

STATE OF CONNECTICUT

Request for Proposal Employee and Retiree Medical Benefits Administrative Services Only



November 20, 2014

Table of Contents

I. REQUEST FOR PROPOSAL INTRODUCTION

II. PROPOSAL REQUIREMENTS/QUESTIONNAIRE

III. FINANCIAL PROPOSALS

Additional Information and Attachments

IV. BENEFIT SUMMARIES

V. STATE CERTIFICATIONS/AFFIDAVITS, INTENT TO BID FORM,
VERIFICATION OF ACCURACY FORM

VI. STATE OF CONNECTICUT CONTRACT

(To be Provided with Receipt of Intent to Bid)

VII. CENSUS and BENEFIT INFORMATION

VIII. CLAIMS EXPERIENCE, NETWORK PROVIDER LIST

IX. DATA WAREHOUSE FORMATS

I. REQUEST FOR PROPOSAL INTRODUCTION

The Office of State Comptroller, State of Connecticut (the “State”), acting through the Health Care Cost Containment Committee (“HCCCC”), is soliciting proposals for vendors to administer its current self-insured medical benefits plans for active employees, retirees (both Medicare-eligible and non-Medicare), and their dependents. Due to collective bargaining contracts, the State **must** duplicate current plan designs and funding arrangements. In addition to providing benefits to State employees and retirees, the State also covers employees in the probate court system, General Assembly members, former legislators, and other groups, as authorized by statute.

The State also offers medical benefits through its current medical benefits vendors to local municipalities under the Connecticut Partnership Plan. At this time, the following cities and municipalities are part of the Partnership Plan:

City of New London and New London Board of Education
Town of Griswold and Griswold Board of Education
Town of Sprague
Town of Voluntown
Uncas Health District
Town of Union
Town of Bozrah
Valley Council of Governments
Waterbury Housing Authority

Each Partnership Plan participant also enrolls in a medical plan as described in the benefit summaries below. Details of the operation for the Partnership Plan are attached as an appendix.

The current Medical Plan’s contracts expire on June 30, 2015. The State of Connecticut is seeking the most cost-effective solution that will match current benefit designs and provide high quality service to its covered employees, retirees, and their dependents through a network of providers. The State is also asking for suggestions that could improve efficiency, as well as a self-insured financial proposal.

The State’s medical benefits plans are defined through a collective bargaining agreement that remains in effect through June 2022. Therefore, it is imperative that entities responding to this RFP provide a proposal that duplicates the current benefit structure without modification. The State currently provides its employees access to a number of health benefits options which are offered through two medical insurers, one PBM, and one dental insurer. Although there are currently two medical carriers, the structure of the benefits and plan designs are the same. The only substantive differences between the benefit options are the breadth of the networks and the pricing offered by each carrier.

The State has established a relationship with a vendor, to provide data aggregation services, care coordination, and management services for the State’s Health Enhancement Program (HEP). State employees, certain retirees, and their dependents who enroll in the HEP program are

required to seek age-appropriate preventive services. Enrollees who are identified with one of five medical conditions (diabetes types I and II, asthma and Chronic Obstructive Pulmonary Disease (COPD), coronary artery disease, hypertension, and hyperlipidemia) must also adhere to certain condition-specific education requirements. The enhanced benefit design reduces copays for certain services to remove barriers to care for these services. The details of these benefit waivers are described more fully below.

Because enrollment in HEP is voluntary, the State requests that you provide proposals for both a HEP (Health Enhancement Program) option and non-HEP plan. See the benefit designs in the “Benefit Summaries” appendix for details of the HEP Benefit offerings.

Currently, the State offers all plan designs through two carriers.

The RFP requests proposals for medical benefits only. Pharmacy and dental are not part of this RFP.

The State requests that you provide rates and fees (if any) separately for each benefit described below.

Entities responding to this RFP should also note that the State is requiring access to certain information and that detailed claims data must be provided to the State’s data warehouse vendor and healthcare consultants. Submission of your proposal will acknowledge acceptance of these requirements. The financial requirements include initial and renewal pricing and projection controls.

Background

The State Comptroller is empowered by Connecticut General Statutes § 5-259 to arrange and procure a "group hospitalization and medical and surgical insurance plan" for employees and retirees of the State of Connecticut. In 2010, the State elected to provide these benefits on a self-insured basis. Public Act 10-174 affords the State the ability to offer the financial arrangement and services of these plans to local municipalities.

The HCCCC was established through collective bargaining in 1985 and is composed of six labor representatives and six management representatives. It is responsible for implementing cost control measures, monitoring and improving plan quality, and implementing health promotion and wellness activities for state employees, retirees, and their eligible dependents.

On October 1, 1993, as an outcome of collective bargaining, elements to manage care were introduced into the state medical plan with the goal of restraining health care costs while maintaining access and quality of care.

The State implemented new wellness plan initiatives in 2011 as a result of negotiations between management and the State employee unions. The resulting Health Enhancement Program (HEP) affects active employees, certain retirees, and their dependents. Upon initial medical benefit enrollment, employees decide if they will participate in HEP. Employees and eligible retirees

are given the opportunity to opt out of the program or enroll in the program once per year during the annual Open Enrollment period. Participation requires that employees receive all age and gender appropriate wellness services during the year (e.g. physical exam, cholesterol screening, well-woman exam, and one dental cleaning) and diagnosis screenings (e.g. colorectal cancer screening, Pap smears, mammograms, vision exams). In addition, persons with any of five specified chronic conditions, namely Diabetes Type I & II, Heart Failure/Heart Disease (Coronary Artery Disease), Asthma and COPD (Chronic Obstructive Pulmonary Disease), Hyperlipidemia (High Cholesterol), Hypertension (High Blood Pressure), must comply with requirements appropriate to the proper care of the condition. The preventive visits are provided without charge to the employee, and those persons with one or more of the specified conditions receive condition-related prescription drugs at reduced copays and will have copays waived for office visits related to those conditions. Employees who do not comply with HEP requirements or who choose not to participate in HEP face a \$350 annual deductible per-person (maximum of \$1,400 per family) for in-network care and pay \$100 more per month for medical and pharmacy coverage. Presently, the vast majority of employees participate in HEP.

The State of Connecticut is most interested in having its members receive care from providers practicing in highly coordinated inter-disciplinary care delivery systems. At present, approximately 40% of the plan members are being treated in such practices.

Going forward, we want to enhance opportunities for our members to obtain support in such areas as obesity prevention or reduction, tobacco cessation, and depression screening in advanced primary care settings. We would ask that you consider these programs in your responses.

Please be mindful that this RFP covers medical services only.

A. Current Medical Plans:

Point of Service ("POS") – Currently the State offers three POS plans. All of the POS plans have provider options with national networks; the UnitedHealthcare/Oxford Freedom Select plan, the Anthem State BlueCare POS plan, and the Anthem State Preferred POS plan.

Within the POS option, each time medical services are required, employees elect whether to access a network provider (and receive higher levels of plan benefits), or access a non-network provider (and receive lower levels of plan benefits). Note that the POS plans provide open access to employees and do NOT require a referral to access network specialists.

Point of Enrollment ("POE") – This option operates as a typical "lock-in" Health Maintenance Organization ("HMO"). That is, benefits are only available if care is rendered by a network provider or authorized by the Health Plan. Note that the POE plans do NOT require a referral to access network specialists. The POE plan offerings are provided through Anthem (using the same network that supports the State Blue Care POS plan) and United Healthcare/Oxford.

Point of Enrollment Gated ("POE-G") – This option operates as a typical "lock-in" Health Maintenance Organization ("HMO") with a gatekeeper. That is, benefits are only available if care is rendered by a network provider or authorized by the Health Plan. Note that the POE-G plans DO require a referral to access network specialists. The POE-G plan offerings are provided through Anthem (using the same network that supports the State Blue Care POS plan) and United Healthcare/Oxford.

Out-of-Area ("OOA") – This option currently consists of a preferred provider organizations ("PPO") available to employees and retirees who reside outside of the carrier's regional coverage area. This plan is provided through Anthem and UnitedHealthcare/Oxford. Anthem provides national access for this plan by utilizing the Blue Cross/Blue Shield network. United offers national network access through its established Choice Plus national network.

The plans are available to active and retired employees. Benefits for Medicare eligible retirees consist of a Medicare Carve-out approach (some post-65 retirees are not eligible for Medicare). The plan's normal benefits are first determined, from which Medicare benefits are subtracted. The balance, if any, represents the plan's liability.

All medical plans are currently self-insured and the State does not purchase any stop-loss coverage.

The State's recent active employees and retirees' open enrollment planners provide benefit summaries, an illustration of employee contributions and an illustration of differences in the breadth of the current networks. You may find the planners and additional benefits information on the State's web site at: <http://www.osc.ct.gov/benefits.htm>

See the "Benefit Summaries" appendix for additional detail on each medical plan.

B. RFP Objective

The objective of this RFP is to obtain bids for medical plans that duplicate the current medical benefits in the most cost-effective manner, match current benefit designs, and provide high quality service to covered employees, retirees, and their dependents through a network of providers. The State seeks to duplicate (and possibly extend) the network of utilized providers.

In addition, the State seeks suggestions from vendors as to whether alternative benefit approaches might improve the covered population's overall health without increasing the cost to the State. Bidders are encouraged to provide bids for alternative services to be added at 100% co-pay. Keep in mind that changes in benefits will need to conform to the current State Employee Bargaining Agent Coalition (SEBAC) requirements.

C. Planned Schedule of RFP Activities

It is the State's intention to comply with the following schedule:

Date	Activity
November 20, 2014	Release RFP
November 26, 2014	Deadline for Intent to Bid
November 26, 2014	Vendor Question Deadline by 2:00 PM EST via email
December 3, 2014	Vendor Questions Answered
January 14, 2015	Proposals Due by 2:30 PM EST
February 13 - 19, 2015	Finalist Interviews (If Necessary)
February 27, 2015	Final Decision
March 1, 2015	Begin Implementation
July 1, 2015	Effective Date for Contract

- These dates represent a tentative schedule of events. The State reserves the right to modify these dates at any time, with appropriate notice to prospective bidders.
- This RFP does not commit the State to award a contract. The State reserves the right to reject all proposals, and at its discretion, may withdraw or amend this RFP at any time.
- The State may revise and amend the RFP prior to the due date for the proposal. If, in the opinion of the State, revisions or amendments will require substantive changes in proposals, the due date may be extended.
- The State reserves the right to reject any and all proposals received, for specific reasons, which include, but are not limited to, non-compliance with RFP requirements.
- Responses to this RFP will be the primary source of information used in the evaluation process. Each bidder is requested and advised to be as complete as possible in its response. The State reserves the right to contact any bidder to clarify any response or make a presentation.

D. Intent to Bid

By November 26, 2014, please email the Intent to Bid form (contained in Section V) to osc.rfp@ct.gov and state whether or not you intend to bid. The Intent to Bid form is included at the back of this RFP. Upon receipt of the Intent to Bid, the State will provide vendors with detailed claims information, data warehouse formats, and other information to be used in responding to the RFP.

E. Vendor Questions

The State intends to answer questions from any Vendor that is considering a response to this RFP. Questions received by the deadline of **2:00 P.M. (ET) on November 26, 2014**, will be

answered. Questions must be in writing and submitted by email to osc.rfp@ct.gov. Questions will not be accepted over the telephone. The State reserves the right to provide a combined answer to similar questions. Any and all questions and answers to this RFP will be posted by **December 3, 2014** on the OSC website at <http://www.osc.ct.gov/vendor/index.html>.

F. Proposal Submission

All proposals must be received by 2:30 P.M. (ET), January 14, 2015 in order to be considered. Proposals received later than the time and date specified will not be considered. If you choose not to offer a proposal, please confirm this in writing with the specific reasons for your declination.

We ask that your proposals limit the amount of materials submitted in paper form. We would expect large bulky printouts, such as geo-access reports, marketing materials, provider lists, etc., to be included on the CD-ROM or DVD but not included as paper copies. Written materials should be printed double-sided where possible.

One (1) original and ten (10) paper copies and four (4) CD-ROMs or other electronic format, as specified by the State, of the entire proposal shall be placed in a sealed envelope, bearing the name and address of the Respondent. The envelope must be clearly marked with the words, State Medical Benefits and submitted to:

**Office of the State Comptroller
Business Services Office
State of Connecticut
55 Elm Street, Room 301
Hartford, CT 06106
ATTN: RFP – Medical**

Ownership of Proposals - All proposals submitted in response to this RFP are to be the sole property of the State, and subject to the applicable Freedom of Information (“FOIA”) provisions of Connecticut General Statutes, Sections 1-200-1-259. Any proposer that submits matter that the proposer in good faith determines to contain trade secrets or confidential commercial or financial information, which is proprietary or not readily available to the public from other sources, should mark such information as ‘CONFIDENTIAL’ and must provide two redacted copies of its RFP response in a CD-ROM or DVD (an original and one copy), which may be disclosed without objection in the event that the State receives a FOIA request for its proposal.

G. Evaluation of Proposals

1. Bidder’s experience with and ability to provide required services.
2. Conformity with specifications.

2. Proposed cost: (provider discounts, administrative costs, guarantees, demonstration of robust approach to control costs, robust fraud, waste and abuse prevention systems).
3. Effectiveness of care: carrier's commitment to improving quality of care and patient outcomes as evidenced by value based and ACO contracting, development of infrastructure sufficient to support these initiatives, ability to demonstrate results, ability to provide continuity of care during contract period).
4. Availability and competence of personnel.
5. Adequacy of bidder's network (sufficient coverage by general, specialist and pediatric physicians and facilities, average wait times for appointments, number of physicians accepting new patients, willingness to expand network, as needed).
6. Demonstration of a robust provider panel for mental and behavioral health, and treatment for substance abuse (and willingness to expand network as needed).
7. Sufficiency of Eligibility Management, Payment and Billing Systems, Customer Service, Flexibility, References, Reporting Capability, Member Services, and Quality Assurance Programs.
8. Implementation and Communications Plan (workability of transition and implementation schedule; efficiency and fairness of appeals process, sufficiency of member communication programs and systems, assistance with distribution of benefit descriptions, educational materials, notices required by ACA and other federal laws).
9. Information Services and Reporting: Ability to exchange HEP-related claims and other data with State's data warehouse provider and the State's healthcare consultant and other healthcare vendors, availability of standard reports and ad hoc reporting functionality; willingness to work cooperatively with State's other healthcare vendors, and sufficiency of infrastructure to support population health management and improve quality of care and health outcomes.
10. Demonstration of bidder's commitment to affirmative action by full compliance with the regulations of the Commission on Human Rights and Opportunities.
11. Willingness to accept the terms and conditions of the State's proposed contract.
12. Commitment to transparency.
13. At the option of the review committee, bidder's oral interview.

