your spouse, child, brother, sister, parent, in-law, or self.
- **Fertility services after naturally occurring menopause.** Fertility services for a person with natural menopause is not covered under this Plan. Menopause is considered a natural process.
- **Fertility treatment.** Fertility procedures not specified in this document.
- **Fraud, waste, abuse, and other inappropriate billing services from an out-of-network Provider.** This includes an out-of-network Provider's failure to submit medical records required to determine the appropriateness of a claim.
- **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 or any state liability or occupational disease law; that were denied under a managed workers' compensation program as out-of-network retail pharmacy services; or which, by law, were rendered without expense to the covered person.
- **Health club memberships and fitness services.** 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 use courses.
- **Hospital services billed separately.** Services rendered by Hospital resident Physicians or interns that are billed separately. This includes separately billed charges for services rendered by Employees of Hospitals, labs or other institutions, and charges included in other duplicate billings.

- **Maintenance therapy.** Rehabilitative treatment given when no further gains are clear or likely to occur, unless required under state or federal law. Maintenance therapy includes care that helps you keep your current level of function and prevents loss of that function, but does not result in any change for the better. This exclusion does not apply to habilitative services, as described under *Covered Services*.
- **Medical chats.** Chats or text chats and texting are not a Covered Service unless appropriately provided via a secure and compliant application, according to applicable legal requirements.
- **Medical equipment, devices, and supplies:**
  - Replacement or repair of purchased or rental equipment because of misuse, abuse, or loss/theft.
  - Surgical supports, corsets, or articles of clothing unless needed to recover from surgery or injury.
  - Non-Medically Necessary enhancements to standard equipment and devices.
  - Supplies, equipment, and appliances that include comfort, luxury, or convenience items or features that exceed what is Medically Necessary in your situation. Reimbursement will be based on the Maximum Allowed Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary. Any expense that exceeds the Maximum Allowed Amount for the standard item which is a Covered Service is your responsibility.
  - Disposable supplies for use in the home, such as bandages, gauze, tape, antiseptics, dressings, Ace-type bandages, and any other supplies, dressings, appliances, or devices that are not specifically listed as covered under *Covered Services*.
- **Missed or canceled appointments.** Charges for missed or canceled appointments.
- **Non-approved Facility.** Services from a Provider that does not meet the definition of Facility.
- **Non-Medically Necessary services.** Services the Plan concludes are not Medically Necessary. This includes services that do not meet our medical policy, clinical coverage, or benefit policy guidelines.
- **Nutritional or dietary supplements.** Nutritional and/or dietary supplements, except as described in this document or that must be covered by law. This exclusion includes, but is not limited to, nutritional formulas and dietary supplements that you can buy over the counter and those you can get without a written prescription or from a licensed pharmacist.
- **Personal care, convenience, and mobile/wearable devices**, including, but not limited to:
  - Items for personal comfort, convenience, protection, and cleanliness, such as air conditioners, humidifiers, water purifiers, sports helmets, raised toilet seats, and shower chairs

  - First aid supplies and other items kept in the home for general use (bandages, cotton-tipped applicators, thermometers, petroleum jelly, tape, nonsterile gloves, heating pads)
  - Home workout or therapy equipment, including treadmills and home gyms
  - Pools, whirlpools, spas, or hydrotherapy equipment
  - Hypoallergenic pillows, mattresses, or waterbeds
  - Residential, auto, or place-of-business structural changes (ramps, lifts, elevator chairs, escalators, elevators, stair glides, Emergency alert equipment, handrails)
  - Consumer wearable/personal mobile devices (such as a smartphone, smartwatch, or other personal tracking devices), including any software or applications
- **Private duty nursing.** Private duty nursing services given in a Hospital or Skilled Nursing Facility. Private duty nursing services are an excluded benefit except as described in this document.
- **Prosthetics.** Prosthetics for sports or cosmetic purposes unless required by law.
- **Reduction in benefits and penalties.** Any reduction in benefits, including penalties, are not considered a cost-share and do not apply to your out-of-pocket limit. Any reduction in benefits or penalties imposed by another plan are not reimbursable as a Covered Service under this Plan.
- **Residential accommodations.** Residential accommodations to treat medical or behavioral health conditions, except when provided in a Hospital, hospice, Skilled Nursing Facility, or Residential Treatment Center.
- **Routine physicals and immunizations.** Physical exams and immunizations required for enrollment in any insurance program, as a condition of employment, for licensing, for sports programs, or for other purposes that are not required by law.
- **Sexual dysfunction.** Treatment for sexual dysfunction, including sex therapy, unless otherwise covered under this document or Medically Necessary for behavioral health treatment.
- **Standby charges.** Standby charges of a Physician or other Provider.
- **Sterilization.** Services to reverse an elective sterilization.
- **Surrogate mother services.** Surrogate pregnancy services or supplies for a person not covered under this Plan (including, but not limited to, the bearing of a child by another woman for an infertile couple).
- **Travel costs.** Mileage, lodging, meals, and other Member-related travel costs except as described in this Plan.
- **Vein treatment.** Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) for cosmetic purposes.
- **Waived cost-shares out-of-network.** For any service for which you are responsible under the terms of this Plan to pay a copayment, coinsurance, or deductible, and the copayment, coinsurance, or deductible is waived by an out-of-network Provider.

- **Weight loss programs.** Commercial weight loss programs (e.g., Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs, or as Medically Necessary for behavioral health treatment.
- **Wilderness or other outdoor camps and/or programs.** Unless otherwise covered under this document as a residential treatment center program.

Submitting a Claim for Covered Services

For benefits to be paid, Anthem must receive written notice of your claim after you receive Covered Services.

- **In-network Providers will submit claims for you.** In-network Providers are responsible for ensuring that claims have the information needed to determine benefits. If the claim does not include enough information, Anthem will ask the in-network Provider for more details, and they will be required to supply those details within certain time frames.
- **Out-of-network claims can be submitted by the Provider if the Provider is willing to file on your behalf.** However, if your out-of-network Provider is not submitting on your behalf, you will be required to submit the claim. You can download a claim form at carecompass.ct.gov/forms or submit an out-of-network claim electronically through your online portal.

Out-of-network claims must be submitted within 90 days. In certain cases, state or federal law may allow additional time to file a claim, if you could not reasonably file within the 90-day period. Out-of-network claims will not be accepted if filed 180 days or more after the service.

The claim must have the information Anthem needs to determine benefits. Bills and receipts should be itemized and show:

- Patient's name, date of birth, address, phone number, and relationship to enrollee
- Patient's Plan identification number
- Name and address of person or company providing the service or supply
- Dates that services or supplies were furnished
- Diagnosis
- Type of each service or supply
- Charge for each service or supply

If the claim does not include enough information, Anthem will ask you for more details and inform you of the time by which they need to receive that information. Once Anthem receives the additional information, they will process the claim according to the terms of the Plan.

Failure to submit the information in the time listed in Anthem's request could result in the denial of your claim, unless state or federal law requires an extension.

Please contact Member Services if you have any questions or concerns about how to submit out-of-network claims.

Claims review process

Anthem has processes to review claims before and after payment to detect fraud, waste, abuse, and other inappropriate activity. Members seeking services from out-of-network Providers could be balance billed by the out-of-network Provider for those services that are determined to be not payable as a result of these review processes.

Payment of benefits

The Plan has authorized Anthem to make payments for Covered Services directly to in-network Providers. For out-of-network Providers, Anthem may make payments for Covered Services directly to you instead of the out-of-network Provider. In these cases, it is the Member's responsibility to pay the out of network Provider directly.

Regardless of any assignment of benefits limitations or restrictions in this certificate, Anthem will not deny or refuse to honor an assignment of benefits for Covered Services made to a dentist or oral surgeon, provided the assignment complies with applicable Connecticut insurance law. Any payment Anthem makes (whether to a Provider for Covered Service or to you) will satisfy the Plan's obligation to pay for those Covered Services.

Federal/state taxes/surcharges/fees

Federal or state laws or regulations may require a surcharge, tax, or other fee. If applicable, Anthem will include any such surcharge, tax or other fee as part of the claim charge.

Explanation of Benefits (EOB)

After Anthem receives a claim for your medical care, you should receive an Explanation of Benefits (EOB). The EOB is a summary of services received and how your coverage was applied to those services. The EOB is not a bill. It is a statement from Anthem to help you understand what services were submitted and how your coverage applied to those services.

The EOB shows:

- Total amounts charged for services/supplies received.
- The amount of the charges covered by your medical Plan.
- The amount you are responsible for (if any).
- General information about your rights to an appeal and your rights regarding any action after the appeals process.

Post-service claims procedure

Upon receiving a claim, Anthem will process it within 20 days for electronic claims or 60 days for paper claims unless another time frame is required under state or federal law. If the claim does not include enough information, Anthem will send a request for additional information. Once Anthem receives the required information, the claim will be processed according to the terms of your Plan.

Your responsibility

Please reply promptly when Anthem requests additional information. Anthem may delay processing or deny benefits for your claim if you do not respond. Anthem's timeline for

responding to your claim is stayed while they await additional information needed to process your claim.

