STATE OF CONNECTICUT
HEALTH BENEFIT PLAN

PLAN DOCUMENT

Restated as of January 1, 2016

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INTRODUCTION

This document describes the State of Connecticut Health Benefit Plan ("Benefit Plan") for employees, retirees and eligible Dependents. The Benefit Plan is a self-funded governmental health Benefit Plan that is not subject to Employee Retirement Income Security Act ("ERISA"). The State has contracted with two insurance carriers, Anthem Blue Cross and Blue Shield (Anthem BCBS) and UnitedHealthcare/Oxford, to provide claims processing, disease management and other administrative services. Subject to collective bargaining, the State has the right to change the benefits under the health Benefit Plan and to interpret the meaning of the Plan Document.

This Plan Document explains the benefits, exclusions, limitations, terms and conditions of membership, and the guidelines that must be followed to obtain benefits for Covered Services. All the defined terms used in this Plan Document have been capitalized and have the meanings set forth below. The terms of this Plan Document shall govern and supersede any previous versions thereof and any outlines or other summaries distributed by the State of Connecticut.

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

Office of the State Comptroller
Healthcare Policy & Benefit Services Division
55 Elm Street
Hartford, CT 06016

II. PLAN DESCRIPTIONS

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

A. POE Gated —Point of Enrollment Gatekeeper

The point of enrollment gatekeeper plan offers healthcare services only from a defined network of Providers. Out-of-Network care is covered only in the case of emergencies. You must select a primary care physician (PCP) to coordinate all care, and referrals are required for all specialist services. Healthcare services obtained outside the network may not be covered.

B. POE—Point of Enrollment

The point of enrollment plan offers healthcare services only from a defined network of Providers. Out-of-Network care is covered in the case of emergencies. No referrals are necessary to receive care from In-Network Providers. Healthcare services obtained outside the network may not be covered.

C. POS—Point of Service

The point of service plan offers healthcare services both within and outside a defined network of Providers. No referrals are necessary to receive care from In-Network Providers. Healthcare services obtained outside the network may require precertification and are generally reimbursed at 80% of the allowable cost (after payment of the annual deductible). You will also pay 100% of the amount that your Out-of Network Provider bills above the Maximum Allowable Amount. When you use an Out-of-Network Provider, you will pay more for most services. Members using Out-of-Network services may also be subject to service limits that are not applicable to In-Network care. Using an Out-of-Network Provider will result in higher Member costs.

D. State Preferred—POS

This plan is closed to new Members. The State Preferred point of service plan offers healthcare services both within and outside a defined network of Providers. No referrals are necessary to receive care from In-Network Providers. Healthcare services obtained outside the network may require precertification and are reimbursed at 80% of the allowable cost (after you pay the annual deductible). You will also pay 100% of the amount that your Out-of Network Provider bills above the Maximum Allowable Amount. When you use an Out-of-Network Provider, you will pay more for most services. Members using Out-of-Network services may also be subject to service limits that are not applicable to In-Network care. The State Preferred point of service plan is only offered

through Anthem Blue Cross Blue Shield and has a slightly different Provider network than the other Anthem plans.

E. Out of Area Plan

The Out of Area point of service plan offers healthcare services both within and outside a defined network of Providers. This plan is only available to Members who reside outside the state of Connecticut. No referrals are necessary to receive care from In-Network Providers. Healthcare services obtained outside the network may require precertification and will be reimbursed at 80% of the allowable cost (after payment of the annual deductible). You will also pay 100% of the amount that your Out-of Network Provider bills above the Maximum Allowable Amount. When you use an Out-of-Network Provider, you will pay more for most services. Members using Out-of-Network services may also be subject to service limits that are not applicable to In-Network care. Using an Out-of-Network Provider will result in higher Member costs.

F. Health Enhancement Program

The Health Enhancement Program ("HEP") is an incentive program that rewards Members who commit to taking an active role in managing their health. Members who sign up for HEP will qualify for lower premiums, reduced Co-pays for certain services and medications, and waiver of annual deductibles on In-Network services. All family members enrolled in HEP must obtain age-appropriate preventive care and screenings; those with one or more chronic conditions (diabetes, asthma and COPD, heart failure or heart disease, hyperlipidemia, and hypertension) may be required to participate in counseling or condition management programs services.

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

Care Management Solutions, Inc.
175 Scott Swamp Road
Farmington, CT 06034
877-687-1448

G. Carrier Contact Information

For information about Physicians and Providers in each Carrier's network Members can contact Anthem Blue Cross and Blue Shield or UnitedHealthcare/Oxford by calling the telephone number printed on your ID card or as follows:

Anthem Blue Cross and Blue Shield Member Services 108 Leigus Road Wallingford, CT 06492 1-800-922-2232 www.anthem.com/statect	**UnitedHealthcare/Oxford** PO Box 29135 Hot Springs, AR 71903 1-800-385-9055 http://stateofct.welcometouhc.com

II. SCHEDULE OF BENEFITS

POINT OF ENROLLMENT (POE) POINT OF ENROLLMENT – GATEKEEPER (POE-G)	
GENERAL INFORMATION	**Cost-Share**
Lifetime Maximum Benefit	None
Upfront Deductible Waived for HEP Members and pre-October 2, 2011 Retirees	$350 per person, $1400 family maximum
Maximum Out of Pocket (Annual) (Excluded from calculation: premiums, balance billing, out-of-pocket cost sharing, deductibles, charges for non-covered services)	$2000 individual $4000 family
Person Responsible for Obtaining Prior Authorization	Primary Care Physician/Provider
PREVENTIVE CARE	**Cost-Share**
Well Child Care	No Co-pay
Adult Physical Exams	No Co-pay
Preventive Gynecological exam	No Co-pay
Mammography	No Co-pay
Immunizations and vaccinations (Includes those needed for travel)	No Co-pay
MEDICAL SERVICES	**Cost-Share**
Primary Care Physician (Including in-office procedures)	$15 per visit ($5 for pre-1999 retirees)
Participating Physician (Specialist) (Includes in-office procedures)	$15 per visit ($5 for pre-1999 retirees)
Vision exam and Refraction One exam refraction per Calendar Year (Co-pay waived for HEP members every other year)	$15 per visit
Routine Hearing Screening: One per calendar year (when performed as part of an exam)	$15 per visit
Outpatient Surgery performed in hospital or licensed ambulatory surgery center (Includes colonoscopy) **Prior Authorization may be required)**	No Co-pay*
Non-Surgical Services of a Physician or Surgeon (Other than medical office visit, may include after care or attending medical care)	No Co-pay*

*Non-HEP Members must satisfy deductible before being covered at "no charge" for Participating Provider care. Deductible does not apply to Preventive Care.

MEDICAL SERVICES	Cost-Share
Maternity—Prenatal services ((first visit only))	$15 Co-pay ($5 for pre-1999 retirees)
Infertility Services Office Visit Outpatient Hospital /Inpatient Hospital	 $15 Co-pay/ ($5 for pre-1999 retirees) No Co-pay*
Gender Identity Disorder Services Office Visit Outpatient Hospital/ Inpatient Hospital	 $15 Co-pay/ ($5 for pre-1999 retirees) No Co-pay*
Bariatric Surgery Office Visit Outpatient Hospital/ Inpatient Hospital	 $15 Co-pay/ ($5 for pre-1999 retirees) No Co-pay*
Allergy Office Visit/Testing	$15 per visit ($5 for pre-1999 retirees)
Allergy Injection--Immunotherapy or other therapy treatments	No Co-pay *
Surgical Removal of breast implant	No Co-pay*
HOSPITAL SERVICES	**Cost-Share**
All Inpatient Admissions including childbirth (Prior Authorization required)	No Co-pay*
Ancillary Services (Prior Authorization required)	No Co-pay*
Skilled Nursing Facility (Prior Authorization required)	No Co-pay*
Hospice Care Inpatient Unlimited **(Prior Authorization required)**	No Co-pay*
EMERGENCY SERVICES/ URGENT CARE/WALK-IN CLINICS	**Cost-Share**
Emergency Room Treatment **Co-payment waived if Admitted to Hospital**	 $35[1] Co-pay
Emergency Ambulance Services	No Co-pay*
Urgent Care Center/ Walk-in Clinic (no coverage for out-of-network providers with exception of urgent care services provided outside of United States)	$15 per visit /($5 for pre-1999 retirees)
OTHER HEALTH CARE SERVICES	**Cost-Share**
Radiological and High Cost Diagnostic Tests: MRI, MRA, CAT, CTA, PET and SPECT scans (Prior Authorization required)	No Co-pay*
Radiation Therapy	No Co-pay*
Diagnostic, Laboratory and X-ray Services	No Co-pay*
Nutritional Counseling **Maximum 3 visits per Covered Person Per Calendar Year**	 No-Co-pay*
Private Duty Nursing **(Prior Authorization required)**	No Co-pay*
Infusion Therapy	No Co-pay*
Acupuncture (Coverage may vary by Carrier)	$15 per visit

[1] Not required for pre-October 2, 2011 retirees

*Non-HEP Members must satisfy deductible before being covered at "no charge" for Participating Provider care. Deductible does not apply to Preventive Care.

OTHER HEALTH CARE SERVICES	Cost-Share
Home Health Care Maximum benefit	No Co-pay* 200 visits per calendar year
In-Home Hospice	No Co-pay*
OUTPATIENT REHABILITATION SERVICES:	**Cost Share**
Physical or Occupational Therapy (Prior Authorization Required)[2]	No Co-pay*
Speech therapy—Coverage limited to treatment resulting from autism, stroke, tumor removal, injury or congenital anomalies of the oropharynx	No Co-pay*
Chiropractic Therapy	No Co-pay*
Autism Services: Behavioral Therapy/Outpatient Rehabilitation	No Co-pay*
Cardiac Rehabilitative Therapy	No Co-pay*
Other Therapy Services: Radiation, Chemotherapy for treatment of cancer, Electroshock, Kidney Dialysis in Hospital or free-standing dialysis center	No Co-pay*
MEDICAL DEVICES/SUPPLIES	**Cost Share**
Durable Medical Equipment **(Prior Authorization may be required)**	No Co-pay
Home Oxygen / Diabetic equipment and supplies / **Medical and ostomy supplies**	No-Co-pay
Hearing Aids—Coverage limited to Dependent children 12 years of age or younger. (Limited to one set of hearing aids within a 24 month period) **Effective July 1, 2016—**Age restriction on Coverage will be removed, benefit limited to one set of hearing aids within a 24 month period	No Co-pay
Prosthetic Devices and Appliances	No Co-pay
Wig-- Covered only if prescribed by a licensed oncologist for patient suffering hair loss due to chemotherapy, **ONE PER CALENDAR YEAR.**	No Co-pay
Specialized Formula (Subject to Prior Authorization)	No Co-pay
Foot Orthotics	No Co-pay
MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES	**Cost Share**
Outpatient Mental Health	$15 per visit /$5 for pre-1999 retirees
Inpatient Mental Health (Subject to Prior Authorization)	No Co-pay *
Outpatient Substance Abuse	$15 per visit /$5 for pre-1999 retirees
Inpatient Substance Abuse (Subject to Prior Authorization)	No Co-pay*

[2] Waived for pre-Oct. 2, 2011 retirees

*Non-HEP Members must satisfy deductible before being covered at "no charge" for Participating Provider care.

POINT OF SERVICE PLANS		
GENERAL INFORMATION	**IN-NETWORK**	**OUT-OF-NETWORK**
Covered Person Upfront Deductible (Waived for HEP members and pre-October 2, 2011 Retirees)	$350 per person, $1400 family maximum*	Not Applicable
Out-of-Network Deductible	Not Applicable	$300 individual, $600 two person, $900 family
Out-of-Network Cost-Share (Coinsurance after meeting Deductibles)	Not Applicable	20% of allowable charges plus 100% of billed charges in excess of allowable charges
Maximum Out of Pocket (Annual) (Excluded from calculation: premiums, balance billing, out-of-pocket cost sharing, deductibles, charges for non-covered services)	$2000 individual/$4000 family	$2000 individual/$4000 family
Lifetime Maximum	None	None
Person responsible for obtaining Prior Authorization	Participating Provider	Member
Penalty for failing to obtain Prior Authorization		$500 or 20% of allowable charges, whichever is less
PREVENTIVE SERVICES	**Cost Share**	**Cost Share**
Well Child Care:	No Co-pay	Deductible plus Coinsurance
Adult Physical Exams:	No Co-pay	Deductible plus Coinsurance
Preventive Gynecological Visit	No Co-pay	Deductible plus Coinsurance
Mammography	No Co-pay	Deductible plus Coinsurance
Immunizations and Vaccinations Includes those needed for travel	No co-pay	Deductible plus Coinsurance
MEDICAL SERVICES	**Patient Share**	**Patient Share**
Primary Care Physician (Includes in-office procedures)	$15 Co-pay $5 for pre-1999 retirees	Deductible plus Coinsurance
Specialist Physician (Includes in-office procedures)	$15 Co-pay $5 for pre-1999 retirees	Deductible plus Coinsurance
Vision exam and Refraction: Limit	$15 Co-pay ** 1 exam per calendar year	Deductible plus 50% Coinsurance 1 exam per calendar year
Routine Hearing Screening: One per calendar year (when performed as part of an exam)	$15 Co-pay	Deductible plus Coinsurance
Outpatient Surgery performed in hospital or licensed ambulatory surgery center (Includes colonoscopy) **(Prior Authorization required)**	No Co-pay*	Deductible plus Coinsurance

*Non-HEP Members must satisfy deductible before being covered at "no charge" for Participating Provider care
**(Co-pay Waived for HEP members every other year)

POINT OF SERVICE PLANS		
GENERAL INFORMATION	**IN-NETWORK**	**OUT-OF-NETWORK**
Non-Surgical Services of a Physician or Surgeon(Other than medical office visit, may include after care or attending medical care)	No Co-Pay*	Deductible plus Coinsurance
Maternity Outpatient (first visit only)	$15 Co-pay ($5 for pre-1999 retirees)	Deductible plus Coinsurance
Infertility Services Office Visit Outpatient Hospital/ Inpatient Hospital	 $15 Co-pay/ ($5 for pre-1999 retirees) No Co-pay*	Deductible plus Coinsurance
Gender Identity Disorder Services Office Visit Outpatient Hospital/Inpatient Hospital	$15 Co-pay/$5 for pre-1999 retirees) No Co-pay*	Deductible plus Coinsurance
Bariatric Surgery Office Visit Outpatient Hospital/ Inpatient Hospital	 $15 Co-pay No Co-pay*	Deductible plus Coinsurance
Allergy Office Visit/Testing	$15 Co-pay $5 for pre-1999 retirees	Deductible plus Coinsurance
Allergy Injections Immunotherapy or other therapy treatments	No Co-pay*	Deductible plus Coinsurance
EMERGENCY/ URGENT CARE SERVICES	**Cost Share**	**Cost Share**
Emergency Room Treatment **Waived if patient Admitted to hospital**	$35 Co-pay [3]	$35 Co-pay [4]
Urgent Care Clinic/Walk-in Clinic (Out of country urgent care --$15 co-pay)	$15 Co-pay $5 for pre-1999 retirees	Deductible plus Coinsurance
Emergency Ambulance	No Co-pay *	No Co-pay*
OTHER HEALTHCARE SERVICES	**Cost Share**	**Cost Share**
High Cost Radiological & Diagnostic Tests: MRI, MRA, CAT, CTA, PET and SPECT scans (Prior authorization required)	No Co-pay*	Deductible plus Coinsurance
Diagnostic, Laboratory and X-ray Services	No Co-pay*	Deductible plus Coinsurance
Radiation Therapy	No Co-pay*	Deductible plus Coinsurance

[3] Not required for pre-October 2, 2011 retirees

*Non-HEP Members must satisfy deductible before being covered at "no Co-pay" for all In-Network services except Preventive Care.

[4] Not required for pre-October 2, 2011 retirees

POINT OF SERVICE PLANS		
GENERAL INFORMATION	**IN-NETWORK**	**OUT-OF-NETWORK**
Nutritional Counseling **Maximum of 3 visits per Covered Person per Calendar Year**	No Co-pay*	Deductible plus Coinsurance
Private Duty Nursing **(Prior Authorization Required)**	No Co-pay*	Deductible plus Coinsurance
Home Health Care **Utilization Limits**	No Co-pay* 200 visits per calendar year	Deductible plus Coinsurance 200 visits per calendar year
In-Home Hospice	No Co-pay*	Deductible plus Coinsurance 200 visits per calendar year
Acupuncture (Coverage may vary by Carrier)	$15 Co-pay	Deductible plus Coinsurance
Infusion Therapy **Unlimited**	No Co-pay*	Deductible plus Coinsurance
Surgical Removal of breast implant	No Co-pay*	Deductible plus Coinsurance
HOSPITAL SERVICES	**Cost Share**	**Cost Share**
All Inpatient Admissions including Childbirth **(Prior Authorization required)**	No Co-pay*	Deductible plus Coinsurance
Ancillary Services (Prior Authorization required	No Co-pay*	Deductible plus Coinsurance
Specialty Hospital **(Prior authorization required)** Utilization limit	No Co-pay* None	Deductible plus Coinsurance 60 days per Covered Person per calendar year
Skilled Nursing Facility **(Prior authorization required)** Utilization limit	No Co-pay* None	Deductible plus Coinsurance 60 days per Covered Person per calendar year
Inpatient Hospice Care **(Prior authorization required)** Utilization limit	No Co-pay* None	Deductible plus Coinsurance 60 days per Covered Person per calendar year

OUTPATIENT REHABILITATION SERVICES	Cost Share	Cost Share
Physical or Occupational Therapy **Prior Authorization may be required**[5] **Benefit limit**	No Co-pay* None	Deductible plus Coinsurance 30 visits per calendar year
Chiropractic Therapy **Benefit Limit**	No Co-pay* None	Deductible plus Coinsurance** 30 visits per calendar year
Speech therapy: Covered only for treatment resulting from autism, stroke, tumor removal, injury or congenital anomalies of the oropharynx **Benefit limit:**	No Co-pay* None	Deductible plus Coinsurance 30 visits per condition per Calendar Year
Autism Services: Behavioral Therapy, Outpatient, Rehabilitation, Physical, occupational & speech therapy	No Co-pay*	Deductible plus Coinsurance
Cardiac Rehabilitation Therapy	No Co-pay*	Deductible plus Coinsurance
Other Therapy Services: Radiation, Chemotherapy for treatment of cancer, Electroshock, Kidney Dialysis **(Prior Authorization may be required)**	No Co-pay*	Deductible plus Coinsurance
MEDICAL DEVICES/SUPPLIES	**Cost Share**	**Cost Share**
Durable Medical Equipment and Prosthetic Devices **(Prior Authorization may be required)**	No Co-pay	Deductible plus Coinsurance
Home Oxygen **Diabetic equipment and supplies**	No Co-pay	Deductible plus Coinsurance
Specialized Formula **Prior Authorization required)**		Deductible plus Coinsurance
Wig—Covered only for patient who suffers hair loss as result of chemotherapy (One per Covered Person per Calendar Year)	No Co-pay	No Co-pay
Foot Orthotics **(Prior Authorization may be required)**	No Co-pay	Deductible plus Coinsurance
Medical and Ostomy Related Services		Deductible plus Coinsurance
Hearing Aids—Coverage limited to Dependent children 12 years of age or younger. (Limited to one set of hearing aids within a 24 month period) **Effective July 1, 2016—**Age restriction on Coverage will be removed, benefit limited to one set of hearing aids within a 24 month period **(Prior Authorization may be required)**		Deductible plus Coinsurance

[5] Waived for pre-October 2, 2011 retirees

*Non-HEP Members must satisfy deductible before being covered at "no Co-pay" for all In-Network services except Preventive Care.

MENTAL HEALTH/ADDICTION	Cost Share	Cost Share
Outpatient Treatment for Mental Health Care	$15 per visit ($5 for pre-1999 retirees)	Deductible plus Coinsurance
Inpatient Treatment In a Hospital or Residential Treatment Center for Mental Health Care **(Prior Authorization required)**	No Co-pay*	Deductible plus Coinsurance
Outpatient: Substance Abuse	$15 per visit ($5 for pre-1999 retirees)	Deductible plus Coinsurance
Inpatient Substance Abuse Treatment In a Hospital or Substance Abuse Treatment Facility **(Prior Authorization required)**	No Co-Pay*	Deductible plus Coinsurance

*Non-HEP Members must satisfy deductible before being covered at "no charge" for Participating Provider care. Deductible does not apply to Preventive Care.

III. DEFINITIONS

ADMISSION means the period from the date the Covered Person enters the Hospital, Skilled Nursing Facility, Substance Abuse Treatment Facility, Residential Treatment Facility, Hospice, or other Inpatient Facility as an Inpatient until the date of discharge. When counting days of Inpatient services, the date of entry and date of discharge are combined to count together as one day.

> **ELECTIVE ADMISSION** means an Inpatient Admission which is Medically Necessary, and scheduled in advance where the Covered Person does not require immediate medical treatment to prevent death, disability or serious impairment of bodily part or function.

AFFORDABLE CARE ACT means the Patient Protection and Affordable Care Act (P.L. 111-148) and the Health Care and Education Reconciliation Act of 2010.

AUTHORIZE means that approval has been obtained from the Carrier for the Emergency Admission of a Covered Person to a Hospital, Skilled Nursing Facility, Substance Abuse Treatment Facility, Residential Treatment Facility, or Hospice when required under the terms of this Benefit Plan.