H. Contract Period

The State of Connecticut is seeking a contract-effective date commencing July 1, 2015. Proposals should include fees that are guaranteed for a period of no less than three-years beginning July 1, 2015 through June 30, 2018. There will also be the potential for two one-year extensions. Your proposal should provide pricing guarantees for three-years, with the potential for two one-year extensions. The template that should be used for your financial terms is included in this RFP in Section III.

I. Restriction on Contact with State Personnel

Except as called for in this RFP, from the date of release of this RFP until the right to negotiate a contract is awarded as a result of this RFP, any communications with personnel employed by the Comptroller's Office, members of the Health Care Cost Containment Committee, and RFP committee members about the RFP until selection of the successor bidders are prohibited. All communications must be directed to the dedicated e-mail address: osc.rfp@ct.gov.

J. Conflict of Interest

The bidder shall certify in writing that no relationship exists between the bidder and the State of Connecticut that interferes with fair competition or is a conflict of interest, and no relationship exists between the bidder and another person or organization that constitutes a conflict of interest with respect to any State contract. Any successful bidder must execute a contract and grant disclosure and certification form.

The bidder shall provide assurances that it presently has no interest and shall not acquire any interest, either directly or indirectly, which will conflict in any manner or degree with the performance of its services hereunder. The bidder shall also provide assurances that no person having any such known interests shall be employed during the performance of this contract.

K. Governing Law

The contract shall be governed in all respects by the laws of the State of Connecticut.

L. Verification of Accuracy

Your response must designate the individual responsible for coordinating proposal responses and for binding the company to the responses to this RFP. A copy of this form is contained in Section V).

Name: _____ Phone #: _____

Title: _____

Your response must designate the chief actuary or independent actuary retained by the proposer who certifies the method used to determine and report requested discount information.

Name: _____

Phone #: _____

Title: _____

Your response must designate proposer's Medical Director or Chief Medical Officer.

Name: _____

Phone #: _____

Title: _____

M. Instructions to Bidders

1. Terms and Conditions

Bidders responding to this RFP must be willing to adhere to the following conditions and must affirmatively state their adherence to these requirements with a transmittal letter appended to their proposal response.

- a. **Acceptance or Rejection by the State** - The State reserves the right to accept or reject any or all proposals submitted for consideration. All proposals will remain sealed until the deadline for submission has passed.
- b. **Conformance with Statutes** - Any contract awarded as a result of this RFP must be in full conformance with statutory requirements of the State of Connecticut.
- c. **Ownership of Proposals** - All proposals in response to this RFP are to be the sole property of the State;
- d. **Ownership of Subsequent Products** - Any product, whether acceptable or unacceptable, developed under the contract awarded as a result of this RFP is to be the sole property of the State, unless otherwise stated in the RFP or contract.
- e. **Availability of Work Papers** - All work papers and data used in the process of performing this project must be available for inspection by the State of Connecticut Auditors of Public Accounts for a period of three (3) years or until audited.
- f. **Timing and Sequence** - Timing and sequence of events resulting from this RFP will ultimately be determined by the State.
- g. **Stability of Proposed Prices** - Any price offerings from Contractors must be valid for a period of one hundred eighty (180) days from the due date of contractor proposals.
- h. **"Not to Exceed" Quotations** - All cost estimates will be considered as "not to exceed" quotations.
- i. **Exclusion of Taxes from Prices** - The State of Connecticut is exempt from the payment of excise, transportation, and sales taxes imposed by the Federal Government and the State. Such taxes must be excluded from quoted prices.
- j. **Prohibition of Commissions** - The State of Connecticut will contract directly with organizations capable of performing the requirements of this RFP. Contractors must be represented directly. Participation by brokers or commissioned agents will not be allowed during the proposal process or during the term of the proposed contract. You must certify in your response that no provision for commissions has been included in your fees. The

State **WILL NOT** accept proposals with provisions for commission arrangements, nor will the State pay commissions to any brokers

- k. **Oral Agreements** – Any alleged oral agreement or arrangement made by a Contractor with any agency or employee will be superseded by the written agreement.
- l. **Amending or Canceling Requests** – The State reserves the right to amend or cancel this RFP, prior to the due date and time, if it is in the best interests of the State.
- m. **Rejection for Default or Misrepresentation** – The State reserves the right to reject the proposal of any Contractor which is in default of any prior contract or for misrepresentation.
- n. **State's Clerical Errors in Awards** – The State reserves the right to correct inaccurate awards resulting from its clerical errors.
- o. **Rejection of Qualified Proposals** – Proposals are subject to rejection in whole or in part if they limit or modify any of the terms and conditions and/or specifications of the RFP.
- p. **Contractor Presentation of Supporting Evidence** – A Contractor, if requested, must be prepared to present evidence of experience, ability, service facilities, and financial standing necessary to satisfactorily meet the requirements set forth or implied in the proposal.
- q. **Changes to Proposal** – No additions or changes to the original proposal will be allowed after submittal. While changes are not permitted, clarification at the request of the State may be required at the Contractor's expense.
- r. **Changes to Personnel**—Each Bidder must certify that the key personnel identified in its response to this RFP will be the persons actually assigned to the engagement.
- s. **Collusion** – By responding, the Contractor implicitly states that the proposal is not made in connection with any competing Contractor submitting a separate response to the RFP, and is in all respects fair and without collusion or fraud.
- t. **Standard Contract.** Each Bidder must indicate its acceptance of the Comptroller's standard contract language and conditions. .
- u. **Freedom of Information** – After the contract is awarded all materials associated with this RFP and the eventual contract may be subject to disclosure under the Connecticut Freedom of Information Act ("FOIA") and all corresponding rules, regulations and interpretations.
- v. **Confidential Commercial Information/Trade Secrets.** Any Contractor who submits matter that the Contractor in good faith determines to contain trade secrets or confidential commercial or financial information must be specifically identified as such. If the Contractor specifically and clearly marks said documentation as "Confidential" the Comptroller will endeavor to keep such information confidential, to the extent permitted by law. The Comptroller has no obligation to initiate, prosecute or defend any legal proceeding or to seek a protective order or other similar relief to prevent disclosure of any information that is sought pursuant to a FOIA request. The Contractor shall have the burden of establishing the FOIA exemption in any proceeding where it is an issue. In no event shall the Comptroller or the State have any liability for disclosure of any documents in its possession which the Comptroller believes are required to be disclosed pursuant to FOIA or other requirements of law.
- w. **Redacted RFP.** Each bidder must submit two copies of a redacted version of its RFP response in electronic format (CD-ROM or DVD), from which all material asserted to constitute a trade secret, confidential or proprietary information has been redacted and

which may be disclosed without objection in the event that the State receives a FOIA request for its proposal.

2. State Contracting Requirements:

a. Affirmative Action

The contract to be awarded is subject to contract compliance requirements mandated by Sections 4a-60 and 4a-60a of the Connecticut General Statutes; and, when the awarding agency is the State, Sections 46a-71(d) and 46a-81i(d) of the Connecticut General Statutes. There are Contract Compliance Regulations codified at Section 46a-68j-21 through 43 of the Regulations of Connecticut State Agencies, which establish a procedure for awarding all contracts covered by Sections 4a-60 and 46a-71(d) of the Connecticut General Statutes. According to Section 46a-68j-30(9) of the Contract Compliance Regulations, every agency awarding a contract subject to the contract compliance requirements has an obligation to consider certain factors when reviewing the Proposer's qualifications under the contract compliance requirements.

By submitting a bid, the Proposer is acknowledging that it has reviewed the applicable statutes and regulations as noted above and is aware of the factors that will be considered by the Commission in this area. More information about the State of Connecticut's Contract Compliance requirements is available on the Commission on Human Rights and Opportunities' web site at www.state.ct.us/chro under "Contract Compliance." The Proposer must complete and submit the CHRO's ***Bidder Contract Compliance Monitoring Report and Bidder Notification form*** (attached) with the proposal.

b. Contract Compliance Requirements.

Each Bidder should also complete the following forms attached to the RFP

- 1. Consulting Agreement Affidavit**
- 2. Affirmation of Receipt of State Ethics Summary**
- 3. Gift and Campaign Contribution Certification**
- 4. SEEC Form 10**
- 5. Iran Certification**
- 6. Non-Discrimination Affidavit**

II. PROPOSAL REQUIREMENTS/QUESTIONNAIRE

A. Claims Management

Case Management

1. Provide a detailed description of your case management program, including any specialty programs that are included in your proposal.
2. Are you willing to offer a specific team of account managers for the State of Connecticut membership? If so, please provide a brief resume of the account managers who will service the State.
3. At what dollar level is a claim case-managed? Aside from cost, what specific criteria are used to identify cases for case management? Describe the means used to screen the population for case management. When and how is case management initiated?
4. What is the process for assigning pre-certification, large case management and appeals to external providers for review? What percent of cases typically require external provider involvement? At what point is external provider involvement initiated?
5. Will your firm provide case management for out-of-network cases? For what percentage of your clients do you routinely provide case management for out-of-network cases?
6. Describe any additional programs available that are not included in the proposal and the fees associated with those programs.
7. Describe how you calculate case management savings. Include details on any classification schemes (e.g., hard and soft savings)?
8. Provide a description of the standard case management reports provided. Indicate the frequency, level of reporting, and define the data included. Provide a copy of the report template.

Coordination of Benefits (COB)

9. When you are the secondary payer in a COB situation, do you use your usual, customary, and reasonable (UCR) profiles, reduced network fees, or those of the primary carrier in determining your level of reimbursement?
10. During the COB process, how is the State (and the State's employee) held harmless as the claim amounts are negotiated with the secondary payer? Is the employee ever required to make payment to the provider? How are COB disputes resolved?

11. How the State is held harmless for erroneous payments made by you during the COB process?
12. Please complete the following table:

	Average COB savings as a percent of total plan	Will you guarantee COB Savings?
Active/Early Retiree		Y/N
Medicare Eligible		Y/N

Health Promotion, Wellness and Prevention Programs

13. Describe the health promotion, wellness, prevention and similar kinds of programs, including health risk appraisals that are included in your proposal. The State is specifically interested in favorably influencing lifestyle diseases (e.g., asthma, COPD, coronary artery disease, diabetes, heart failure, high blood pressure, and obesity) as well as depression screenings and tobacco cessation programs.
14. Describe any optional health promotion/ wellness/ prevention programs you offer.
15. Provide the specific additional administrative fees, if any, related to each of these programs.
16. Describe the value of these programs (*i.e.* cost-benefit analysis).
 - a. How do they integrate with other vendors if separate (e.g., pharmacy, employee assistance program (EAP))?
 - b. How do they integrate with other health care management programs (e.g., case management, disease management)?
 - c. How do you incorporate the results into your other health care management programs?
 - d. What type of consumer tools/services do you provide to enable people to make the best choices when they need health care? Describe in detail your web-based member tools and transparency capabilities?
17. What ROI have you experienced with your health promotion, wellness and/ or prevention programs? Describe the specific programs and methods used to calculate the ROI.
18. How successful have you been in encouraging members to get preventive services, including preventive office visits, vision exams, dental cleanings, cholesterol screenings, and cancer screenings? What strategies have you utilized and what measurable outcomes have been realized? Be specific.

19. Provide any other findings and outcomes you have experienced with your health promotion, wellness and/ or prevention programs.
20. Provide a description of the standard health promotion, wellness and/or prevention reports provided. Indicate the frequency, level of reporting (e.g., book of business, specific to the State) and define the data included. Provide a copy of the report template.
21. Would you be willing to partner with other organizations to manage health promotion, wellness, and prevention programs? Please provide examples of such partnerships your organization has successfully implemented.
22. After a year with your services, what impact do you believe your program will have on the State's:
 - a. Inpatient utilization – frequency of admits and duration of stay.
 - b. Outpatient utilization – frequency and duration of treatment.
 - c. Out-of-network utilization – steerage to in-network usage.
 - d. Emergency room utilization – steerage to less expensive urgent care facility usage when applicable.
 - e. Other.
23. Do you offer obesity screening programs or tobacco cessation programs? If so,
 - a. What types of programs do you offer?
 - b. What are the costs of these programs?
 - c. How have members responded to these programs?
 - d. What are the results of these programs (e.g. successful long term weight loss, successful long term smoking cessation, reduced claim costs, etc.)?
24. Do any primary care practices in your network have a mental health professional on site that can perform depression screenings and evaluate whether a patient is in need of behavioral health services? If so,
 - a. Describe the behavioral health and/or depression screening programs.
 - b. How are claims coded for these services?
 - c. Are these services typically covered as part of preventive services, treatment of an illness, or not covered?
 - d. Are services covered separately as part of a single visit?

General Health Care Management

25. Indicate in the table below the size of the self-funded and fully-insured book of business for which you provided the following services in 2013.

	2013 Number of Covered Lives	
	Self-Funded	Fully-Insured
Inpatient prior authorization		
Outpatient prior authorization		
Acute inpatient concurrent review		
Skilled nursing facility concurrent review		
Retrospective medical necessity review		
DRG review		
Nurse Call Center		
Wellness Programs		
Case Management		
Disease Management		

26. Indicate the type of ownership or relationship for any aspect of your utilization review, wellness/prevention, case management, disease management or other health care management functions, including all vendors and subcontractors.
- Are you and any subcontractors authorized/licensed to do business in Connecticut, if required to do so?
 - For vendors or subcontractors, provide the name of the organization, address, nature of the relationship and services provided.
 - Do you or any subcontractors anticipate any major changes in your or subcontractor's organization or corporate structure over the next 12 to 24 months? If so, explain. How will this affect service or costs under the contract, if you are awarded the contract?
 - Have you or your subcontractors relocated staff, changed computer/telephone systems or undertaken any technology, communication or health care management initiatives in the last 12 months? Are any planned for the next 12 months? If so, please explain.
27. Explain any financial or other incentives established for providers to comply with utilization management protocols, treatment standards or other aspects related to health care management.
28. What level and type of provider quality and cost data do you make available to members?
29. Do you have the ability to incentivize members to use value-driven providers? Please suggest models that do not require adjustments to the State's existing collectively bargained benefit design.