You will be expected to complete and submit to Anthem all authorizations, consents, releases, assignments, and other documents that may be needed in order to obtain or ensure reimbursement under Medicare, workers' compensation or any other governmental program, or to coordinate benefits with another plan.

Authorized representative

You may designate an authorized representative to act on your behalf for filing a claim or to appeal claims decisions to Anthem. For urgent care claims, a health care professional with knowledge of your medical condition will be permitted to act as your authorized representative without your express consent. For the purposes of this section, we are also referring to your authorized representative when we refer to you.

Coordinating Benefits with Medicare and Other Coverage

When you have other health coverage

The coordination of benefits (COB) provision applies to this Plan when you have health coverage under more than one plan. If you are covered by this Plan and another plan, the order of benefit determination rules in this section shall determine which plan is primary.

The benefits of this Plan:

- Shall not be reduced when under the order of benefit determination rules that this Plan is determined to be the primary plan; but
- May be reduced or the reasonable cash value of the Covered Services provided under this Plan may be recovered from the primary plan when under the order of benefit determination rules another plan is the primary plan.

Penalties imposed on you by the primary carrier are not subject to COB.

You must submit the explanation of benefits from the primary plan to Anthem within 180 days from the day of the primary plan's explanation of benefits in order to be eligible for payment under this coordination of benefits section.

Claim determination period

The claim determination period is your Benefit Period. However, it does not include any part of a Benefit Period during which a person has no coverage under this Plan, or any part of a Benefit Period before the date this COB provision or a similar provision takes effect.

Plan

For the purpose of this section, a plan means any of the following which provides benefits or services for, or because of, medical care or treatment:

- Group health insurance, group-type coverage, whether fully insured or self-insured, or any other contract or arrangement where a health benefit is provided. This includes prepayment, staff or group practice association health maintenance organization coverage.
- 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, or 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 in excess of those of any private insurance program or other nongovernmental program.
- Medical benefits coverage of no-fault and traditional automobile fault contracts, as provided in this section.

Each contract or other arrangement for coverage as described above is a separate plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate plan.

Primary plan

A primary plan is a plan whose benefits for a person's health care coverage must be determined without taking the existence of any other plan into consideration. A plan is a primary plan if either provision below is true:

- The plan either has no order of benefit determination rules or it has rules which differ from those stated in this section; or
- All plans which cover the person use the order of benefit determination rules as stated in this section 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 Plan is the primary plan, Covered Services are provided or covered without considering the other plan's benefits.

Secondary plan

A secondary plan is a plan which is not a primary plan. If you are covered by more than one secondary plan, the order of benefit determination rules of this section decide the order in which your 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 which, under the rules of this section, has its benefits determined before those of the secondary plan.

When this Plan is the secondary plan, benefits for Covered Services under this Plan may be reduced and Anthem may recover from the primary plan, the Provider, or you the reasonable cash value of the Covered Services provided by this Plan.

Order of benefit determination rules

General rule

When you receive Covered Services by or through this Plan or are otherwise entitled to claim benefits under this Plan and have followed all the guidelines and procedures, including Precertification requirements as specified in this document, and the Covered Services are a basis for a claim under another plan, this Plan is a secondary plan which has its benefits determined after those of the other plan, unless:

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

The Plan shall be secondary in coverage to any medical payments provision, no-fault automobile insurance policy, or personal injury protection policy regardless of any election

made by anyone to the contrary. The Plan shall also be secondary to any excess insurance policy, including, but not limited to, school and/or athletic policies. This provision applies notwithstanding any coordination of benefits term to the contrary.

Coordination rules

Anthem determines the order of benefits, on behalf of the state, using the following rules:

- **Other than a Dependent.** The benefits of the plan which covers the person as a subscriber (that is, other than as a Dependent) are primary to those of the plan which covers the person as a Dependent.
- **Dependent child/parents not separated or divorced.** When this Plan and another plan cover the same child as a Dependent of different persons (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.** When a claim is made for a Dependent child:
  - When the parents are separated or divorced and the parent with legal custody of the child has not remarried, the benefits of a plan which covers the child as a Dependent of the parent with legal custody of the child shall be determined before the benefits of a plan which 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 benefits of a plan which covers the child as a Dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a Dependent of the stepparent.

  The benefit of a plan which covers that child as a Dependent of the stepparent shall be determined before the benefits of a plan which covers that child as a Dependent of the parent without legal custody.

  If the specific terms of a court order state that one of the parents is financially responsible for the health care expenses of the child, then the plan which covers the child as a Dependent of the financially responsible parent shall be determined before the benefits of any other plan which covers the child as a Dependent child. 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 payer has that actual knowledge.
- **Active/inactive Employee.** A plan which covers you as an Employee who is neither laid off nor retired (or a plan that covers you as a Dependent) is primary to a plan which covers you as a laid-off or retired Employee (or a plan that covers you as a 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 which covered you longer is primary to the plan which covered you for a shorter time.

Effect of this Plan on the benefits

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

When this Plan is the secondary plan, Anthem will provide benefits under this Plan so that the sum of the reasonable cash value of any Covered Service provided by this Plan and the benefits payable under the other plans shall not total more than the Maximum Allowed Amount.

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.

Anthem will never pay, on behalf of the state, 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 Plan is determined to be secondary under this Plan's COB provisions, the amount of benefits payable under this Plan shall be determined on the basis of this Plan being secondary. If the noncomplying plan does not provide the information needed by this Plan to determine its benefits within a reasonable time after it is requested to do so, this Plan shall assume that the benefits of the noncomplying plan are identical to its own, and this Plan shall pay its benefits accordingly. However, this Plan must adjust any payments it makes based on such assumption whenever information becomes available as to the actual benefits of the noncomplying plan.

Right to receive and release needed information

Certain information is needed to apply these COB rules. Anthem has the right to decide which information it needs. By enrolling in this Plan, you consent to the release of information necessary to apply the COB rules. Anyone claiming benefits under this Plan must furnish information to Anthem which they determine is necessary for the coordination of benefits.

Facility of payment

A payment made or a service provided under another plan may include an amount which should have been paid or provided under this Plan. If it does, Anthem may pay, on behalf of the state, that amount to the organization which made that payment. Such amount shall then be considered as though it were a benefit paid under this Plan.

Right of recovery

If the amount of the payments made by Anthem, on behalf of the state, is more than it should have paid under this COB provision, or if it has provided services which should have been paid by the primary plan, Anthem may recover the excess or the reasonable cash value of the Covered Services, as applicable, from one or more of the persons it has paid or for whom it has paid insurance companies or other organizations.

The right of the Plan to recover from you shall be limited to the Maximum Allowed Amount that you have received from another plan. Acceptance of Covered Services will constitute consent by you to the state's right of recovery. You agree to take all further action to execute and deliver such documents that may be required and do whatever else is necessary to secure the Plan's rights to recover excess payments. Your failure to comply may result in a withdrawal of benefits already provided or a denial of benefits requested.

Anthem has the right to enforce the Plan's rights under this provision.

When you have Medicare

As a general rule, if you are enrolled in this Plan as the result of active employment with the State or a State Partnership group and eligible for Medicare, this Plan will coordinate with Medicare. This Plan will pay as the primary plan. There are separate and distinct rules for End Stage Renal Disease (ESRD).

Any benefits covered under both this Plan and Medicare will be covered according to Medicare Secondary Payer legislation, regulations, and Centers for Medicare & Medicaid Services guidelines, subject to federal court decisions. Federal law controls whenever there is a conflict among state law, document terms, and federal law.

Except when federal law requires this Plan to be the primary payer, the benefits under this Plan for Members age 65 and older, or Members otherwise eligible for Medicare, do not duplicate any benefit for which Members are entitled under Medicare. Where Medicare is the responsible payer, all sums payable by Medicare for services provided to you shall be reimbursed by or on your behalf to this Plan, to the extent this Plan has made payment for such services.

Payments will not be reduced based on if you are eligible for Medicare by reason of age, disability, or end-stage renal disease, unless you enroll in Medicare. If you enroll in Medicare, any such reduction shall be only to the extent such coverage is provided by Medicare.

State of Connecticut Retirees and/or their enrolled dependents eligible for Medicare are not eligible for continued participation in this Plan. They must be enrolled in the State's Medicare Advantage plan. Such members should coordinate enrollment with the Office of the State Comptroller Retiree Health Unit by calling 860-702-3533.

For more detailed information on "What is Medicare?" and "Should I enroll in Medicare?" please contact Medicare at 800-Medicare (800-633-4227), TTY: 711, or **medicare.gov**.

General Plan Provisions

Clerical error

A clerical error will never disturb or affect your coverage, as long as your coverage is valid under the rules of the Plan. This rule applies to any clerical error, regardless of whether it was the fault of the Plan, Anthem, or Quantum.

Confidentiality and release of information

By your application, you have agreed to allow your Providers to give Anthem the needed information about the care they provide to you, to the extent permitted by law.

Applicable state and federal law requires the state to undertake efforts to safeguard your medical information.

For informational purposes only, please be advised that a statement describing the policies and procedures regarding the protection, use, and disclosure of your medical information is available at **carecompass.ct.gov** and can be furnished to you upon request by contacting Member Services.

Obligations that arise under state and federal law, and policies and procedures relating to privacy that are referenced but not included in this document, are not part of the contract between the parties and do not give rise to contractual obligations.