AUTISM BEHAVIORAL THERAPY means Behavioral Therapy provided by, or under the supervision of, a behavior analyst certified by the Behavior Analyst Certification Board, a licensed Physician, or a licensed psychologist. "Supervision" means at least 1 hour of face-to-face supervision of the Autism Services Provider for each ten hours of Behavioral Therapy provided by the supervised certified assistant behavior analyst or behavior therapist.

AUTISM SPECTRUM DISORDERS means "autism spectrum disorder "as set forth in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders," The results of an autism spectrum disorder diagnosis shall be valid for a period of twelve months unless the Covered Person's licensed Physician, licensed psychologist, or licensed clinical social worker determines a shorter period is appropriate or changes the results of the Covered Person's diagnosis.

BEHAVIORAL THERAPY means any interactive behavioral therapies derived from evidence-based research, including, but not limited to, applied behavior analysis, cognitive behavioral therapy, or other therapies supported by empirical evidence of the effective treatment of individuals diagnosed with an autism spectrum disorder, that are: (A) Provided to children less than twenty-one years of age, and (B) provided or under the supervision of an Autism Behavioral Therapy Provider.

BENEFIT PLAN means the State of Connecticut Health Benefit Plan identified on the cover page of the Plan Document and described herein.

Active Benefit Plan refers to the health benefit plan and premium structure applicable to Covered Employees while they are actively employed by the State of Connecticut.

Retiree Benefit Plan refers to the healthcare coverage and premium shares applicable to Covered Employees who have retired from employment with the State of Connecticut. In some instances, benefit limitations and Prior Authorization requirements may be waived for retired employees who retired on or before a specified date.

BIRTHCENTER means a facility separate from a Hospital that provides room, board and Special Services related to the management of normal childbirth. Synonymous terms are Birthing Center and Childbirth Center.

CALENDAR YEAR means a period beginning 12:01 a.m. on January 1 and ending midnight on December 31 of the same year.

CANCER CLINICAL TRIAL 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 in human beings, except that a clinical trial for the prevention of cancer is eligible for coverage only if it involves a therapeutic intervention and is a Phase III clinical trial that is conducted at multiple institutions. A Cancer Clinical Trial must be conducted under the auspices of an independent peer-reviewed protocol that has been reviewed and approved by:

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

CARRIER means either Anthem Blue Cross and Blue Shield or UnitedHealthcare/Oxford, the entities chosen by the State of Connecticut to administer benefits and process claims under the Benefit Plan. With regard to administration of benefits, the term shall refer to the Carrier that has issued an ID card to the Covered Person.

CASE MANAGEMENT means the process of evaluating and arranging for Medically Necessary treatment for patients, identified through the use of one or more managed care programs.

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

COINSURANCE means a fixed percentage of the Maximum Allowed Amount for Covered Services which the Covered Person is required to pay as specified in the Schedule of Benefits.

CONCURRENT REVIEW means a process to monitor an Inpatient Admission to decide its continued Medical Necessity, starting from the assignment of the initial Prior Authorization of days and continuing to the Covered Person's discharge.

CO-PAYMENT means a fixed amount which the Covered Person is required to pay for Covered Services as listed in the Schedule or Benefits. This fee is payable by a Covered Person at the time that those services are rendered.

COST-SHARE means the amount which the Covered Person is required to pay for Covered Services. Where applicable, Cost-Shares can be in the form of Co-payments, Coinsurance, and/or Deductibles.

COST-SHARE MAXIMUM means the Deductible and Coinsurance amounts which are paid by the Covered Person on a Calendar Year basis. The Cost-Share Maximum does not include Co-payments, Penalties, Cost-Shares applicable to Inpatient Hospital/Inpatient Facility Admission, Cost-Shares applicable to service beyond the Benefit Plan's limits for those benefits, Cost-Shares for human organ and tissue transplants when the facility is not designated and approved by the Carrier, and charges that exceed the Maximum Allowed Amount.

COVERED EMPLOYEE means an active or retired employee of the State of Connecticut who satisfies the requirements for eligibility and who is duly enrolled in the Benefit Plan.

COVERED PERSON means a person who becomes eligible for Covered Services under this Benefit Plan, has enrolled in this Benefit Plan, and in whose name an ID card is issued by a Carrier.

COVERED SERVICES means services, supplies or treatment as described in this Plan Document. To be a Covered Service, the service, supply or treatment must be:

- Medically Necessary or otherwise specifically included as a benefit under this Plan Document.
- Within the scope of the license of the Provider performing the service.
- Rendered while coverage under this Plan Document is in force.
- Not Experimental or Investigational or otherwise excluded or limited by the Plan Document.
- Authorized in advance by Carrier if such Prior Authorization is required under the Plan Document.

CUSTODIAL CARE means care primarily for the purpose of assisting the Covered Person in the activities of daily living or in meeting personal rather than medical needs,

and which is not specific treatment for an illness or injury. It is care which cannot be expected to substantially improve a medical condition and has minimal therapeutic value. Such care includes, but is not limited to:

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

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

DATE OF PLACEMENT means the assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of adoption of the child.

DAY/NIGHT VISIT means continuous treatment consisting of not less than 4 hours and not more than 12 hours in any 24 hour period when received in a General or Specialty Hospital or in a Substance Abuse Treatment Facility.

DEDUCTIBLE means an annual fixed dollar that a member has to pay before the Plan pays for covered medical services. The deductible starts to accrue as of July 1st of each year. The Deductible excludes premiums, co-payments, coinsurance, balance billed charges, and payments for services the Plan does not cover. There are two Deductibles under this Plan, an Out-of Network Deductible and the Upfront Deductible. Both Deductibles begin on July 1st, the first day of the Plan Year.

Out-of-Network Deductible means the amount you have to pay up to the deductible amount before this Plan begins to pay for covered Out-of-Network services you use. The Out-of Network Deductible is $300 per individual and $900 per family per year. You can avoid this deductible by using In-Network services.

Upfront Deductible means an amount you must pay up to the deductible amount before this Plan begins to pay for covered services you use. This deductible applies to In-Network services. For In-Network services the Upfront Deductible applies only to

services listed as “no copay” with the exception of those listed under “Preventive Care”. The Upfront Deductible is $350 per individual and $350 per family member up to a maximum of $1400 per year. You can avoid the Upfront Deductible by enrolling in the Health Enhancement Plan.

DEPENDENT means a Covered Employee’s lawful spouse under a legally valid existing marriage or civil union and any children who meet the requirements for coverage as a Dependent as set forth in Eligibility Section below.

DURABLE MEDICAL EQUIPMENT means equipment which:

- Is designated for repeated use in the Medically Necessary Care, diagnosis, or treatment of an illness or injury;
- Improves the function of a malformed body part or prevents, or retards further worsening of the Covered Person’s medical condition; and
- Is not useful in the absence of injury or illness.

EFFECTIVE DATE means the date a Covered Person and his or her Dependents, if any, are enrolled in coverage and eligible to receive benefits for Covered Services under this Benefit Plan.

EXPERIMENTAL OR INVESTIGATIONAL means any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, 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 Carrier determines in its sole discretion to be Experimental or Investigational.

A. The Carrier 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:

1. Cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (“FDA”), or any other state or federal regulatory agency, and such final approval has not been granted; or
2. Has been determined by the FDA to be contraindicated for the specific use; or
3. 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

4. Is subject to review and approval of an Institutional Review Board ("IRB") or other body serving a similar function; or
5. 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.

B. Any service not deemed Experimental or Investigational based on the criteria in subsection A may still be deemed to be Experimental or Investigational by the Carrier. In determining whether a service is Experimental or Investigational, the Carrier will consider the information described in subsection C and assess the following:

1. Whether the scientific evidence is conclusory concerning the effects of the service or health outcomes;
2. Whether the evidence demonstrates that 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;
3. 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; and
4. Whether the evidence demonstrates the service has been shown to improve the net health outcomes of the total population of whom the service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.

C. The information considered or evaluated by the Carrier to determine whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental or Investigational under subsections A and B may include one or more items from the following list, which is not all inclusive:

1. Published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or
2. Evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or
3. 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

4. Documents of an IRB or other similar body performing substantially the same function; or
5. 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
6. 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
7. Medical records; or
8. The opinions of consulting Providers and other experts in the field.

D. The Carrier has the sole authority and discretion to 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 if they have successfully completed a Phase III clinical trial of the Federal Food and Drug Administration, 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.

GENDER IDENTITY DISORDER means a condition in which a person feels a strong and persistent identification with the opposite gender accompanied with a severe sense of discomfort in their own gender.

HOSPICE means a facility, organization or agency certified by Medicare that is primarily engaged in providing pain relief, symptom management, and supportive services to terminally ill people and their families.

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

1. **General Hospital** means a Hospital which is licensed as such by the State of Connecticut and has appropriate accreditation from the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

If out-of-state, a General Hospital must have equivalent state licensure and accreditation.

2. **Specialty Hospital** means a Hospital which is not a General Hospital but which is licensed by the State of Connecticut as a certain type of Specialty Hospital and has appropriate accreditation from the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

   If out-of-state, a Specialty Hospital must have state equivalent licensure and accreditation.

3. **Participating Hospital** means a Hospital designated and accepted as a Participating Hospital by the Carrier to provide Covered Services to Covered Persons under the terms of the Benefit Plan.
4. **Non-Participating Hospital** means any appropriately licensed Hospital which is not a Participating Hospital under the terms of the Benefit Plan.
5. **Mobile Field Hospital** means a modular, transportable facility used intermittently, deployed at the discretion of the Governor, or the Governor's designee, for the purpose of training or in the event of a public health or other emergency for isolation care purposes or triage and treatment during a mass casualty event, or for providing surge capacity for a hospital during a mass casualty event or infrastructure failure and is licensed as such by the State of Connecticut.

The following shall not be considered a Hospital:

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

ID CARD means the card issued by the Carrier to a Covered Person for identification purposes which must be shown by the Covered Person to obtain Covered Services.

IN-NETWORK means that a Physician, Provider, or Facility has a participation contract with the Carrier that has issued the ID card to the Covered Person enrolled in that Benefit Plan.

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

INPATIENT means a Covered Person who occupies a bed in a Hospital or other 24 hour care facility, receives board as well as diagnosis, care, or treatment and is counted as an Inpatient at the time of a Hospital or 24 hour care facility census.

INPATIENT FACILITY means a facility other than a Hospital that provides board as well as a diagnosis, care, or treatment on a 24 hour-a-day basis to patients, such as a Skilled Nursing Facility, Hospice, Substance Abuse Treatment Facility, Substance Care Facility, or Residential Treatment Facility.

LATE ENROLLEE means an eligible employee and/or Dependent who requests health benefit coverage following the Open Enrollment Period Effective Date, if applicable, or more than 31 days after the employee's and/or Dependent's earliest chance to enroll for coverage under the Benefit Plan.

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

LOCAL NETWORK AREA means the State of Connecticut and any area outside of the State of Connecticut that the Carrier designates as part of the Local Network Area for the Covered Person.

MAINTENANCE CARE means treatment provided for the Covered Person's continued well-being by preventing deterioration of the Covered Person's chronic clinical condition, and maintenance of an achieved stationary status which is at a point where little or no measurable objective improvement in musculo-skeletal function can be effectuated despite therapy.

MAXIMUM ALLOWED AMOUNT (MAA) means the maximum amount of reimbursement the Carrier will allow for services and supplies:

- that meet the Benefit Plan's definition of Covered Services, to the extent such services and supplies are not excluded,
- that are Medically Necessary, and
- that are provided in accordance with all applicable Prior Authorization, utilization management or other requirements set forth in this Benefit Plan.

Reimbursement for services rendered by Participating and Non-Participating Providers is based on the Benefit Plan's Maximum Allowed Amount for the Covered Service. When you receive Covered Services from a Provider, the Carrier will apply claim processing rules to the claim submitted for those Covered Services. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the procedure and diagnosis codes included in the claim. Applying these rules may affect the Carrier's determination of the Maximum Allowed Amount.

The Carrier's application of these rules does not mean that the Covered Services you received were not Medically Necessary. It only means the Carrier has determined that the claim submission was inconsistent with procedure coding rules and/or reimbursement policies. For example, a Provider may have submitted the claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed. When this occurs, the Maximum Allowed Amount will be based on the single procedure code rather than a separate Maximum Allowed Amount for each billed code.

When multiple procedures are performed on the same day by the same Provider, or other healthcare professional, the Carrier may reduce the Maximum Allowed Amounts for those secondary and subsequent procedures because reimbursement at 100% of the Maximum Allowed Amount for those procedures would represent duplicative payment for components of the primary procedure that may be considered incidental or inclusive.

Impact of Provider Network Status

The Maximum Allowed Amount may vary depending upon whether the Provider is a Participating Provider or a Non-Participating Provider of the Carrier that has issued the ID card to the Covered Person.

In-Network Services. A Participating Provider is a Provider who has a participation contract with the Carrier that has issued the ID card to the Covered Person, who is in the network for this specific Benefit Plan or in a special center of excellence or other closely managed specialty network of the Carrier. For Covered Services performed by a Participating Provider, the Maximum Allowed Amount under the Benefit Plan is the rate the Provider has agreed to accept as reimbursement for the Covered Services. Participating Providers have agreed to accept the Maximum Allowed Amount as payment in full for those Covered Services; they should not send a bill or collect for amounts beyond the applicable Co-pay.

Out-of-Network Services. Providers who have not signed any contract with the Carrier and are not in any of the Carrier's networks are Non-Participating or Out-of-Network Providers. For Covered Services received from a Non-Participating Provider, the Maximum Allowed Amount for your Benefit Plan will be one of the following as determined by the Carrier:

1. An amount based on its Non-Participating Provider fee schedule/rate, which may be modified from time to time, after considering reimbursement amounts for like/similar Providers, for the same services or supplies, and other industry cost, reimbursement and utilization data; or
2. An amount based on the level and/or method of reimbursement used by the Centers for Medicare and Medicaid Services for the same services or supplies; or
3. An amount based on information provided by a third party vendor, which may reflect: (a) the complexity or severity of treatment, (b) level of skill and experience required for the treatment, or (c) comparable Providers' fees and costs to deliver care; or

4. An amount negotiated by the Carrier or a third party vendor which has been agreed to by the Provider, which may include rates for services coordinated through case management; or
5. An amount equal to the total charges billed by the Provider, but only if such charges are less than the Maximum Allowed Amount calculated by using one of the methods described above.

Providers who are not contracted for your particular Plan with a Carrier (for example a POE plan), but did contract for other Plans offered by the same Carrier (for example, the POS plan), are also considered Non-Participating. For your Benefit Plan the Maximum Allowed Amount reimbursement for services from these Providers will be one of the five methods shown above unless the contract between The Carrier and that Provider specifies a different amount.

Non-Participating Providers may bill the Covered Employee and collect for the amount of the Provider's charge that exceeds the Carrier's Maximum Allowed Amount. The Covered Employee is responsible for paying the difference between the Maximum Allowed Amount and the amount the Provider charges. This amount can be significant. Choosing a Participating Provider will likely result in lower out of pocket costs. Call your Carrier's Customer Service for help in finding a Participating Provider.

Each Carrier's Customer Service can assist you in determining the Benefit Plan's Maximum Allowed Amount for a particular service from a Non-Participating Provider. To calculate your out-of-pocket responsibility you will need to obtain from your Provider the specific procedure code(s) and diagnosis code(s) for the services the Provider will render, and the Provider's charges. Each Carrier's Customer Service can assist you with this pre-service information; however, the final Maximum Allowed Amount will be based on the actual claim submitted.

Covered Person Cost-Share

For certain Covered Services a Covered Person may be required to pay a part of the Maximum Allowed Amount as a Cost-Share amount (for example, Deductible, Co-payment, and/or Coinsurance).

The Cost-Share amount and Cost-Share Maximum limits may vary depending on whether services were provided by a Participating or Non-Participating Provider or depend upon the benefit plan selected. The Schedule of Benefits in this Plan Document summarizes the Cost-Share responsibilities and limitations. The Carrier's Customer Service can advise how Benefit Plan benefits or Cost-Share amounts may vary by the type of Provider used.

In some instances you may only be asked to pay the lower In-Network Cost-Share amount when you use a Non-Participating Provider. For example, if you go to a Participating Hospital or Provider Facility and receive Covered Services from a Non-Participating Provider, such as a radiologist, anesthesiologist or pathologist who is employed by or contracted with a Participating Hospital or facility, you will pay the In-Network Cost-Share amounts for those Covered Services. However, you also may be

liable for the difference between the Maximum Allowed Amount and the Non-Participating Provider's charge. In addition, if you receive Covered Services in a Non-Participating General Hospital in Connecticut, you will pay the lower In-Network Cost-Share amount and will not be balance billed for any difference between the In-Network and Non-Participating Hospital's charge.

Non-Covered Services

The Benefit Plan will not provide any reimbursement for non-covered services. You will be responsible for the total amount billed by your Provider for non-covered services, regardless of whether such services are performed by a Participating or Non-Participating Provider. Non-covered services are those specifically excluded by the terms of your Benefit Plan and those received after benefits have been exhausted or your eligibility has lapsed. Benefits may be exhausted by exceeding, for example, benefit maximums or day/visit limits.

Authorized Services

In some non-Emergency circumstances, such as where there is no Participating Provider available for a Covered Service, the Carrier may authorize the network Cost-Share amounts (Co-payment, and/or Coinsurance) to apply to a claim for a Covered Service received from a Non-Participating Provider. In such circumstances, you must contact the Carrier before obtaining the Covered Service. The Carrier also may authorize the In-Network Cost-Share amounts to apply to a claim for Covered Services if you receive Emergency services from a Non-Participating Provider and are not able to contact the Carrier until after the Covered Service is rendered. If the Carrier authorizes a Covered Service, you may still be liable for the difference between the Maximum Allowed Amount and the Non-Participating Provider's charge. Contact your Carrier's Customer Service or to request Authorization or information.

MAXIMUM OUT-OF-POCKET means the most that a Covered Member would pay during a coverage period (usually one year) for his or her share of the cost of covered services. The following are not included in calculating the Maximum Out of Pocket: premiums, balance-billed charges, out-of-network coinsurance or cost shares, health care services the plan does not cover, co-payments, and upfront deductibles.

MEDICAL EMERGENCY means a medical or behavioral condition the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect in the absence of immediate medical attention to result in: (a) placing the health of the afflicted Participant in serious jeopardy, or in the case of a behavioral condition placing the health of such Participant or others in serious jeopardy; (b) serious impairment to the member's bodily functions; (c) serious dysfunction of any bodily organ or part of such Participant; or (d) serious disfigurement of such Participant.

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

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

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

All medical emergencies that meet the criteria of a Medical Emergency will be treated as an In-Network service regardless of where care is received, provided that notification protocols have been followed.

MEDICALLY NECESSARY (MEDICALLY NECESSARY CARE, MEDICAL NECESSITY) means health care services that are determined to be Medically Necessary for the diagnosis or treatment of an accidental injury, sickness, disease or pregnancy based on and consistent with standards approved by the Carrier's medical personnel. A determination that a service or supply is not Medically Necessary may apply to the entire service or supply or to any part of the service or supply. The following standards are developed in part with consideration whether the service or supply meets the following:

1. It is clinically appropriate, in terms of type, frequency, extent, site and duration and considered effective for diagnosis or treatment of the patient's illness, injury or disease;
2. It is safe and effective according to accepted clinical evidence reported by generally recognized medical professionals or publications; and
3. There is not a less intensive or more appropriate diagnostic or treatment alternative that could have been used in lieu of the service or supply given.

MEDICARE means Title XVIII of the Social Security Act of 1965, as amended.

MENTAL HEALTH CARE means services provided to treat a mental disorder as defined in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders". Mental Health Care does not include care for: (1) mental retardation, (2) learning disorders, (3) motor skills disorder, (4) communication disorders, (5) caffeine-related disorders, (6) relational problems, and

(7) additional conditions that may be a focus of clinical attention, that are not otherwise defined as mental disorders in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders'.

OPEN ENROLLMENT PERIOD means the period of time during which Employees may select or make changes to their group health coverage.

OUT-OF-NETWORK means that services have been obtained from a Non-Participating Physician, Non-Participating Hospital or other Non-Participating Provider not affiliated with your Carrier under your Benefit Plan. Depending upon the Benefit Plan in which you are enrolled, obtaining treatment or care from an Out-of-Network Provider may result in services not being covered at all (in the case of the POE or POE-G Plans) or being covered but requiring the Covered Person to satisfy a deductible, pay a portion of the allowed amount (usually 20%) and remain liable for payment of billed charges that exceed the Carrier's Maximum Allowed Amount for the service obtained.

OUTPATIENT means that the Covered Person receives services in a Hospital emergency room, Physician's office, or ambulatory surgical facility, and leaves in less than 24 hours.

PARTIAL HOSPITALIZATION means continuous treatment in a General Hospital, Specialty Hospital, or Residential Treatment Facility consisting of not less than 4 hours and not more than 12 hours in any 24 hour period.

PARTICIPANT/MEMBER means a full-time Participant/Member of the Employer who meets the eligibility requirements specified in the Plan.

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

PHYSICIAN means any licensed doctor of medicine (M.D.), osteopathic Physician (D.O.), dentist (D.D.S./D.M.D.), podiatrist (Pod. D/D.S.C./D.P.M.), doctor of chiropractic (D.C.), naturopath (N.D.), optometrist (O.D.), or psychologist (Ph.D./Ed.D./PsyD.) who is licensed to practice in the state in which services are rendered.