30. Describe any specialized programs (e.g., centers of excellence, specialty networks, etc.) you have in place for other groups that you feel would be advantageous to the State. For each such program, answer the following questions:
- Would these programs be provided by the proposer or by a sub-contractor?
 - Include a list of the facilities/ providers and the types of services that will be referred to these specialized programs.
 - Describe your process for introducing members to these programs.
 - Do you provide any measures to encourage members to utilize centers of excellence, specialty networks, etc.? If so, describe them.
 - Which programs or incentives have been successfully utilized to increase the use of providers included in your preferred provider list? Please quantify your response.
 - How do you analyze and illustrate the effectiveness of these specialized programs? How often are they reviewed and analyzed for continued inclusion? Please provide the specific methods and algorithm.
31. Will you accept claims data from the State's dental carrier and pharmacy benefit manager and lab data from providers for health care management purposes? If yes, explain the process for this and how the information will be used. Is there an additional cost for this service?

B. Cost and Quality Controls

Performance Guarantees and Performance Penalties

32. Detail the performance guarantees, including the amounts of performance penalties, that you are offering the State in connection with: (1) Implementation, (2) Overall Account Management/Client Satisfaction, (3) Claims Time to Process; (4) Claims Financial Accuracy, (5) Claims Payment Accuracy, (6) Telephone Responsiveness – First Call Resolution, (7) Average Speed of Answer, (8) Call Abandonment Rate, (9) Eligibility Processing, (10) Timeliness and Accuracy of ID cards, (11) Any additional guarantees your firm wishes to offer. The State expects that vendors will put forth aggressive guarantees as part of their overall proposal.
33. Detail the performance guarantees, including amounts of performance penalties, that you are offering the State in connection with your services. The State expects that vendors will put forth an aggressive guarantee on performance that conforms to your strategies for claims cost controls.

Cost Management

34. How does your organization control costs? Describe any cost control programs that you have in place.
35. Will you offer guarantees regarding your cost control efforts?

Quality Management

36. How do you assess physician performance? What programs do you have in place, what quality metrics are used, and how do you monitor and measure performance results? What performance information would be shared with the State? What performance information is shared with providers? Please provide the exact algorithms used to perform physician assessments.
37. Are any of your health care management programs accredited? If so, list which programs (e.g., utilization review, case management), by what organization (NCQA, URAC) and the current accreditation status?
38. What percentage of physicians, non-physician providers and facilities are credentialed prior to contracting (including physicians with leased health plans)?
39. Are there formal, written credentialing/re-credentialing standards for general medical and surgical hospitals? If "yes," provide a copy.
40. What classes or types of providers are not considered for credentialing? For example, are Board Certified Behavior Analysts who treat autism spectrum disorders credentialed and included in your network?
41. Submit copies of your Healthcare Effectiveness Data and Information Set (HEDIS) reports for the last reporting period.
42. Describe your quality improvement initiatives implemented in 2013.
43. Describe the appeals process for both clinical and administrative appeals. What is the maximum turnaround time for each step?
44. How do you detect underutilization/overutilization by providers, specifically those in shared savings or risk bearing contracts? How are such situations addressed?
45. List the top five member complaints in 2013. How have you addressed them? When you get member complaints, how and when do you relay that information back to the State?
46. How often do you conduct customer satisfaction surveys? Who performs the surveys? Please provide the survey methodology used, typical response rate and survey population.
47. Submit the results of your last two completed surveys, and confirm that you will submit the results of the customer satisfaction surveys if awarded the contact.
48. Can members access information to help choose an individual physician or hospital based on comparative cost and/or quality?

49. Do you routinely collect data on infection rates at participating hospitals? Will you share infection rate data with the State?

Accountable Care Organization (ACO) and Patient Centered Medical Home (PCMH)

The following section asks you to describe your organization's commitment to and involvement in ACOs. It may be that your organization is transitioning from a PCMH to an ACO program. If that is the case, please answer these questions for your PCMH and/or ACO programs.

50. List all shared savings programs currently under contract. Also provide a list of all provider groups that you anticipate putting under contract in the next 24 months, along with the timing for each. For each program, list the associated providers including their specialty and National Provider Identifier and provide a copy of the financial terms for each separate contract.
51. Over the next five years, what are your strategies for evolving payment arrangements, provider organizations (ACO, PCMH, etc.), and financial risk sharing? How will this benefit the State? Comment on specific payment initiatives, provider incentives, and quality and efficiency measures. Describe how you would collaborate with the State in these efforts.
52. What types of measures are used to determine the performance-based payments?
- a. Measurement of achievement relative to a target or peers for NQF-endorsed process measures
 - b. Measurement of achievement relative to a target or peers for NQF-endorsed outcome measures
 - c. Measurement of improvement over time for NQF-endorsed process measures
 - d. Measurement of practice efficiency relative to a target or peers
 - e. Measurement of the application of specific ACO practices
 - f. Measurement of patient satisfaction
 - g. Other (specify): _____
53. What is the expected value of the provider payments?
- a. 0-5% of primary care practice annual payment
 - b. 6-10% of primary care practice annual payment
 - c. 11-15% of primary care practice annual payment
 - d. 16-20% of primary care practice annual payment
 - e. 21-25% of primary care practice annual payment
 - f. >25% of primary care practice annual payment
54. Are there any defined expectations as to how the added payments paid to practices should be used?
- a. None.

- b. Funding employment of, or contracting with, clinical case managers within the practice.
 - c. Providing group visits
 - d. Providing group education on self-management
 - e. Other (specify): _____
55. Are there any consumer incentives contained within the ACO program that were not previously described?
- a. Agreement with employer on waived or decreased premium (or premium equivalent) share for use of the medical home
 - b. Waived or decreased co-payments/deductibles for use of the medical home (specify)
 - c. Office visits
 - d. Tests recommended for chronic conditions, etc.
 - e. Waived or decreased co-payments/deductibles for reaching biometric goals (e.g., BMI level or change, HbA1c improvement or levels, etc.)
 - f. Waived or decreased co-payments/deductibles for enrollment or affiliation with a medical home in non-HMO products
 - g. Waived or decreased co-payments/deductibles for use of selected chronic care medications
 - h. Incentives to adhere to evidence-based self-management guidelines
 - i. Incentives to adhere to recommended care coordination encounters
56. What support mechanisms (tools) are available in the ACO program to support decisions and self-management, and who provides them?
57. How is the ACO program promoted to members?
- a. General education materials to members
 - b. Enrollment meetings coordinated with employees of the State
 - c. Performance reports comparing ACO practices with non-ACO practices
 - d. Designation in the physician directory of ACO status
 - e. Linked messages with web-based tools to support decision-making
 - f. Messages in EOB if member not using ACO practice
 - g. Steerage at times of interaction with telephonic or in-person interaction with wellness or disease management programs.
 - h. Steerage at times of telephonic interaction with nurse line or telephonic treatment support
 - i. Financial incentives unavailable through other plan options
 - j. Please provide the following information:

% ACO Member		
Consumer Support	Participants Affected	Who Provides?
Evidence-based shared decision tools (e.g., Health Dialog, Healthwise Decision Points)		1. Plan 2. ACO Practice 3. Plan-Practice Shared
Specialist performance reports		1. Plan 2. ACO Practice 3. Plan-Practice Shared
Hospital performance reports		1. Plan 2. ACO Practice 3. Plan-Practice Shared
Electronic personal health record		1. Plan 2. ACO Practice 3. Plan-Practice Shared
Reminders about gaps in preventive care		1. Plan 2. ACO Practice 3. Plan-Practice Shared
Reminders about gaps in Rx fills		1. Plan 2. ACO Practice 3. Plan-Practice Shared
Reminders about non-Rx gaps in management of chronic conditions		1. Plan 2. ACO Practice 3. Plan-Practice Shared
Web-based consultations		1. Plan 2. ACO Practice 3. Plan-Practice Shared
E-mail with physician office		1. Plan 2. ACO Practice 3. Plan-Practice Shared

58. Who is evaluating the pilot?
- The carrier
 - An independently funded evaluator
 - Other (specify): _____
59. What is the evaluation method?
- Pre/post evaluation
 - Matched control group
 - Randomized control trial
60. Does your firm have any data with respect to the costs and benefits, specifically patient outcomes and lowered plan costs, related to your experience with ACOs?

61. Which variables are being evaluated?
 - a. Evidence-based processes of preventive care
 - b. Evidence-based processes of chronic care
 - c. Evidence-based outcomes of chronic care (including experience of care measures)
 - d. Utilization of services
 - e. Cost
 - f. Primary care practice organization and care delivery
 - g. Primary care clinician experience
62. How many PCPs do you have participating in PCMHs, and how many PCPs do you have participating in ACOs? What percent is this of your full book of business of PCPs?
63. Please provide a table of each currently contracted ACO and the number of members attributed to the ACO.
64. For members in a shared savings arrangement, what do you anticipate paying out to providers for shared savings per member per month? Please list separately for each ACO Arrangement. (This may be supplied in the financial template. If so, please so indicate).

Fraud, Waste and Abuse

65. Have there been any governmental investigations of your organization due to Medicare fraud? If so, please describe.
66. Please describe your existing programs for detecting fraud, waste and abuse in connection with self-insured and fully insured medical benefit plans.
67. Describe any difference in the administration (including scope and frequency) of your organization's fraud, waste and abuse prevention programs with respect to fully insured versus self-insured customers.
68. How do you measure success for your organization's fraud, waste and abuse prevention programs?
69. Describe all standard reports that are made available the Plan Sponsor in connection with fraud, waste and abuse monitoring programs.
70. Confirm that, if selected, all agreements with providers (including subcontracted providers) will include express language to the effect that compliance with all applicable federal and state laws and regulations, including licensing requirements, is a condition of payment.

71. Confirm that, if selected, all agreements with providers (including subcontracted providers) will include express language to the effect that compliance with all of your policies and procedures is a condition of payment.
72. Confirm that, if selected, you will assure that at least annually every participating provider is given written notice--in prominent language and bold typeface--to the effect that compliance with all applicable federal and state laws and regulations and your policies and procedures, is a condition of payment.
73. Confirm that, if selected, all notices sent to providers regarding required policies and procedures will be made available to the Healthcare Policy & Benefit Division of the Office of the State Comptroller/or the Connecticut Attorney General in connection with plan administration, referrals and/or investigations carried out pursuant to Public Act 14-217.
74. Confirm that, if selected, you are required to provide notice and consult with the Office of the State Comptroller and may be required to provide notice and consult with the Connecticut Attorney General upon the Comptroller's request prior to suspending payments to a provider or recovering any funds in a matter in which fraud, waste or abuse are suspected. Should the Comptroller require consultation with the Connecticut Attorney General you will adhere to the Connecticut Attorney General's reasonable requests to assure maximum opportunity to properly investigate the matter pursuant to Public Act 14-217.

C. Operations

Claim Adjudication

75. Describe how you plan to comply with the new International Classes of Diseases-10 (ICD-10) requirements in 2015, and any challenges you have identified.
76. Based upon the latest 12 month period: (Please answer all parts of this question)
 - a. What is the average number of business days to process a claim from date received to date check/explanation of benefits (EOB) issued?
 - b. What percent of all claims submitted (regardless of information provided on claim) are processed (from date received to date check/EOB issued) within 10 business days? ____%
 - c. What percent of all claims submitted (regardless of information provided on claim) are processed (from date received to date check/EOB issued) within 30 business days? ____%
77. For each claim office proposed, please provide the following data:

Financial and Coding Accuracy	Latest 36 months
Financial accuracy as a percent of total claims dollars paid (include over/underpayments)	____%
Coding accuracy (claims without error) as a percent of total claims submitted	____%

78. What are your procedures for recovery of overpayments or duplicate payments? How do those procedures differ for in-network vs. out-of-network providers?
79. What are your procedures for recovery of overpayments on claims that require subrogation?
80. How do you screen for and identify claims that could be the responsibility of a third-party? Please explain your process in detail including details on any subcontractors or vendors your organization uses to research and/or recoup.
81. Do you agree to return 100% of all recovered monies from overpayments, duplicate payments, and overpayments on third-party liability or subrogation claims, or other processing errors to the State?
82. Describe your process for claim coding audits. How often and what percent of claims are audited for proper claim coding?
83. Do you agree to hold the State harmless for any liability arising from your firm's payment processing errors that result in overpayment or duplication of payments to providers?
84. Do you do Medicare eligibility audits? If yes, will you share results with the State? Will you assist in reprocessing claims through Medicare?

ASO Claim Reimbursement/Banking Arrangements

85. The State of Connecticut makes payment in arrears and provides claims reimbursements twice per month. Please indicate your company's willingness to adhere to that schedule.
86. Please describe any administrative services that you provide to fully insured clients that are not included in your proposal (for example, distribution of summary plan descriptions, distribution of notices required under the Affordable Care Act, etc.).
87. What are the payment options from the State to the Vendor?
 - a. ACH
 - b. Wire Transfer
 - c. Other (please describe)

Administrative Services

88. Confirm that you can coordinate medical claim administration with behavioral health, dental, and prescription drug vendor/subcontractor.
89. Will you transfer claim information and other administrative records at no charge to any carrier/TPA that would replace you in the event of termination of this contract?

Vendor Responsiveness to Client

90. Connecticut Account Team: Provide an organizational chart showing the key staff members who will handle account management for the State's account, and indicate which staff members will be 100% dedicated. Include the following: Account manager assigned to the State, underwriter for the State account, day-to-day account representative assigned to the State, claims manager for the State account, medical director/disease management manager for the State account.
91. Include the following information for each individual identified in the response to the prior question:
 - a. Name, title, address, telephone number, role in the State account
 - b. A brief biography, including:
 - ✓ Relevant qualifications and large client experience
 - ✓ Length of service with your organization
 - ✓ Account responsibilities other than the State
92. If an escalated claim is presented to you by the State, will the Connecticut Account Team noted above be available for direct outreach to members?

Implementation

93. Describe in detail your implementation process. Include a detailed implementation timetable, including developing the vendor contract with the State.
94. How will you handle transitions where a person is in treatment with a provider not in your network on the date of implementation? Will you permit a grace period? If so, for how long?
95. How and when would staff supporting the client be trained on the client's account and benefits?