Conformity with the law

Any term of the Plan which conflicts with State of Connecticut laws will hereby be automatically amended to conform with the minimum requirements of such laws.

Entire agreement

This document, the Administrative Services Agreement, the state's application, any riders, endorsements or attachments, and the individual applications of the subscriber and Dependents constitute the entire Agreement between the state and Anthem as of the Effective Date and supersede all other agreements. Any and all statements made to Anthem by the state and any and all statements made to the state by Anthem are representations and not warranties. No such statement, unless it is contained in a written application for coverage under the Plan, shall be used in defense to a claim under the Plan.

Government programs

The benefits under this Plan shall not duplicate any benefits that you are entitled to under any other governmental program. This does not apply if any particular laws require the state to be the primary payer. If Anthem has, on behalf of the state, duplicated such benefits, all money

paid by such programs to you for services you have received or are receiving shall be returned by you or on your behalf to the Plan.

If Anthem overpays you

We will make diligent efforts to recover benefit payments that Anthem made in error but in good faith. Anthem may reduce subsequent benefit payments to offset overpayments.

Anthem will generally first seek recovery from the Provider if they paid the Provider directly, or from the person (covered family Member, guardian, custodial parent, etc.) to whom they sent the payment.

In most instances, such recovery or adjustment activity shall be limited to the calendar year in which the error is discovered.

Medical policy and technology assessment

Anthem reviews and evaluates new technology according to its technology evaluation criteria developed by its medical directors. Technology assessment criteria are used to determine the Experimental/Investigational status or Medical Necessity of new technology. Guidance and external validation of Anthem's medical policy is provided by the Medical Policy and Technology Assessment Committee (MPTAC), which consists of approximately 20 Physicians from various medical specialties, including Anthem's medical directors, Physicians in academic medicine, and Physicians in private practice.

Conclusions made are incorporated into medical policy used to establish decision protocols for particular diseases or treatments and applied to Medical Necessity criteria used to determine whether a procedure, service, supply, or equipment is covered.

Modifications

The state may change the benefits described in this benefit document, and the Member will be informed of such changes as required by law. In accordance with any of its provisions, this benefit document shall be subject to amendment, modification, and termination by the state or by mutual agreement between Anthem and the state without the consent or concurrence of any Member. By electing medical and Hospital benefits under the Plan or accepting the Plan benefits, all Members legally capable of contracting, and the legal representatives of all Members incapable of contracting, agree to all terms, conditions, and provisions hereof.

Not liable for Provider acts or omissions

The Plan is not responsible for the actual care you receive from any person. This document does not give anyone any claim, right, or cause of action against Anthem or the Plan based on the actions of a Provider of health care, services, or supplies. The state, Anthem, and in-network Providers are independent entities contracting with each other for the sole purpose of carrying out the provisions of the Plan. The Plan will not be liable for any act or omission of any

Provider or any agent or Employee of a Provider. In-network Physicians maintain the Physician-patient relationship with Members and are solely responsible to Members for all medical services they provide.

Relationship of parties (Anthem and in-network Providers)

The relationship between Anthem and in-network Providers is an independent contractor relationship. In-network Providers are not agents or employees of Anthem, nor is Anthem, or any employee of Anthem, an employee or agent of in-network Providers.

Your health care Provider is solely responsible for all decisions regarding your care and treatment, regardless of whether such care and treatment is a covered Service under this Plan. Anthem shall not be responsible for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by you while receiving care from any in-network Provider or in any in-network Provider's Facilities.

Value-added programs

On behalf of the state, Anthem may offer health or fitness related programs to the Plan's Members, through which Members may access discounted rates from certain vendors for products and services available to the general public. Products and services available under this program are not Covered Services under this Plan but are in addition to Plan benefits. As such, program features are not guaranteed under this Plan and could be discontinued at any time.

The state does not endorse any vendor, product, or service associated with this program. Program vendors are solely responsible for the products and services you receive.

Value of Covered Services

For purposes of subrogation, reimbursement of excess benefits, or reimbursement under any workers' compensation or employer liability law, the value of Covered Services shall be the amount the Plan paid for the Covered Services.

Waiver

No agent or other person, except an authorized officer of the state, is able to disregard any conditions or restrictions contained in this document, to extend the amount of time for making a payment to the Plan, or to bind the Plan by making any promise or representation or by giving or receiving any information.

Definitions

If a word or phrase in this document has a special meaning, it will appear in ALL CAPS the first time it is referenced in the document, in Initial Caps for subsequent references, and be defined below. If you have questions about any of these definitions, please call Member Services.

Accidental Injury

An unexpected injury for which you need Covered Services while enrolled in this Plan. It does not include injuries for which you receive benefits under any workers' compensation, state's liability, or similar law.

Administrative Services Agreement

The agreement between Anthem and the State of Connecticut regarding the administration of certain elements of the health care benefits of the Plan.

Anthem Local Network Area

The geographical area where Covered Services can be received from an in-network Provider. The Local Network Area for this Plan includes Connecticut and areas outside of Connecticut designated as part of the Local Network Area.

Behavioral Health Services

Behavioral Health Services are services that can affect a patient's overall well-being and include mental health and substance use services.

A mental health disorder, also known as a mental illness, a mental health condition, or a psychiatric disorder, is characterized by a pattern of behavior or mental function that significantly impairs personal functioning or causes considerable distress. Mental health disorders are defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM) and can include anxiety disorders, depression, attention-deficit hyperactivity disorder (ADHD), bipolar disorder, personality disorders, and schizophrenia, among others.

Substance use disorder (SUD) is a mental disorder that affects a person's brain and behavior, leading to their inability to control their use of substances, including legal or illegal drugs, alcohol, or medications. Symptoms can be moderate to severe, with addiction being the most severe form of SUD. People with an SUD may also have mental health disorders, and people with mental health disorders may also struggle with substance use.

Benefit Period

The length of time the Plan covers benefits for Covered Services. The Benefit Period for State and Partnership Plans is the calendar year (from January 1 to December 31).

Clinical Peer(s) or Peer

The term means a Physician or other health care professional who holds a current nonrestricted license in a U.S. state or territory in the same or similar specialty as typically manages the medical condition, procedure, or treatment under review.

Refer to *Prior approval is required for certain services* (page 26) for specific request categories.

Clinical Trial

The term means 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, or disabling, or life-threatening chronic disease, in human beings, except that a Clinical Trial for the prevention of cancer, or disabling, or life-threatening chronic disease, is eligible for coverage only if it involves a therapeutic intervention and is conducted at multiple institutions. A Clinical Trial must be conducted under the auspices of an independent Peer-reviewed protocol that has been reviewed and approved under *Covered Services* (page 38).

Covered Services

Health care services, supplies, or treatment described in this document that are given to you by a Provider. Covered Services must be described in the Provider records.

Custodial Care

Any type of care, including room and board, that:

- Does not require the skills of professional or technical workers;
- Is not given to you or supervised by professional or technical workers;
- Does not meet the rules for post-Hospital Skilled Nursing Facility care; or
- Is given after reaching the greatest level of physical or mental health without likelihood of further improvement.

Custodial Care includes any type of care meant to help with activities of daily living that do not require the skill of a professional or technical worker. Examples of Custodial Care include:

- Help in walking, getting in and out of bed, bathing, dressing, eating, or using the toilet
- Changing dressings of non-infected wounds after surgery or for chronic conditions
- Preparing meals and/or special diets
- Feeding by utensil, tube, or gastrostomy
- Common skin and nail care
- Supervising administration of medicine that may be self-administered

- Catheter care, general colostomy or ileostomy care
- Routine services which Anthem determines may be safely done by the Member or a person without the help of trained medical and paramedical workers
- Residential care and adult day care
- Protective and supportive care, including education
- Rest and convalescent care.

Care can be Custodial even if it is recommended by a Physician or performed in a Facility, such as a Hospital or Skilled Nursing Facility, or at home.

Dependent

A person with a relationship to the State of Connecticut Employee who meets the rules in *Eligibility* and who has enrolled in the Plan.

Effective Date

The date coverage begins under this Plan.

Emergency

The term means a medical or behavioral health condition of recent onset and sufficient severity, including, but not limited to, severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that not getting immediate medical care could result in:

(a) placing the patient's health or the health of another person in serious danger or, for a pregnant woman, placing the woman's health or the health of her unborn child in serious danger; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part. Such conditions include, but are not limited to, chest pain, stroke, poisoning, serious breathing problems, unconsciousness, severe burns or cuts, uncontrolled bleeding, or seizures and such other acute conditions as may be determined to be emergencies by the Plan.

Emergency Care

This term means a medical or behavioral health exam done in the Emergency department of a Hospital or freestanding Emergency Facility, and includes services routinely available in the Emergency department to evaluate an Emergency condition. It includes any further medical or behavioral health exams and treatment required to stabilize the patient.

Employee

A person who is engaged in active employment with the state and is eligible to receive Plan benefits or a person retired from employment with the state and is eligible to receive Plan benefits.

Experimental or Investigational (or Experimental/Investigational)

An Experimental or Investigational service is any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition which the Plan determines to be Experimental or Investigational.