> **Participating Physician** means any appropriately licensed Physician designated and accepted as a Participating Physician by the Carrier to provide Covered Services to Covered Persons.
>
> **Non-Participating Physician** means any appropriately licensed Physician who is not a Participating Physician with the Carrier.

PLAN means any Plan which provides benefits or services for Hospital, medical/surgical, or other health care diagnosis or treatment on a group basis.

PLAN DOCUMENT means this document, which describes the benefits, terms and conditions applicable to the Benefit Plan, as it may be amended from time-to-time.

PLAN SPONSOR means the State of Connecticut acting by and through the Office of the State Comptroller.

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

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

2. Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;

3. With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA);

4. With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the HRSA; and

5. With respect to women, Preventive Care benefits include the cost of renting one breast pump per pregnancy in conjunction with childbirth. Benefits for breast pumps also include the cost of purchasing one breast pump per pregnancy in conjunction with childbirth. Benefits are only available if breast pumps are obtained from a DME Provider, Hospital or Physician.

PRIOR AUTHORIZATION (PRIOR AUTHORIZED) means verification of benefits and determination of Medical Necessity, which enables a Covered Person to receive benefits for certain Covered Services.

PROOF means any data that may be required in order to satisfactorily determine an individual's eligibility for coverage or compliance with any provision of this Benefit Plan.

PROSTHETIC DEVICE means any device which replaces all or part of a body organ (including contiguous tissues), or replaces all or part of the function of a permanently inoperative, absent, or malfunctioning part of the body, including leg, arm, back, or

neck braces, or artificial legs, arms or eyes, and any prosthesis with supports, including replacement if a Covered Person's physical condition changes.

PROVIDER means any appropriately licensed or certified health care professional or facility providing health care services or supplies to Covered Persons.

> **Participating Provider** means any appropriately licensed or certified health care professional or facility designated and accepted as a Participating Provider by the Carrier to provide Covered Services to Covered Persons.
>
> **Non-Participating Provider** means any appropriately licensed or certified health care professional or facility that is not a Participating Provider.

QUALIFYING STATUS CHANGE means a change affecting an individual's eligibility for coverage under the Plan (resulting from a change in marital or employment status, number or age of Dependents, or residency) which entitles that individual to make changes in health care enrollment outside of the annual Open Enrollment Period or that would create a right in the affected individual(s) to obtain continuation of coverage under COBRA.

RESIDENTIAL TREATMENT FACILITY means a treatment center which provides residential care and treatment for emotionally disturbed individuals and is accredited by the Council on Accreditation or the Joint Commission on the Accreditation of Health Care Organizations as a Residential Treatment Facility.

ROUTINE PATIENT CARE COSTS means Costs for Medically Necessary health care services that are incurred as a result of treatment rendered to a Covered Person for purposes of a Cancer Clinical Trial that would otherwise be covered if such services were not rendered in conjunction with a Cancer Clinical Trial. Such services shall include those rendered by a Physician, diagnostic or laboratory tests, hospitalization or other services provided to the Covered Person during the course of treatment in Cancer Clinical Trial and coverage for Routine Patient Care Costs incurred for off-label drug prescriptions. Hospitalization for Routine Patient Care Costs shall include treatment at an Out-of-Network facility if such treatment is not available In-Network and is not eligible for reimbursement by the sponsors of such clinical trial. Out-of Network Hospitalization will be rendered at no greater cost to the insured person than if such treatment was available In-Network; all applicable In-Network Cost-Shares will apply.

Routine Patient Care Costs shall not include:

1. The cost of an investigational new drug or device that has not been approved for market for any indication by the federal Food and Drug Administration,
2. The cost of a non-health care service that a Covered Person may be required to receive as a result of the treatment being provided for the purposes of the Cancer Clinical Trial;
3. Facility, ancillary, professional services and drug costs that are paid for by grants or funding for the Cancer Clinical Trial;

4. Costs of services that (a) are inconsistent with widely accepted and established regional or national standards of care for a particular diagnosis, or (b) are performed specifically to meet the requirements of the Cancer Clinical Trial; or
5. 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 Cancer Clinical Trial, for the Covered Person or any family member or companion.

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

SKILLED NURSING FACILITY means any institution that:

1. Accepts, and charges for patients on an Inpatient basis;
2. Is primarily engaged in providing skilled nursing care, rehabilitative, and related services to patients requiring medical, and skilled nursing care;
3. Is under the supervision of a licensed Physician;
4. Provides 24 hour a day nursing service under the guidance of a registered nurse, and
5. Is not a place mainly used for the treatment of nervous-mental disorders, pulmonary tuberculosis, a place of rest, Custodial Care, or acute Inpatient level of care.

SPECIALIZED FORMULA means amino acid modified preparations and low protein modified food products prescribed and administered by a Physician for the treatment of an inherited metabolic disease for individuals who are or will become malnourished or suffer from disorders, which, if left untreated, will cause chronic disability, mental retardation or death**.**

SPECIALIZED INFANT FORMULA means a nutritional formula for children up to age of twelve that is exempt from the general requirements for nutritional labeling under the statutory and regulatory guidelines of the Federal Food and Drug Administration and is intended for use solely under medical supervision in dietary management of specific diseases.

SUBSTANCE ABUSE CARE means services to treat alcoholism or drug dependency.

SUBSTANCE ABUSE TREATMENT FACILITY means a facility which is established primarily to provide 24-hour Inpatient treatment of substance abuse and licensed for such care by the State of Connecticut Department of Public Health and

Addiction Services or other appropriate licensing agency if located outside the State of Connecticut.

TOTALLY DISABLED means that because of an injury or disease a Covered Person is unable to perform the duties of any occupation for which he or she is suited by reason of education, training, or experience.

A Dependent shall be Totally Disabled if because of an injury or disease he or she is unable to engage in substantially all of the normal activities of persons of like age and sex in good health.

The Carrier will determine if a Covered Person is Totally Disabled under the terms of the Benefit Plan. The Covered Person will be required to provide Proof of continued disability if requested to do so.

URGENT CARE means care for an illness or injury which is not a Medical Emergency, but requires immediate medical attention.

URGENT CARE FACILITY means a Provider from whom Urgent Care services may be obtained when a Covered Person's Physician or covering Physician is not available to treat the Covered Person.

VARIABLE HOUR EMPLOYEE means an employee for whom at the time of hire the employer is unable to reasonably determine whether he or she will work an average of 30 hours per week.

WALK-IN CLINIC means a free-standing center providing episodic health services without appointments for diagnosis, care, and treatment of non-urgent conditions or symptoms.

IV. ELIGIBILITY, ENROLLMENT AND TERMINATION OF COVERAGE

A. ELIGIBILITY

1. Active Employees

(a) Unless otherwise specified in an applicable Collective Bargaining Agreement or by the terms of employment an employee must work at least one-half (½) the hours per pay period of a full-time employee in his or her position (0.5 Full Time Equivalent—FTE) to be eligible to participate in the Active Benefit Plan unless the employee's coverage is otherwise required pursuant to the Affordable Care Act. Special rules apply to employees not in classified service, part-time professional employees in higher education agencies, and to non-employee groups participating in the State Employee plans under Section 5-259 of the General Statutes.

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

a. A permanent employee, or

b. A permanent employee in a durational position, following completion of required service as set forth in any applicable union contract or by the first day of the month following the completion of 60 days of required service, whichever is earlier; or

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

d. An employee in the classified service who is hired provisionally (and whose service is extended because of delays in the examination process) should be enrolled for coverage effective on the first day of the month following the completion of 60 days of continuous service.

(b) **Eligibility Rule for "Variable Hour" Employees.**

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

2. Retired Employees

Eligibility for coverage under the Retiree Benefit Plan is determined by statute, collective bargaining agreements, and Memoranda issued by the Office of the State Comptroller.

Medicare-Eligible Retirees

Any retired employee (and his or her enrolled spouse) who is eligible to do so must enroll in both Parts A and B of Medicare. The Retiree Benefit Plan is supplemental to Medicare and will provide benefits to a retired employee (and his or her enrolled spouse, if applicable) only to the extent that coverage for such Services is not provided under Medicare.

Retirees who do not enroll in Medicare under Parts A and B (if eligible to do so) will only be covered for those benefits (approximately 20%) that would not have been covered by Medicare.

Prohibition of Dual Coverage

No individual is permitted to maintain dual coverage as a Covered Employee under the Active Benefit Plan and as a Dependent under the Retiree Benefit Plan (or vice versa). It is also prohibited for the same individual to be simultaneously enrolled as Dependent or beneficiary of more than one State of Connecticut retiree or as the Dependent or beneficiary of a member of the Active Benefit Plan and the Retiree Benefit Plan. A Covered Employee who is dually enrolled in violation of this provision will have 31 days to choose a single plan in which to participate; such election will be applicable with respect to all Dependents enrolled by the Covered Employee. Anyone who fails to make an election within that time will remain in the Plan with the earlier enrollment date (for which they remain eligible), and their duplicate, later coverage will be terminated. If such person subsequently becomes ineligible for coverage as a Dependent of a retiree, such person shall be enrolled in the Plan for which he or she remains qualified.

3. Dependents

This section describes the individuals who are eligible to be enrolled in the Health Benefit Plan as Dependents of a Covered Employee, whether active or retired. The Covered Employee and all Dependents must be enrolled in the same Plan. **The State of Connecticut reserves the right to request Proof of Dependent status at any time.**

The following are eligible to be enrolled as a Dependent:

a. **Spouse or Recognized Civil Union Partner**
The lawful spouse of the Covered Employee under a legally valid, existing marriage or a recognized Civil Union Partner.

Note:

- **In event of the preretirement death of a Covered Employee, a spouse who was not legally married to the deceased employee**

for at least 12 months prior to the date of death is not eligible for continued coverage.

- **An individual from whom you are divorced or legally separated is not eligible for coverage as a "spouse".**

Exceptions:
(1) An individual from whom the Covered Employee is legally separated may be continued under the Plan for up to three (3) years following the date of the judgment or until or remarriage of either party, whichever first occurs, provided the former spouse was covered by the Plan immediately before entry of the legal separation judgment and the Covered Employee 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 Employee's cost of coverage; or

(2) An individual from whom the Covered Employee is divorced may be continued under the Plan for up to three (3) years following the date of the judgment or until or remarriage of either party, whichever first occurs, provided the ex-spouse was covered by the Plan immediately before the divorce and the judgment requires the Covered Employee to provide health insurance coverage for the ex-spouse. Covered Employee 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 Employee's cost of coverage.

b. **Child of the Covered Person or Spouse**
A child of the Covered Employee (includes a step-child, a child legally placed for adoption, a legally adopted child, or a child under the age of 26 for whom the Covered Employee has been designated as the responsible party under a Qualified Medical Child Support Order) will be eligible for coverage..

c. **Newborn Dependent Child**
A newborn child of the Covered Employee will be covered from the moment of birth. In order to maintain coverage the Covered Employee must submit a completed application to add the newborn within 31 days following the date of birth. Eligibility requirements must be met as specified in the preceding section.

Benefits for Covered Services for a newborn shall consist of Medically Necessary care and treatment of injury or sickness, including medically diagnosed congenital defects and birth abnormalities, subject to the terms, conditions, exclusions and limitations of this Plan Document

d. **Newborn Child of an Enrolled Female Dependent Child**
A newborn child of an enrolled female Dependent child will be covered from the moment of birth up to and including 31 days immediately following birth, but is not eligible for coverage enrollment beyond the initial 31-day period unless the Covered Employee has been appointed by a court as legal guardian of the child, the child resides with the Covered Employee and Proof of such legal guardianship is provided.

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e. **Totally Disabled Dependent Child**
A Totally Disabled Dependent child who is incapable of sustaining employment by reason of physical or mental handicap may continue as an enrolled Dependent beyond the age limit set forth in the Health Benefit Plan, provided he or she:

- is unmarried and over the age of 26;
- is incapable of sustaining employment by reason of physical or mental handicap as certified by a Physician and for whom the Covered Person or his or her spouse or Civil Union Partner, is chiefly responsible for support and maintenance; and
- became disabled prior to the limiting age for a Dependent child (age 26) and had comparable coverage as a Dependent at the time of enrollment.

Proof of such incapacity and dependency must be received by the Plan Sponsor within 31 days of the date upon which the child's coverage would have terminated in the absence of such incapacity. The disability must be certified at that time or at the time of enrollment by a Physician and then no more than annually thereafter.

f. **Minor Child for whom a Covered Employee is Legal Guardian.**
A minor child who resides with a Covered Employee and for whom the Covered Employee (or his or her spouse) has been named the legal guardian of the person by a court of competent jurisdiction may be enrolled as a Dependent. Coverage will end when the child attains 18 years of age or upon the termination of the guardianship, whichever first occurs.

g. **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 Benefit Plan immediately prior to reaching the age of 18 continues to be dependent upon him or her (either as a "Qualifying Child" or a "Qualifying Relative" for federal income tax purposes) coverage may be available beyond termination of the legal guardianship to age 26. Proof of continued dependency must be

provided annually. If the Covered Person continues in a parental/supportive relationship to a former ward who was enrolled in the Benefit Plan immediately prior to 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.

4. Notice of Change in Status

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

Active employees must provide written notice of the qualifying event (divorce/legal separation/child's attainment of age 26/or termination of a legal guardianship) to the personnel/payroll office of their employing agency. Retirees should notify the Retirement Health Unit, Healthcare Policy & Benefit Services Division, Office of the State Comptroller.

Examples of status changes that must be reported within 31 days include:

- A covered child's attainment of age 26,
- Termination of a legal guardianship for an enrolled child as result of court order, expiration of temporary guardianship, operation of law, or the child's attainment of age 18, whichever first occurs; or
- Divorce or entry of a judgment of legal separation.

Note: The above status changes are events that provide your former dependents with the right to continue medical coverage at their own expense for a limited period of time under a federal law, known as COBRA. See Section XI below. Although the plan requires notification and termination of coverage for ineligible individuals within 31 days of the status change, federal regulations give you and/or your ineligible dependent up to 60 days to notify the Plan Sponsor of the change in status in order to obtain COBRA continuation coverage. If notice of the change in status is <u>no</u>t provided within the 60-day period after the qualifying event, the Plan is not obligated to provide COBRA continuation coverage.

Proof of Dependent Status

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

- Marriage – Marriage Certificate and the first two pages of an Employee's or Retiree's most recent federal income tax return confirming claimed marital status.

- Civil Union,–,Certificate of Civil Union and submission of Covered Employee's most recent state income tax return confirming claimed status (where applicable).
- Biological child – Birth Certificate.
- Step-child – Birth Certificate showing parent/child relationship between the Covered Employee'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.
- A valid Support Enforcement Order from the State Department of Social Services shall satisfy the above requirements for proof of relationship with regard to a minor child. In such case, the child must be added to the Covered Employee's coverage, as ordered, with or without the consent of the Covered Employee.
- Custody of a minor child – Proof of Guardianship or Custody from a court of competent jurisdiction. **The minor child must reside with the Covered Employee to be eligible for coverage under the Plan.** A custody agreement from another state will not be honored unless it has been approved by a State of Connecticut Court or the State of Connecticut Department of Children and Families.

Penalties for Enrollment of Ineligible Individual

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

- An active employee may be subject to disciplinary action, including termination of employment, for enrolling or maintaining the enrollment for a person who is not eligible for coverage as a Dependent
- Subject to 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);
- Subject to liability for the value of claims paid on behalf of an ineligible former spouse or Dependent;
- Restitution for the State share of any premiums advanced for the ineligible Dependent;
- Rescission of coverage;
- Suspension from eligibility for coverage under the Benefit Plan; or
- Prosecution for fraud.

B. ENROLLMENT PROCEDURES

1. Newly Hired Employees – In order to become a Covered Employee, you must enroll within 31 days of commencing employment (or within 31 days of completion of any required waiting period for healthcare eligibility). If you do not enroll during that period you may be required to wait until the annual Open Enrollment Period, unless there is a Qualifying Status Change, which results in a loss of healthcare coverage. To enroll, submit the Health Insurance Enrollment Application specifying your choice of medical Plan, to the payroll\personnel office of your employing agency.

2. 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 you do not enroll at the time or retirement or within 31 days of satisfying the Rule of 75 you may be required to wait until the next annual Open Enrollment Period, unless there is a Qualifying Status Change, which results in a loss of healthcare coverage. Retirees follow the same Open Enrollment time period as active employees; Plan changes should be submitted to the Office of the State Comptroller, Retirement Health Unit of the Healthcare Policy & Benefit Services Division.

3. Annual Open Enrollment – Each year there is an Open Enrollment Period for approximately one month, during which all Plan Participants may make changes to their health Plan enrollment. The annual Open Enrollment Period is normally the only time employees may change Carriers, change Plans, or change Dependent coverage. Changes made during Open Enrollment are effective for July 1st, unless Open Enrollment has been delayed due to the collective bargaining process. For active employees, enrollment and change forms must be submitted to the employing agency payroll, personnel office.

Mid-Year Enrollment due to Qualifying Status Changes – Under certain conditions, an employee or retiree may make or change an election that corresponds to a change in family or work status outside of the Open Enrollment Period. All requests for change of election due to a Qualifying Status Change must be submitted to the Office of the State Comptroller, Retirement Health Unit of the Healthcare Policy & Benefit Services Division within thirty-one (31) days of the event.

Examples of Qualifying Status Changes:

- A newborn child or new spouse may be added to your Plan within 31 days of the event.
- If your spouse loses health benefits provided through his\her employer, or there are substantive changes in that Plan that negatively affect the cost or such coverage, you may add your spouse and any eligible Dependent children who were covered by your spouse's Plan effective as of the day the former coverage is no longer in effect, or if that date is not the first day of a month, the first day of the month preceding the loss of coverage.

4. 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.

a. Newly hired employees: Coverage for the employee and any eligible Dependents will commence as of the first day of the month following enrollment. For example, an employee whose first day of work is in January is eligible for coverage as of February 1, if he or she timely enrolls.

b. Retirees: Coverage for retirees will commence on the first day of the month after the month in which retirement occurs. Example: If you retire effective October 1, you will be covered under the Retiree Benefit Plan effective November 1st. In the case of individuals subject to a waiting period for commencement of retiree health benefits under the Rule of 75, coverage will commence on the first day of the month following enrollment, which must take place within 31 days of the individual's retirement date or his or her attainment of the requisite qualifying age—whichever last occurs.

c. New Spouse: Coverage for a new spouse will be effective on the first day of the month following the enrollment, which must take place within 31 days of the marriage or at Open Enrollment.

d. Children: A newborn child of a Covered Employee is automatically covered for 31 days following birth, but will not be covered after that period unless an enrollment application is submitted within 31 days of the birth.

A child who is newly adopted or placed for adoption with a Covered Employee must be enrolled within 31 days of the Date of Placement for Adoption or the date of Adoption. Coverage will be effective on the first day of the month following the month in which the qualifying event occurs.

A step-child may be enrolled within 31 days of the date when eligibility requirements are first met. Coverage will be effective on the first day of the month following the date of enrollment. For example, as the result of marriage, a Covered Employee may enroll the child of his or her new spouse within 31 days of the marriage.

5. Effect of hospitalization on Coverage: If you or an eligible Dependent is confined in a Hospital on the date when that person would otherwise become eligible for coverage, that person will not be eligible for coverage under the Benefit Plan until the confinement ends, provided that the person is not Totally Disabled on that date.

C. COVERAGE DURING LEAVES OF ABSENCE

1. Paid Leave: Health benefits will continue unchanged during the period an active employee is on active payroll status.

2. Unpaid Leave:

Family and Medical Leave – The State will continue to contribute the employer share of applicable premiums to maintain Benefit Plan coverage for an employee on leave under the Family and Medical Leave Act (FMLA) for up to 24 weeks (12 pay periods) in any two year period, provided that the employee premium share for such coverage, if any, is made directly to the employing agency on a timely basis. An employee who is eligible for federal but not State FMLA is entitled to up to 12 weeks of continued coverage for health benefits in any 12-month period, provided that employee premium share, if any, is made directly to the employing agency on a timely basis.

Employee Medical Leave – The State will continue to contribute the employer share of applicable premiums to maintain Benefit Plan coverage for an employee on personal medical leave for the length of the illness, up to 12 calendar months, provided that 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 (4) months duration--If the duration of leave is expected to be less than four months, the employee may stay enrolled in the Benefit Plan by paying the full amount of the premium (employee and state share) directly to the agency.

Four (4) Months or Over – If the duration of leave is expected to be, or extends for four months or longer, the employee will be offered continuation coverage under COBRA procedures.

Other Medical Leave – In addition to any leave under FMLA or personal medical leave in excess of 12 months, an additional period of coverage may be allowed if provided for in a specific collective bargaining agreement.

3. 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 Benefit Plan. As required by statute, the State will continue to contribute the employer share of applicable premiums to maintain Benefit Plan coverage while the employee is receiving Workers Compensation benefits. The employee must continue to pay the employee premium share, if any. The affected employee must make arrangements for either direct payment to the agency, or if leave benefits are used to supplement Workers Compensation, by payroll deduction of the employee's premium share.

4. Effect of Leave on Open Enrollment

An employee on leave status of any kind has the right to change coverage during the annual Open Enrollment Period.