Member and Provider Services (*i.e.*, Customer service, Internet access)

96. Will there be a Customer Service team established strictly for State members? Will there be a Customer Service team established strictly for providers?
97. Confirm that a specific toll-free number will be made available to participants (members and providers) at no additional charge to handle claims or other service issues.
98. What hours will the telephone lines be staffed by actual customer service representatives? (Please do not include hours the telephone line is staffed by an answering service. Include weekend hours.) Hours: _____
99. Do you offer a 24-hour telephone Nurse Triage (nurse advice/demand management) telephone program for enrollees? If so, what is its primary function? How does it integrate with other health care management components?
100. Will you offer a State dedicated website for employees and retirees? Please describe the functionality.
101. Provide details on any smartphone applications available.
102. Confirm that, if selected, your firm will pay its pro rata share of cost of preparing and mailing open enrollment materials to plan members.
103. Provide the specific location(s) of your customer service, provider service, and information technology centers.

D. Miscellaneous

Organizational Questions

104. Provide three (3) references of like size and complexity to the State account. Include contact name, address, phone number, e-mail, size of the group and products administered.
105. Provide two (2) references of previous clients that no longer obtain services through your company. Include contact name, address, phone number, e-mail, size of the group and products administered.
106. Confirm that you and all proposed subcontractors are authorized/licensed to do business in Connecticut.

107. Have you ever failed to complete any work awarded to you? If so, where and why?
108. Have you ever defaulted on a contract? If so, where and why?
109. Is there any pending litigation which could affect your organization's ability to perform this agreement? If so, please describe.
110. Has your firm ever had a contract terminated for cause within the past five years? If yes, provide details.
111. Has your firm been named in a lawsuit related to errors and omissions within the past five years? If yes, provide details.
112. During the past seven years, has your firm ever filed for protection under the Federal bankruptcy laws? If yes, provide details.
113. How have you performed in third party audits, and would you be willing to share results?
114. Have you ever been fined for a HIPAA violation?
115. Do you anticipate any changes in your organization's basic ownership structure or any other significant changes in your organization within the next 12 months? If so, please describe.
116. Are there any other factors or information that could affect your firm's ability to provide the services being sought about which the State should be aware?

COBRA Services

COBRA services must be included. ASO Administrative Fees should include pricing for COBRA services.

117. Describe your standard COBRA services.
118. Do your COBRA services include distribution of a COBRA General Notice at the same time a new member's identification card is issued?
119. Can COBRA eligibility be provided through an on-line data entry system? Describe your system and the process for submitting COBRA eligibility.
120. How will you bill and collect COBRA premiums from the COBRA participants? How will you provide billing and collection reporting for COBRA to the State?
121. How will you communicate and house enrollment eligibility for COBRA participants? Are you equipped to maintain member and dependent enrollment data for all plans?

122. Describe how you will track those that elect COBRA, when they are no longer eligible, when they are delinquent in premium payments, when they must be terminated and how you will communicate this information to the State.

123. If relevant, how will the vendor bill ASO fees and based on what enrollment figures?

Financial Condition of Organization

124. Indicate any reinsurance policies in place or special cash reserves set aside to continue paying claims for existing clients in the event your organization ceases to operate due to bankruptcy, liquidation or other factors.

125. Do you meet all NAIC, minimum state insurance and managed care organization net worth and reserve requirements? If no, explain.

126. Indicate your **most current** claims-paying abilities as rated by:

Independent Rating Agency	Rating	Date
AM Best		
Standard & Poor		
Moody's		
Other/Not Rated (circle one and explain)		

127. Has there been any downgrade in your ratings in the last 2 years?

- ☐ Yes, please explain the nature and reason(s) for the change
- ☐ No

128. Provide your current risk-based capital ratio.

Liability Insurance/Pending Legal Action

129. A. Are there any outstanding legal actions pending against your organization?

- ☐ Yes, please explain the nature and current status of the action(s) to the extent possible.
- ☐ No

B. Can you assure the State these actions will not disrupt business operation?

- ☐ Yes
- ☐ No

130. What fidelity and surety insurance or bond coverage do you carry to protect your clients? Specifically describe the type and amount of the fidelity bond insuring your

employees that would protect this plan in the event of a loss. [Please provide copies of such policies].

131. A. Indicate your firm's liability INSURANCE LIMIT with regard to errors, omission, negligence, and malpractice. Annual dollar limit per occurrence: _____

B. Provide name of insurer: _____

Reporting

132. Client Reports: Proposers are asked to provide a full package of their available reports and to indicate which reports are available to the client on-line. In addition to providing your full reporting package, please respond to the questions in this section.
133. Provide a description of the standard utilization management reports provided. Indicate the frequency, level of reporting (e.g., book of business, State-specific) and define the data included. Provide a copy of the report template.
134. Provide a sample of weekly detailed claims and enrollment data downloads including file layouts and documentation.
135. Confirm that there is no additional cost for these reports and electronic data downloads as required by the State.
136. What information/reports are available via on-line access?
137. With regard to your computer systems, please describe your record retention and destruction policy, including how long records are retained.
138. What types of security do you have with regard to your website and the transfer of data?
139. Please describe the requirements on the user/client site to access your site (i.e. levels of passwords required for users to log onto the site).
140. Are you willing to provide a weekly feed of detailed claims data to the State's chosen vendors as the State may require? Are you flexible in the format of the claims data dump provided? Please provide a sample format.
141. Do you collect Electronic Medical Records from providers? Will those be provided as part of the weekly data exchange?
142. Do you collect lab results data? Will that data be provided as part of the weekly data exchange?

143. Are you willing to provide monthly eligibility data, lab results data, provider network data, PCP payments and capitation detail data, electronic medical record data, and billing provider bank identifiers (for fraud waste and abuse purposes) to the State?
144. Please indicate the earliest possible availability of detailed claims data for analysis. Can your systems provide information to the State and its vendors about member utilization within 24 hours of occurrence?
145. Do you currently use technology or have a relationship with a vendor to collect real-time data concerning a member's patients' visits to providers? If yes,
- a. Describe your methods for collecting such data
 - b. Will you share the data with the State or its contracted vendors?
 - c. What cost is associated with such technology?
 - d. What is the predicted ROI with using such technology?
146. Are you capable and willing to receive dental and pharmacy data from the State's vendors for medical management purposes and ACO contracting analysis?
147. Are you capable and willing to provide a detailed three year history for your book-of-business medical (including pharmacy and behavioral health) data to the State or a designated third party that is updated annually?
148. What components of the data do you consider to be proprietary?

Federal Health Care Reform

149. To what extent will implementation of Federal Health Care Reform affect your pricing?
150. What specific impact(s) on the State's current plan options do you foresee that Federal Health Care Reform will have (benefits and costs)? Please be specific.
151. Confirm that you will supply the new benefit summaries as required by Affordable Care Act (ACA) for delivery to the State members.
152. Describe any ACA required forms/notices that you currently distribute or may be required to distribute on behalf of fully-insured clients that are excluded from your ASO proposal. How does the requirement for distribution of such forms/notices impact the pricing of your commercial fully insured product?

Provider Reimbursement

153. What maximum annual increase to network provider fees will you guarantee in year 2 of this contract 7/1/2016? For example, maximum increase may be defined as the weighted average increase in physician charges based on a uniform list of top 100 CPT

codes. Will the amounts exceeding the maximum increase be reimbursed dollar for dollar to the State?

154. What is the maximum annual increase to network facility fees you will guarantee in year 2 of this contract (after July 1, 2016)? Please define the method for defining facility fee increases. Will the amounts exceeding the maximum increase be reimbursed dollar for dollar to the State?
155. How often do you monitor and report increases in physician payments for both in-network and out-of-network providers? Do you have the ability to monitor and report significant changes or “outliers” to the State in real time?
156. Indicate non-network provider fees, such as UCR percentile or maximum allowable charge, used for non-network reimbursement.
157. Indicate source of non-network provider fees (First Health, Medicare, ADP, Other).
158. Will claim payment data be made available by CPT code and zip code?
- i. Plan_____ _ Yes_____No_____
- ii. To Participant Yes_____No_____
159. How do you determine situations that warrant assistant surgeon reimbursement?
160. Do you have policies in place to limit utilization of non-network assistant surgeons without prior authorization or advance notice to patient? If so, please describe
161. Do you reimburse the assistant surgeon a percentage of the primary surgical allowance for the specific surgery performed? What percentage do you use? If you use another method of reimbursement, please explain.
162. Do your provider contracts with network hospitals limit utilization of non-network providers (assistant surgeons, hospitalists, anesthesiologists, radiologists, pathologists, etc.) without patients’ knowledge or consent?
163. Do your provider contracts with network hospitals contain restrictions on billing for services provided by non-network providers without patients’ knowledge or consent?
164. Do your provider contracts with network hospitals require that member be informed of the possibility of balance billing by non-network providers operating within the facility (for example, anesthesiology, radiology or emergency department services) in advance of admission to or treatment within such facility?
165. Describe how network hospitals are reimbursed. If reimbursement varies by geographic location, identify reimbursement arrangements by area for those relevant to the State’s membership. Please be specific for each Connecticut hospital.

Predominant Area: <i>State of Connecticut</i>	Full Service Hospital Acute Care		Ambulatory Surgical Facility	Behavioral Health Facilities	Other
	Inpatient Facility	Outpatient Facility			
Number of Hospitals/ Facilities					
Hospital Payment Method Per diem, per admission, other describe:					
Ratio of network hospital charges to Medicare payment	%	%	%	%	%
Minimum network hospital discount guarantee (as a ratio of Medicare payments)	%	%	%	%	%
What overall maximum increase to network hospital room and board rates will you guarantee in the second year of this contract?					

166. How are network outpatient facilities such as surgicenters, imaging centers and laboratories reimbursed (on a discounted fee arrangement, percent of Medicare APCs, prepaid capitated arrangement)?
- If a scheduled fee arrangement is the basis for reimbursement, describe how the scheduled fees are derived.
167. Describe any other contractual relationships you maintain with any other providers such as pharmacies, physical therapists, orthotics suppliers, prosthetic suppliers, vision care and home health care providers.
168. Do you have special arrangements with “Centers of Excellence” facilities?
- Describe the illnesses/conditions and services associated with your Centers of Excellence programs.
 - Are services bundled with regard to reimbursement?
 - Is the facility at risk for costs incurred in excess of the negotiated charge?
 - Include the actual bundled charge for each condition, AND list the facilities by name and region.
169. Explain any financial incentives (bonuses) or disincentives (withholds) in network provider contracts or for network hospitals that are tied to utilization goals, specialty referrals, member survey results, readmission rates, quality of care outcomes or other performance results.
170. Please provide a sample contract that you use for network hospitals.
171. Please provide a copy of your current contracts with all State of Connecticut hospitals.

Rating Practices

This section's intent is to explore your approach to contracting with providers and the rationale and standards applied in determining how to reimburse them. (A separate section asks for specific information about the contracts themselves.) You are also asked to provide detailed claims data for the repricing exercise set forth in the section below.

172. Please describe your rating practices as you see them evolving over the next five years, including any changes related to the Affordable Care Act or contracting with ACOs.
173. Please describe how you arrived at the administrative costs provided in this proposal. Provide multi-year administrative cost (including any network access fee) guarantees for the 2015, 2016, and 2017 policy periods. If you are proposing either rates or maximum increases for the two optional one year extension periods of 2018 and 2019, please illustrate them accordingly.
174. Would you charge the Partnership Plan the same ASO fee as the State?
175. What are your current annual trend rates for prospective rate setting purposes? Are these the trend rates that were used in developing your proposed claims projections? Please describe how you calculated trends separately for inpatient, outpatient facility and professional services.
176. Do you currently administer any bundled payment methods? If yes please describe the services contracted and the expected volume of payments for those services. Do you anticipate increasing the number of bundled payment arrangements over the next three years? Please describe your strategy and which services you anticipate targeting.
177. Please provide the contract expiration date and anticipated renegotiation date for each hospital in the State of Connecticut. If you anticipate renegotiating provider contracts in the next 12, 24 or 36 months please describe the planned changes and anticipated impact on your book-of-business premium rates.
178. Describe how the State's members will be held harmless if a provider leaves the network prior to the member's receiving notification of a change in network status. .
179. Will you take on the role as the fiduciary for the plan? If so, please explain your role as a fiduciary and the additional risk you will assume.
180. Is there an additional cost for taking on the role of fiduciary? If so, what is the additional cost?

181. Describe how a member will access out of state networks. For example, in a POE plan where a member is traveling and needs to use a network provider, describe how this will work. In a POE plan, is there any limit to the amount of time a member may use an out of state network provider – i.e., a non-Medicare eligible retiree moves to Arizona and remains in the POE plan.
182. The State is interested in understanding the movement in your discounts over time. Illustrate the change in your provider discounts, as a percentage increase or decrease, for each of the past five (5) years. Please provide them separately for hospital inpatient, hospital outpatient, and professional services.
183. If a scheduled fee arrangement is the basis for reimbursement, describe how the scheduled fees are derived. For example, if utilizing Resource Based Relative Value Scale (RBRVS), please provide your percentage correlation to the Medicare (adjusted for Connecticut) schedule.
184. Is any part of your network leased? If yes, identify owner of the network and the geographic service area.
185. Do you use a secondary (wrap) network for providers not in your primary provider network? If so, please describe the network used.
186. Please describe any surcharges, adjustments, mark-ups or other fees that would be included in claims or applied in connection with using a network provider located outside your geographic area.
187. Do you use billing and coding criteria for emergency room visits? If yes, please provide a copy of the criteria and a list of Connecticut hospitals contracted to apply the criteria. Please provide results for any hospital audits performed to ensure compliance.
188. Do your contracts require hospitals to bill urgent care rates for urgent care visits even if they present in an emergency room for treatment. For example, if a patient schedules a visit through the emergency room in advance, does your contract require urgent care billing for these services?
189. Please confirm that your firm will require participating hospitals to bill services rendered at free-standing emergency rooms separately from emergency room services performed at the hospital's main facility. (☐ Yes/ ☐ No)
190. Can you provide site of service (the exact address where the service occurred) on all claims? If not, on which claims can you provide it?
191. Will you facilitate payment for claims deemed as urgent care visits by the payer at the urgent care rate even if the hospital initially bills for an emergency room visit.