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

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

  - Cannot be legally marketed in the United States without the final approval of the U.S. Food and Drug Administration ("FDA"), or any other state or federal regulatory agency, and such final approval has not been granted; or
  - Has been determined by the FDA to be contraindicated for the specific use; or
  - Is provided as part of a clinical research protocol or Clinical Trial or is provided in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or
  - Is subject to review and approval of an Institutional Review Board ("IRB")[7] or other body serving a similar function; or
  - Is provided pursuant to informed consent documents that describe the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental or Investigational, or otherwise indicate that the safety, toxicity, or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is under evaluation.
- Any service not deemed Experimental or Investigational based on the criteria above may still be deemed to be Experimental or Investigational by the Plan. In determining whether a service is Experimental or Investigational, the Plan will consider the above information and assess the following:
  - Whether the scientific evidence is conclusory concerning the effects of the service or health outcomes;

[7] Under FDA regulations, an IRB is an appropriately constituted group that has been formally designated to review and monitor biomedical research involving human subjects at an institution.

- Whether the evidence demonstrates the service improves the net health outcomes of the total population for whom the service might be proposed by producing beneficial effects that outweigh any harmful effects;
- Whether the evidence demonstrates the service has been shown to be as beneficial for the total population for whom the service might be proposed as any established alternatives; or
- Whether the evidence demonstrates the service has been shown to improve the net health outcomes of the total population for whom the service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.

- The information considered or evaluated by the Plan to determine whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental or Investigational may include one or more items from the following list, which is not all inclusive:
  - Published authoritative, Peer-reviewed medical or scientific literature, or the absence thereof; or
  - Evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or
  - Documents issued by and/or filed with the FDA or other federal, state, or local agency with the authority to approve, regulate, or investigate the use of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or
  - Documents of an IRB or other similar body performing substantially the same function as an IRB; or
  - Consent document(s) used by the treating Physicians, other medical professionals, or Facilities or by other treating Physicians, other medical professionals or Facilities studying substantially the same drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or
  - The written protocol(s) used by the treating Physicians, other medical professionals, or Facilities or by other treating Physicians, other medical professionals or Facilities studying substantially the same drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or
  - Medical records of the Member requesting treatment; or
  - The opinions of consulting Providers and other experts in the field accepted as reasonable by the majority of CLINICAL PEERS.
- The Plan will identify and weigh all information and determine all questions pertaining to whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental or Investigational.

Notwithstanding the above, services or supplies will not be considered Experimental or Investigational if they have successfully completed a U.S. Food and Drug Administration Phase

III Clinical Trial, for the illness or condition being treated, or the diagnosis for which it is being prescribed.

In addition, services and supplies for routine patient care costs in connection with a cancer Clinical Trial will not be considered Experimental or Investigational.

Facility/Facilities

A covered Facility is a physical location where health care services are provided to Members including, but not limited to, a Hospital, ambulatory surgery/surgical center, chemical dependency treatment Facility, Residential Treatment Center, Skilled Nursing Facility, or behavioral health Facility, as defined in this Plan. The Facility must be licensed as required by law, satisfy Anthem's accreditation requirements, and be approved by Anthem.

The facility must be licensed as an Intensive Outpatient Program in the state in which it is located and be accredited by The Joint Commission (TJC), the Commission on Accreditation of Rehabilitation Facilities (CARF), the National Integrated Accreditation for Healthcare Organizations (NIAHO), or the Council on Accreditation (COA).

Home Health Care Agency

A Provider licensed when required by law that:

- Provides skilled nursing and other services on a visiting basis in a Member's home; and
- Supervises the delivery of services under a plan prescribed and approved in writing by the attending Physician.

Hospital

An institution, or a distinct portion of an institution, that:

- Primarily provides diagnostic and therapeutic facilities for surgical and medical diagnoses, treatment, and care of injured and sick persons, which are provided or supervised by a staff of licensed doctors of medicine (M.D.) or licensed doctors of osteopathy (D.O.), for compensation from its patients, on an Inpatient or outpatient basis;
- Continuously provides 24-hour-a-day professional registered nursing (R.N.) services; and
- Does not include a Provider, or that part of a Provider, used mainly for nursing care, rest care, convalescent care, care of the aged, Custodial Care, educational care, or subacute care.

Identification Card (or ID Card)

The card given to a Member for identification purposes, which includes group numbers and other information concerning the ID cardholder's plan. Members enrolled in the Plan receive their own ID Cards. In order for Members to receive services or treatment, the ID Card must be shown because only Members have the right to services or benefits under the Plan. If anyone

gets services or benefits to which they are not entitled under the terms of this Plan, they must pay for the actual cost of the services.

Inpatient

A Member who is admitted to a Hospital for medical treatment and has at least one overnight stay.

Intensive Outpatient Program (or IOP)

A distinct and organized outpatient program of psychiatric services provided for patients who have an acute mental illness, which includes, but is not limited to, conditions such as depression, schizophrenia, and substance use disorders. Patients receive at least three (3) hours of therapeutic services at least three (3) days per week as part of an Intensive Outpatient Program.

The facility must be licensed as an Intensive Outpatient Program in the state in which it is located and be accredited by The Joint Commission (TJC), the Commission on Accreditation of Rehabilitation Facilities (CARF), the National Integrated Accreditation for Healthcare Organizations (NIAHO), or the Council on Accreditation (COA).

Maximum Allowed Amount

The maximum amount that the Plan will pay for a covered health care service. Under certain circumstances, if your Provider is out-of-network and charges more than the health plan's Maximum Allowed Amount, you may have to pay the difference. This is called balance billing.

Medical Necessity (or Medically Necessary)

The terms mean health care services that 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 are:

- In accordance with generally accepted standards of medical practice; and
- 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 health care Provider; and
- Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease.

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

For the purpose of this definition, “not more costly” means services are cost-effective compared to alternative interventions, including no intervention or the same intervention in an alternative setting. Cost-effective does not always mean lowest cost. It does mean that as to the diagnosis or treatment of the Member’s illness, injury, or disease, the service is: (1) not more costly than an alternative service or sequence of services that is medically appropriate, or (2) the service is performed in the least costly setting that is medically appropriate. For example, the Plan will not provide coverage for an Inpatient admission for surgery if the surgery could have been performed on an outpatient basis.

Member(s)

People, including the Employee and their eligible Dependents, who have met the eligibility rules, applied for coverage, and enrolled in the Plan.

Open Enrollment

A period of time during which Employees and their eligible Dependents can enroll without penalty after the initial enrollment period. See *Enrollment* on page 15.

Partial Hospitalization Program (or PHP)

A program that offers Members structured, multidisciplinary behavioral health treatment that offers nursing care and active individual, group, and family therapy in a program that operates no less than 6 hours per day on at least 5 days per week.

The facility must be licensed as a Partial Hospitalization Program in the state in which it is located and be accredited by The Joint Commission (TJC), the Commission on Accreditation of Rehabilitation Facilities (CARF), the National Integrated Accreditation for Healthcare Organizations (NIAHO), or the Council on Accreditation (COA).

Physician

An individual when licensed by law:

- Doctor of Medicine (M.D.), legally licensed to practice medicine and perform surgery
- Doctor of Osteopathic Medicine (D.O.), legally licensed to practice medicine and perform surgery
- Doctor of Chiropractic (D.C.), legally licensed to perform the duties of a chiropractor
- Doctor of Podiatric Medicine (D.P.M.), legally licensed to practice podiatry
- Doctor of Dental Medicine (D.D.M.), legally licensed to provide dental services
- Doctor of Dental Surgery (D.D.S.), legally licensed to provide dental services, and

- Doctors of Optometry (O.D.), Clinical Psychologists (Ph.D.), Doctors of Naturopathic Medicine (N.D.), and surgical podiatrists are also Providers (but are not Physicians) when legally licensed and giving Covered Services within the scope of their licenses.

Plan

The arrangement chosen by the State of Connecticut to fund and provide for delivery of the medical benefits to Employees and Dependents.

Precertification

Precertification is the determination made by Anthem that selected medical services meet Medical Necessity criteria under the Plan. Precertification includes a review of the medical service, the setting, and the number of days precertified, if applicable.

Premium

The monthly amount paid by Members to participate in the Plan.

Prescription Drug

A substance, also known as a legend drug, that requires a prescription in order to be dispensed by a pharmacy. Under the Federal Food, Drug, and Cosmetic Act, Prescription Drugs may only be prescribed by Physicians, Physician assistants, nurse practitioners, and other advanced practice nurses, dentists, and optometrists. These drugs must bear a message on their original packing label that says "Caution: Federal law prohibits dispensing without a prescription." These drugs include the following:

- Compounded (combination) medications, when all of the ingredients are FDA-approved, require a prescription to dispense and are not essentially the same as an FDA-approved product from a drug manufacturer.
- Insulin, diabetic supplies, and syringes.

Primary Care Physician (PCP)

A Physician who is selected by a Member to supervise, direct, and give initial care and basic medical services and be in charge of ongoing care. The PCP may work in family practice, general practice, internal medicine, pediatrics, geriatrics, or any other practice allowed by the Plan.