D. TERMINATION OF COVERAGE

Coverage under this Plan may terminate for the following reasons:

1. Non-Payment – In the event you do not pay the required employee share of the premium, coverage will terminate at the end of the month for which premium payment were received. Coverage that is canceled for non-payment will not be reinstated unless the full amount in arrears is paid. Failure to pay the employee premium share (or total premium if applicable) when due may result in cancellation of coverage, with no right to COBRA continuation coverage**.**

2. Change of Work Status – If you are terminated from employment or laid off your health benefits will terminate on the first day of the month following the event. If you have a change of work status such that you are employed less than the equivalent of one-half of the full-time hours (0.5 FTE) for your position or transferred to a position not eligible for health benefits your health benefits will terminate on the first day of the month following the change in status. Notwithstanding any reduction in hours, coverage for a Variable Hour Employee who became eligible for health benefits after the initial 12-month measurement period coverage will not terminate until the first day of the month following twelve months of participation in the Plan or upon termination of employment, which ever first occurs.

3. Death– All coverage of Dependents under this Plan will automatically terminate on the first day of the month following the death of the Covered Employee, unless they are eligible for continued coverage as Dependents of a deceased retired State employee or elect COBRA continuation coverage, as set forth in Section IX below.

4. Change in Marital Status– If you become legally separated or divorced, or if your marriage is annulled, the coverage of your former spouse (and any enrolled step-child) will terminate on the first day of the month following the date of separation, divorce, or annulment. Failure of the Covered Person to provide notice of a change in marital status within 60 days of the event will result in loss of rights to COBRA continuation coverage.

5. Loss of Dependent Child Status – The coverage of a child under this Plan will automatically terminate:

- On the first day of the month following the child's twenty-sixth (26) birth date, unless they elect COBRA continuation coverage, as set forth in Section IX below; or
- In the case of an unmarried child over twenty-six (26) years of age who has been covered by reason or physical or mental disability, on the last day of the month in which the child is no longer incapable of self-support or on the last day of the month after the child's marriage.

COBRA continuation coverage. You and your covered Dependents may have rights to continue coverage under the COBRA Plan. See Section IX, COBRA Continuation below. Individuals who were ineligible for participation in the Plan as Dependents are not entitled to COBRA Continuation Coverage**.**

V. MANAGED CARE GUIDELINES

Subject to the terms and conditions of the Benefit Plan, a Covered Person is eligible for benefits for Covered Services for Medically Necessary Care when prescribed or ordered by a Physician and when in accordance with the provisions of this Section.

A. INTRODUCTION

A Covered Person's right to benefits for Covered Services provided under this Plan is subject to certain policies or guidelines and limitations, including, but not limited to: Prior Authorization, Concurrent Review, and Case Management. A description of each of these provisions is described in this Section. Failure to follow the Managed Care Guidelines for obtaining Covered Services from your Carrier may result in a reduction or denial of benefits.

Members with questions regarding Managed Care Guidelines and services for which Prior Authorization is required should call the telephone number on the back of the Identification Card issued by the Carrier or consult your Carrier's website:

Anthem—www.anthem.com or

UnitedHealthcare/Oxford—http://stateofct.welcometouhc.com.

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

B. MEDICAL POLICY

Each Carrier's medical policy sets forth the standards of practice and medical interventions that have been identified as reflecting appropriate medical practice. The purpose of each Carrier's medical policy is to assist in the determination of Medical Necessity. Medical technology is constantly changing, and each Carrier has the right to review and update its medical policy periodically. It is the intention of the Plan Sponsor that benefits under this Plan should not vary significantly depending upon the Carrier a Covered Employee has selected. Slight variations in procedure, such as whether or not Prior Authorization is required for a particular service, do not constitute differences in Covered Services or benefits. The benefits, exclusions and limitations in the Plan Document take precedence over each Carrier's medical policy.

C. MEMBER RESPONSIBILITIES WHEN OBTAINING HEALTH CARE—PRIOR AUTHORIZATION

Prior Authorization, also known as precertification, is required for certain services so that the Carrier can review the service to verify that it is Medically Necessary and that the treatment provided is the proper level of care. Prior Authorization may be obtained by contacting the Carrier at the telephone number located on the back of the Covered Person's Identification Card. It is the Participating Provider's responsibility to notify the

Carrier that Prior Authorization is sought for the services listed below. If a Covered Person decides to receive services from a Non-Participating Physician, Hospital or Provider, it is the Covered Person's responsibility ensure that obtain Prior Authorization is obtained from the Carrier before receiving services. The Covered Person and Physician or Provider will receive written notification regarding approval or denial of a Prior Authorization.

Issuance of Prior Authorization indicates that the Carrier has determined that the services are Medically Necessary and will pay for such approved services, if they are otherwise covered under the Plan, the Coinsurance/Co-payment/Deductible requirements are met, and the patient is covered on the date care is received. The Prior Authorization will indicate a period for approval. Any service that is not performed within the specified time frame will need to be re-authorized.

Treatment or services for which the required Prior Authorization has not been obtained from the Carrier will be subject to review and will not be eligible for coverage if they are determined not to have been Medically Necessary. Penalties may also apply for obtaining services from a Non-Participating Provider without the required Prior Authorization.

1. **Services Requiring Prior Authorization**

Air Ambulance	Internal & External Prosthetic Devices
Bariatric Surgery	Oral Surgery
Chemotherapy	Organ Transplant
Colonoscopy (Oxford Plans only)	Orthoptic Exercises
Dialysis (Oxford Plans only)	Outpatient Occupational Therapy
Durable Medical Equipment over $500	Outpatient Physical Therapy
High Cost Diagnostic Imaging (MRI, MRA, CAT, CTA, PET, SPECT scans)	Outpatient Surgery
Gender Reassignment Surgery	Partial Hospitalization (under 12 hours) Mental Health/Substance Abuse
Hearing Aids (Bone-Anchored)	Private Duty Nursing
Infertility Treatments	Skilled Nursing Facility Admission
Inpatient Non-Emergency Care	Sleep Studies (Oxford Plans Only)
Inpatient Hospice	Specialized Formula
Inpatient, Mental Health	Specialized Infant Formula
Inpatient, Substance Abuse Treatment	Specialty Hospital Admission
	Substance Abuse Residential Treatment

2. **Obtaining Prior Authorization**

   Participating Providers in each Carrier's network know which services require Prior Authorization and will obtain the Prior Authorization when required. Participating Providers have detailed information regarding the Carrier's managed care guidelines procedures and are responsible for assuring that those requirements are met. Members in a POS Plan who are using an Out-of-

Network Provider should advise that Provider to contact the Carrier for information on obtaining Prior Authorization.

3. **Who is responsible for obtaining Prior Authorization?**
   Services provided by a Network Provider:

   The Provider is responsible for obtaining Prior Authorization.

   Services provided by Non-Participating Provider: The Covered Person is responsible for obtaining the Prior Authorization.

   Note: The Covered Person will be financially responsible for the cost of obtaining services and/or care in settings that are not covered under the Benefit Plan if the Carrier makes an adverse determination that such services are not Medically Necessary or are Experimental or Investigational.

4. **Prior Authorization for Inpatient Admissions**
   Prior Authorization is required for Hospital Admissions, Inpatient Facility Admissions, or Admission to a Partial Hospitalization or Day/Night Program.

   In-Network: When a Covered Person is scheduled for an In-Network Admission to a Hospital, Skilled Nursing Facility, or inpatient hospice care, the Participating Provider is responsible for obtaining the Prior Authorization from the Carrier, unless the Admission is due to a Medical Emergency.

   Out-of-Network: When a Covered Person is scheduled for an Admission to an Out-of-Network Hospital, Skilled Nursing Facility, or inpatient hospice care, it is the responsibility of the Covered Person or his or her representative to obtain Prior Authorization from the Carrier, unless the Admission is due to a Medical Emergency.

5. **Failure to obtain Prior Authorization**
   Members who obtain non-emergency services from a Non-Network Provider without obtaining the required Prior Authorization may be subject to a penalty equal to $500 or 20% of the cost of such services, whichever is less**.** In addition, if the services provided are deemed to be Experimental or Investigational or not to be Medically Necessary, coverage for such services may be denied.

6. Medical Emergency Admissions

This Benefit Plan provides benefits for Medical Emergency Admissions. It is the Participating Provider's responsibility to notify the Carrier within 48 hours of an Inpatient Admission due to a Medical Emergency. If the Covered Person receives services from a Non-Participating Physician, Hospital, or Provider, the Covered Person must notify the Carrier within 48 hours of an Inpatient Admission due to a Medical Emergency.

Upon receiving proper notification of the Medical Emergency Admission, the Carrier must Authorize and manage continued Inpatient or Outpatient care related to the Medical Emergency in order for such care to be covered under this Benefit Plan.

If the Covered Person has an Inpatient Admission due to a Medical Emergency and the Carrier is not notified within two (2) business days, benefits for Covered Services shall only be provided if the Covered Person's condition at the time of diagnosis, care or treatment is confirmed to have been a Medical Emergency.

After the cessation of the Medical Emergency any follow-up diagnosis, care, or treatment performed must be provided by a Participating Physician or Provider in order for benefits to be considered as In-Network.

After the cessation of the Medical Emergency any follow-up diagnosis, care or treatment provided by a Non-Participating Physician or Provider will be subject to the Cost-Shares specified in the Schedule of Benefits for Out-of-Network services.

D. CONCURRENT REVIEW

The provision of benefits for Inpatient Services will be subject to Concurrent Review conducted by the Carrier, which will determine whether:

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

No benefits will be provided for Inpatient Services that are billed by a Hospital and/or the Admitting Physician after the specific date indicated in the Carrier's Authorization notice.

VI. COVERED SERVICES

A. PRIMARY AND PREVENTIVE CARE

Primary Care consists of office visits, house calls and Hospital visits provided by your Primary Care Provider (PCP) (in the POE and POE Gated Plans) or other Network Provider or Non-Network Provider for consultations, diagnosis and treatment of injury and disease.

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

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;
- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA);
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the HRSA; and
- Preventive Care Benefits defined under the HRSA requirements include the cost of renting one breast pump per Pregnancy in conjunction with childbirth. Benefits for breast pumps also include the cost of purchasing one breast pump per Pregnancy in conjunction with childbirth. Benefits are only available if breast pumps are obtained from a DME Provider, Hospital or Physician.

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

1. Well-Baby and Well-Child Care—Covered Benefits

The Benefit Plan covers well-baby and well-child care, which consist of routine physical examinations, including vision and hearing screenings, developmental assessment, anticipatory guidance, and laboratory tests ordered at the time of the visit, as recommended by the American Academy of Pediatrics. Immunizations and boosters as recommended by the State of Connecticut are also covered.

HPV immunization is covered for Males and Females between the ages of 9 and 26.

Exclusions and Limitations

- Special foods and diets, supplements, vitamins and enteral feedings are not covered except as otherwise noted in this Plan Document.
- Third party requests for physical examinations, diagnostic services and immunizations done in connection with obtaining or continuing employment, obtaining insurance coverage, school admission or attendance, including examinations required for participation in athletic activities.
- Services for the evaluation or treatment (including remedial education) of learning disabilities or minimal brain dysfunction, mental retardation, developmental and learning disorders or behavioral problems, except as noted under the "Early Intervention Services/Birth to Three Program" section are not Covered. The Plan also does not cover behavioral training, visual perceptual or visual motor training related to learning disabilities, or cognitive rehabilitation. Behavioral and learning disorders related to congenital abnormalities, such as Down Syndrome, are not covered.
- All applicable "Exclusions and Limitations" listed in Section VII below.

2. Adult Physical Examinations

Periodic adult physical examinations are covered.

The Plan will cover one physical exam per calendar year for every member over the age of 19. The Plan will cover an annual prostate screening for males age 50 and older and for symptomatic males and for males whose biological father or brother has been diagnosed with prostate cancer.

Exclusions and Limitations

The following services are not covered:

- Examinations for the purpose of obtaining or maintaining any license issued by a municipality, state or federal government, obtaining insurance coverage, school admission or attendance, including examinations required for participation in athletic activities;
- Court ordered psychological or behavioral evaluations or counseling related to marital disputes, divorce proceedings, or child custody proceedings; and
- All applicable "Exclusions and Limitations" listed in Section VII below.

3. Well-Woman Routine Gynecological Examinations

Well-woman examinations consist of a routine gynecological examination, breast examination and Pap smear.

- Mammograms are covered.

- Members enrolled in the POE Gatekeeper plans may receive their well-woman examinations and any necessary follow-up care, services for acute care and care related to pregnancy from their selected Primary Provider of OB/GYN Care without a referral.
- **Family Planning:** Covered services include counseling on use of contraceptives and related topics. The costs related to the insertion (or removal) of a birth control implant, or the measuring or fitting of a contraceptive device, including a diaphragm cervical cap, or intrauterine device, are also covered. For Members enrolled in a POE-G Plan, these services will be provided by your selected Primary Provider of OB/GYN Care without a Referral from your PCP.
- **Breast Pumps:** Preventive Care Benefits include the cost of renting one breast pump per Pregnancy in conjunction with childbirth. Benefits for breast pumps also include the cost of purchasing one breast pump per Pregnancy in conjunction with childbirth. Benefits are only available if breast pumps are obtained from a DME Provider, Hospital or Physician.

Exclusions and Limitations

- The Plan does not cover birth control pills, condoms, foams or contraceptive jellies and ointments even if they are being prescribed or recommended for a medical condition other than birth control.
- The Plan does not cover breast pumps purchased or rented prior to July 1, 2013.
- The Plan does not cover breast pumps that are not obtained from a DME Provider, Hospital or Physician.

4. Immunizations

Adult or childhood immunizations as recommended by the U.S. Department of Health and Human Services or as required for foreign travel are covered. Meningitis vaccinations are covered as part of a Participant's routine annual or age-appropriate physical.

5. Colorectal Cancer Screenings

The Plan will cover an annual fecal occult blood test, colonoscopy, flexible sigmoidoscopy or radiologic imaging. Coverage will be in accordance with the recommendations established by the American College of Gastroenterology, after consultation with the American Cancer Society as to the type and frequency with which such test should be performed (e.g., age intervals, family history, etc.).

For Oxford members, a colonoscopy, flexible sigmoidoscopy or radiolgic imaging is subject to Prior Authorization.

6. Diabetes Management (Equipment, Supplies and Education)

These services are covered as follows:

Supplies: The following equipment and related supplies are covered for insulin dependent and non-insulin dependent diabetic Participants when Medically Necessary, as determined by the Covered Person's Physician:

Acetone Reagent Strips
Acetone Reagent Tablets
Alcohol or Peroxide by the pint
Alcohol Wipes
All insulin preparations
Automatic Blood Lance Kit
Blood Glucose Kit
Blood Glucose Strips—Test or Reagent
Blood Glucose Monitor and strips
Cartridges for the visually impaired
Diabetes data management systems
Disposable insulin and pen cartridges
Drawing-up devices for visually impaired
Equipment for use of the Pump
Glucose Acetone Reagent Strips
Glucose Reagent Strips
Glucose Reagent Tape
Injection aides
Injector (Busher) Automatic
Insulin Cartridge Delivery
Insulin infusion devices
Insulin Pump
Lancets

Please note: The above list is not intended to be all-inclusive.

Diabetes Self-Management and Education: Outpatient self-management training will be provided for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin-using diabetes. For purposes of this coverage, "outpatient self-management training" includes, but is not limited to, education and medical nutrition therapy.

Upon initial diagnosis, the Plan will cover up to ten hours of Medically Necessary self-management training for the care and treatment of diabetes. Such training includes, but is not limited to, counseling in nutrition and proper use of equipment and supplies for diabetes. An additional four hours of training will be covered for any subsequent diagnosis which results in a significant change in an individual's symptoms or condition, which requires modification of the individual's program of self-management of diabetes. An additional four hours of Medically Necessary training and education will also be covered for newly developed techniques and treatment of diabetes.

Diabetes Self-Management training shall be provided by a certified, registered or licensed health care professional trained in the care and management of diabetes and authorized to provide such care within the scope of their license.

The following are not covered:

- Membership in health clubs, diet plans, or other organizations, even if: recommended by a Physician or a qualified health Provider for the purpose of losing weight;
- Any counseling or courses in diabetes management other than as described above;

- Stays at special facilities or spas for the purpose of diabetes education/management;
- Special foods, diet aids and supplements related to dieting; and
- Any item that is not both Medically Necessary and prescribed by the Participant's Physician or qualified health Provider.

7. Vision Exams

One vision exam including refraction per Covered Person per Calendar Year is covered both In-Network and Out-of-Network. HEP Members are entitled to one In-Network vision exam every other year without a Co-pay.

8. Hearing Exams

One examination per Covered Person per Calendar Year is covered. Members in the POE-G Plan must obtain a referral for hearing examinations.

Coverage includes screening to determine the Medical Necessity for hearing correction when performed by a Participating Physician or Non-participating Physician certified as an otolaryngologist or a legally qualified audiologist holding a Certificate of Clinical Competence in Audiology from the American Speech and Hearing Association in the absence of any applicable licensing requirements.

9. Naturopathic Physicians

The Plan will cover services performed by a Naturopathic Physician for the treatment of illness or injury otherwise covered under this Plan Document. Members in a POE-G Plan must obtain a referral from their Primary Care Physician to see a Naturopath.

10. Laboratory Tests

Any Medically Necessary laboratory tests will be covered in accordance with the terms and conditions of the Plan Document.

B. SPECIALTY CARE

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

1. Surgical Services

The Plan requires Prior Authorization for all surgical procedures whether rendered as an Inpatient or on an Outpatient basis in a Hospital or a licensed ambulatory surgical center not located in a Hospital. Covered Services include the services of the surgeon or specialist assistant and anesthetist or anesthesiologist together with preoperative and post-operative care.

For Oxford members colonoscopy, flexible sigmoidoscopy or radiologic imaging is considered Elective Surgery that requires Prior Authorization

Pre-Admission testing procedures must be rendered on an Outpatient basis prior to the scheduled surgery. The Covered Person will be responsible for Pre-Admission testing charges if he or she cancels or postpones the scheduled surgery.

Requirement of Notice for Admission following Outpatient Surgery: If a Covered Person is Admitted as an Inpatient as result of Outpatient surgery, the Covered Person must notify the Carrier within two business days of the Admission in accordance with the Managed Benefits Section of this Plan Document.

Exclusions and Limitations:

- The Plan does not cover cosmetic surgery, reconstructive or plastic surgery that is performed for a condition that does not meet the specific criteria stated in "Reconstructive and Corrective Surgery".
- Remedial work is not covered. Remedial work is any medical procedure to correct either undesired results or an unsuccessful procedure connected to a prior non-covered Cosmetic surgery/procedure.
- All applicable "Exclusions and Limitations" listed in Section VII.

2. Reconstructive and Corrective Surgery

Reconstructive and corrective surgery is covered only when:

- It is performed to correct a Dependent child's congenital birth defect which has resulted in a functional defect; or
- It is incidental to surgery or follows surgery that was necessitated by trauma, infection or disease of the involved part, and the reconstructive or corrective surgery must be performed within two years of the surgery that was necessitated by the trauma, infection or disease; or
- It is breast reconstruction following a mastectomy (including surgery on the healthy breast to restore and achieve symmetry of implanted breast prostheses).

Exclusions and Limitations

Cosmetic, reconstructive or plastic surgery that is performed for a condition that does not meet the specific criteria stated above, including but not limited to cosmetic, plastic or reconstructive surgery performed primarily to improve the appearance of any portion of the body including, but not limited to surgery for sagging skin or extra skin, any augmentation or reduction procedure (e.g., mammoplasty), liposuction, rhinoplasty and rhinoplasty done in conjunction with a covered nasal or covered sinus surgery.

- Complications of such surgeries are covered only if they are Medically Necessary and are otherwise Covered.

- Remedial work is not covered. Remedial work includes any medical procedure to correct either undesired results or an unsuccessful procedure connected to a prior non-covered Cosmetic surgery/procedure.
- All applicable "Exclusions and Limitations" listed in Section VII.

3. Inpatient and Outpatient Dental Services:

The following are Covered Services, as determined by the Carrier:

a. An initial visit for the prompt immediate repair of trauma, due to an accident or injury to the jaw, natural teeth, cheeks, lips, tongue and/or the roof of the mouth. Benefits for services provided during the initial visit include, but are not limited to, the following:

i. Evaluation;

ii. Radiology to evaluate extent of injury;

iii. Treatment of the wound, tooth fracture or evulsion;

iv. Oral surgical services for treatment of lesions, tumors and cysts on or in the mouth. Oral surgery services for treatment related to tumors of the oral cavity, treatment of fractures of the jaw and/or facial bones, and dislocation of the jaw;

b. Excision of unerupted or impacted tooth or tooth root and related anesthesia; and

c. Cutting procedures on gums (osseous surgery) including related anesthesia.

d. Surgical treatment of temporomandibular joint (TMJ) syndrome and craniomandibular disorder;

e. Anesthesia, nursing, and related charges for Inpatient dental services, Outpatient Hospital dental services, or one-day dental services are covered if deemed Medically Necessary by the treating dentist or oral surgeon and the patient's Physician per the Prior Authorization requirements and:

i. the patient has been determined by a licensed dentist along with the patient's licensed Primary Care Physician to have a dental condition complex enough that it requires Inpatient services, Outpatient Hospital dental services, or one-day dental services; or

ii. the patient has a developmental disability, as determined by a licensed Primary Care Physician, that places him or her at serious risk.