192. Describe your capability to provide transparency of pricing and other financial information, including compensation and prices, allowed and billed claim costs, and the terms of any risk sharing arrangements, incentives, and pay-for-performance reimbursement.

193. How will you prevent price increases for medications (such as oncology drugs or other infusions) that are administered through the medical benefit plan?

E. Requirements

The following are base requirements that need to be satisfied in order for your organization to be considered as a proposer. Please complete the table below and indicate “YES” or “NO” to your organization’s ability to comply:

REQUIREMENTS	YES	NO
(1) Vendor will provide all labor, equipment, facilities, supplies, and services as needed/specified.		
(2) Administration of benefit plans for active and retired State employees and dependents and affiliated groups participating in the program described in Section I:		
a. Vendor must agree to administration of the plan as mutually agreed to by the vendor and the State, with final determination to be made by the State. All operational aspects of the plan must be clearly described and the State must reserve the right to review and audit the operations of the plan.		
b. Develop and maintain an employee benefit plan providing benefits as specified by the State. The benefit plans to be offered are described on the State’s website at http://www.osc.ct.gov/stemploy.htm .		
c. Vendor must allow the State to test website structure, pages, and review and approve content for usability as determined by the State; usability concerns must be resolved within two (2) business days.		
d. Vendor must agree that all data, records, files and other information relating to the plan belong to the State and are subject to release to the State if the contract is terminated.		
e. Vendor must provide a copy of their emergency operations/disaster recovery/business continuity/pandemic flu plan as part of their response to this RFP.		
f. Vendor must provide detailed information on insurance, bonding, and guarantees offered in the event of issues caused by loss of operations due to an emergency or disaster.		
g. Vendor must provide subrogation services.		

h. Vendor must disclose offshore relationships, if any.		
i. Vendor must receive prior approval for all communications to members. This includes all written website, electronic communication including, but not limited to, media advertising and regulatory mailings required under federal and/or state law. During open enrollment periods, all general media advertising in the State of Connecticut media markets must also be approved by the State. Failure to comply will result in a penalty payment of 0.50% of total expenses, no less than \$30,000 and no greater than \$100,000.		
j. What on-line services/functions will be made available to the State?		
i. Claims Summary and detail		
ii. Billing History		
iii. Provider Directory		
iv. Enrollment Summary		
v. Specific Plan Details		
vi. Medical Cost Tracker by Member		
vii. Last Vision Service Payment		
viii. Ability to Order New Member Materials		
ix. Ability to Print Temporary ID Cards		
x. Health Topics/Medical Information		
xi. COBRA Enrollment		
xii. Special Group Enrollment		
xiii. Medical Coverage Positions/Coverage Stance (i.e. Cochlear Implants)		
xiv. Other		
(3) Eligibility:		
a. Vendor must agree to accept and provide electronic data feeds in the appropriate HIPAA or State defined format on a schedule determined by the State. Currently for active employees and retirees, enrollment data is sent via the HIPAA 834 format. All carriers will receive the identical format and data structure as defined by the State.		
b. Vendor must agree to share data with health benefits administrators and the State's healthcare consultant and actuary, data manager and wellness plan coordinator.		
c. Vendor must agree to accept the eligibility structure as defined by the State.		

d. Enrollment data that does not pass carrier system edits must either be corrected or bypassed by the carrier. The remaining data must be posted without delay. Issues related to errant data must be addressed with the employing agency's benefit staff or the Healthcare Policy and Benefit Services Division as appropriate.		
e. Vendor must agree to the State-defined Eligibility Periods; award of this contract means that any eligible employee and their dependents will be eligible for coverage.		
f. Open enrollment shall be the period announced by the State to allow eligible subscribers to join the plan, change coverage, or add eligible dependents. The open enrollment periods are generally from May 1st to June 1st each year for active employees and retirees.		
g. HIPAA Events: members may add, drop or make changes as appropriate if an allowable qualifying event occurs.		
h. The vendor must agree to process active and retiree enrollment additions, changes and deletions correctly within seven (7) days of the creation date of the file or information provided by the State. The State will provide a weekly file to report any changes within their enrollment data (to be known as the Change File). This file will include additions, terminations, coverage class changes, changes in dependent enrollment, etc. Towards the end of each month, the State will provide a monthly file to report a snapshot of all current live enrollment data (to be known as the Full File). The Full File is typically not loaded and used for comparative purposes only. After receipt of the monthly Full File, the vendor must reconcile all active employee and retiree enrollment data and report any discrepancies, in a format defined by the State, by the 15th of the next month to the appropriate State agency personnel; aggregate information must be sent to the Healthcare Policy and Benefit Services Division. The State will review the discrepancies and provide feedback appropriate to the condition being reported and make any necessary corrections to State enrollment information.		
i. Group Numbers – Department ID, as defined by the State, will substitute for any arbitrary vendor group number that might otherwise be assigned to a State agency or location. More specifically, enrollment and remittance information from the State will include the Department ID as the sole identifier of an employee's location. The vendor may translate the data to accommodate their own systems, however; all communications to and from the State and its data warehouse vendor, whether electronic or otherwise, will refer to the Department ID.		
j. The vendor will capture and report the State provided Employee ID (EMPLID) in data stores and data transfers with the State and other state vendors. The member's EMPLID must also be connected to all associated dependents.		

k. The vendor will provide the State with online access to their enrollment information in real time.		
<p>(4) File Exchange Protocol</p> <p>There are currently two methods for exchanging files with the State's Core-CT system:</p> <ol style="list-style-type: none"> 1. The carrier logs into the secure Core-CT Production Supplier Portal via https to download files. The URL is https://corect.ct.gov:10400/psp/PSPRD/signon.html -or- 2. The carrier logs into the secure Core-CT Axway Server. The URL is https://sfile.ct.gov/ For those using an automated system Axway has a client available at http://www.axway.com/productssolutions/securetransport <p>Testing Requirements</p> <p>At least one test cycle must be completed successfully prior to going live employing one of the previously mentioned file transports.</p> <p>The Core-CT Supplier Portal uses a non-standard port (10400 for Production, 15000 for Test) and that may require action by the carrier's Tech Support area to accomplish this. Vendors must report in their response to this RFP whether they were able to successfully reach the portal sign on page at: https://corect.ct.gov:10400/psp/PSPRD/signon.html or have obtained Axway client software and successfully connected to: https://sfile.ct.gov/</p> <p>For testing purposes, the link to the TEST supplier portal is:</p> <p>https://corect.ct.gov:15000/psp/PSTPR/?cmd=login&languageCd=ENG&</p> <p>Additional information for all parties that exchange data with State's Core-CT system is available at: http://www.core-ct.state.ct.us/hrint/</p>		
<p>(5) Network Development, Rental and Management:</p> <p>a. Vendor must assist with developing a proprietary network, if the State so chooses. The successful vendor's network should be very similar to or more robust than the current network.</p>		
<p>b. Vendor will be responsible for maintaining all provider contracts, terms and conditions, within its claims payment system.</p>		

c. Vendor will handle all provider quality issues.		
(6) Administrative or Executive Support:		
a. Vendor must verify and commit that during the length of the contract, it shall not undertake a major conversion for, or related to, the system used to deliver services to the plan without specific written notice to the State. This does not apply to any program fixes, modifications and enhancements.		
b. Vendor must notify the State prior to any changes in vendor's representatives.		
c. Vendor must agree to change the assigned vendor's representatives at the State's request.		
(7) Vendor must comply with performance standards as identified in this RFP (examples provided in Performance Standards are provided for illustrative purposes only and may be expanded at the State's option.)		
(8) Audits:		
a. Vendor must agree to audits conducted by the State or their chosen auditor and/or legislative audit.		
b. Vendor must agree to annually provide a SSAE-16 Report if the State determines there is a need (allowable time will be given to provide this information, if the vendor doesn't currently have a completed or a SAS 70) and any other applicable audits and certifications.		
c. Vendor must agree to make available all provider records to the State or its representatives (e.g. State Auditors, the State's actuary, etc.).		
d. Vendor will guarantee to the State or its appointees the right to reasonable inspection of facilities, equipment, and system support operations to ensure the continued ability of the vendor to support the plan; failure to comply with a reasonable request to inspect will result in a penalty; failure to respond to a finding from an inspection within 30 calendar days will result in a penalty.		
(9) Data Requirement:		
a. Vendor must agree to provide claims data in the format outlined by the State on a schedule determined by the State.		
b. Vendors must agree to provide requested claims, enrollment, and related data to the State's consultant and data manager for inclusion in the State's claims database.		
c. Vendor must agree to supply weekly medical claims including procedure and diagnosis codes and payment data to the State or its designated data manager vendor (Currently Conifer).		

d. Vendor must agree that all claims data is the property of the State for use in plan administration and other health-related purposes, such as participation in State healthcare initiatives.		
(10) Reporting Requirements:		
a. Vendor must provide some form of on-line ad hoc reporting capability with full description of the tools available.		
b. Vendor must provide reporting based on the divisions defined by the State.		
c. Vendor will provide a detailed description of its capability to track and report on telephone services to include categories being monitored; at a minimum, the vendor must provide a monthly report of types of calls, number of calls resolved during the month, phone abandonment rate, and average response times.		
d. Vendor must negotiate with the State to develop mutually agreeable reporting formats and deadlines; the State reserves the right to establish formats and deadlines, if negotiations fail.		
e. Vendor must provide basic provider background information, cost data, and quality data on a scheduled basis as determined by the State.		
(11) Accounting/Actuary Requirements:		
a. Vendor must provide a year-end report at the appropriate plan year end.		
b. Vendor will respond to all requests for additional information within a 24-hour period.		
c. Vendor will provide a copy of the data dictionary for all fields that are operational in any system proposed. This data dictionary must include the length of the field and a specific description of the data stored in each field.		
(12) Privacy & Security:		
a. Vendor must comply with HIPAA, PPACA and other federal and/or state mandates to include privacy, security and electronic data transfer requirements.		
b. Vendor must describe any breaches, complaints or grievances with regards to protected health information (e.g., security or privacy) for their complete book of business; list the event and resolution in detail		
c. Vendor must disclose any event where its employees have willfully committed acts that compromise member information, regardless of whether it is PHI or not.		
d. Vendor must describe its HIPAA policies, procedures and training related to quality and provider data.		

(13) Administration Fees:		
a. Are your fees quoted guaranteed for the initial 36-month policy period?		
b. Will your fees be guaranteed for each succeeding full twelve-month period?		
c. Will this provision be included in your contract? A yes answer will require contract to include such language.		
d. Do you agree to include a minimum of 120 days advance notice of renewal fees in your contract? <i>(If no, please explain.)</i>		
e. Do you guarantee discounts, per diems and any other provider reimbursement allowances provided on a dollar-for-dollar basis? (Any claims amounts above the discount guarantee will be absorbed by the vendor). <i>(If no, please explain.)</i>		
f. Will you guarantee savings from any of the following programs, if they are being proposed? (Define Structure & Penalties Proposed)		
i. Utilization Management		
ii. Disease Management		
(14) Are you willing to share pricing differences for the same service at different network facilities with State members? For example, could members see the cost of a colonoscopy at different facilities?		
(15) The State expects respondents to provide aggressive performance guarantees. The proposal must include identification of your specific performance guarantees and financial incentives.		

III. FINANCIAL PROPOSALS

A. RATES AND FEES

The Illustration of your ASO cost Proposal(s) will be illustrated in the attached Financial Proposal Exhibit.xls

1. ASO Proposals: Provide multi-year administrative and network access fee guarantees for the three policy years beginning July 1, 2015 and July 1, 2016, and July 1, 2017. The State will have the option to extend the contract annually for up to two additional one-year periods. Therefore, the State requests that you provide fee proposals for 2 additional one-year time periods. If you are proposing fees, rates or maximum increases for the two optional one-year extension periods of July 1, 2018, and July 1, 2019. Please illustrate them accordingly. See Excel spreadsheet within the folder titled “Financial Proposal” for proposal format request.
2. You must confirm that all proposals are provided with fee and rate guarantees as requested herein.
3. Proposed cancellation clauses that include monetary penalties or liquidated damages clauses for termination prior to the end of the guarantee period are undesirable and will be considered a negative factor by the State in evaluating proposals received.

B. CLAIMS REPRICING AND DISRUPTION INSTRUCTIONS

Upon submission of a Notice of Intent to Bid bidders will be provided contact information to obtain access the Milliman Secure FTP Web Transfer Console. Upon receipt of the request Milliman will send the log in information to the requester in order to allow the proposer to download the password protected re-pricing data for your proposal. The instructions for accessing the FTP site are as follows:

Milliman Secure FTP Web Transfer Console

OVERVIEW

The Milliman SFTP server supports use of a Web Transfer Console (WTC). This allows clients to continue to use a Web browser to securely transfer files with Milliman but overcomes certain limitations. The enhanced WTC, provides the ability to transfer multiple files at once, delete files, and a progress transfer box. This option keeps the convenience of using a Web browser (no client install, easy to use) while offering features of a traditional FTP client software package.

The enhanced WTC uses Java, and you must have Java enabled on your Web browser to use it. Java can be installed by visiting www.java.com. If you are not able to install Java then you can use the regular Web transfer option.

INSTRUCTIONS

1. Open a Web browser and go to <https://ftp.milliman.com>
2. Type in your Milliman user name and password.
3. If you wish to use the enhanced version, check off the use Java enabled version.

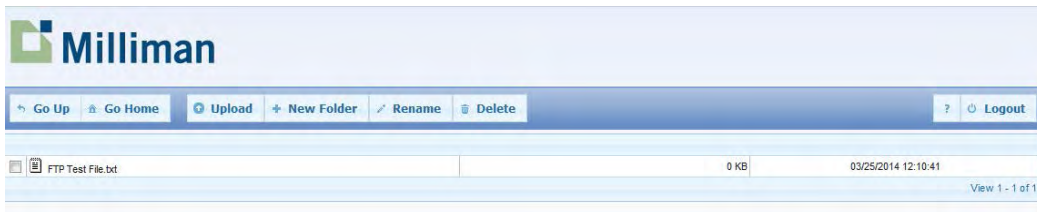


The screenshot shows a web browser window with a login form. At the top left of the form is a tab labeled "Log In". Below it are two input fields: "Username:" and "Password:". Under the password field is a checkbox labeled "Use Java™ enabled version". Below the checkbox is a line of text: "If you experience any issues with the java version, please log out and uncheck the Use Java version box and log back in". At the bottom center of the form is a "Log In" button.