Provider

A professional or facility licensed individual (when required by law) who gives health care services within the scope of that license, satisfies Anthem's accreditation requirements and, for

in-network Providers, is approved by Anthem. Details on Anthem's accreditation requirements can be found at **anthem.com/provider/individual-commercial/join-our-network**.

Rehabilitation/Rehabilitative

Health care services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services consist of physical therapy, occupational therapy, and speech therapy in an inpatient and/or outpatient setting.

Residential Treatment Center/Facility

Residential Treatment Centers provide residential treatment for medical conditions, behavioral health conditions, and/or substance use disorders. The facility must be licensed as a Residential Treatment Center in the state in which it is located and be accredited by The Joint Commission (TJC), the Commission on Accreditation of Rehabilitation Facilities (CARF), the National Integrated Accreditation for Healthcare Organizations (NIAHO), or the Council on Accreditation (COA).

The term Residential Treatment Center/Facility does not include a Provider, or that part of a Provider, used mainly for nursing care, rest care, convalescent care, care of the aged, Custodial Care, educational care, or subacute care.

Site-of-Service Provider

A Site-of-Service (SOS) Provider is a laboratory that meets cost and other criteria established by the Plan, including:

- A Provider that is not part of or owned by a Hospital and bills independently (i.e., not under a Hospital's name or ID number). Reference laboratories that meet these criteria are considered "freestanding" Site-of-Service Providers.
- An outpatient facility location owned by a Hospital that is contracted with Anthem and meets the criteria to be considered Site-of-Service.

SOS Providers provide health care services, such as laboratory tests, that are typically lower cost options for Members. Each in-network facility is subject to specific licensing, accreditation, and credentialing requirements.

Skilled Nursing Facility

A Skilled Nursing Facility is an Inpatient rehab and medical treatment center. It is not a place mainly for care of the aged, for Custodial Care or domiciliary care, or a place for rest, education, or similar services.

Specialist

A Specialist is a Physician who focuses on a specific area of medicine or group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions. A non-Physician Specialist is a Provider who has added training in a specific area of health care.

Specialty Drugs

Drugs that typically need close supervision and checking of their effect on the Member by a Provider. Specialty Drugs often need special handling, such as temperature-controlled packaging and overnight delivery, and are often not available at retail pharmacies. Specialty Drugs may be administered through many methods, including, but not limited to, injection, infusion, inhalation, and oral administration.

Urgent Care Facility (or Urgent Care Center)

A facility where urgent care services may be obtained. Urgent care services consist of care for an illness or injury that is not a medical Emergency but requires immediate medical attention.

Schedule of Benefits

The State of Connecticut offers several medical plan options. The Covered Services for all medical plans are intended to be the same. The differences among the plans are related to applicable cost-shares, the plan's applicable Provider network, and the ability for Members to use out-of-network Providers. Typically, your benefits and cost-shares are based on the setting in which Covered Services are received (e.g., in a Physician's office, or at an outpatient Hospital Facility). Please see page 19 for additional information about how your deductible and out-of-pocket works, and other important notices pertaining to your benefits, limits, or cost-shares.

This Plan provides the option to lower out-of-pocket costs for certain services by going to Site-of-Service Providers for routine lab work. Use the Find a Provider tool at carecompass-providerlookup.emboldhealth.com/login. Look for the Site-of-Service (SOS) indicator under the Recognitions(/Tier) link to the right of the Provider's name.

Primary Care Access (State BlueCare Point of Enrollment Plus [POE-G Plus]) and Standard Access (State BlueCare Point of Enrollment [POE])

The table below shows what **you** pay for Covered Services.

Benefit	In-Network	Out-of-Network
Upfront Deductible In-network deductible may not apply to all services. Deductible waived for HEP enrolled/compliant and pre-October 2, 2011 retirees.	$350 per individual; $1,400 per family	Does not apply
Out-of-Pocket Maximum Includes deductibles, copayments, and coinsurance.	$2,000 per individual; $4,000 per family	Does not apply
Lifetime Maximum	None	Does not apply
Person Responsible for Obtaining Precertification	Primary Care Physician (PCP) or in-network Provider	Does not apply
Adult/Pediatric Preventive Visit	$0 copayment	Not covered

Benefit	In-Network	Out-of-Network
Preferred Tier 1 Primary Care and Specialty Care Provider Visit[8] Includes in-person and/or virtual visits for illness, injury, follow-up care, and consultations.	$0 copayment per visit	Not covered
Primary Care Physician Visits (PCP) Includes in-person and/or virtual visits for illness, injury, follow-up care, and consultations.	HEP chronic condition-related visit: $0 copayment per visit Anthem Tier 1 preferred provider visit: $0 copayment per visit In-person visit: $15 copayment per visit; $5 copayment for pre-1999 retirees Virtual visit: $15 copayment per visit	Not covered
Specialty Care Provider Visits (SCP) Includes in-person and/or virtual visits.	Anthem Tier 1 preferred provider visit: $0 copayment per visit In-person visit: $15 copayment per visit Virtual visit: $15 copayment per visit	Not covered
Preferred Tier 1 Mental Health and Substance Use Disorder Provider Visits (MH/SUD) Includes in-person and/or virtual visits.	$0 copayment per visit	Not covered
Mental Health and Substance Use Disorder Provider Visits (MH/SUD)	$15 copayment per visit; $5 copayment for pre-1999 retirees	Not covered

[8] See page 21 for more information about Providers.

Benefit	In-Network	Out-of-Network
Includes in-person and/or virtual visits, outpatient treatment, and in-home behavioral health programs.		
LiveHealth Online	$5 copayment per visit	Not covered
LiveHealth Online for HEP Chronic Conditions	$0 copayment per visit	Not covered
Routine Radiology Including x-ray, breast tomosynthesis, and other diagnostic services.	$0 copayment	Not covered
Advanced Radiology Including MRI, CAT, CT, PET scans, and other diagnostic services. Precertification may be required.	$0 copayment	Not covered
Laboratory Services[9]	Site-of-Service Providers: $0 copayment Outpatient Hospital Facility (non-Site-of-Service): 20% coinsurance after deductible	Not covered
Physical and Occupational Therapy Precertification required after 24 visits.	$0 copayment	Not covered
Speech Therapy: Treatment resulting from autism, stroke, tumor removal, injury or congenital anomalies of the oropharynx	$0 copayment	Not covered
Speech Therapy: Other conditions Limit of 30 visits per calendar year.	$0 copayment	Not covered

[9] Retiree groups 1-4 pay a $0 copayment for all in-network laboratory services; Site-of-Service does not apply.

Benefit	In-Network	Out-of-Network
Chiropractic Care	$0 copayment	Not covered
Diabetic Equipment and Supplies Please note that diabetic supplies are covered under the pharmacy benefit.	$0 copayment	Not covered
Durable Medical Equipment (DME), Medical Devices, and Supplies Precertification may be required.	$0 copayment	Not covered
Home Health Care Services Nursing (intermittent skilled nursing services), therapeutic, and home health aide services provided by a home health care agency. Limit: 200 visits per calendar year.	$0 copayment	Not covered
Private duty nursing (including continuous complex skilled nursing services) Precertification required.	$0 copayment	Not covered
Acupuncture Limit: 20 visits per calendar year.	$15 copayment	Not covered
Allergy Testing and Treatment Injection, serum, immunotherapy, or other therapy treatments. Office visits covered as PCP or Specialist office visit as applicable (see above).	$0 copayment	Not covered
Cardiac Rehabilitation Therapy	$0 copayment	Not covered
Nutritional Counseling Limit: 3 visits for diagnosis not included as part of ACA	$0 copayment	Not covered
Dialysis and Hemodialysis	Office visits covered as PCP or Specialist office visit (see above).	Not covered

Benefit	In-Network	Out-of-Network
Home Dialysis, Infusion Therapy, and Chemotherapy	$0 copayment	Not covered
Hospice Outpatient Services Includes outpatient hospice services, home hospice services, bereavement, and outpatient respite care. $420 annual limit on medical social services.	$0 copayment	Not covered
Other Therapy Services Including radiation, chemotherapy, and respiratory therapy. Precertification may be required.	$0 copayment	Not covered
Prosthetics Precertification may be required.	$0 copayment	Not covered
Outpatient Services Including surgery, fertility, and diagnostic colonoscopy. Precertification may be required.	$0 copayment	Not covered
Inpatient Hospital Acute Care Facility Including behavioral health, substance use disorder, maternity, fertility, and human organ and tissue transplant services. Precertification required.	$0 copayment	Not covered
Inpatient Rehabilitation Facility Precertification required.	$0 copayment	Not covered
Mental Health and Substance Use Disorder Treatment Partial Hospitalization Program (PHP) Services Precertification by Anthem required for partial hospitalizations in excess of 24 visits per calendar year.	$0 copayment	Not covered

Benefit	In-Network	Out-of-Network
Mental Health and Substance Use Disorder Treatment Intensive Outpatient Program (IOP) Services in a Facility Precertification by Anthem required for partial hospitalizations in excess of 24 visits per calendar year.	$0 copayment	Not covered
Mental Health and Substance Use Disorder Services Residential Treatment Center Precertification required.	$0 copayment	Not covered
Skilled Nursing Facility Precertification required.	$0 copayment	Not covered
Ambulance Services Must be Medically Necessary medical transport. Precertification is required for non-emergent air ambulance.	$0 copayment	$0 copayment
Emergency Room Copayment waived if admitted.	$250 copayment; $35 copayment for retirees with a retirement date from October 2, 2011 to October 1, 2017; Plan pays 100% for retirees with a retirement date on or before October 1, 2011	$250 copayment; $35 copayment for retirees with a retirement date from October 2, 2011 to October 1, 2017; Plan pays 100% for retirees with a retirement date on or before October 1, 2011
Urgent Care/Walk-In Clinic Services Urgent care services may be received in various settings. Please refer to those sections of the Schedule for details on what you will pay.	$15 copayment per visit; $5 copayment for pre-1999 retirees	Not covered

Expanded Access (State BlueCare Point of Service [POS]), State Preferred Point of Service (POS), and Out of Area (OOA)

The table below shows what **you** pay for Covered Services.