Exclusions and Limitations

- General dental services are not 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.
- All applicable Exclusions and Limitations listed in Section VII below.

4. Allergy Testing and Treatment

The Plan covers testing and evaluations to determine the existence of an allergy. Allergy injections or other immunotherapy services are covered.

Exclusions and Limitations

- All serums must be mixed by an Allergist. All testing must be administered by an Allergist.
- The Plan does not cover self-administration of allergy serums or the administration of allergy serums in a location where emergency resuscitative equipment and trained personnel are not present.
- The Plan only covers allergy testing and evaluations that are determined by the Carrier to be consistent with current practice guidelines of Board Certified Allergists and Immunologists. On the basis of current studies, The World Health Organization does not recommend and therefore, the Plan does not cover, serums delivered orally, sublingually, or bronchially.
- Subject to the Exclusions and Limitations listed in Section VII below.

5. Obstetrical/Maternity Care: Pregnancy, Delivery, Interruption of Pregnancy

a. Services and supplies for maternity care provided by a Physician, Certified Nurse Midwife, Hospital or Birthing Center will be covered for prenatal care (including one visit for genetic testing), postnatal care, delivery and complications of pregnancy. The Plan provides a minimum Inpatient stay of 48 hours following a vaginal delivery and 96 hours following a cesarean delivery for both the mother and the newly born child or children. While in the Hospital, maternity care also includes, at a minimum, parent education, assistance and training in breast or bottle feeding, and performance of any necessary maternal and newborn clinical assessments.

Birthing Center services are covered at 100% when In-Network in the same manner as services rendered at an acute care facility; Coverage is subject to deductible and Co-Insurance when Out-of-Network.

The mother has the option to leave the Hospital sooner than as described above. If she and the newborn child are discharged early, she will be provided with two home visits. The first home visit will be provided within 48 hours following discharge. The second follow-up visit will be provided within 7 days of discharge.

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

Care related to complications of pregnancy, including surgery and interruptions of pregnancy, is covered.

b. **Interruption of Pregnancy**: Therapeutic abortions are covered as an unlimited benefit. Non-therapeutic abortions in cases of rape, incest or fetal malformation are also covered as an unlimited benefit. One elective abortion per Participant, per Calendar Year, is covered, subject to the benefit limits listed in the Summary of Coverage.

c. **Vasectomy and Tubal Ligations**: The Plan covers vasectomies and tubal ligations.

6. Newborn Care

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

Routine nursery and preventive Newborn Care does not require Prior Authorization. Circumcision performed by a Licensed Medical Practitioner during the delivery Inpatient stay does not require Pre-certification. Prior Authorization must be obtained for surgery or circumcision that is performed after the Inpatient stay for delivery.

Exclusions and Limitations

- An adopted newly born infant's initial Hospital stay is not covered if the natural parent has coverage available for the infant's care.
- Special foods and diets, supplements, vitamins and enteral feedings are not covered except as noted under the “Medically Necessary Infant Formula and Specialized Formulas” section.
- All other applicable “Exclusions and Limitations” listed in Section VII below.

7. Infertility Services

Covered services include Medically Necessary care for the diagnosis and treatment of infertility, including, but not limited to, ovulation induction, intrauterine insemination, in-vitro fertilization (IVF), uterine embryo lavage, embryo transfer, gamete intra-fallopian transfer (GIFT), zygote intra-fallopian transfer (ZIFT) and low tubal ovum transfer. Prior Authorization is required for all services.

Exclusions and Limitations:

- Injectable infertility drugs such as Pergonal, Metrodin, etc.;
- Service which is not deemed Medically Necessary under the Carrier's clinical guidelines;
- Cost for an ovum donor or donor sperm;
- Sperm storage costs;
- Cryopreservation and storage of embryos;
- Ovulation predictor kits;
- In-vitro services for women who have undergone tubal ligation;
- Reversal of tubal ligations;
- Any infertility services if the male has undergone a vasectomy;
- All costs for and relating to surrogate motherhood (maternity services are covered for Participants acting as surrogate mothers);
- Services to reverse voluntary sterilizations;
- All other applicable "Exclusions and Limitations" listed in Section VII below.

8. Nutritional Counseling

The Plan covers up to 3 visits per Covered Person per calendar year for individualized nutritional evaluation and counseling by a registered dietitian.

Exclusions and Limitations

- Coverage is limited to 3 visits per Covered Person per calendar year.
- The Plan does not cover nutritional programs or meal replacement programs.
- All other applicable "Exclusions and Limitations" listed in Section VII below.

9. Mental Health Services

The Plan will cover 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 which meet such definition will be covered to the same extent as the medical/surgical coverage described in the Plan Document. To the "same extent" means that the same number of

visits, days, Co-pays that apply to other Outpatient specialty treatments and/or Inpatient Hospital stays will also apply to the treatment of mental or nervous conditions.

Outpatient care for mental health includes services rendered in the following locations: a non-profit community mental health center, a non-profit licensed adult mental health center, a non-profit licensed adult psychiatric clinic operated by an accredited Hospital or in a Residential Treatment Facility when provided by or under the supervision of a Physician practicing as a Psychiatrist, licensed psychologist, Certified Independent Social Worker, Certified Marriage and Family Therapist or a Licensed or Certified Alcohol and Drug Counselor, or appropriately licensed professional counselor.

Outpatient care for mental illness includes services by a person with a master's degree in social work when such person renders service in a child guidance clinic or in a Residential Treatment Facility under the supervision of a Physician practicing as a Psychiatrist, licensed Psychologist, Certified Independent Social Worker, Certified Marriage and Family Therapist or a Licensed or Certified Alcohol and Drug Counselor or appropriately licensed professional counselor.

Inpatient Hospital Services for mental health in a Hospital, or Residential Treatment Center Facility are subject to Medical Necessity and Prior Authorization. Inpatient Covered Services for eligible Participants upon confinement in a Residential Treatment Facility must be based on an Individual Treatment Plan prescribed by the attending Physician and approved by the Carrier's Medical Director. For the purpose of this benefit, eligible Participants must meet all of the following criteria: a) the Participant has a serious mental illness which substantially impairs the person's thought, perception of reality, emotional process, or judgment or grossly impairs behavior as manifested by recent disturbed behavior; b) the Participant has been confined in a Hospital for such illness for a period of at least three days immediately preceding such confinement in a Residential Treatment Facility; and c) such illness would otherwise necessitate continued confinement in a Hospital if such care and treatment were not available through a Residential Treatment Facility for children and adolescents.

For purposes of this benefit, the following definitions apply:

"Residential Treatment Facility" means a 24 hour mental health facility that is licensed or approved by the Department of Children and Families and that operates for the purpose of effecting positive change and normal growth and development for behavior disorders and emotionally disturbed and socially maladjusted children.

"Individual Treatment Plan" means a treatment Plan prescribed by a Physician with specific attainable goals and objectives appropriate to both the patient and the treatment modality of the program.

Exclusions and Limitations

- Services must be provided by Providers who are certified by the appropriate state agency to provide such services and whose programs for such services have been approved by the Carrier.

- The Plan does not cover treatment for learning and behavioral disorders. Services for the evaluation or treatment (including remedial education) of learning disabilities or minimal brain dysfunction, mental retardation, developmental and learning disorders or behavioral problems are not covered except as noted under the "Early Intervention/Birth to Three Program" section. The Plan also does not cover behavioral training or cognitive rehabilitation.
- The Plan does not cover court-ordered services or services that have been ordered as a condition of probation or parole. However, these services may be covered if the Carrier agrees that they are Medically Necessary, are otherwise covered, and the Participant has not exhausted any benefit limit for the Calendar Year, and the treatment is provided in accordance with the Carrier's policies and procedures.
- The Plan does not cover non-medical services and long term rehabilitation services for the treatment of Mental Illness, including rehabilitation services in a specialized Inpatient or residential facility.
- All applicable "Exclusions and Limitations" listed in Section VII below.

10. Substance Abuse

Outpatient care: Coverage is provided for Outpatient visits for Substance Abuse Care services in both POE and POS Plans.

Inpatient Care

Inpatient Hospital Services for Alcohol and Substance Abuse in a Hospital, or Residential Treatment Center, or Substance Abuse Treatment Facility are subject to Medical Necessity and Prior Authorization. Such Inpatient rehabilitation services may include Hospitals, Residential Treatment Facilities or other facilities which are certified by the appropriate state division of alcoholism and alcohol abuse or substance abuse and approved in advance by the Carrier.

Exclusions and Limitations

- Services must be provided by Providers who are certified by the appropriate state agency to provide such services and whose programs for such services have been approved by the Carrier.
- The Plan does not cover court ordered services or services that have been ordered as a condition of probation or parole. However, these services may be covered if the Carrier agrees that the services are Medically Necessary, are otherwise covered, the Participant has not exhausted any applicable benefit for the Calendar Year, and the treatment is provided in accordance with the Claims Administrator's policies and procedures.
- Except as specifically covered under this Plan Document, the Plan does not cover non-medical services and long-term rehabilitation for treatment of alcoholism or drug abuse, including rehabilitation services in a specialized Inpatient or residential facility.

- All applicable "Exclusions and Limitations" listed in Section VII below.

11. Diagnostic Procedures

a. Laboratory and X-Ray Services

X-ray and laboratory procedures, services and materials, including diagnostic X-rays, X-ray therapy, fluoroscopy, electrocardiograms, laboratory tests, and therapeutic radiology services are covered.

b. High Cost Diagnostic Imaging

Major diagnostic procedures, such as MRI, MRA, CAT, CTA, PET and SPECT scans, require Prior Authorization. A Participating Provider will know when it is necessary and is responsible for obtaining the Prior Authorization. If you obtain High Cost Diagnostic Imaging Services from an Out-of-Network Provider, without Prior Authorization, you will be assessed a penalty of $500 or 20% of the cost of such service, whichever is less.

Exclusions and Limitations applicable to POE and POE-Gated Plans

- All tests and procedures must be performed by a Network Provider. Unless you are receiving preadmission testing, Network Hospitals are not Network Providers for laboratory procedures and tests.
- The Plan does not cover laboratory procedures or any other procedure if the Participant has not obtained the required Referral.

12. Acupuncture

Coverage for this benefit varies slightly according to the Carrier selected.

a. For **Oxford** members, acupuncture is covered up to a limit of 20 visits per calendar year.
b. For **Anthem** members, the use of acupuncture is considered Medically Necessary for treatment of osteoarthritis ~~of the knee and hip~~[6], nausea and vomiting associated with surgery, chemotherapy, or pregnancy. Acupuncture for any other indication, including but not limited to, the treatment of pain other than specified above, is considered not Medically Necessary and is not covered.

13. Gender Identity Disorder Treatment

The Plan will cover services for the treatment of "gender dysphoria" or gender identity disorder as defined in the most recent edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders. Covered services include psychotherapy and gender reassignment surgery. Coverage for this benefit is subject to Prior Authorization pursuant to each Carrier's medical necessity guidelines. Transsexual surgical benefits are subject to the following general criteria: The patient:

[6] Corrected 5.04.2016

- Must be 18 years of age or older
- Must have completed 12 months of successful continuous full-time real-life experience in the desired gender;
- May be required to complete continuous hormonal therapy if ordered and not contraindicated;
- May be required to undergo psychotherapy, if recommended.

Exclusions and Limitations

The following surgeries are considered cosmetic when used to improve the gender specific appearance of an individual who has undergone or is planning to undergo gender reassignment surgery and are not Covered:

- Liposuction/ body contouring
- Rhinoplasty
- Facial bone reconstruction
- Voice Modification surgery
- Hair removal
- Face lift
- Blepharoplasty
- Reversal of genital surgery
- Sperm preservation in advance of hormone treatment or surgery
- Cryopreservation in advance of hormone treatment or surgery
- Surgical treatment of anyone under the age of 18.

14. Bariatric Surgery

The Plan will cover Medically Necessary Gastric bypass and gastric restrictive procedures for the treatment of clinically severe obesity for selected adults (18 years and older). Coverage for this benefit is subject to Prior Authorization pursuant to each Carrier's medical necessity guidelines.

15. Snoring (Sleep Studies)

The Plan will cover Medically Necessary treatment for snoring if that treatment is determined to be part of a proven treatment for documented obstructive sleep apnea (OSA). Refer to each Carrier's applicable medical policy to determine if the treatment proposed is proven for OSA. For Oxford members, Prior Authorization is required for attended sleep studies.

C. HOSPITAL AND OTHER FACILITY-BASED SERVICES

1. Inpatient Admissions

Non-Emergency Admissions to a Hospital, Skilled Nursing Facility, or Specialty Hospital require Prior Authorization from your Carrier. All Pre-Admission Testing must be rendered on an Outpatient basis before the scheduled Admission and not repeated upon Admission for Surgery. The Covered Person will be responsible for the Pre-Admission Testing charges if he or she cancels or postpones the scheduled Admission.

For Mastectomy or lymph node dissection, Covered Services will include at least a 48-hours stay after the procedure unless both the Covered Person and Physician agree to a shorter stay.

Admission to a Specialty Hospital is subject to Prior Authorization. For POS Plan Members Inpatient care at In-Network Specialty Hospitals is an unlimited benefit. For POS Plan Members using Out-of-Network Specialty Hospitals, the benefit period is limited to 60 days per Covered Person per calendar year.

The Plan covers non-custodial services provided in a Skilled Nursing Facility, including care and treatment in a semi-private room, as described above. Custodial, convalescent or domiciliary care is not covered. In addition to Prior Authorization, Admission to a Skilled Nursing Facility must be supported by a treatment plan prepared by your Carrier.

POE Plan Participants are restricted to Participating Skilled Nursing Facilities. For POS Plan Members Inpatient care at an In-Network Skilled Nursing Facility is an unlimited benefit.

For POS Plan Members using an Out-of-Network Skilled Nursing Facility, the benefit period is limited to 60 days per Covered Person per calendar year.

The following services will be covered:

- Room and board for a semi-private Hospital room. If a private room is used, this Benefit Plan shall only provide benefits for covered Services up to the cost of the semi-private room rate, unless the Carrier decides that a private room is Medically Necessary;
- Administration of blood and blood processing;
- Anesthesia, Anesthesia supplies, and services;
- Chemotherapy for treatment of cancer;
- Diagnostic services;
- Electroshock therapy;
- Inpatient Hospital services and supplies;
- Laboratory tests;
- Medical and surgical dressing, supplies, casts, and splints;

- Operating, delivery, and treatment room usage and equipment (including: intensive care);
- Pre-Admission testing for surgery (to be performed on Outpatient basis);
- Prescribed drugs;
- Rehabilitative and restorative physical and occupational therapy, and speech therapy for treatment expected to result in the sound improvement of a Covered Person's condition;
- Radiation therapy;
- Services for hemodialysis, or peritoneal dialysis for chronic renal disease, including: equipment, training, and medical supplies until the Covered Person is eligible for the Medicare End Stage Renal Disease program;
- Services connected with accidental consumption, or ingestion of a controlled drug or other substance; and
- X-ray or imaging studies.

Exclusions and Limitations

- Coverage is limited to amount of days shown in the Summary of Coverage.
- Private or special duty nursing services during an Inpatient Admission are not covered.
- The Plan does not cover Custodial Care, convalescent care, domiciliary care, long-term care, maintenance care, adult day care or rest cures. The Plan does not cover room, board, nursing care or personal care which is rendered to assist a Participant who, in the Carrier's opinion, has reached the maximum level of physical or mental function possible and will not make further significant clinical improvement.
- The Plan does not cover rehabilitation services or physical therapy on a long-term basis.
- Non-eligible institutions. The Plan does not cover any services or supplies furnished by a non-eligible institution, which is defined as other than a Hospital or Skilled Nursing Facility, and which is primarily a place of rest, a place for the aged, or any similar institution, regardless of how denominated.
- All applicable exclusions and limitations as listed in the "Exclusions and Limitations" Section VII below.

2. Outpatient Surgery

Prior Authorization may be required for Outpatient Surgery, whether rendered in a Hospital setting on an Outpatient basis or in a licensed ambulatory surgical center not located in a Hospital.

Note: For Oxford members a colorectal screening, colonoscopy, or flexible sigmoidoscopy, is considered Outpatient Surgery requiring Prior Authorization required.

Pre-Admission testing procedures must be rendered to a Covered Person as an Outpatient prior to the scheduled surgery. The Covered Person will be responsible for Pre-Admission testing charges if he or she cancels or postpones the scheduled surgery.

Requirement of Notice for Admission following Outpatient Surgery: If a Covered Person is Admitted as an Inpatient as a result of Outpatient surgery, the Covered Person must notify the Carrier within 48 hours of the Admission in accordance with the "Managed Benefits" provisions in Section V.

3. Walk-In Medical Centers or Clinics

Services provided at a Walk-In Clinic or Center are deemed not to be Emergency Medical Services and will be covered only if treatment of the Covered Person is determined to be Medically Necessary, based on the signs and symptoms at the time of treatment.

Exclusions and Limitations

Adult routine physicals and well child care exams in excess of the guidelines are not covered if performed at a Walk-in Medical Clinic or Center.

POE and POE-Gated Plan Participants

The Covered Person does not need a referral from the Primary Care Physician to obtain services at a Participating Walk-In Center. Non-Emergency treatment obtained at a Non-Participating Walk-in Center or Clinic is not covered for Members in such Plans.

4. Urgent Care Centers

Urgent Care means care for an illness or injury that is not a Medical Emergency but requires immediate medical attention. Medically Necessary treatment at an Urgent Care Facility (either free-standing or located in a Hospital) will be covered. Members in the POE-G and POE Plans do not need to obtain a referral to go to a Participating Urgent Care Facility when a Covered Person's Primary Care Physician or covering Physician is not available to treat the Covered Person. Urgent Care services obtained outside the United States will be subject to a $15 co-pay.

5. Hospital Emergency Rooms—Medical Emergencies

This Benefit Program shall only provide benefits for Medical Emergency services if the care is found to be for a Medical Emergency. If the emergency calls for the Covered Person to be taken to the nearest Hospital, this Benefit Program shall provide benefits for Covered Services for the Medical Emergency, whether or not the nearest Hospital is a Participating Hospital or Non-Participating Hospital. This benefit is subject to a $35 Co-

pay, which will be waived if the Member is Admitted to the Hospital or if the Member had no reasonable medical alternative.

The determination whether or not a reasonable medical alternative exists shall depend upon the facts and circumstances existing at the time of treatment, including without limitation, the time of day, day of the week, the nature of the symptoms or injury, and whether or not the Member telephoned the Carrier's 24-hour helpline for assistance in finding appropriate care before seeking Emergency Medical services, and the number of times the Member has sought Emergency care for conditions not deemed to be a Medical Emergency.

All Admissions due to a Medical Emergency must be reported to and approved by the Carrier within 48 hours of the diagnosis, care, or treatment of the Medical Emergency.

Claims for services rendered to the Covered Person shall be reviewed by the Carrier; the Covered Person may be liable for Cost-Shares or the full cost of all services rendered, if the Carrier determines that the services provided were not for a Medical Emergency. Medical Emergency Covered Services are limited to the treatment rendered during the first visit only.

POE and POE-G Plans. A PCP Referral is not required for Emergency care.

International: Both Carriers provide Coverage for Medical Emergencies and Urgent Care when a Covered Employee is traveling internationally. The Covered Employee may be required to pay applicable Cost-Shares at the time of discharge or may be required to pay a Physician in full at the time of service and to seek reimbursement for Emergency and Urgent Care from his or her Carrier for treatment rendered outside the United States.

6. Ambulance Services

Medically Necessary medical transport services are covered as follows:

- From the place where the Covered Person is injured by an accident or taken ill to a General Hospital where treatment is to be given; or
- From a General Hospital where a Covered Person is an Inpatient to another General Hospital, or a free-standing facility to receive specialized diagnostic or therapeutic services not available at the first General Hospital, and the return to the first General Hospital, if that payment is only made for one such transport during the period between the day of Admission to the General Hospital, and the day of discharge from the General Hospital; or
- From a General Hospital to another General Hospital when the discharging General Hospital does not have the proper facilities for treatment, and the receiving General Hospital has the proper treatment facilities; and
- To provide in the course of such transport, such care as may be reasonably necessary to maintain the life of, or stabilize the condition of such Covered Person.

- Medical Transportation Service provided through a Home Health Agency in conjunction with Home Health Services is covered as follows:

  From a Hospital to a Provider to Home:
  To and from a Hospital or a Provider for treatment;
  From Home to a Hospital or Provider, if readmission is required.

Exclusions and Limitations:

The following are not Covered Services:

- Transport for Elective Hospital Admissions;
- Transport solely for the ease or convenience of the Covered Person.

D. THERAPY SERVICES

1. Autism Services

Coverage shall be provided for the Medically Necessary diagnosis and treatment of Autism Spectrum Disorders based on an approved treatment plan. A treatment plan will be reviewed not more than once every six months unless the Covered Person's licensed Physician, licensed psychologist or licensed clinical social worker agrees that a more frequent review is necessary or as a result of changes in the Covered Person's treatment plan.

Covered Services include:

- Behavior Therapy rendered by an Autism Behavioral Therapy Provider and ordered by a licensed Physician, psychologist or clinical social worker in accordance with a treatment plan developed by a licensed Physician, psychologist or licensed clinical social worker provided to children less than twenty-one years of age;
- Direct psychiatric or consultative services provided by a licensed psychiatrist;
- Direct psychiatric or consultative services provided by a licensed psychologist;
- Physical therapy provided by a licensed physical therapist;
- Speech therapy provided by a licensed speech and language pathologist; and
- Occupational therapy provided by a licensed occupational therapist.