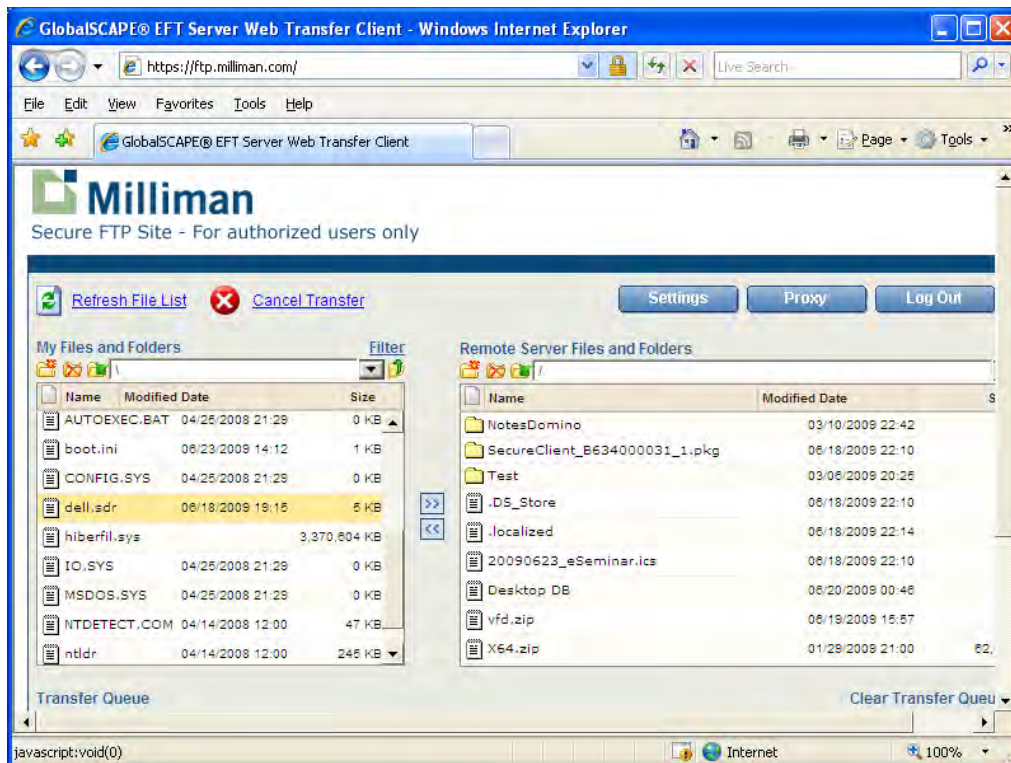
4. You may get the prompt below. Click the box and choose Run. You must allow this for the client to work.



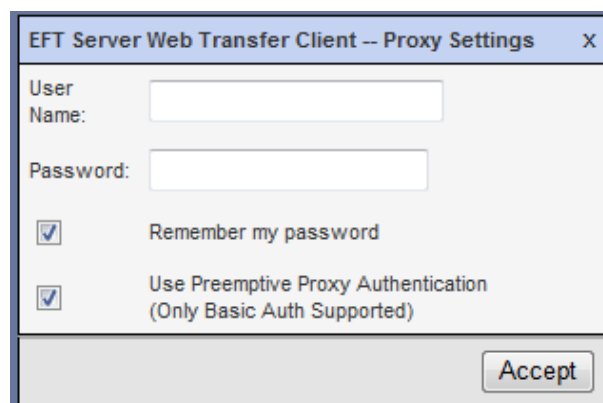
5. In the basic console you will see the contents of your folder and the links to modify existing files and/or upload new files.
 - a. Hit Upload to add a file and browse to the file location.
 - b. To download a file, right click on the file and select Save target as...



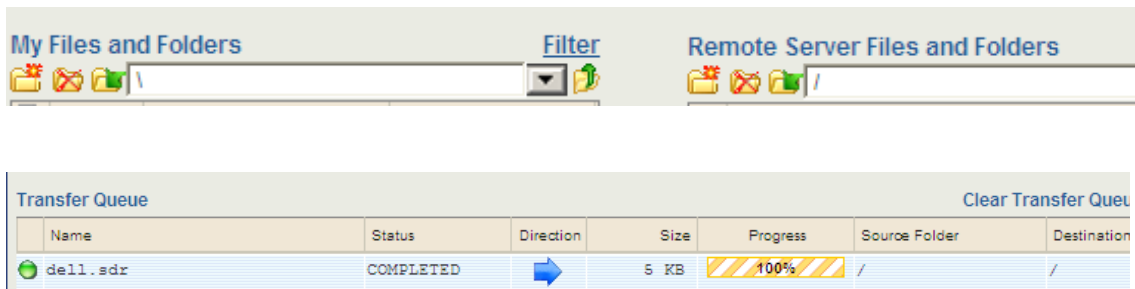
6. In the enhanced Java console, after the client loads you will see your local computer in the left pane and the Milliman remote directory in the right pane. To upload a file, select it in the left pane and press the right arrow key to transfer to Milliman. To download a file, select it in the right pane and press the left arrow key to transfer to your computer.



7. If your organization uses a proxy server, you will need to enter that information by hitting the Proxy button.



8. In the bottom pane under Transfer Queue you will see the progress of your upload/download.



9. When you have completed your transfer, click on the Log Out button in the top left hand corner of the screen.



10. After logging out you will see the Milliman Security Notice. After reading, close your Web browser. Your transfer is now complete.



You are now logged out.

Directory listings and other screens may be retained by your browser's history. We recommend you delete temporary files if extremely sensitive data is involved.

Password security reminder:

Please treat your password as confidential. As a security reminder, we recommend that you periodically change your password (if this policy is enabled by the server administrator)

Security notice:

When logging on to this server, we will never ask for any personal information other than your account login name and password.

If you are ever prompted for additional personal information upon attempting to log in, please contact the server administrator.

Detailed claims data is included on the FTP site for claims incurred 7/1/2013 – 6/30/2014 paid through 9/30/2014. The file is provided as a tab-delimited text file with a double-quote text qualifier and column headings. All proposers must supply repricing results based on a historical repricing approach for the same time period as the data provided. Discounts used to reprice the claims should reflect actual negotiated reimbursement and not include any non-covered/ineligible amounts.

The FTP site also contains a spreadsheet, which the proposers should use to populate their repricing and disruption results. The data includes a “Milliman Claim Type” field that identifies the type of claim billed (*i.e.*, inpatient hospital, outpatient hospital, physician, or other). Use this field to summarize the repricing results on the "Repricing Summary - Aggregate" tab in the Excel summary spreadsheet. Please populate the yellow-highlighted cells with your results.

The data contains a “MSA” field based on the location of the member on the claim line. Use this field to summarize your repricing results on the "Repricing Summary - By Market" tab. The total in this tab should equal the repricing results on the "Repricing Summary - Aggregate" tab.

Identify each provider in the "Provider Summary" tab as "I" (In-Network) or "O" (Out-of-Network) based on the provider's network status for the network that is being quoted. The total of in-network and out-of-network dollars in this exhibit should match the in- and out-of-network dollars on the "Repricing Summary - Aggregate" tab.

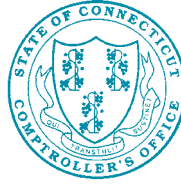
Each proposer should summarize the reasons for exclusion of any claims in the file along with the associated eligible billed amounts. Note that Milliman has already excluded pending, denied, voided and secondary claims from the historical file prior to sending it to the proposers. Ending Dollars on the “Reconciliation” tab should equal the aggregate Historical Billed on the "Repricing Summary - Aggregate" tab. Insert additional rows as needed on the “Reconciliation” tab. Identify the excluded "Row Numbers"

In addition to the repricing and disruption, each proposer should fill out the repricing questionnaire included with the data. Proposer responses can be supplied directly in the questionnaire.

The summarized repricing results in the spreadsheet will require the proposers to roll up their results to a major service category and market level so that proprietary, provider-specific discounts are not disclosed. If a proposer needs Milliman to enter into a confidentiality/non-disclosure agreement to receive the requested summarized results, then the proposer must present an agreement acceptable to Milliman along with its Notice of Intent to Bid no later than November 26, 2014.

IV. BENEFIT SUMMARIES

For State of Connecticut

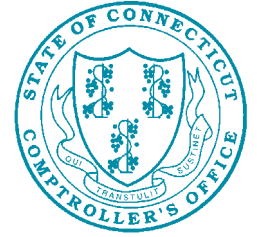


Employees



HEALTH CARE OPTIONS PLANNER

2013-2014



A Message from State Comptroller Kevin Lembo

Our daily choices affect our health and what we pay out of pocket for health care. Even if you're happy with your current coverage, it's a good idea to review the plan options each year during open enrollment.

All of the State of Connecticut medical plans cover the same services, but there are differences in each network's providers, how you access treatment and care, and how each plan helps you manage your family's health. If you decide to change your health care plan now, you may be able to keep seeing the same doctors, yet reduce your cost for health care services.

During this open enrollment, if you have not previously enrolled in the Health Enhancement Program (HEP), you must decide if you want to participate in HEP for 2013-2014. HEP is designed to help you and your family work with your medical providers to make the best decisions about your health.

If you want to enroll in HEP, you must do so by June 7, 2013 or you will not be allowed to participate in HEP until the next open enrollment.

Those who participated in HEP during 2012-2013 and have successfully met all of the HEP requirements will be automatically re-enrolled in HEP again for 2013-2014 and will continue to pay lower premiums for their health care coverage.

Please take a few minutes to consider your options and choose the best value for you and your family. Everyone wins when you make smart choices about your health and your health care.

Kevin Lembo
State Comptroller
May 2013

Table of Contents

New HEP Website www.cthep.com

Create your account (even if you had one before), check your HEP compliance status, and check out the new features. Be sure that your spouse and any dependents age 18 and over also create an account.

See page 6.

What You Need to Do	2
Current Employees	2
New Employees	2
Who's Eligible	2
Make Sure You Cover Only Eligible Dependents	3
Qualifying Status Change	3
Your Medical Plans at a Glance	4
Health Enhancement Program	5
Making Your Decision	8
Comparing Networks	9
Comparing Plan Features	11
Frequently Asked Questions	16
Your Prescription Drug Coverage at a Glance	18
Your Dental Plan Choices at a Glance	20
Your 2013-2014 Payroll Deductions	25
Your Benefit Resources	26



What You Need to Do

Current Employees

Open Enrollment Is Now Through June 7, 2013

Open enrollment is May 13 – June 7, 2013. Now is your opportunity to adjust your health care benefit choices. It's a good time to take a fresh look at the plans, consider how your and your family's needs may have changed, and choose the best plan option for you. For 2013 Open Enrollment information, please go to the Comptroller's website at www.osc.ct.gov or check with your personnel office.

During Open Enrollment, you may change medical and/or dental plans, add or drop coverage for your eligible family members, or enroll if you previously waived coverage.

If you'd like to make a change for 2013-2014, contact your agency personnel or payroll office to request a Benefit Enrollment Form.

New Employees

To enroll for the first time, follow these steps:

1. Review this booklet and choose the medical and dental options that best meet your needs.
2. Complete the enrollment form (available from Human Resources).
3. Return the form within 31 calendar days of the date you were hired.

If you enroll as a newly hired employee, your coverage begins the first day of the month following your hire date. For example, if you're hired on October 15, your coverage begins November 1.

The elections you make now are effective through June 30, 2014 unless you have a qualifying status change (see page 3).

Who's Eligible

It's important to understand who you can cover under the plan. It's critical that the State is providing coverage only for those who are eligible under the rules of the plan.

Eligible dependents generally include:

- Your legally married spouse or civil union partner;
- Your children, including stepchildren and adopted children, up to age 26 for medical and age 19 for dental;
- Children for whom you are legal guardian up to age 18 unless proof of continued dependency is provided.

Disabled children may be covered beyond age 26, with proper documentation from the medical insurance carrier.

Documentation of an eligible relationship is required when you enroll a family member. It is your responsibility to notify your Agency Human Resources Office when any dependent is no longer eligible for coverage.

Refer to www.osc.ct.gov for details about dependent eligibility.



Make Sure You Cover Only Eligible Dependents

As your children get older or your family situation changes, be sure you consider whether the people you have covered under the plan are still eligible. It can be a costly oversight if you continue to cover an ineligible person.

Did your child reach age 19? Once your child is 19, they are no longer eligible for dental benefits (unless disabled).

Did your child reach age 26? Once your child is 26, they are no longer eligible for medical and pharmacy benefits (unless disabled).

Did you get divorced or legally separated?

Once a judgement of divorce or legal separation is entered, your former spouse must be removed from the plan.

If you are covering someone who is **not** an eligible dependent, you will have to pay federal and state tax on the fair market value of benefits provided to that individual.

Please refer to the Comptroller's website at www.osc.ct.gov for details about dependent eligibility.

Qualifying Status Change

Once you choose your medical and dental plans, you cannot make changes July 1, 2013 – June 30, 2014 unless you experience a qualifying status change. If you do have a qualifying status change, you must notify Human Resources within 31 days of the event. The change you make must be consistent with your change in status.

Please call Human Resources if you experience a qualifying status change – which include changes in:

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

If you experience a change in your life that affects your benefits, contact Human Resources. They'll explain which changes you can make and let you know if you need to send in any paperwork (for example, a copy of your marriage certificate).

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This planner provides a brief summary of covered expenses. See Your Benefit Resources on page 26 to receive more detailed information.