Benefit	In-Network	Out-of-Network
Upfront Deductible In-network deductible may not apply to all services. Deductible waived for HEP enrolled/compliant and pre-October 2, 2011 retirees.	$350 per individual; $1,400 per family	Individual: $300 Two persons: $600 Family: $900
Out-of-Pocket Maximum Includes deductibles, copayments, and coinsurance.	$2,000 per individual; $4,000 per family	$2,000 per individual plus out-of-network deductible; $4,000 per family plus out-of-network deductible
Lifetime Maximum	None	None
Person Responsible for Obtaining Precertification	Primary care Physician (PCP) or in-network Provider	Covered person
Adult/Pediatric Preventive Visit	$0 copayment	20% coinsurance, after deductible
Preferred Tier 1 Primary Care and Specialty Care Provider Visit[8] Includes in-person and/or virtual visits for illness, injury, follow-up care, and consultations.	$0 copayment per visit	20% coinsurance, after deductible
Primary Care Physician Visits (PCP) Includes in-person and/or virtual visits for illness, injury, follow-up care, and consultations.	HEP chronic condition-related visit: $0 copayment per visit Anthem Tier 1 preferred provider visit: $0 copayment per visit In-person visit: $15 copayment per visit; $5 copayment for pre-1999 retirees Virtual visit: $15 copayment per visit	20% coinsurance, after deductible

Benefit	In-Network	Out-of-Network
Specialty Care Provider Visits (SCP) Includes in-person and/or virtual visits.	Anthem Tier 1 preferred provider visit: $0 copayment per visit In-person visit: $15 copayment per visit; $5 copayment for pre-1999 retirees Virtual visit: $15 copayment per visit	20% coinsurance, after deductible
Preferred Tier 1 Mental Health and Substance Use Disorder Provider Visits (MH/SUD) Includes in-person and/or virtual visits	$0 copayment per visit	Not covered
Mental Health and Substance Use Disorder Provider Visits (MH/SUD) Includes in-person and/or virtual visits, outpatient treatment, and in-home behavioral health programs.	$15 copayment per visit; $5 copayment for pre-1999 retirees	20% coinsurance, after deductible
LiveHealth Online	$5 copayment per visit	Not covered
LiveHealth Online for HEP Chronic Conditions	$0 copayment per visit	Not covered
Routine Radiology Including x-ray, breast tomosynthesis, and other diagnostic services.	$0 copayment	20% coinsurance, after deductible
Advanced Radiology Including MRI, CAT, CT, PET scans, and other diagnostic services. Precertification may be required.	$0 copayment	20% coinsurance, after deductible
Laboratory Services[9]	Site-of-Service Providers: $0 copayment Outpatient Hospital Facility (non-Site-of-Service): 20% coinsurance	40% coinsurance, after deductible
Physical and Occupational Therapy Precertification required after 24 visits.	$0 copayment	20% coinsurance, after deductible Limit: 30 visits per calendar year

Benefit	In-Network	Out-of-Network
Speech Therapy: Treatment resulting from autism, stroke, tumor removal, injury, or congenital anomalies of the oropharynx	$0 copayment	20% coinsurance, after deductible Limit: 30 visits per calendar year for stroke, tumor removal, injury or congenital anomalies of the oropharynx.
Speech Therapy: Other conditions Limit of 30 visits per calendar year.	$0 copayment	20% coinsurance, after deductible
Chiropractic Care	$0 copayment	20% coinsurance, after deductible Limit: 30 visits per calendar year
Diabetic Equipment and Supplies Please note that diabetic supplies are covered under the pharmacy benefit.	$0 copayment	20% coinsurance, after deductible
Durable Medical Equipment (DME), Medical Devices, and Supplies Precertification may be required	$0 copayment	20% coinsurance, after deductible
Home Health Care Services Nursing (intermittent skilled nursing services), therapeutic, and home health aide services provided by a home health care agency. Limit: 200 visits per calendar year.	$0 copayment	20% coinsurance, after deductible
Private duty nursing (including continuous complex skilled nursing services) Precertification required.	$0 copayment	20% coinsurance, after deductible
Acupuncture Limit: 20 visits per calendar year.	$15 copayment	20% coinsurance, after deductible
Allergy Testing and Treatment Injection, serum, immunotherapy, or other therapy treatments. Office visits covered as PCP or Specialist office visit as applicable (see above).	$0 copayment	20% coinsurance, after deductible

Benefit	In-Network	Out-of-Network
Cardiac Rehabilitation Therapy	$0 copayment	20% coinsurance, after deductible
Nutritional Counseling Limit: 3 visits for diagnosis not included as part of ACA	$0 copayment	20% coinsurance, after deductible
Dialysis and Hemodialysis	Office visits covered as PCP or Specialist office visit (see above).	20% coinsurance, after deductible
Home Dialysis, Infusion Therapy, and Chemotherapy	$0 copayment	20% coinsurance, after deductible
Hospice Outpatient Services Includes outpatient hospice services, home hospice services, bereavement, and outpatient respite care. $420 annual limit on medical social services.	$0 copayment	20% coinsurance, after deductible Limit: 200 visits per calendar year
Other Therapy Services Including radiation, chemotherapy, and respiratory therapy. Precertification may be required.	$0 copayment	20% coinsurance, after deductible
Prosthetics Precertification may be required.	$0 copayment	20% coinsurance, after deductible
Outpatient Services Including surgery, fertility, and diagnostic colonoscopy. Precertification may be required.	$0 copayment	20% coinsurance, after deductible
Inpatient Hospital Acute Care Facility Including behavioral health, substance use disorder, maternity, fertility, and human organ and tissue transplant services. Precertification required.	$0 copayment	20% coinsurance, after deductible
Inpatient Rehabilitation Facility Precertification required.	$0 copayment	20% coinsurance, after deductible
Mental Health and Substance Use Disorder Treatment Partial Hospitalization Program (PHP) Services Precertification by Anthem required for partial hospitalizations in excess of 24 visits per calendar year.	$0 copayment	20% coinsurance, after deductible

Benefit	In-Network	Out-of-Network
Mental Health and Substance Use Disorder Treatment Intensive Outpatient Program (IOP) Services in a Facility Precertification by Anthem required for partial hospitalizations in excess of 24 visits per calendar year.	$0 copayment	20% coinsurance, after deductible
Mental Health and Substance Use Disorder Services Residential Treatment Center Precertification required.	$0 copayment	20% coinsurance, after deductible
Skilled Nursing Facility Precertification required.	$0 copayment	20% coinsurance, after deductible Limit: 60 days per covered person per calendar year
Ambulance Services Must be Medically Necessary medical transport. Precertification is required for non-emergent air ambulance.	$0 copayment	$0 copayment
Emergency Room Copayment waived if admitted.	$250 copayment; $35 copayment for retirees with a retirement date from October 2, 2011 to October 1, 2017; Plan pays 100% for retirees with a retirement date on or before October 1, 2011	$250 copayment; $35 copayment for retirees with a retirement date from October 2, 2011 to October 1, 2017; Plan pays 100% for retirees with a retirement date on or before October 1, 2011
Urgent Care/Walk-In Clinic Services Urgent care services may be received in various settings. Please refer to those sections of the Schedule for details on what you will pay.	$15 copayment per visit; $5 copayment for pre-1999 retirees	20% coinsurance, after deductible

Quality First Select Access Plan

The table below shows what **you** pay for Covered Services.