Visit limits for physical, speech and occupational therapy will not apply to Autism Spectrum Disorder services on any basis other than lack of medical necessity.

2. **Chemotherapy** for the treatment of cancer.

3. **Chiropractic Therapy**.

4. **Early Intervention Services** are provided for an eligible enrolled child from birth to age three (36 months) who is not eligible for special education and related services pursuant to Connecticut law.

Services under this section are limited to children who:

a. Are experiencing a significant developmental delay as measured by standardized diagnostic instruments and procedures, including informed clinical opinion, in one or more of the following areas:

- Cognitive development;
- Physical development, including vision or hearing;
- Communication development;
- Social or emotional development; or
- Adaptive skills; or

b. Are diagnosed as having a physical or mental condition that has a high probability of resulting in a developmental delay.

For the purpose of this benefit, Early Intervention Services are services:

- Designed to meet the developmental needs of an eligible Participant and the needs of his or her family related to enhancing the child's development;
- Selected in collaboration with the parents of the eligible Participant;

5. **Electroshock Therapy.**

6. **Infusion Therapy:** Benefits will be provided for Infusion Therapy administered in an Outpatient Hospital, Physician's Office or home under the following conditions:

- A plan of care for such services is prescribed in writing by a Physician (M.D.);
- The plan of care is reviewed, and certified by the Physician (M.D.), and, in the case of POE Plan Members, approved by the Carrier.

Infusion Therapy is limited to:

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

Covered Services include supplies, solutions and pharmaceuticals.

Exclusions and Limitations

Whether Infusion Therapy is provided in an Outpatient Hospital program, Physician's office or a combined Outpatient Hospital and home program covered under this Benefit Plan, the benefits will not exceed the amount shown on the Schedule of Benefits.

7. **Kidney Dialysis** in a Hospital or free-standing dialysis center. For Oxford members, Prior Authorization is required. this service.

8. **Outpatient cardiac rehabilitation therapy.**

9. **Outpatient physical and occupational therapy** (requires Prior Authorization[7]); Physical and occupational therapy is covered only when reasonable and necessary to correct a condition that is the result of a disease, injury or congenital physical deformity that inhibits normal function.

To be considered reasonable and necessary, the following conditions must be met:

a. The services must be considered under accepted standards of medical practice to be a specific, safe, and effective treatment for the Member's condition;

b. The services must be of such a level of complexity and sophistication or the condition of the Member must be such that the services required can safely and effectively be performed only by a qualified physical therapist or by a qualified physical therapy assistant under the supervision of a qualified physical therapist, by a qualified speech-language pathologist, or by a qualified occupational therapist or a qualified occupational therapy assistant under the supervision of a qualified occupational therapist. Services that do not require the performance or supervision of a physical therapist or an occupational therapist are not considered reasonable or necessary physical therapy or occupational therapy services, even if they are performed by or supervised by a physical therapist or occupational therapist;

c. There must be an expectation that the Member's condition will improve materially in a reasonable (and generally predictable) period of time based on the Physician's assessment of the Member's restoration potential and unique medical condition, or the services must be necessary to establish a safe and effective maintenance program required in connection with a specific disease, or the skills of a therapist must be necessary to perform a safe and effective maintenance program. If the services are for the establishment of a maintenance program, they may include the design of the program, the instruction of the Member, family, or home health aides, and the necessary infrequent reevaluations of the Member and the program to the degree that the specialized knowledge and judgment of a physical therapist, or occupational therapist is required; and

d. The amount, frequency, and duration of the services must be reasonable.

e. For out-of network services, coverage is limited to 30 outpatient days of service per calendar year, prior authorization may be required.

[7] Prior Authorization is not required for pre-October 2, 2011 retirees.

10. **Short-term Inpatient physical therapy and rehabilitation services. Radiation therapy.**

12. **Speech therapy** is a Covered Service when prescribed by a Physician (M.D.), and provided by a licensed speech pathologist for treatment resulting from autism, stroke, tumor removal, injury or congenital anomalies of the oropharynx.

E. HOSPICE CARE (INPATIENT OR HOME BASED)

Hospice Care is available to Participants who have a prognosis of six months or less to live. Prior Authorization is required for Inpatient Hospice Care.

Coverage consists of palliative care rather than curative treatment. Hospice Care will be covered only when provided as part of a Hospice Care program certified by the state where such services are provided. Such certified programs may include Hospice Care delivered by a Hospital (Inpatient or Outpatient), Home Health Care Agency, Skilled Nursing Facility or a licensed Hospice facility.

The Co-payment will correspond to the place of treatment**.** If you receive care in a Hospice unit in a Hospital or a Skilled Nursing Facility, you will pay the Co-payment applicable to Inpatient Admissions. If you receive Hospice Care in your home, you will pay the applicable Home Health Care Co-payment.

Home-based Hospice – Covered Services include Hospice Care provided by a Home Health Care Agency and the following:

- Psychological and dietary counseling;
- Consultation or Case Management services by a Physician;
- Medical supplies and drugs prescribed by a Physician;
- Part-time nursing care by a registered nurse, or licensed practical nurse, and services of a home health aide for patient care up to 8 hours per day; and
- Medical/social services for patient and patient's covered family members, subject to limits indicated below.

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

Exclusions and Limitations

1. The Plan does not cover funeral arrangements, pastoral, bereavement counseling, financial or legal counseling, homemaker, caretaker or respite care;
2. Custodial Care; and
3. All applicable "Exclusions and Limitations" listed in Section VII below.

F. HOME HEALTH CARE

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

1. Skilled nursing care by a registered nurse (R.N.), or a licensed practical nurse (L.P.N.) under the supervision of a R.N. when the services of a R.N. are not on hand;
2. Skilled, progressive, and rehabilitative services of a licensed physical therapist;
3. Occupational, speech, and respiratory therapy;
4. Medical and surgical supplies, and prescribed Durable Medical Equipment;
5. Oxygen and its administration;
6. Home health aide services that consist of patient care of a medical or therapeutic nature;
7. Laboratory services;
8. Services with regard to diet and nutrition;
9. Transport to and from a Hospital for treatment, re-admission, or discharge by the most safe and cost-effective means available.

Benefit Period:

A benefit period for Home Health Care begins:

- After an Admission, commencing within 7 days after discharge from the Hospital;
- In lieu of an Admission, upon receipt of Prior Authorization; or
- For a terminal illness upon diagnosis by a Physician.

With regard to post-discharge services, the Covered Person must be confined at home and home health care services must be rendered to treat the same illness or injury for which the Covered Person was hospitalized.

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

Exclusions and Limitations

- Meals, personal comfort items, and housekeeping services;
- Nursing services rendered in the home by a relative, even if that person is a registered nurse or a licensed practical nurse; and
- All applicable “Exclusions and Limitations” listed in Section VII below.

G. HUMAN ORGAN TRANSPLANTS

Subject to Prior Authorization, coverage is provided for the following Human Organ Transplants:

Heart, lung, heart-lung, pancreas, liver (adult or child), kidney, bone marrow, peripheral stem cell procedures when performed along with the administration of high dose chemotherapy

The Program shall provide benefits without Prior Authorization for the following when used in connection with human organ and tissue transplant services:

Blood transfusion, cornea transplant, bone and cartilage grafting, skin grafting.

The following Hospital Covered Services are covered with Prior Authorization from the Carrier:

Room and board for a semi-private room (if a private room is used, this Benefit Plan will only provide benefits for Covered Services up to the cost of the semi-private room rate, unless Carrier decides that a private room is Medically Necessary);

Services and supplies furnished by the Hospital;

Care given in a special care unit that has all the facilities, equipment, and supportive services needed to provide an intensive level of care for critically ill patients;

Use of operating and treatment rooms;

Diagnostic services;

Rehabilitative and restorative physical therapy services;

Hospital supplies;

Prescribed drugs;

Whole blood, administration of blood, and blood processing;

Anesthesia, anesthesia supplies, and services; and

Medical and surgical dressings and supplies.

The following Surgical Services are covered when used with covered human organ and tissue transplants with Prior Authorization from the Carrier:

Surgery, including diagnostic services related to a surgery (separate payment will not be made for pre-operative and post-operative services or for more than one surgery done during one operative session);

Services of a Physician who actively assists the operating surgeon; and

Meting out of anesthesia ordered by the attending Physician, and rendered by a Physician or Provider other than the surgeon or assistant at surgery.

The following Medical Services related to human organ and tissue transplants with Prior Authorization are covered:

Inpatient medical care visits;

Intensive medical care rendered to a Covered Person whose condition needs a Physician's constant attendance, and treatment for a prolonged length of time;

Medical care given at the same time with surgery during the Hospital stay by a Physician, other than the operating surgeon for treatment of a medical condition, and separate from the condition for which the surgery was performed;

Medical care by two or more Physicians during the same Hospital stay when the nature or severity of the Covered Person's condition requires the skills of separate Physicians;

Consultation services given by another Physician at the request of the attending Physician, other than staff consultations, which are needed per Hospital rules and regulations;

Home, office, and other Outpatient medical care visits for exam, and treatment of the Covered Person; and

Diagnostic services, which includes a referral for evaluation.

The following Rehabilitative and restorative therapy services are covered:

Services provided in a Skilled Nursing Facility, with Prior Authorization from the Carrier, which are neither custodial, nor for the ease of the Covered Person or the Physician, and only until the Covered Person has reached the maximum level of recovery possible for the given condition, and no longer needs skilled nursing care, or definitive treatment other than routine supportive care;

Home health care Covered Services to a homebound Covered Person when prescribed by the Covered Person's attending Physician in lieu of hospitalization, and arranged prior to discharge from the Hospital;

Medically Necessary immunosuppressants prescribed with covered human organ and tissue transplants, and which, under Federal law, may only be dispensed by prescription, and which are approved for general use by the Food and Drug Administration;

Benefits for transport and lodging for the transplant recipient and companion(s) limited to a maximum of $10,000 per transplant, except as otherwise stated in the Exclusions Subsection of this Section;

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:

1. 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
2. Lodging for the Covered Person while receiving Medically Necessary post-operative Outpatient care at the Hospital.

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

1. Transport of the surgical harvesting team, and donor organ, or tissue, and
2. 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 shown in this Section.

When only the recipient is a Covered Person, both the donor and the recipient are entitled to the Covered Services as shown in this Section:

1. The 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.
2. Benefits provided to the donor will be charged against the Covered Person's Benefit Plan.

When the recipient is uninsured, and the donor is a Covered Person, this Benefit Plan will only provide benefits related to the procurement of the organ up to the maximum stated in this Subsection.

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

This Benefit Plan shall provide benefits for human organ and tissue transplant services only with Prior Authorization from the Carrier. The Hospital must be designated and approved by the Carrier to perform the Covered Services provided under this Section. It should be noted that not every designated Hospital performs each of the Covered Services. In addition, the Covered Person must follow all provisions in this Benefit Plan.

The term “donor” means a person who provides organ tissue for transplant in a histo-compatible recipient.

Only those organ and tissue transplants and related procedures shown in this Section are Covered Services under this Benefit Plan. As shown in the Schedule of Benefits, the benefits for Covered Services described in this Section are unlimited per Covered Person enrolled under this Benefit Plan.

Covered Services do not include:

Benefits for services if the Covered Person is not a suitable candidate, as determined by the Hospital designated and approved by the Carrier to provide such services.

Benefits for services for donor searches or tissue matching, or personal living expenses related to donor searches or tissue matching, for the recipient or donor, or their respective family or friends.

Any human organ and tissue transplant service that is determined to be Experimental or Investigational is not a Covered Service.

Benefits for transportation and lodging for the transplant recipient and companion(s), when the human organ or tissue transplant is provided in a Hospital or other facility not designated and approved by the Carrier.

H. OTHER MEDICAL SERVICES AND SUPPLIES

1. **Durable Medical Equipment:** The Plan covers Durable Medical Equipment, which is (a) designed and intended for repeated use; (b) primarily and customarily used to serve a medical purpose; (c) generally not useful to a person in the absence of disease or injury; and (d) is appropriate for use in the home. For Oxford members Prior Authorization is required for all items (including molded foot orthotics) costing more than $500.

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

   Replacements are covered when growth or a change in the Participant's medical condition make replacement Medically Necessary. The Plan does not otherwise cover the cost of repairs or replacement that results from misuse or abuse by the Participant).

2. **Prosthetic Devices and Appliances:** Coverage will be provided for Prosthetic Devices and Appliances, whether surgically implanted or worn as an anatomic supplement, when prescribed subject to the following:

- Repair, replacement, fitting, and adjustments are covered when made necessary by normal wear and tear or by body growth or change;
- Appliances such as a leg, arm, back or neck brace or artificial legs, arms or eyes or any prosthesis with supports, are covered including replacement if a Covered Person's physical condition changes;
- The Plan covers braces (and some orthotic devises that are used with braces) that are worn externally. The brace must temporarily or permanently assist all or part of an external body part function that has been lost or damaged because of an injury, disease or defect;
- In cases of a tumor of the oral cavity, non-dental Prosthetic Devices, including maxillo-facial Prosthetic Devices used to replace anatomic structures removed during treatment of head or neck tumors, and additional appliances essential for the support of such Prosthetic Devices;
- Surgically implanted internal breast prostheses will be covered to improve or restore the function of a breast that has been removed or damaged due to injury or disease. The Plan does not cover surgical implantation of a breast protheses for cosmetic reasons except following a mastectomy;
- Removal of an internal breast prosthesis will be covered when Medically Necessary due to recurring infection, overlying contracture or ruptured or leaking silicone implants or where implant removal is necessary to restore symmetry post-prophylactic/therapeutic mastectomy or there is a personal history of breast cancer and family history of malignant neoplasm of breast; and
- Removal of an internal breast prosthesis is not covered for non-specific systemic symptoms in patients who have silicone implants.

3. **Hearing Aid Coverage:** Hearing aid coverage is limited to children 12 years of age or younger, subject to a maximum benefit of one set of hearing aids per 24-month period.
Effective July 1, 2016, Age restriction will be removed; Coverage will be limited to a maximum benefit of one set of hearing aids per 24-month period. Prior authorization may be required for certain bone-anchored devices.

4. **Foot Orthotics:** . The Plan covers Medically Necessary shoe inserts prescribed by a Physician for the following conditions:

- Diabetes with neurological manifestations
- Diabetes with peripheral circulatory disorders
- Lesion of plantar nerve
- Ulcer of lower limb except pressure ulcer

- Tibialis tendinitis
- Calcaneal spur
- Other bursitis disorders
- Plantar fascial fibromatosis.

5. **Ostomy Related Services:** Ostomy bags, catheters and supplies required for their use, and any other Medically Necessary ostomy-related appliances including, but not limited to, collection devices, irrigation equipment and supplies, and skin barriers and protectors.

6. **Specialized Formula:** Coverage includes amino acid modified preparations and low protein modified food products for the treatment of an inherited metabolic disease for individuals who are or will become malnourished or suffer from disorders, which if left untreated, will cause chronic disability, mental retardation or death. These products must be prescribed and administered under the direction of a Physician. This benefit requires Prior Authorization.

   For the purposes of this benefit:

   a. Inherited metabolic disease includes (i) a disease for which newborn screening is required; and (ii) cystic fibrosis.

   b. "Low protein modified food product" is a product formulated to have less than 1 gram of protein per serving and is intended for the dietary treatment of an inherited metabolic disease under the direction of a Physician.

   c. "Amino acid modified preparation" is a product intended for the dietary treatment of an inherited metabolic disease under the direction of a Physician.

7. **Medically Necessary Specialized Infant Formula:** The Plan provides coverage for Specialized Formula for children up to the age of 12. Coverage is provided for formulas that are exempt from the general requirements for nutritional labeling (under the statutory and regulatory guidelines of the federal Food and Drug Administration) and intended for use solely under medical supervision in the dietary management of specific diseases. Such formulas will be covered when they are Medically Necessary for the treatment of a disease or condition and are administered under the direction of a Physician. The benefit is subject to Prior Authorization. For Anthem members only Prior Authorization is not required in the case of a child diagnosed with metabolic syndrome.

8. **Wigs:** Wigs are covered only if prescribed by a licensed oncologist for a patient who suffers hair loss as a result of chemotherapy for the treatment of leukemia and outpatient chemotherapy following surgical procedures in connection with the treatment of tumors and is subject to a limit of one wig per Covered Person per calendar year.

I. OTHER COVERED SERVICES

1. **Blood and blood plasma** which are not replaced, or will not be replaced by blood donors, or a blood bank.

2. **Blood derivatives** when purchased through a blood derivative supplier.

3. **Blood lead screenings** and clinically indicated risk assessments.

4. **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. More treatment is Covered if recommended by a board-certified rheumatologist, infectious disease specialist, or neurologist.

5. **Medically Necessary Pain Management** procedures when ordered by a pain management specialist.

6. **Routine Patient Care Costs in connection with Cancer Clinical Trial.**

   A Cancer Clinical Trial must be conducted under the auspices of an independent peer-reviewed protocol that has been reviewed and approved by:

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

   Hospitalization for Routine Patient Care Costs in connection with Cancer Clinical Trials shall include treatment at an Out-of-Network facility if such treatment is not available In-Network and not eligible for reimbursement by the sponsors of such clinical trial, Out-of Network Hospitalization will be rendered at no greater cost to the insured person than if such treatment was available In-Network, all applicable In-Network Cost-Shares will apply.

7. **Private Duty Nursing.** Coverage is provided for medically necessary intermittent and temporary, complex skilled nursing care on an hourly basis in the home by a Registered Nurse (RN) or a Licensed Practical Nurse (LPN) and performed under the direction of a physician. Private duty nursing care includes assessment, monitoring, skilled nursing care, and caregiver/family training to assist with transition of care from a more acute setting to home. Such benefit is subject to Prior Authorization.

VII. EXCLUSIONS AND LIMITATIONS

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

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

If a service is not covered, then all services performed in conjunction with that service are not covered. The Carrier is responsible for determining whether services or supplies are Medically Necessary, subject to the appeals process set forth in Section VIII below.

B. The listed Exclusions below are in addition to those set forth elsewhere in the Plan Document. Except when approved by the Carrier as part of Case Management, the following services are not covered Services under the Plan:

1. Benefits for services which are not:
   a. Described in the Plan Document;
   b. Rendered or ordered by a Physician;
   c. Within the scope of a Physician's, Provider's or Hospital's license; and
   d. Medically Necessary Care for the proper diagnosis or treatment of the Covered Person.

2. Benefits for services rendered before the Covered Person's Effective Date under this Benefit Plan.

3. Benefits for services rendered after the person's Benefit Plan has been rescinded, suspended, cancelled, interrupted, or terminated. Any person getting services after his or her Benefit Plan is rescinded, suspended, cancelled, interrupted, or terminated for any reason will be liable for payment of such services.

4. Benefits that are reduced under the Managed Care Guidelines. Any reduced or denied benefits paid by the Covered Person do not count towards any applicable Cost-Share Maximums shown in the Schedule of Benefits.

5. Any reduction in benefits, including, but not limited to, penalties imposed by another Plan, which are like those identified in the Managed Benefits – Managed Care Guidelines, will not be paid as a Covered Service under this Plan.

6. Care for conditions that are required by State or Local law to be treated in a public facility.

7. Services and care in a Veteran's Hospital or any Federal Hospital, except as may be required by law.

8. Services covered in whole, or in part by public, or private grants.

9. Studies related to pregnancy, except for major medical reasons.

10. Simplified or self-administered tests, and multiphasic screening.

11. Prenatal medical conferences with a pediatrician regarding an unborn child, unless the visit is the result of a medical referral.

12. Charges for the Covered Person's room and board when the Covered Person has a leave of absence from a Hospital, Substance Abuse Treatment Facility, or other Inpatient Facility.

13. Vaccines (other than Adult or childhood immunizations recommended by the U.S. Department of Health and Human Services for the Covered Person or immunizations required for foreign travel).

14. Services, medical supplies, or supplies not listed as Covered Services. These include, but are not limited to educational therapy, marital counseling, sex therapy, weight control programs, nutritional programs, and exercise programs.

15. Any Experimental or Investigational treatment, procedure, facility, equipment, drugs, devices, or supplies and any services associated with, or as follow-up to any of the above is not a Covered Service.

16. Any treatment, procedure, facility, equipment, drug, device, or supply which requires Federal or other governmental agency approval that has not been granted at the time services are rendered. Any service associated with, or as follow-up to, any of the above is not a Covered Service.

17. Any services by a Physician or Provider to himself or herself, or for services rendered to his or her parent, spouse, children, grandchildren, or any other close family member or relation, even if a Participating Physician or Participating Provider.

18. Services which the Covered Person or the Carrier is not legally required to pay.

19. Wigs, and other cranial prostheses, except as noted in the Covered Services section.

20. Inpatient services which can be properly rendered as Outpatient services.

21. Diseases contracted or injuries resulting from war.

22. Charges after the Provider's or Hospital's regular discharge hour on the day indicated for the Covered Person's discharge by his/her Physician.

23. Eyeglasses and contact lenses.

24. Travel, whether or not recommended by a Physician.

25. Certain pulmonary function tests which, in the opinion of the Carrier, do not meet the definition of a covered diagnostic laboratory test.

26. Services or procedures rendered without regard for specific clinical indications, routinely for groups or persons, or which are performed solely for research purposes.