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Your Medical Plans at a Glance

BENEFIT FEATURES	BOTH CARRIERS		BOTH CARRIERS
	POE, POE-G AND OUT-OF-AREA IN NETWORK	POS IN NETWORK	POS OUT-OF-NETWORK
Outpatient Physician Visits, Walk-in Centers and Urgent Care Centers	\$15 co-pay		80% ¹
Preventive Care	No co-payment for preventive care visits and immunizations		80% ¹
Emergency Care	\$35 co-pay ²		\$35 co-pay
Diagnostic X-Ray and Lab	100% (prior authorization required for diagnostic imaging)		80% ¹ (prior authorization required for diagnostic imaging)
Pre-Admission Testing	100%		80% ¹
Inpatient Physician	100% (prior authorization required)		80% ¹ (prior authorization required)
Inpatient Hospital	100% (prior authorization required)		80% ¹ (prior authorization required)
Outpatient Surgical Facility	100% (prior authorization required)		80% ¹ (prior authorization required)
Ambulance	100% (if emergency)		100% (if emergency)
Short-Term Rehabilitation and Physical Therapy	100% (prior authorization may be required)		80% ¹ up to 60 inpatient days, 30 outpatient days per condition per year (prior authorization may be required)
Routine Eye Exam	\$15 co-pay, 1 exam per year ⁵		50%, 1 exam per year
Audiological Screening	\$15 co-pay, 1 exam per year		80% ¹ , 1 exam per year
Mental Health/Substance Abuse	Prior authorization required		Prior authorization required
Inpatient	100%		80% ¹
Outpatient	\$15 co-pay (prior authorization may be required)		80% ¹ (prior authorization may be required)
Family Planning			
Vasectomy	100% (prior authorization may be required)		80% ¹ (prior authorization may be required)
Tubal Ligation	100% (prior authorization may be required)		80% ¹ (prior authorization may be required)
Durable Medical Equipment	100% (prior authorization may be required)		80% ¹ (prior authorization may be required)
Prosthetics	100% (prior authorization may be required)		80% ¹ (prior authorization may be required)
Skilled Nursing Facility	100% (prior authorization required)		80% ¹ up to 60 days/year (prior authorization required)
Home Health Care	100% (prior authorization may be required)		80% ¹ up to 200 visits/year (prior authorization may be required)
Hospice	100% (prior authorization required)		80% ¹ up to 60 days (prior authorization required)
Annual Deductible	Individual: \$350 ⁴ Family: \$350 each member ⁴ (\$1,400 maximum)		Individual: \$300 Family: \$900
Annual Out-of-Pocket Maximums	Individual: \$350 ⁴ Family: \$350 each member ⁴ (\$1,400 maximum)		Individual: \$2,000 (plus deductible) Family: \$4,000 (plus deductible)
Lifetime Maximum	None		None
Pre-admission Authorization/ Concurrent Review	Through participating provider		Penalty of 20% up to \$500 for no authorization

¹ You pay 20% of the allowable charge plus 100% of any amount your provider bills over the allowable charge.

² Waived if admitted.

³ HEP participants have \$15 co-pay waived once every two years.

⁴ Waived for HEP-Compliant Members.

Health Enhancement Program

The Health Enhancement Program (HEP) has several important benefits. First, it helps you and your family work with your medical providers to get and stay healthy. Second, it saves you money on your health care. Third, it will save money for the state long term by focusing our health care dollars on prevention. It's your choice whether or not to participate, but there are many advantages to doing so.

You Save Money by Participating!

When you and all of your enrolled family members participate in HEP, you will pay lower monthly premiums and have no deductible for in-network care for the plan year. If one of you has one of the five chronic conditions identified on page 6, you may also receive a \$100 payment, provided you and all enrolled family members comply with HEP requirements. You also save money on prescription drugs to treat that condition (see page 6).

If You Do Not Enroll in HEP

Unless you enroll in HEP, your premiums will be \$100 per month higher and you will have an annual \$350 per individual (\$1,400 per family) in-network medical deductible.

How to Enroll in HEP

Current Employees:

For those who are not currently participating in HEP, you can enroll during open enrollment. Forms are available at your agency Payroll/ Human Resources office or by visiting the Office of the State Comptroller website, www.osc.ct.gov.

Those who participated in HEP during 2012-2013 and have successfully met all of the HEP requirements will be automatically re-enrolled in HEP again for 2013-2014 and will continue to pay lower premiums for their health care coverage.

New Employees:

If you are a new employee, you must complete the HEP enrollment form upon making your benefit elections. HEP enrollment forms are available at your agency Payroll/ Human Resources office or by visiting the Office of the State Comptroller website, www.osc.ct.gov. You will not have to meet the HEP requirements until the first calendar year in which you are enrolled in coverage on January 1st. If you do not wish to continue participation in HEP, you can disenroll during open enrollment.

HEP encourages employees and enrolled family members to take charge of their health and health care by following health guidelines defined by the Program.



Health Enhancement Program Requirements

You and your enrolled family members must get age-appropriate wellness exams, early diagnosis screenings (such as colorectal cancer screenings, Pap tests, mammograms, and vision exams).

For calendar year 2013 you must complete at least one dental cleaning. All of the plans cover up to two cleanings per year (HEP enrollees are covered 100% for these cleanings). Periodontal maintenance is not subject to an annual maximum for HEP participants; however, cost shares and frequency limits may still apply. See page 22 for additional information.

Additional Requirements for Those With Certain Conditions

If you or any of your enrolled family members have **1) Diabetes (Type 1 or 2), 2) asthma or COPD, 3) heart disease/heart failure, 4) hyperlipidemia (high cholesterol), or 5) hypertension (high blood pressure)**, you or that family member will be required to participate in a disease education and counseling program for that particular condition. You will receive free office visits and reduced pharmacy co-pays for treatments related to your condition (see Your Prescription Drug Coverage at a Glance on page 18 for cost details).

These particular conditions are targeted because they account for a large part of our total health care costs and have been shown to respond particularly well to disease education and counseling programs. By participating in these programs, affected employees and family members will be given additional resources to improve their health.

New HEP Administrator and Website



Care Management Solutions, an affiliate of ConnectiCare, is the new administrator for the Health Enhancement Program (HEP). The HEP participant portal has new features to help you manage your health and your HEP requirements. You can visit www.cthep.com to:

- View HEP requirements and download HEP forms
- Check your HEP compliance status
- Access a library of health information and articles
- Set and track personal health goals
- Exchange messages with HEP Nurse Case Managers and professionals.

You can also call Care Management Solutions to speak with a representative.

Care Management Solutions

www.cthep.com

(877) 687-1448 Monday – Friday, 8:00 a.m. – 5:00 p.m.

An online tutorial has been created to provide information about the new site and help you with registering. Visit www.cthep.com and click on the hyperlink to your right.

Visit www.cthep.com to Create a New Account

All HEP enrollees, spouses, and dependents age 18 and over need to create a new online account the first time they visit www.cthep.com (even if you already participate in HEP and had an account on the old website).

Check Your Status

You have until December 31, 2013 to complete your 2013 HEP requirements. However, now is a great time to check your status and confirm which requirements you still need to complete.



Frequently Asked Questions

1. *By joining HEP, will my family and I have access to the same network of doctors and health care practitioners?*

Yes, the network of participating providers is the same whether or not you participate in HEP.

2. *If I participate in HEP, will the state have access to my private health care information?*

No. All claim and diagnosis data is kept strictly confidential, and will only be reviewed by the HEP administrator to ensure you follow the HEP requirements.

3. *If I participate in the HEP program and I am enrolled in the United Enhanced dental plan, are my dental cleanings covered at 100%?*

Yes. However, you must use an in-network dentist. If you go out of network, you may be subject to balance billing (if your out-of-network dentist charges more than the maximum allowable charge).

4. *If I don't follow the HEP requirements, what will happen?*

If you do not get required tests or screenings, or participate in the disease counseling and education program for your chronic condition, if applicable, you will be given appropriate notice and opportunity to meet HEP requirements. You may be removed from HEP and required to pay an increased premium and an in-network deductible for the next year.

5. *If I participate in the disease education and counseling program but my health condition gets worse, will I be removed from HEP?*

Not at all! HEP is designed to enhance the patient's ability to work with their doctors to make the most informed decisions about staying healthy, and, if ill, to treat their illness. The purpose of the disease education and counseling program is to encourage healthy behaviors. Whether or not your condition actually improves or gets worse will not affect your eligibility to continue participating and receiving the financial discounts.



Making Your Decision

Each of the medical plans offered by the State of Connecticut is designed to cover the same medical benefits – the same services and supplies. And, the amount you pay out of pocket at the time you receive services is very similar. Yet, your payroll deduction varies quite a bit from plan to plan. How do you decide?

When it comes to choosing a medical plan, there are four main areas to look at:

1. **What is covered** – the services and supplies that are covered benefits under the plan. This comparison is easy to make at the State of Connecticut because all of the plans cover the same services and supplies. (See page 4.)
2. **Cost** – what you pay when you receive medical care and what is deducted from your paycheck. What you pay at the time you receive services is similar across the plans (see the chart on page 4). However, your payroll deduction varies quite a bit (see page 25).
3. **Networks** – whether your provider or hospital has contracted with the insurance carrier. (See page 11.)
4. **Plan features** – how you access care and what kinds of “extras” the insurance carrier offers. Under some plans you must use network providers except in emergencies; others give you access to out-of-network providers. Finally, you may prefer one insurance carrier over the other (see pages 9 – 11).

The following pages are designed to help you compare your options.



Comparing Networks

When Was the Last Time You Compared Your Medical Plan to the Other Options?

If you're like many people, you made a choice when you were first hired and haven't really looked at it since. The State of Connecticut offers a wide variety of medical plans, so you can find the one that best fits your needs. Did you know that you might be able to take advantage of one of the lower-cost plans while keeping your doctor and receiving the same health care services?

Many doctors belong to multiple provider networks. Check to see if your doctor is a network provider under more than one of the plan options. Then, take a fresh look at your options. You may be able to save money every month without changing doctors.

Why Networks Matter

All of the plans cover the same health care services and supplies. The provider networks are one of the main ways in which your medical plan options differ. Getting your care within the network provides the highest benefit level:

- If you choose a **Point of Enrollment (POE)** plan, you must use in-network providers for your care (except in emergencies).
- If you choose a **Point of Service (POS)** plan or one of the Out-of-Area plans, you have the choice to use in-network or out-of-network providers each time you receive care – but, you'll pay more for out-of-network services.
- If you choose a **Point of Enrollment - Gatekeeper (POE-G)** plan, you must use in-network providers for your care (except in emergencies) and you must obtain a referral for most specialist care.

Is a National Network Important to You?

All State of Connecticut plans have a national provider network. That means they contract with doctors and hospitals across the country to provide you with nationwide access to the highest level of benefits.

- Thinking of retirement and planning to travel out of the region?
- Have a college student attending school hours away from home?
- Wish to get care at a specialty hospital that's not in Connecticut or the coverage region?

The State of Connecticut offers affordable options with great coverage within the region and nationwide. All plans have a national network available. Take a look at your options before you decide.



How the Plans Work

Point of Service (POS) Plans – These plans offer health care services both within and outside a defined network of providers. No referrals are necessary to receive care from in-network providers. Health care services obtained outside the network may require prior authorization and are reimbursed at 80% of the allowable cost (after you pay the annual deductible).

Point of Enrollment (POE) Plans – These plans offer health care services only from a defined network of providers (out-of-network care is covered in emergencies). No referrals are necessary to receive care from in-network providers. Health care services obtained outside the network may not be covered.

Point of Enrollment – Gatekeeper (POE-G) Plans – These plans offer health care services only from a defined network of providers. (Out-of-network care is covered in emergencies.) You must select a Primary Care Physician (PCP) to coordinate all care, and referrals are required for all specialist services.

The Point of Enrollment - Gatekeeper (POE-G) plans generally require the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider. Until you make this designation, the medical insurance carrier designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the medical insurance carrier (see Your Benefit Resources on page 26).

You do not need prior authorization from the medical insurance carrier or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the medical insurance carrier (see Your Benefit Resources on page 26).

Using Out-of-Network Providers

When you enroll in one of the State of Connecticut POS plans, you can choose a network or out-of-network provider each time you receive care. When you use an out-of-network provider, you'll pay more for most services. The plan pays 80% of the allowable charge after you pay your annual deductible. Plus, you pay 100% of the amount your provider bills above the allowable charge.

In the POS plans there are no referral or prior authorization requirements to use out-of-network providers – you are free to use the network or out-of-network provider of your choice. However, since certain procedures require prior authorization (see page 4), call your plan when you anticipate significant out-of-network expenses to find out how those charges will be covered. You'll avoid an unpleasant surprise and have the information you need to make an informed decision about where to seek health care.

Where You Live or Work Affects Your Choices

You must live or work within a plan's regional service area to enroll in that plan – even though the plan has a national network. For example, if you want to enroll in the UnitedHealthcare Oxford Freedom Select Plan (POS), you must live or work within the Oxford regional provider network. If you live and work outside that area, you should choose one of the Out-of-Area plans. Both Out-of-Area plans give you access to a national provider network.



Comparing Plan Features

All State of Connecticut plans cover the same health care services and supplies. However, they differ in these ways:

- **How you access services** – Some plans allow you to see only network providers (except in the case of emergency). Some provide you access to out-of-network providers when you pay more of the fees. Some require you to select a Primary Care Physician (PCP).
- **Health promotion** – Remember, there's more to a health plan than covering doctor visits. All of the plans offer health information online; some offer additional services such as 24-hour nurse advice lines and health risk assessment tools.
- **Provider networks** – You'll want to check with each plan to see if the doctors and hospitals you want are in each network. (See Your Benefit Resources on page 26 for phone numbers and websites.)
- **Discounts** – Both insurance carriers offer discounts to members for certain health-related expenses such as gym memberships and eyeglasses.

	POINT OF ENROLLMENT - GATEKEEPER (POE-G) PLANS		POINT OF ENROLLMENT (POE) PLANS		POINT OF SERVICE (POS) PLANS			OUT OF AREA PLANS	
	Anthem State BlueCare POE Plus	UnitedHealthcare Oxford HMO	Anthem State BlueCare	UnitedHealthcare Oxford HMO Select	Anthem State BlueCare	Anthem State Preferred POS*	UnitedHealthcare Oxford Freedom Select	Anthem OOA	UnitedHealthcare Oxford USA
National network	X	X	X	X	X	X	X	X	X
Regional network	X	X	X	X	X	X	X	X	X
In- and out-of-network coverage available					X	X	X	X	X
In-network coverage only (except in emergencies)	X	X	X	X					
No referrals required for care from in-network providers			X	X	X	X	X	X	X
Primary care physician (PCP) coordinates all care	X	X							

* Closed to enrollment.

Comparing Plans: A Message From Anthem

Your Plan Options From Anthem

	State BlueCare POE Plus In Network	State BlueCare POE In Network	State BlueCare POS In/Out-of-Network	Anthem Out of Area Plan
Office Visit Co-pay	\$15*	\$15*	\$15*	\$15*
Specialist Co-pay	\$15*	\$15*	\$15*	\$15*
Specialist Referral	Yes	No	No	No
Local & National Provider Networks	Yes	Yes	Yes	Yes
Hospital Network	Local and national	Local and national	Local and national	Local and national
National Access	Yes	Yes	Yes	Yes
International Access	Yes	Yes	Yes	Yes

* Retiree co-pays may vary

Value-added programs such as wellness programs and discounts offered by the plan are not negotiated benefits and are subject to change at any time at the discretion of the plan.