Benefit	In-Network: Tier 1	In-Network: Tier 2	Out-of-Network
Out-of-Pocket Maximum Includes deductibles, copayments and coinsurance.	$3,000 per individual; $6,000 per family	$3,000 per individual; $6,000 per family	$6,000 per individual; $12,000 per family
Lifetime Maximum	None	None	None
Person Responsible for Obtaining Precertification	Primary care Physician (PCP) or in-network Provider	Primary care Physician (PCP) or in-network Provider	Covered person
Adult / Pediatric Preventive Visit	$0 copayment	$0 copayment	20% coinsurance, after deductible
Primary Care Visit[8] Includes in-person and/or virtual visits for illness, injury, follow-up care, and consultations.	$0 copayment per visit	$50 copayment per visit	20% coinsurance, after deductible
Specialty Care Provider Visits (SCP) Includes in-person and/or virtual visits.	$0 copayment per visit	$100 copayment per visit	20% coinsurance, after deductible
Mental Health and Substance Use Disorder Provider Visits (MH/SUD) Includes in-person and/or virtual visits, outpatient treatment, and in-home behavioral health programs.	$0 copayment per visit	$0 copayment per visit	20% coinsurance, after deductible
LiveHealth Online	$0 copayment per visit	N/A	N/A
Routine Radiology	Site-of-Service Provider: $0 copayment	Site-of-Service Provider:$0 copayment	40% coinsurance, after deductible

Benefit	In-Network: Tier 1	In-Network: Tier 2	Out-of-Network
Including x-ray, breast tomosynthesis, and other diagnostic services.	Non-Site-of-Service Provider: 20% coinsurance, after deductible	Non-Site-of-Service Provider: 20% coinsurance, after deductible	
Advanced Radiology Including MRI, CAT, CT, PET scans, and other diagnostic services. Precertification may be required.	Site-of-Service Provider: $0 copayment Non-Site-of-Service Provider: 20% coinsurance, after deductible	Site-of-Service Provider:$0 copayment Non-Site-of-Service Provider: 20% coinsurance, after deductible	40% coinsurance, after deductible
Laboratory Services[9]	Site-of-Service Provider: $0 copayment Non-Site-of-Service Provider: 20% coinsurance, after deductible	Site-of-Service Provider:$0 copayment Non-Site-of-Service Provider: 20% coinsurance, after deductible	40% coinsurance, after deductible
Physical and Occupational Therapy Precertification required after 24 visits.	$0 copayment	$0 copayment	20% coinsurance, after deductible
Speech Therapy: Treatment resulting from autism, stroke, tumor removal, injury, or congenital anomalies of the oropharynx	$0 copayment	$0 copayment	20% coinsurance, after deductible Limit: 30 visits per calendar year for stroke, tumor removal, injury or congenital anomalies of the oropharynx.
Speech Therapy: Other conditions Limit of 30 visits per calendar year.	$0 copayment	$0 copayment	20% coinsurance, after deductible
Chiropractic Care	$0 copayment	$0 copayment	20% coinsurance, after deductible
Diabetic Equipment and Supplies Please note that diabetic supplies are covered	$0 copayment	$0 copayment	20% coinsurance, after deductible

Benefit	In-Network: Tier 1	In-Network: Tier 2	Out-of-Network
under the pharmacy benefit.			
Durable Medical Equipment (DME), Medical Devices, and Supplies Precertification may be required.	$0 copayment	$0 copayment	20% coinsurance, after deductible
Home Health Care Services Nursing (intermittent skilled nursing services), therapeutic, and home health aide services provided by a home health care agency. Limit: 200 visits per calendar year	$0 copayment	$0 copayment	20% coinsurance, after deductible
Private duty nursing (including continuous complex skilled nursing services) Precertification required.	$0 copayment	$0 copayment	20% coinsurance, after deductible
Acupuncture Limit: 20 visits per calendar year.	$0 copayment	$0 copayment	20% coinsurance, after deductible
Allergy Testing and Treatment Injection, serum, immunotherapy, or other therapy treatments. Office visits covered as PCP or Specialist office visit as applicable (see above).	$0 copayment	$0 copayment	20% coinsurance, after deductible
Cardiac Rehabilitation Therapy	$0 copayment	$0 copayment	20% coinsurance, after deductible
Nutritional Counseling	$0 copayment	$0 copayment	20% coinsurance, after deductible

Benefit	In-Network: Tier 1	In-Network: Tier 2	Out-of-Network
Limit: 3 visits for diagnosis not included as part of ACA			
Dialysis and Hemodialysis	Office visits covered as PCP or Specialist office visit (see above).	Office visits covered as PCP or Specialist office visit (see above).	20% coinsurance, after deductible
Home Dialysis, Infusion Therapy, and Chemotherapy	$0 copayment	$0 copayment	20% coinsurance, after deductible
Hospice Outpatient Services Includes outpatient hospice services, home hospice services, bereavement, and outpatient respite care. $420 annual limit on medical social services.	$0 copayment	$0 copayment	20% coinsurance, after deductible
Other Therapy Services Including radiation, chemotherapy, and respiratory therapy. Precertification may be required.	$0 copayment	$0 copayment	20% coinsurance, after deductible
Prosthetics Precertification may be required.	$0 copayment	$0 copayment	20% coinsurance, after deductible
Outpatient Services Including surgery, fertility, and diagnostic colonoscopy. Precertification may be required.	$0 copayment	$0 copayment	20% coinsurance, after deductible
Inpatient Hospital Acute Care Facility Including behavioral health, substance use disorder, maternity, fertility, and human organ	$0 copayment	$0 copayment	20% coinsurance, after deductible

Benefit	In-Network: Tier 1	In-Network: Tier 2	Out-of-Network
and tissue transplant services. Precertification required.			
Inpatient Rehabilitation Facility Precertification required.	$0 copayment	$0 copayment	20% coinsurance, after deductible
Mental Health and Substance Use Disorder Treatment Partial Hospitalization Program (PHP) Services Precertification by Anthem required for partial hospitalizations in excess of 24 visits per calendar year.	$0 copayment	$0 copayment	20% coinsurance, after deductible
Mental Health and Substance Use Disorder Treatment Intensive Outpatient Program (IOP) Services in a Facility Precertification by Anthem required for partial hospitalizations in excess of 24 visits per calendar year.	$0 copayment	20% coinsurance, after deductible	20% coinsurance, after deductible
Mental Health and Substance Use Disorder Services Residential Treatment Center Precertification required.	$0 copayment	$0 copayment	20% coinsurance, after deductible
Skilled Nursing Facility Precertification required.	$0 copayment	$0 copayment	20% coinsurance, after deductible
Ambulance Services Must be Medically Necessary medical transport. Precertification is required for non-emergent air ambulance.	$0 copayment	$0 copayment	$0 copayment

Benefit	In-Network: Tier 1	In-Network: Tier 2	Out-of-Network
Emergency Room Copayment waived if admitted.	$250 copayment; $35 copayment for retirees with a retirement date from October 2, 2011 to October 1, 2017; Plan pays 100% for retirees with a retirement date on or before October 1, 2011	$250 copayment; $35 copayment for retirees with a retirement date from October 2, 2011 to October 1, 2017; Plan pays 100% for retirees with a retirement date on or before October 1, 2011	$250 copayment; $35 copayment for retirees with a retirement date from October 2, 2011 to October 1, 2017; Plan pays 100% for retirees with a retirement date on or before October 1, 2011
Urgent Care/Walk-In Clinic Services Urgent care services may be received in various settings. Please refer to those sections of the schedule for details on what you will pay.	$35 copayment	$35 copayment	20% coinsurance, after deductible

Required Notices

Newborns' and Mothers' Health Protection Act of 1996

Under federal law, group health plans and health insurance companies generally must provide any Hospital length of stay of no less than forty-eight (48) hours following a vaginal delivery and no less than ninety-six (96) hours following a cesarean section in connection with childbirth for the mother or newborn child. Federal law, however, may allow a mother's or newborn's attending Provider, after consulting with the mother, to discharge the mother or her newborn earlier than the complete 48- or 96-hour period.

If you have questions about Hospital stays for labor and delivery, please call the telephone number on the back of your ID Card, and Member Services will assist you.

Women's Health and Cancer Rights Act of 1998

For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending Physician and the Member, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical benefits provided under this Plan.

For more information on these benefits, please call the telephone number on the back of your ID Card and Member Services will assist you.

Coverage for a child due to a Qualified Medical Child Support Order (QMCSO)

If a Member is required, due to a QMCSO, to provide coverage for a child(ren), please call the telephone number on the back of your ID Card, and Member Services will assist you, without charge, to obtain a written statement outlining the procedures for getting coverage for such child(ren).

Mental Health Parity and Addiction Equity Act of 2008

In general, group health plans offering mental health and substance use disorder benefits cannot set day/visit limits on mental health or substance use disorder benefits that are lower than any such day or visit limits for medical benefits. A group health plan that does not impose day or visit limits on medical benefits may not impose such day or visit limits on mental health

and substance use disorder benefits offered under said plan. Also, the plan may not impose deductibles, copayments, coinsurance, and out-of-pocket expenses on mental health and substance use disorder benefits that are more restrictive than deductibles, copayments, coinsurance and out-of-pocket expenses applicable to other medical benefits.

If you have questions about the usage of mental health or substance use disorder benefits, please call the telephone number on the back of your ID Card, and Member Services will assist you.

Your medical and claims records are confidential

The Plan will keep your medical and claims information confidential. The Plan may use, for bona fide medical research or education, aggregated medical record information that does not disclose your identity.

The Plan may disclose your medical and claims information (including your Prescription Drug utilization) to Anthem, Quantum, Caremark, and any treating Physicians or dispensing pharmacies.

Applicable state and federal law requires the Plan and the Plan's third-party administrators to undertake efforts to safeguard your medical information.

For informational purposes only, please be advised that a statement describing the policies and procedures regarding the protection, use, and disclosure of your medical information is available at **quantum-health.com/privacy-policy** and can be furnished to you upon request by contacting Member Services.