27. Services or procedures which have become obsolete, or are no longer medically justified as determined by appropriate medical fields.

28. Radiation therapy as a treatment for acne vulgaris.

29. Services required by third parties for employment, membership, enrollment, or insurance, such as school or employment physicals, physicals for summer camp, enrollment in health, athletic, or similar clubs, premarital blood work or physicals, or physicals required by insurance companies or court-ordered alcohol or drug abuse courses.

30. Durable Medical Equipment and other items for home or personal use, except as provided in the Benefit Section.

31. Prosthetic Devices, except as provided in the Benefit Section. Examples of non-covered items include, but are not limited to:
    - Bite plates/dental prosthetics, except for maxillo-facial Prosthetic Devices used to replace anatomic structures lost during treatment of tumors;
    - Optical, or visual aids, including eyeglasses or contact lenses, except for the treatment of: congenital aphakia, or for aphakia following cataract surgery when an intraocular lens is not medically possible;
    - Penile implants;
    - Xomed audiant bone conductors;
    - Foot Orthotics (except as Medically Necessary and subject to Prior Authorization); or
    - Experimental or research prostheses.

32. Treatment of pattern baldness.

33. Items generally used for personal comfort and/or useful to the Covered Person's household, including but not limited to:
    - Air conditioners, humidifiers, air cleaners, filtration units, and related apparatus;
    - Whirlpools, saunas, and related apparatus;
    - Vans, and van lifts;
    - Stair and chair lifts;
    - Exercise bicycles and other types of exercise equipment.

34. Physical therapy, chiropractic care, occupational therapy, speech therapy, and cardiac rehabilitative therapy, except as provided in the Benefit Section.

35. Testing for or treatment of a Learning Disability, except as provided in the Benefit Section.

36. Testing, training, or rehabilitation for educational or developmental purposes, except as provided in the Benefit Section.

37. Cosmetic surgeries, procedures and services performed primarily to improve appearance and not otherwise determined by the Carrier to meet the coverage criteria for reconstructive surgeries, procedures and services as set forth in this Plan Document.

38. Dental diagnosis, care, treatment or diagnostic imaging studies, except as provided in the Benefit Section. 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. Prosthetic Devices are not a Covered Service, except as provided in the Benefit Section.

39. Oral surgery, except as provided in the Benefit Section. An example of a non-covered service includes but is not limited to the correction of malposition of the teeth or jaw.

40. Except for the initial visit, all services related to the non-surgical treatments of temporomandibular joint dysfunction or syndrome, also called myofascial pain dysfunction or craniomandibular pain syndrome are not covered. Examples of non-covered services include but are not limited to physiotherapy, such as therapeutic muscle exercises, galvanic or transcutaneous nerve stimulation, vapocoolant sprays, ultrasound, or diathermy, behavior modification such as

biofeedback, psychotherapy, appliance therapy and or dental orothodic devices such as occlusal appliances (splints) or other oral prosthetic devices and their adjustments, orthodontic therapy such as braces, prosthodontic therapy such as crowns, bridgework, and occlusal adjustments.

41. Routine foot care rendered:
    a. In the exam, treatment or removal of all or part of corns, callosities, hypertrophy, or hyperplasia of the skin, or subcutaneous tissues of the foot, except when Medically Necessary in the treatment of those diagnosed with Type 1 or Type 2 diabetes; or
    b. In the cutting, trimming, or other non-operative partial removal of toenails, except when Medically Necessary in the treatment of neuro-circulatory conditions or of those diagnosed with Type 1 or Type 2 diabetes.

42. Emergency room services that are not related to a Medical Emergency.

43. Custodial Care when:
    a. Primarily to provide room and board (with or without nursing care),
    b. Needed to help to support the essentials of daily living; and
    c. Supervisory care by a Physician for a Covered Person who is mentally or physically disabled, and who is not under active and specific medical, surgical, and/or psychiatric treatment which would be expected to reduce the disability to the extent needed for the Covered Person to function outside a protected, monitored, and/or controlled environment, or when despite such treatment there is no reasonable likelihood that the disability shall be so reduced.

    Care shall be considered custodial even if:

    (i) The Covered Person is under the care of the Primary Care Physician, or a Participating Physician;
    (ii) The Primary Care Physician or the Participating Physician prescribes services to: support, and maintain the Covered Person's condition; or
    (iii) The services and supplies are being provided by a registered nurse, or licensed practical nurse.

    e. Ambulance services, including but not limited to:

- Transport for elective Hospital Admissions; and
- Transport solely for the convenience of the Covered Person, family, or Physician or Provider, except when Medically Necessary, or in the case of a Medical Emergency.

44. Private room accommodations, except as noted in the Benefit Section.

45. Prescription drugs or over-the-counter medications prescribed for use as an Outpatient, except as otherwise stated herein.

46. Whole blood, blood plasma, and other blood derivatives, and donor services that are provided by the American Red Cross.

47. Reversal of voluntary sterilization.

48. Sperm collection and preservation, all services related to surrogate parenting arrangements and preparatory treatment.

49. Marriage counseling other than for the treatment of a diagnosed mental illness, stress management, parent-child management, and pain control.

50. Psychiatric and other treatment for sexual dysfunction, including sex therapy, unless documented by a medical condition and with Prior Authorization from the Carrier.

51. Care, treatment, procedures, services, or supplies which are primarily for dietary control including, but not limited to weight reduction programs, except as stated in the Benefit Section.

52. Special nutritional formulas for the treatment of Crohn's disease.

53. Hypnosis.

54. Human organ and tissue transplants, or associated donor costs, except as stated in the Benefit Section.

55. Care, treatment, service, or supplies to the extent that the Covered Person has obtained benefits under any applicable law, government program, or public or private grant, except for Medicare, Medicaid, or any similar state program.

56. Any illness or injury for which benefits are paid, payable, or eligible for coverage under any Worker's Compensation Law, Automobile insurance or no-fault other similar law to the extent permissible by law.

57. The Plan does not cover expenses of services for which the Covered Person or the Carrier is not legally required to pay.

58. Routine eye exams or refractions, except as provided in the Benefit Description.

59. Radial keratotomy.

60. Human growth hormone therapy, except when Medically Necessary for cases of hypopituitarism, and with Prior Authorization from the Carrier.

61. Hospital Outpatient clinic services.

62. Penalties imposed on a Covered Person by the primary payer.

63. Inpatient private duty nursing or outpatient private duty nursing for the convenience of the member or member's family.

64. Any medication or drug, which has a biotechnical application, is a genetically engineered biological product, or is listed in the formulary as such.

65. Hypodermic needles or syringes prescribed by a Physician, except for the purpose of administering medicine for medical conditions, provided such medicines are Covered Services.

66. No benefits will be available for Maintenance Care which is:

    a. Treatment provided for the Covered Person's continued well-being by preventing deterioration of a chronic clinical condition, and

    b. Maintenance of an achieved stationary status, which is a point where little or no improvement in musculo-skeletal function can be made despite therapy.

    This includes without limitation, Methadone and Suboxone maintenance or any other similar maintenance therapy program and its related testing, supplies, visits and treatment.

67. All other services and items of care not listed in this Plan Document.

68. Benefits for services caused by or resulting from the Covered Person's participation in a riot or civil disorder, act of or attempt to commit an assault or felony.

69. Services for Chronic Care.

70. The following is a list of procedures which are not covered:

    a. Allogeneic, or Syngeneic Bone Marrow Transplant, or other forms of stem cell rescue, and stem cell infusion (with or without high dose chemotherapy and/or radiation) with a donor other than the patient. They are not covered, unless:

        1. At least five out of six histocompatibility complex antigens match between the patient, and the donor;

        2. The mixed leukocyte culture is non-reactive; and

        3. One of the following conditions is being treated:

            - Severe aplastic anemia;

- Acute nonlymphocytic leukemia in first or subsequent remission or early first relapse;
- Myelodysplastic syndrome;
- Secondary acute nonlymphocytic leukemia as initial therapy;
- Acute lymphocytic leukemia in second or subsequent remission;
- Acute lymphocytic leukemia in first remission;
- Chronic myelogenous leukemia in chronic and accelerate phase;
- Non-Hodgkin's lymphoma, high grade, in first or subsequent remission;
- Hodgkin's lymphoma low grade, which has undergone conversion to high grade;
- Neuroblastoma, stage 3 or relapsed stage 4;
- Ewing's sarcoma;
- Severe combined immunodeficiency syndrome;
- Wiskott-Aldrich syndrome;
- Osteopetrosis, infantile malignant;
- Chediak-Higashi syndrome;
- Congenital life-threatening neutrophil disorders to include Kostmann's syndrome, chronic granulomatous disease, and cartilage hair hypoplasia;
- Diamond Blackfan syndrome;
- Thalassemia;
- Sickle cell anemia;
- Primary thrombocytopathy including Glanzmann's syndrome;
- Gaucher disease; or
- Mucopolysaccharidoses, and lipidoses to include Hurler's syndrome, Sanfilippo's syndrome, Maroteaux-Lamy syndrome, Morquio's syndrome, Hunter's syndrome, and metachromatic leukodystrophy.

All other uses of Allogeneic, or Syngeneic Bone Marrow Transplants, or other forms of stem cell rescue, and stem cell infusion (with or without high dose chemotherapy or radiation) are not covered.

b. Autologous Bone Marrow Transplantation, or other forms of stem cell rescue, and stem cell infusion (in which the patient is the donor) with high dose chemotherapy or radiation are not covered except for the following:

1. Non-Hodgkin's lymphoma, high grade, first or subsequent remission. No morphological evidence of bone marrow involvement should be evident;
2. Hodgkin's disease as defined above with an absence of bone marrow involvement;
3. Acute nonlymphocytic leukemia in second remission, in which no HLA matched donor exists, or an allogeneic transplant is inappropriate;
4. Acute lymphocytic leukemia in second remission, in which no HLA matched donor exists, or an allogeneic transplant is inappropriate;
5. Retinoblastoma, adjuvant setting after successful induction (consolidation); or
6. Neuroblastoma, adjuvant setting after successful induction (consolidation).

71. No-show charges assessed by a Provider for a missed appointment.

72. Any exclusion above will not apply to the extent that coverage is specifically provided by name in this Plan, or coverage of the charges is required under any law that applies to the coverage.

73. Special foods and diets, supplements, vitamins and enteral feedings are not covered except as otherwise noted in this Plan Document.

74. Services for the evaluation or treatment (including remedial education) of learning disabilities or minimal brain dysfunction, mental retardation, developmental and learning disorders or behavioral problems except as noted under the "Early Intervention Services/Birth to Three Program" section are not covered. The Plan also does not cover behavioral training, visual perceptual or visual motor training related to learning disabilities, or cognitive rehabilitation. Behavioral and learning disorders related to congenital abnormalities, such as Down Syndrome, are not covered.

75. Court ordered psychological or behavioral evaluations or counseling related to marital disputes, divorce proceedings, or child custody proceedings.

76. Breast pumps purchased or rented prior to July 1, 2013 or breast pumps that were not obtained from a DME Provider, Hospital or Physician.

VIII. APPEALS AND GRIEVANCES

The Covered Person has the right to appeal a Carrier's denial of benefits. The Appeal/Grievance process may be pursued by the Covered Person, the Covered Person's duly authorized representative, the Provider of record, or the Provider of record's duly authorized representative. In most cases, Members are required to comply with the requirements of their Carrier's Internal Appeals process before seeking external review of adverse determinations.

The Connecticut Department of Insurance is available to decide appeals of a Carrier's adverse Utilization Review Determinations where Medical Necessity or clinical judgments are in issue. The Department of Insurance does not entertain appeals based on benefit exclusions, claims payment or coverage issues. Unless a matter is urgent and accepted for an expedited review, the Covered Person must complete the Carrier's Internal Appeals process before filing an External Appeal with the Insurance Department. In urgent situations, the Member may seek an External Appeal directly or may seek both an Internal and an External Appeal simultaneously.

Adverse decisions are classified as follows:

Utilization Management Review Determinations includes judgments on whether services or treatments will be covered or judgments concerning Medical Necessity; this includes determinations concerning cosmetic, custodial and convenience items. An appeal of a utilization review decision may be sought whether the requested services have not been rendered (Prior Authorization or Pre-certification), are currently being rendered (Concurrent Care) or have already been rendered (Retrospective review).

Non-Utilization Management Review Determinations may include denials based on Plan benefit exclusions or limitations, claim payment disputes or administrative disputes not involving Medical Necessity judgments. There is no external appeal for non-utilization review determinations.

A. FIRST LEVEL APPEAL

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

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

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

1. Utilization Management (Clinical) Appeals

First level appeal review requests should be submitted as follows:

:

By Mail	**Anthem Blue Cross and Blue Shield** First Level Appeal Review 108 Leigus Road Wallingford, CT 06492	**UnitedHealthcare/Oxford** Attn: Clinical Appeals Department PO Box 30432 Salt Lake City, UT 84130-0432
By FAX	203-985-7363	877-220-7537
Verbal appeal	Call Member Services at 800-922-2232	Call Member Service Associates at 800-385-9055

Anthem First Level Behavioral Health

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

2. Non-Utilization (Non-Clinical) Management Appeals

Written first level appeal review requests should be submitted as follows:

By Mail	**Anthem Blue Cross and Blue Shield** First Level Appeal Review 108 Leigus Road Wallingford, CT 06492	**UnitedHealthcare/Oxford** Attn: Grievance Review Board PO Box 30432 Salt Lake City, UT 84130-0432
By FAX	203-985-7363	801-938-2100
Verbal appeal	Call Member Services at 800-922-2232	Call Member Service Associates at 800-385-9055

3. Expedited Appeals: In the event of an emergency or a life-threatening situation, or when a claim involves Urgent Care, or when a Covered Person is denied benefits for an otherwise Covered Service on the grounds that it is Experimental and the Covered Person has been diagnosed with a condition that creates a life expectancy of less than two years, an expedited first level appeal review may be requested. A determination will be issued within two (2) business days or 72 hours, whichever is earlier, from the date the expedited appeal request is received.

4. **Timetable for First Level Appeal Decisions**

Appeal Type	Anthem Time* for Issuing Decision	Oxford Time* for Issuing Decision
Utilization Review—Pre or Concurrent Service	30 calendar days	30 calendar days
Utilization Review Post Service	30 calendar days	60 calendar days
Non-Utilization Review	20 calendar days	30 business days
Expedited (Urgent) Following receipt of all required information	72 hours	72 hours

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

B. SECOND LEVEL APPEAL

Both Carriers make a second level appeal process available to Members who are not satisfied with the result of a first level appeal. Members who are enrolled in UnitedHealthcare/Oxford Plans, must complete a second level appeal before seeking external review before the Connecticut Department of Insurance. For Anthem Members, a second level appeal is optional.

The appeal will be determined by employees who were not involved in the initial determination and will not give deference to the denial decision. When an appeal is clinical in nature the appeal will be determined by a licensed Physician who did not review the issue at the first level appeal.

1. Utilization Management (Clinical) Appeals

For Utilization Management (Medical Necessity) second level appeals the requests should be submitted within **60** days of the date of the first level appeal determination as follows:

By Mail	**Anthem Blue Cross and Blue Shield** Grievances and Appeals Second Level Grievance 108 Leigus Road Wallingford, CT 06492	**UnitedHealthcare/Oxford** Attn: Grievance Review Board P.O. Box 29134 Hot Springs, AR 71903
By FAX	203-985-7363	866-352-6053
Verbal appeal	Call Member Services at 800-922-2232	Call Member Service Associates at 800-385-9055

2. Non-Utilization (Non-Clinical) Management Appeals

For Non-Utilization (Non-Medical Necessity) second level appeals the requests should be submitted within **10** calendar days from the date of the first level appeal determination, as follows:

By Mail	**Anthem Blue Cross and Blue Shield** Grievances and Appeals Second Level Grievance Panel 108 Leigus Road Wallingford, CT 06492	**UnitedHealthcare/Oxford** Attn: Grievance Review Board P.O. Box 29134 Hot Springs, AR 71903
By FAX	203-985-7363	203-601-6893
Verbal appeal	Call Member Services 800-922-2232	Call Member Service Associates at 800-385-9055

3. Timetable for Second Level Appeal Decisions

Appeal Type	Anthem Time for Rendering Decision*	Oxford Time for Rendering Decision*
Utilization Review— Pre or Concurrent Service	15 calendar days	30 calendar days
Utilization Review Post Service	30 calendar days	60 calendar days
Non-Utilization Review	20 calendar days	30 business days
Expedited (Urgent) Following receipt of all required information	72 hours	72 hours

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

C. External Appeals

Review by the State of Connecticut Insurance Department is available to a Covered Person who has completed his or her Carrier's internal clinical appeals process. For Anthem Members, only the first level appeal is required; the second level appeal is voluntary. For Oxford Members, both the first and second level appeals must be completed before a Member seeks an external appeal.

You or your designee has the right to request an external appeal when:

- The service, procedure or treatment is a Covered Service under this Plan; and
- You have received a final Adverse Determination through the Carrier's internal review process with a denial based on lack of Medically Necessary criteria or Experimental/Investigational Treatment UNLESS it is determined that the time frame for completion of an internal appeal may cause or exacerbate an emergency or life threatening situation. In an emergency or life threatening situation, a Member does not need to complete all internal appeals in order to file for an external appeal.

Expedited Appeals. In an emergency or life-threatening situation a Covered Person may utilize the external appeal process directly, without exhausting the Carrier's internal appeals if it is determined that the time frame for completion of an expedited internal appeal may cause or exacerbate an emergency or life threatening situation. (See Section 4 below.)

1. Filing an External Appeal

To file a standard (non-expedited) external appeal, a Member has 120 days after completion of your Carrier's internal review process to initiate the appeal through the State of Connecticut Insurance Department. The Insurance Department 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 Commissioner. The Member or his or her designee (and Provider, if applicable) must release all pertinent medical information concerning the medical condition and request for services.

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

The appeal may be sent to the following address:

Connecticut Insurance Department
Attn: External Review
PO Box 816
Hartford, CT 06142-0816
(860) 297-3910.

For Overnight delivery <u>only</u>, send the application for External Review to:

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

2. Contents of Appeal

The following items must be included in the Appeal.

- A completed "Request for External Appeal" form.
- An authorization form allowing the Carrier and your health care professional to release medical information to the independent review organization.
- Evidence of being enrolled in the Plan (photocopy of the identification card issued by the Carrier).
- Copies of all correspondence from the Carrier.
- A copy of the Final Determination letter indicating that all internal appeal mechanisms have been exhausted.
- A copy of the Plan Document or explanation of benefits.
- **The filing fee of $25.**

In addition to the required items outlined above, you may also submit any additional information relevant to your condition.

3. Carrier Confirmation

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

a. You are or were a Member of the Plan at the time of the event that is subject of the Adverse Determination;

b. The service in question reasonably appears to be a Covered Service under the Plan but was denied because it does not meet the Carrier's requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness;

c. The service in question reasonably appears to be a Covered Service under the Plan but was denied because it is Experimental or Investigational for a particular medical condition, is not explicitly listed as an excluded benefit under your health Benefit Plan and your treating health care professional has certified that one of the following situations is applicable:

    - Standard health care services or treatments have not been effective in improving your medical condition;
    - Standard health care services or treatments are not medically appropriate for you;
    - There is no available standard health care service or treatment covered by the Carrier that is more beneficial than the recommended or requested health care service or treatment;

    In addition, your treating health care professional:

    - Has recommended a health care service or treatment that he/she certifies, in writing, is likely to be more beneficial to you, in his/her opinion, than any available standard health care services or treatments; or

- Is a licensed, board certified or board eligible health care professional qualified to practice in the area of medicine appropriate to treat your condition and has certified in writing that scientifically valid studies using accepted protocols demonstrate that the denied health care service or treatment is likely to be more beneficial to you than any available standard health care services or treatments;

d. You have completed both a the Carrier's Internal Review process first level (for Anthem Members) and a Second Level Appeal (for Oxford Members);

e. You have provided all of the required information; and

f. You have paid the required filing fee.

The Carrier will complete this review within 5 business days for an external review request or within 1 day for an expedited external review request. Once the Carrier has completed its review, it will notify you, your designee (if appropriate) and the Insurance Commissioner whether the appeal is complete and eligible for external review and will communicate its findings in writing within 1 business day for an external appeal or on the day the review is completed for an expedited external appeal. If the appeal is not complete, the notice will identify what information or materials are missing. If the appeal is not eligible, the notice will include the reason(s).

4. Expedited External Appeals

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

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

A Member may not file an Expedited External Appeal for services that have already been provided (Retrospective).

5. Timeframes for Resolution

If an appeal is eligible for external review, the Commissioner will assign it to an Independent Review Organization and send a notice advising that (a) an external review or expedited external review has been accepted, and (b) that you have 5 business days from receipt of the notice to submit any additional information.

The Carrier will forward the medical and treatment plan records relied upon in making its determination to the Independent Review Organization. If the documentation represents a material change from the documentation upon which the Adverse Determination or

denial was based, the Carrier will have the opportunity to consider the documentation and amend or confirm its Adverse Determination or denial.

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

- External reviews—within 45 days after assignment from the Commissioner
- External review involving an Experimental or Investigational treatment—within 20 days after assignment from the Commissioner
- Expedited external reviews—as expeditiously as the Member'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 Member's condition requires, but not later than 5 days after assignment from the Commissioner

6. Binding Effect of External Appeal Decision

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

IX. COORDINATION OF BENEFITS

All benefits provided under this Benefit Program are subject to the Coordination of Benefits provisions as described in this Section.