Obligations that arise under state and federal law, and policies and procedures relating to privacy that are referenced but not included in this document, are not part of the contract between the parties and do not give rise to contractual obligations.

Protected health information under HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the privacy regulations issued under HIPAA, contain provisions designed to protect the privacy of certain individually identifiable health information. The Plan has a responsibility under the HIPAA privacy regulations to provide you with a Notice of Privacy Practices. This notice sets forth the state's rules regarding the disclosure of your information and details about a number of individual rights you have under the privacy regulations.

Assistance Reading This Document

Language assistance

This notice has important information about your application or benefits. Look for important dates. You might need to take action by certain dates to keep your benefits or manage costs. You have the right to get this information and help in your language for free. Call the Member Services number on your ID Card for help (TTY/TDD: 711).

Spanish

Este aviso contiene información importante acerca de su solicitud o sus beneficios. Busque fechas importantes. Podría ser necesario que actúe para ciertas fechas, a fin de mantener sus beneficios o administrar sus costos. Tiene el derecho de obtener esta información y ayuda en su idioma en forma gratuita. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación para obtener ayuda. (TTY/TDD: 711)

Albanian

Ky njoftim përmban informacion të rëndësishëm rreth aplikimit ose përfitimeve tuaja. Shihni datat kryesore. Mund t'ju nevojitet të veproni brenda afateve të caktuara për të vazhduar të përfitoni ose për të menaxhuar kostot. Keni të drejtën të merrni falas ndihmë dhe informacion në gjuhën tuaj. Për ndihmë, telefononi numrin e shërbimeve për anëtarët, të shënuar në kartën tuaj ID. (TTY/TDD: 711)

Arabic

قد تحتاج إلى اتخاذ . احرص على تتبع المواعيد المهمة.يحتوي هذا الإشعار على معلومات مهمة حول طلبك أو المزايا المقدمة لك
يحق لك الحصول على هذه المعلومات والمساعدة بلغتك.إجراء قبل مواعيد محددة للاحتفاظ بالمزايا أو لإدارة التكلفة
التعريف الخاصة بك للمساعدة) يُرجى الاتصال برقم خدمات الأعضاء الموجود على بطاقة .مجانًا.(TTY/TDD:711

Chinese

本通知有與您的申請或利益相關的重要資訊。請留意重要日期。您可能需要在特定日期前採取行動以維護您的利益或管理費用。您有權使用您的語言免費獲得該資訊和協助。請撥打您的 ID 卡上的成員服務號碼尋求協助。(TTY/TDD: 711)

French

Cette notice contient des informations importantes sur votre demande ou votre couverture. Vous y trouverez également des dates à ne pas manquer. Il se peut que vous deviez respecter certains délais pour conserver votre couverture santé ou vos remboursements. Vous avez le droit d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour cela, veuillez appeler le numéro des Services destinés aux membres qui figure sur votre carte d'identification. (TTY/TDD: 711)

Greek

Αυτή η ειδοποίηση περιέχει σημαντικές πληροφορίες για την εφαρμογή σας ή τις παροχές σας. Αναζητήστε τις σημαντικές ημερομηνίες. Ενδέχεται να χρειαστεί να κάνετε κάποιες ενέργειες μέχρι συγκεκριμένες ημερομηνίες, ώστε να διατηρήσετε τις παροχές σας ή να διαχειριστείτε το κόστος. Έχετε το δικαίωμα να λάβετε αυτές τις πληροφορίες και αυτήν τη βοήθεια στη γλώσσα σας δωρεάν. Καλέστε τον αριθμό του Τμήματος Υπηρεσιών Μέλους (Member Services) που αναγράφεται στην ταυτότητά σας (ID Card) για βοήθεια. (TTY/TDD: 711)

Haitian

Avi sa a gen enfòmasyon enpòtan sou aplikasyon ou an oswa avantaj ou yo. Veye dat enpòtan yo. Ou ka bezwen pran aksyon avan sèten dat pou kenbe avantaj ou yo oswa jere depans ou yo. Ou gen dwa pou resevwa enfòmasyon sa a ak asistans nan lang ou pou gratis. Rele nimewo Manm Sèvis la ki sou kat idantifikasyon ou a pou jwenn èd. (TTY/TDD: 711)

Hindi

इस सूचना में आपके आवेदन या लाभों के बारे में महत्वपूर्ण जानकारी है। महत्वपूर्ण तिथियाँ देखें। अपने लाभ बनाए रखने या लागत का प्रबंध करने के लिए, आपको निश्चित तिथियों तक कार्रवाई करने की ज़रूरत हो सकती है। आपके पास यह जानकारी और मदद अपनी भाषा में मुफ़्त में प्राप्त करने का अधिकार है। मदद के लिए अपने ID कार्ड पर सदस्य सेवाएँ नंबर पर कॉल करें। (TTY/TDD: 711)

Italian

Il presente avviso contiene informazioni importanti relative alla domanda da lei presentata o ai benefici a lei riservati. Consulti le date importanti riportate. Per continuare a usufruire dei benefici o ricevere assistenza per il pagamento delle spese, potrebbe dover eseguire determinate azioni entro scadenze specifiche. Ha il diritto di ricevere queste informazioni ed eventuale assistenza nella sua lingua senza alcun costo aggiuntivo. Per assistenza, chiami il numero dedicato ai Servizi per i membri riportato sul suo libretto. (TTY/TDD: 711)

Korean

이 공지사항에는 귀하의 신청서 또는 혜택에 대한 중요한 정보가 있습니다. 중요 날짜를 살펴 보십시오. 혜택을 유지하거나 비용을 관리하기 위해 특정 마감일까지 조치를 취해야 할 수 있습니다. 귀하에게는 무료로 이 정보를 얻고 귀하의 언어로 도움을 받을 권리가 있습니다. 도움을 얻으려면 귀하의 ID 카드에 있는 회원 서비스 번호로 전화하십시오. (TTY/TDD: 711)

Polish

Niniejsze powiadomienie zawiera istotne informacje dotyczące wniosku lub świadczeń. Zwróć uwagę na ważne daty. Zachowanie świadczeń lub zarządzanie kosztami może wymagać podjęcia dodatkowych działań w konkretnych terminach. Masz prawo do bezpłatnego otrzymania stosownych informacji oraz uzyskania pomocy w swoim języku. W tym celu

skontaktuj się z Działem Obsługi Klienta pod numerem telefonu podanym na karcie identyfikacyjnej. (TTY/TDD: 711)

Portuguese-Europe

Este aviso contém informações importantes sobre a sua candidatura ou benefícios. Preste atenção a datas importantes. Poderá ser necessário agir até determinadas datas para manter os seus benefícios ou gerir os custos. Tem o direito de receber gratuitamente estas informações e ajuda no seu idioma. Ligue para o número dos Serviços para Membros indicado no seu cartão de identificação para obter ajuda. (TTY/TDD: 711)

Russian

Настоящее уведомление содержит важную информацию о вашем заявлении или выплатах. Обратите внимание на контрольные даты. Для сохранения права на получение выплат или помощи с расходами от вас может потребоваться выполнение определенных действий в указанные сроки. Вы имеете право получить данную информацию и помощь на вашем языке бесплатно. Для получения помощи звоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. (TTY/TDD: 711)

Tagalog

May mahalagang impormasyon ang abisong ito tungkol sa inyong aplikasyon o mga benepisyo. Tukuyin ang mahahalagang petsa. Maaaring may kailangan kayong gawin sa ilang partikular na petsa upang mapanatili ang inyong mga benepisyo o mapamahalaan ang mga gastos. May karapatan kayong makuha ang impormasyon at tulong na ito sa ginagamit ninyong wika nang walang bayad. Tumawag sa numero ng Member Services na nasa inyong ID Card para sa tulong. (TTY/TDD: 711)

Vietnamese

Thông báo này có thông tin quan trọng về đơn đang ký hoặc quyền lợi bảo hiểm của quý vị. Hãy tìm các ngày quan trọng. Quý vị có thể cần phải có hành động trước những ngày nhất định để duy trì quyền lợi bảo hiểm hoặc quản lý chi phí của mình. Quý vị có quyền nhận miễn phí thông tin này và sự trợ giúp bằng ngôn ngữ của quý vị. Hãy gọi cho Dịch Vụ Thành Viên trên thẻ ID của quý vị để được giúp đỡ. (TTY/TDD: 711)

Vision assistance

Separate from language assistance, documents are available in alternate formats for Members with visual impairments. If you have a visual impairment and would like a document in an alternate format, please call the telephone number on the back of your ID Card, and Member Services will assist you.

It’s important we treat you fairly

We follow federal civil rights laws in our health programs and activities. By calling the telephone number on the back of your ID Card, Members can get free in-language support, and free aids and services if you have a disability. We don’t discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age, or disability. For people whose primary language isn’t English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID Card for help (TTY/TDD: 711). If you think Anthem failed in any of these areas, mail a complaint to: Anthem Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279, or directly to the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201. You can also call 1-800-368-1019 (TDD: 1-800-537-7697) or visit **ocrportal.hhs.gov/ocr/portal/lobby.jsf**.



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Quantum Health, Inc. is a renowned health care coordination and consumer navigation company committed to delivering excellent service and support to its Members.