A. APPLICABILITY

1. The Coordination of Benefits (COB) provision applies to this Benefit Program when a Covered Person has health care coverage under more than one Plan as defined below.
2. If the Covered Person is covered by this Benefit Program and another Plan the Order of Benefit Determination Rules in this Section shall decide which Plan is the Primary Plan. The benefits of this Plan:
    a. Shall not be reduced when under the Order of Benefit Determination Rules this Benefit Program is the Primary Plan; but
    b. May be reduced or the reasonable cash value of any Covered Service may be recovered from the Primary Plan when under the Order of Benefit Determination Rules another Plan is the Primary Plan. The above reduction is described in the Effect Of This Benefit Program On The Benefits Policy Subsection;
    c. Penalties imposed on a Covered Person by the primary Carrier are not subject to COB;
    d. The Covered Person must submit the explanation of benefits from the Primary Plan to his or her Carrier, in order to be eligible for payment under this Coordination of Benefits Section.

B. DEFINITIONS

In addition to the defined terms listed in the Definitions Section of this Benefit Program, the following also apply to this Coordination of Benefits Section.

ALLOWABLE EXPENSE: The term Allowable Expense means a Medically Necessary Allowable Expense for an item of expense for health care, when the item of expense, including any Co-payment amounts, is covered at least in part by one or more Plans covering the Covered Person for whom the claim is made. Allowable Expense does not include coverage for dental care, vision care, or prescription drugs. When this Benefit Program provides Covered Services, the reasonable cash value of each Covered Service is the Allowable Expense and is a benefit paid.

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

CLAIM DETERMINATION PERIOD: The term Claim Determination Period means a Calendar Year. However, it does not include any part of a Calendar Year during which

a person has no coverage under this Benefit Program or any part of a Calendar Year before the date this COB provision or a like provision takes effect.

PLAN: For the purpose of this Section, the term Plan means any of the following which provides benefits or services for, or because of, medical care or treatment:

a. 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.

b. 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 more than those of any private insurance program or other non-governmental program.

c. Medical benefits coverage of no-fault and traditional automobile fault contracts, as provided in this Section.

Each contract, or other arrangement for coverage under (a), (b), or (c) 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.

PLAN SPONSOR: The term Plan Sponsor, means State of Connecticut by and through the Office of the State Comptroller.

PRIMARY PLAN: The term Primary Plan means 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 (a) or (b) below is true:

a. The Plan either has no Order of Benefit Determination rules, or it has rules which differ from those stated in this section; or

b. All Plans which cover the person use the Order of Benefit Determination rules as shown in this section, and under those rules the Plan decides 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 Benefit Program is the Primary Plan, Covered Services are provided or covered without considering the other Plan's benefits.

SECONDARY PLAN: The term Secondary Plan means a Plan which is not a Primary Plan. If a person is covered by more than one Secondary Plan, the Order of Benefit Determination rules of this Section will decide the order in which the benefits are determined in relation to each other. The benefits of the Secondary Plan may take into account 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 Benefit Program is the Secondary Plan, benefits for Covered Services under the Benefit Program may be reduced, and the Plan Sponsor may recover from the Primary Plan, the Provider of Covered Services, or the Covered Person, the reasonable cash value of the Covered Services provided by this Benefit Program.

C. ORDER OF BENEFIT DETERMINATION RULES

1. General Rule

When a Covered Person receives Covered Services by or through this Benefit Program or is otherwise entitled to claim benefits under this Benefit Program and has followed the Carrier's guidelines and procedures, including Prior Authorization requirements as shown in this Benefit Program, and the Covered Services are a basis for a claim under another Plan, this Benefit Program is a Secondary Plan which has its benefits determined after those of the other Plan[8], unless:

a. The other Plan has rules coordinating its benefits with those described in this Plan Document; and

b. Both the other Plan's rules and this Benefit Program's coordination rules, as described below, require that this Benefit Program's benefits be determined before those of the other Plan.

2. Coordination Rules

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

a. Other than a Dependent

The benefits of the Plan which covers the person as a Covered Person (that is, other than as a Dependent) are primary to those of the Plan which covers the person as a Dependent.

b. Dependent Child/Parents Not Separated or Divorced:

When this Benefit Program and another Plan cover the same child as a Dependent of different persons, called "parents", the Plan of the parent whose birthday falls earlier in a year is primary to the Plan of the parent whose birthday falls later in that year, but 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.

c. Dependent Child/Separated or Divorced Parents:

In the case of a Covered Person for whom claim is made as a Dependent child:

i. 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

[8] Except when the Carrier is secondary payor.

child shall be determined before the benefits of a Plan which covers the child as a Dependent of the parent without legal custody;

ii. 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 step-parent; and

The benefits of a Plan which covers that child as a Dependent of the step-parent shall be determined before the benefits of a Plan which covers that child as a Dependent of the parent without legal custody.

If the 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. The provisions of this subsection do not apply with respect to any Claim Determination Period or Plan year during which any benefits are actually paid or provided before the payor has that actual knowledge.

d. Active/Inactive Employee

A Plan which covers a person as an employee who is neither laid off, nor retired (or as that employee's Dependent) is primary to a Plan which covers that person as a laid-off or retired employee (or as that employee's Dependent). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule (d) is ignored.

e. Longer/Shorter Length of Coverage

If none of the above rules decides the order of benefits, the Plan which covered a Covered Person longer is primary to the Plan which covered that person for the shorter time.

f. Medicare

If a Covered Person is eligible for Medicare and covered under this Benefit Program, the Carrier will provide the benefits of this Benefit Program except as obliged by law. However, these benefits will be reduced to an amount which, when added to the benefits received pursuant to Medicare, may equal, but not be more than the Allowable Expense. The Carrier shall never pay more than it would have paid as the Primary Plan.

(Note: Certain services may not require Prior Authorization when it is determined that the Carrier is the Secondary Plan. Contact Customer Service before any services are rendered to determine if such services require Prior Authorization. In the event that a later determination finds that the Carrier is the Primary Plan, any services that were obtained without Prior Authorization while the Carrier was administering benefits as a Secondary Plan will not require Prior Authorization as would be required under a Primary Plan.)

D. Effect Of This Benefit Program On The Benefits

1. This subsection applies when in accordance with the Order of Benefit Determination Rules this Benefit Program is a Secondary Plan as to one or more other Plans. In that event, the benefits of this Benefit Program may be reduced under this subsection. Such other Plan or Plans are referred to as "the other Plans."

2. Reduction in this Benefit Program's benefits. When the Benefit Program is the Secondary Plan, the Carrier will provide benefits under the Benefit Program, so that the sum of the reasonable cash value of any Covered Service provided by the Benefit Program, and the benefits payable under the other Plans shall not total more than the Allowable Expense. Benefits will be provided by the Secondary Plan at the lesser of the amount that would have been paid had it been the Primary Plan or the balance of the bill. The Carrier shall never pay more than it would have paid as the Primary Plan.

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

E. Right To Receive And Release Needed Information

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

F. 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 Benefit Program. If it does, the Carrier may pay that amount to the group which made that payment. Such amount shall then be considered as though it were a benefit paid under this Benefit Program.

G. Right Of Recovery

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

The right of the Plan Sponsor to recover from a Covered Person shall be limited to the Allowable Expense that the Covered Person has received from another Plan. Acceptance of Covered Services will constitute consent by the Covered Person to the Plan Sponsor's right of recovery. The Covered Person agrees to take all further action to execute and

deliver such documents as may be needed, and do whatever else is needed to secure the Plan Sponsor's rights to recover excess payments. A Covered Person's failure to comply may result in a withdrawal of benefits already provided, or a denial of benefits requested.

X. RIGHT OF RECOVERY

The purpose of the Benefit Program is to provide Coverage for qualified medical expenses that are not covered by a third party. If the Plan pays benefits for any claim a Covered Person incurs as the result of negligence, willful misconduct or other action or omission of a third party, to the extent permitted by law, the Plan has a right of subrogation and right of recovery for benefits for Covered Services provided under the terms of this Program, where the Covered Person has a right of recovery against third parties for the cost of Covered Services.

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

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

You must notify the Plan immediately if you begin settlement negotiations with or obtain a judgment against a third party or insurer in connection with an accident or injury for which benefits have been paid by the Plan.

A. WORKERS' COMPENSATION

To the extent permitted by law no benefits shall be provided for Covered Services paid, payable or eligible for coverage under any Workers' Compensation Law, employer's liability or occupational disease law, denied under a managed Workers' Compensation program as Out-of-Network services or which, by law, were rendered without expense to the Covered Person.

Plan Sponsor shall be entitled to the following:

1. To charge the entity obligated under such law for the dollar value of those benefits to which the Covered Person is entitled;
2. To charge the Covered Person for such dollar value, to the extent that the Covered Person has been paid for the Covered Services;

3. To reduce any sum owing to the Covered Person by the amount that the Covered Person has received as payment;
4. To place a lien on any sum owing to the Covered Person for the amount Plan Sponsor has paid for Covered Services rendered to the Covered Person, in the event that there is a disputed and/or controverted claim between the Covered Person's Employer Group and the designated Workers' Compensation insurer as to whether or not the Covered Person is entitled to receive Workers' Compensation benefits payments;
5. To recover any such sum owing as described above, in the event that the disputed and/or controverted claim is resolved by monetary settlement to the full extent of such settlement;
6. If a Covered Person is entitled to benefits under Workers' Compensation, employer's liability or occupational disease law, it is necessary to follow all of the guidelines in the Managed Benefits Section in order for this Benefit Program to continue to provide benefits for Covered Services when the Workers' Compensation benefits are exhausted.

B. AUTOMOBILE INSURANCE

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

Plan Sponsor shall be entitled:

1. To charge the insurer obligated under such law for the dollar value of those benefits to which a Covered Person is entitled.
2. To charge the Covered Person for such dollar value, to the extent that the Covered Person has received payment from any and all sources, including but not limited to, first party payment.
3. To reduce any sum owing to the Covered Person by the amount that the Covered Person has received payment from any and all sources, including but not limited to, first party payment.
4. Benefits shall be subject to Coordination of Benefits as described in the Coordination of Benefits Section of this Plan Document, for Covered Services received under an automobile insurance policy which provides benefits without regard to fault.
5. A Covered Person who fails to secure no-fault insurance required by applicable law shall be deemed to be his or her own insurer, and Plan Sponsor shall reduce his or her benefits for Covered Services by the amount of basic reparations benefits or other benefits provided for injury if such a no-fault policy had been obtained.
6. If a Covered Person is entitled to benefits under a no-fault or other automobile insurance policy, benefits for Covered Services will only be provided when a Covered Person follows all of the guidelines stated in the Managed Benefits Section of the Plan Document.

XI. CONTINUATION OF COVERAGE—COBRA

In accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Participants in health Benefits Plans offered to State of Connecticut employees have certain rights and responsibilities regarding continuation of health benefits coverage which is terminated.

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

A. QUALIFYING EVENTS

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

For a Covered Spouse – The spouse of an employee or retiree of the State of Connecticut may have the right to elect continuation coverage if he or she loses such group health Plan coverage for any of the following reasons:

1. A termination of the spouse's employment or a reduction of their spouse's hours of employment with the State of Connecticut;
2. The death of the spouse; or
3. Divorce or legal separation.

For Covered Dependent Children – The Dependent of a Covered Employee covered by the Plan may be entitled to elect continuation coverage if he or she loses group health Plan coverage for any of the following reasons:

1. A termination of the employee's employment or reduction in the employee's hours of employment with the State of Connecticut;
2. The death of the employee;
3. Parent's divorce or legal separation; or
4. Failure to meet eligibility requirements for coverage as a Dependent of the Covered Employee (by, for example, attaining the age of 26).

B. NOTIFICATION REQUIREMENTS

The Covered Employee, spouse, or other family member has the responsibility to inform the State of Connecticut of a divorce, legal separation, or a child losing Dependent status under the state sponsored group health Plan. This notification must be made within 60 days from the date of the event or the date on which coverage would be lost under the terms of the Plan because of the event, whichever is later. This notification must be made to the personnel or payroll office of the employing agency or in the case of a retiree to the Retiree Health Unit of the Healthcare Policy & Benefit Services Division. In most cases a child will cease to qualify as an Eligible Dependent upon his or her 26th birthday. However, coverage may be lost sooner as the result of a divorce, legal separation or, in the case of a child who was under the legal guardianship of a Covered Employee, upon the child's attainment of age 18 or the termination of the guardianship, whichever first occurs.

If this notification is not provided in a timely manner rights to continuation coverage may be forfeited.

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

Notification of Address Change

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

Even you or a Dependent has 60 days to provide notice of a change in status for the purpose of obtaining COBRA continuation coverage for Dependents losing eligibility, a Covered Employee is required to notify his or her employing agency(or the Retirement Health Insurance Unit, in the case of a retiree) within 31 days of the change in status that renders an enrolled Dependent ineligible for coverage and may be subject to disciplinary action for failing to do so. See Section IV, A.4 above.

C. CONTINUATION COVERAGE

1. Election Period

When the employing agency is notified of the occurrence of a qualifying event, it will notify covered individuals (also known as qualified beneficiaries) of their right to elect continuation coverage. Each qualified beneficiary has an independent election right and will have 60 days from the latter of the date coverage ceased under the group health Plan or 60 from the date of notification to elect continuation coverage. **The law does not allow for an extension of this maximum period.** If a qualified beneficiary does not

elect continuation coverage within this election period the right to elect continuation coverage will end.

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

2. Length of Continuation Coverage

30 Months. If the event causing the lack of coverage is layoff, reduction of hours, leave of absence, or termination of employment, other than as a result of death of the employee or as a result of such employee's "gross misconduct," as that term is used in 29 U.S.C. §1163(2), continuation of coverage will be available for such employee and such employee's covered Dependents for a period of thirty months after the date of such layoff, reduction of hours, leave of absence or termination of employment, except that if such reduction of hours, leave of absence or termination of employment results from an employee's eligibility to receive Social Security income, continuation of coverage for such employee and such employee's covered Dependents will last only until midnight of the day preceding such person's eligibility for benefits under Title XVIII of the Social Security Act.

36 Months. If the event causing lack of coverage for a qualified beneficiary is divorce or anything other than an employee's termination of employment, leave of absence or reduction in hours, continuation coverage will be available for such qualified beneficiaries for up to thirty-six months.

3. Termination of Continuation Coverage

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

a. The State of Connecticut ceases to provide any group health Plan to its employees;
b. Any required premium for continuation coverage is not paid in a timely manner;
c. A qualified beneficiary becomes covered under another group health Plan that does not contain any exclusion or limitation with respect to any preexisting condition of such beneficiary;
d. A qualified beneficiary who extended continuation coverage due to a disability is determined by Social Security to be no longer disabled;
e. A qualified beneficiary notifies the COBRA Administrator that he or she wants to cancel continuation coverage.

4. Continuation of Coverage Due To Military Service

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

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

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

- The 24 months beginning on the first date of absence from work; or
- The day after the date on which you fail to apply for or return to a position of employment.

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

COBRA Administrator

Anthem administers the COBRA benefits for all Carriers participating in the State of Connecticut Medical Benefit Plan. The contact information for the Anthem COBRA Unit is as follows: 1-800-433-5436.

XII. GENERAL PROVISIONS

A. This Plan Document supersedes all other agreements or descriptions of the benefits provided under this program.

B. Identification Cards. Cards issued by the Carriers to Participants pursuant to this Plan are for identification purposes only. Possession of an identification card confers no right to Covered Services or other benefits under this Plan. To be entitled to such services or benefits the holder of the card must, in fact, be a Participant on whose behalf all applicable benefit cost contributions under this Plan have been paid. Any person receiving services or other benefits to which he is not then entitled pursuant to the provisions of this Plan will be liable for the actual cost of such services or benefits. In addition, any Covered Employee who fails to notify the Plan Sponsor of a change in circumstances that affects an individual's eligibility status (including without limitation, divorce, legal separation, end of legal guardianship, a child's attainment of age 26, etc.) will have the fair market value of coverage for the ineligible person(s) reported as income and, if actively employed, may be subject to disciplinary action, including termination.

C. Notice. Any notice required under this Plan Document may be given to the Plan Sponsor by U.S. Mail, first class, postage prepaid to the address listed in the front of the document. Notice to a Participant will be sent to the last address the Plan has for that Participant. Participant agrees to provide the Plan Sponsor with notice, within 31 days, of any change of address.

D. Interpretation of Plan. The laws of the State of Connecticut shall be applied to the interpretation of this Plan.

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

F. Modifications. This Plan Document is subject to amendment, modification, and termination in accordance with this provision and applicable collective bargaining agreements affecting health care coverage, benefits and services.

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

H. Policies and Procedures. The Plan may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of the Plan with which Participants shall comply.

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

XIII. PROTECTED HEALTH INFORMATION

A. PROVISION OF PROTECTED HEALTH INFORMATION TO PLAN SPONSOR

1. Unless otherwise permitted by law and subject to obtaining written certification pursuant to paragraph 5 of this section, the Plan may disclose Protected Health Information to the Plan Sponsor provided the Plan Sponsor uses or discloses such Protected Health Information only for the following purposes.

   a. Performing Plan Administration Functions which the Plan Sponsor performs.

   b. Obtaining premium bids from carriers for providing coverage

   c. Modifying, amending or terminating the group health plan.

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

2. Information regarding Participation

Notwithstanding paragraph 1 of this Section, the Plan may disclose to the Plan Sponsor information regarding participation or enrollment.

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

   a. Not use or further disclose the Protected Health Information other than as permitted or required by the Plan or as required by law.

   b. Shall ensure that any agents, contractors or subcontractors to whom it provides Protected Health Information shall agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to Protected Health Information.

   c. Not use or disclose the Protected Health Information for employment-related actions and decisions or in connection with any other employee benefit plan of the Plan Sponsor.

   d. Report any use or disclosure of the information that is inconsistent with the use or disclosures provided for of which it becomes aware;

   e. Make available Protected Health Information in accordance with 45 CFR §164.524

   f. Make available Protected Health Information for amendment and incorporate any amendments to Protected Health Information in accordance with 45 CFR §164.526.

g. Make available the information required to provide an accounting of disclosures in accordance with 45 CFR §164.528.

h. Make its internal practices, books and records relating to the use and disclosure of Protected Health Information available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with subpart E of 45 CFR §164.

i. If feasible, return or destroy all Protected Health Information received that the Plan Sponsor still maintains in any forma and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible.

j. Ensure that adequate separation between Plan and the Plan Sponsor, required by 45 CFR §504(f)(2)(iii) is satisfied.

k. Reasonably and appropriately safeguard electronic PHI that is created, received, maintained, or transmitted to or by the Plan Sponsor on behalf of the Plan.

4. **Certification by Plan Sponsor.** A Carrier with respect to the Plan shall disclose Protected Health Information to the Plan Sponsor only upon receipt of certification that the Plan Sponsor that the Plan Document has incorporated the provisions of 45 CFR §164.504(f)(2)(ii), and that the Plan Sponsor agrees to the conditions of disclosure set forth in Section 4 of this Section. The Plan shall not disclose and may not permit a Carrier to disclose Protected Health Information to the Plan Sponsor as otherwise permitted herein unless the statement required by 45 CFR§164.504(b)(b1)(iii)(C) is included in the appropriate notice.

5. **Adequate Separation between the Plan and the Plan Sponsor.** The Plan Sponsor shall only allow designated employees of the Office of the State Comptroller, Healthcare Policy & Benefit Services Division, access to the Protected Health Information, to perform the Plan Administration Functions that the Plan Sponsor performs for the Plan. In the event that any of these specified employees does not comply with the provisions of the Section, that employee shall be subject to disciplinary action by the Plan Sponsor for non-compliance pursuant to the Plan Sponsor's employee discipline and termination procedures.

6.. **Permitted Uses and Disclosures of Summary Health Information.** Notwithstanding paragraph 1 of this Section a Carrier may disclose summary Health Information to the Plan Sponsor for the purpose of :

a. Obtaining premium bids for providing health benefit coverage under the Plan; or

b. Modifying, amending or terminating the Plan.

B. DEFINITIONS

Plan Administration Functions means administration functions performed by the Plan Sponsor on behalf of the Plan, excluding functions performed by the Plan Sponsor in connection with any other benefit or benefit plan of the Plan Sponsor. In the normal course, such functions can include monitoring compliance with the requirements of the Health Enhancement Program or assisting Members in resolving complaints regarding a Carrier's handling or processing of claims or denial of coverage.

Protected Health Information means individually identifiable health information that is (1) received or created by a health care provider, Carrier or health plan and (2) that relates to the past, present or future physical, mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to the individual and identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual. "Protected Health Information" excludes health information or medical information supplied to the Plan Sponsor in its role as an employer. For example, medical information submitted in support of an application for Family Medical Leave or Disability.

Summary Medical Information means: Information that (1) summarizes the claims history, claims expenses or types of claims experience by individuals for whom a plan sponsor provided health benefits under a Health Plan and from which the information described at 43 CFR §164.514(b)(2)(i) has been deleted, except that the geographic information need only be aggregated o the level of a five-digit zip code.

OFFICE OF THE STATE COMPTROLLER OF THE STATE OF CONNECTICUT, ON BEHALF OF THE STATE OF CONNECTICUT

By:/s/ Kevin Lembo
Kevin Lembo
Title: State Comptroller