Service: putting your health first

We've been in Connecticut for more than 75 years, and we've been serving State of Connecticut employees and retirees for more than 50 of those years. This means we know your needs, and we're ready and able to help. Get answers and information through our:

- **State-dedicated Member Services Unit at 800-922-2232:** Talk with a customer service expert who is located right here in the state and is dedicated solely to State employees and retirees.
- **State-dedicated website at anthem.com/statect:** Find information geared specifically to you and other State employees and retirees.

24/7 NurseLine

You can call the toll-free number — **800-711-5947** — to talk with a nurse about your general health questions any time of the day or night. Whether it's a question about allergies, fever, types of preventive care or any other topic, nurses are always there to provide support and peace of mind. Our nurses can help you choose the right place for care if your doctor isn't available and you aren't sure what to do.

You can also listen to recorded messages on hundreds of health topics. Just call the 24/7 NurseLine number and choose the Audio-Health Library option.

Wellness: making your health a top priority

Lose weight. Join a gym. Control asthma. When it comes to our health, we all have different goals. That's why we have a full range of wellness programs, online tools and resources designed to meet your unique needs.

¹ Anthem Health and Wellness Program Satisfaction Study.

SpecialOffers@Anthem is a service mark of Anthem Insurance Companies, Inc. Vendors and offers are subject to change without notice. Anthem does not endorse and is not responsible for the products, services or information provided by the SpecialOffers@Anthem vendors. Arrangements and discounts were negotiated between each vendor and Anthem for the benefit of our members. All other marks are the property of their respective owners. All of the offers in the SpecialOffers@Anthem program are continually being evaluated and expanded so the offerings may change. Any additions or changes will be communicated on our website, anthem.com. These arrangements have been made to add value for our members. Value-added products and services are not covered by your health plan benefit. Available discount percentages may change or be discontinued from time to time without notice. Discount is applicable to the items referenced.

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Service. Wellness. Better health.

Customer service that's focused on your needs. Wellness programs that support and guide you. Plans that promote better health. Your health care plan should fit into your personal plan.

Anthem's Health and Wellness

From finding an answer to a common health question to getting one-on-one support for a chronic health condition, you can get the help you need through our Anthem Health and Wellness program. Learn more at anthem.com/statect.

SpecialOffers@AnthemSM

As a State employee or retiree, you can get discounts on products that encourage a healthy lifestyle. You'll get "healthy discounts" on things like:

- Weight loss programs through Weight Watchers®, Jenny Craig® and more
- Fitness club memberships, equipment and coaching
- Hearing aids
- Allergy products
- Acupuncture
- Massage therapy
- Baby safe gear
- Senior Care services

A health plan that gives you more health

Your health plan should do more than just help you when you're sick. It should help you be your healthiest. That's why Anthem plans include things like vision benefits and large nationwide networks. So you can get more health from your health care.

Vision

The Anthem plans for the State of Connecticut include vision coverage and discounts:

Eye Exams

Your State of Connecticut health benefits cover you for an annual routine eye exam. No matter which plan you have, you do not need a referral.

Value-Added Discounts

- **1-800 CONTACTS** — Get contact lenses quick and easy — plus discounts only available to Anthem members, like \$20 off when you spend \$100 or more, and free shipping.
- **Glasses.com** — Try on any five of the 1,500 designer frames — at home, for free — before you buy. It's convenient, plus you get exclusive member savings like \$20 off when you spend \$100 or more, and free shipping and free returns.
- **Premier LASIK** — Save 15% on LASIK with all their in-network providers and prices as low as \$695 per eye with select providers. Network access.

Have a question? Call our State-dedicated Member Services Unit at 800-922-2232. We're ready to help you. You'll also find good information at anthem.com/statect.

Network access

Anthem provides expansive coverage nationally and around the world. Through the BlueCard® program, you can use the networks of other Blue Cross and Blue Shield plans, so you can get the care you need — just about anywhere you travel. We can help you find the right care locations outside of Connecticut by calling 800-810-BLUE.

Comparing Plans: A Message From UnitedHealthcare



Value-added programs such as wellness programs and discounts offered by the plan are not negotiated benefits and are subject to change at any time at the discretion of the plan.

Now is the Time to Live Well.

Five Reasons UnitedHealthcare is the right decision for you and your family:

1: Cost Savings

Choosing an Oxford plan from UnitedHealthcare can save you premium dollars all year. You can save even more through our Healthy Bonus member discounts that give you access to discounts and special offers on products and services that can help you make the best kind of investment: a healthy lifestyle.

2: Network

A robust national and local network means your doctor likely already participates with your plan. State of Connecticut employees and retirees have access to all hospitals in Connecticut.

3: Medical and Dental Coverage

You may have our dental coverage, but we offer medical too. Be sure to take a look at the medical plans offered by UnitedHealthcare. For more information on our money-saving medical plans, visit welcometouhc.com/stateofct.

4: Trust

You should trust that you are making a great decision choosing UnitedHealthcare. You need to choose someone you can depend on and with an Oxford Health Plan from UnitedHealthcare you come first. We are committed to helping people live healthier lives.

5: Tools and Resources

Everything you need at your fingertips, 24/7. Search for a doctor, view your claims, online health coaching and much more.

Our Network

All medical plans offer access to our local and national network

UnitedHealthcare offers a robust local and national network. Nationally and in the tri-state area, we have a vast number of physicians, healthcare professionals and hospitals. For years, our members have relied on access to our Connecticut, New York and New Jersey tri-state network. Whichever plan you choose, you'll have seamless access to our UnitedHealthcare Choice Plus Network of physicians and health care professionals outside of the tri-state area. This gives State of Connecticut employees and retirees better access to quality care whether you are in Connecticut, traveling outside the tri-state area or living somewhere else in the country.

For more information about our network or to search for physicians participating in our local and UnitedHealthcare Choice Plus Network, please visit welcometouhc.com/stateofct.

UnitedHealth Premium® Program

UnitedHealth Premium puts quality and cost efficiency information about area physicians and facilities in your hands. Just look for the stars on myuhc.com®.

UnitedHealth Premium® Designation Program

Don't leave your health care choice to chance.

UnitedHealth Premium helps you find the doctor or facility that is right for you

It can be difficult to choose a doctor from just a list of names.

We've done the homework for you

This program identifies doctors and facilities that meet quality criteria using evidence-based medical standards, clinical guidelines, and expert physician advice.

How the program works: Just look for the stars

Doctors and facilities in our network are evaluated on two levels:

★ **Quality**

One star means a physician or facility has met quality of care guidelines by following national evidence-based medical standards and practices.

★★ **Quality and cost efficiency**

Two stars mean a physician or facility has met the criteria for quality of care based on national medical standards and practices, and for cost efficiency.

Easy online access

How do you find a UnitedHealth Premium-designated doctor or facility? The UnitedHealth Premium designation program delivers the results to you at myuhc.com®. Just look for the stars next to your search results. We have evaluated doctors in 21 specialties, as well as cardiac care, congenital heart disease, spine surgery, total joint, infertility, and neonatology facilities.

Oxford On-Call®

Healthcare Guidance 24 hours a day

We realize that questions about your health can come up at any time. That's why we offer you flexible choices in health care guidance through our *Oxford On-Call*® program. Speak with a registered nurse who can offer suggestions and guide you to the most appropriate source of care, chat online with a nurse about your general health questions or listen to recorded messages on over 1,100 health topics – 24 hours a day, seven days a week. That's the idea behind *Oxford On-Call*.

If you are a member and you need to reach Oxford On-Call, please call 800-201-4911. Press option 4. Oxford On-Call can give you helpful information about many topics such as:

General Health Information

Oxford On-Call can give you helpful information about many topics. Call about illness, injury, chronic conditions, prevention, healthy living, and men's, women's and children's health.

Deciding Where to Go for Care

Not sure if your situation calls for a doctor visit? Wonder if you should go to an after-hours urgent care clinic or the emergency room? *Oxford On-Call's* nurses provide information that can help you choose care that is appropriate for your situation.

Choosing Self-Care Measures

Registered nurses provide practical self-care tips to help you manage your condition at home. Nurses can also tell you about signs and symptoms that may indicate the need for a higher level of care.

Communicating With Your Healthcare Provider

Make the most of your doctor visits. Call *Oxford On-Call* before you go to your appointment, and a nurse can help you make a list of questions to ask your doctor.

Guidance for Difficult Decisions

If you or a family member has a serious medical condition, *Oxford On-Call* nurses can be a great resource. Learn more about medical conditions, the possible risks and benefits of treatment options and information to help you take medications safely. The more you know, the better prepared you'll be.

Health Information Library

Listen to more than 1,100 recorded messages on health and well-being topics. To access the library, call the *Oxford On-Call* phone number and choose the option for Health Information Library. Enter PIN number 123. You can ask a nurse about the topics and code numbers.

Live Web Chat

Nurses are available to chat online about a variety of health topics and to confidentially guide you to online resources.

Healthy Bonus® Member Discounts

We understand that rising health care costs nationwide affect our members. We strive to help you stretch your health care dollar by developing programs that aim to help you improve your health.

We recognize there are ways we can help members reduce out-of-pocket health care costs. We believe in the power of prevention: that by taking a little extra time to eat better, exercise and reduce stress, individuals can do a better job of staying on the path of wellness.

Our *Healthy Bonus* program offers access to discounts and special offers on products and services that can help you make the best kind of investment: a healthy lifestyle. Please visit welcometouhc.com/stateofct to obtain information on the discounts offered to you on things like fitness/fitness equipment, diabetes/disease management, keeping kids healthy and overall wellness.

Frequently Asked Questions

Where can I get more details about what the state health insurance plan covers?

All medical plans offered by the State of Connecticut cover the same services and supplies. For more detailed benefit descriptions and information about how to access the plan's services, contact the insurance carriers at the phone numbers or websites listed on page 26.

If I live outside Connecticut, do I need to choose an Out-of-Area Plan?

No, as long as you work in Connecticut, you do not need to choose an Out-of-Area plan.

What's the difference between a service area and a provider network?

A service area is the region in which you need to live in order to enroll in a particular plan. A provider network is a list of doctors, hospitals and other providers. In a POE plan, you may use only network providers. In a POS plan, you may use providers both in- and out-of-network, but you pay less when you use providers in the network.

What are my options if I want access to doctors across the U.S.?

Both State of Connecticut insurance carriers offer extensive regional networks as well as access to network providers nationwide. If you live outside the plans' regional service areas, you may choose one of the Out-of-Area plans. Both have national networks.

Contact each insurance carrier to find out if your doctor is in the network that applies to the plan you're considering. You can search online at the carrier's website (be sure to select the right network; they vary by plan option), or you can call customer service at the numbers on page 26. It's likely your doctor is covered by more than one network.

Can I enroll later or switch plans mid-year?

The elections you make now are in effect through June 30, 2014. If you have a qualifying status change, you may be able to modify your elections mid-year (see page 3). If you decline coverage now, you may enroll during any later open enrollment or if you experience certain qualifying status changes.



Can I enroll myself in one option and my family member in another?

No. You and the family members you enroll must all have the same medical option and/or the same dental option. However, you can enroll certain family members in medical and different family members in dental coverage. For example, you can enroll yourself and your child for medical but yourself only for dental. To enroll an eligible family member in a plan, you must enroll as well.

I am a 65-year-old active state employee. Which health plan card should I present to a doctor's office or hospital?

When visiting a doctor or hospital, present your State of Connecticut employee plan health card (not your Medicare card). Since you are still working, your employer coverage is your primary health insurance provider; Medicare is secondary.

My spouse is covered under my state medical plan and will soon be eligible for Medicare. Should he sign up for Medicare? What else does he need to do?

As long as you are enrolled in health insurance coverage as an active employee and your spouse remains covered under your state plan, the state plan is primary and Medicare is secondary for your spouse. This means that Medicare will only pay for services after your employee plan has made its payment.

Because your spouse has coverage through the state plan, there is no need to take action right away. He can sign up for Medicare parts A and B during a later Medicare enrollment period with no penalty while still covered under the state plan or for a limited time after dropping or otherwise losing state coverage.

For information on Medicare, visit www.medicare.gov.



Your Prescription Drug Coverage at a Glance

Your prescription drug coverage is through Caremark. Prescription benefits are the same no matter which medical plan you choose.

Maintenance Medications

Maintenance drugs are prescriptions commonly used to treat conditions that are considered chronic or long term.

The plan has a 3-tier co-pay structure which means the amount you pay depends on whether your prescription is for a generic drug, a brand-name drug listed on Caremark's preferred drug list (the formulary), or a non-preferred brand-name drug.

PRESCRIPTION DRUG CO-PAYS ARE AS FOLLOWS:

For...	Maintenance Drugs 90-Day Supply	Non-Maintenance Drugs 30-Day Supply
Tier 1: Generic drug	\$5	\$5
Tier 2: Preferred brand-name drug	\$10	\$20
Tier 3: Non-preferred brand-name drug	\$25 (\$10 if your physician certifies the non-preferred brand-name drug is medically necessary)	\$35 (\$20 if your physician certifies the non-preferred brand-name drug is medically necessary)

For those enrolled in the Health Enhancement Program, medications used to treat chronic conditions covered by HEP's disease education and counseling programs cost even less:

- \$0 co-pay for Tier 1 (generic)
- \$5 co-pay for Tier 2 (preferred)
- \$12.50 co-pay for Tier 3 (non-preferred).

There is \$0 co-pay for medications and supplies used to treat diabetes (Type 1 and Type 2).

To check which co-pay amount applies to your prescriptions, visit www.Caremark.com for the most up-to-date information. Once you register, click on "Look up Co-pay and Formulary Status." Simply type the name of the drug you want to look up and you will see the cost and co-pay amounts for that drug as well as alternatives.

Preferred and Non-Preferred Brand-Name Drugs

Which tier a drug is placed in is determined by Caremark. Caremark's Pharmacy and Therapeutics Committee reviews tier placement each quarter. If new generics have become available, new clinical studies have been released, new brand-name drugs have become available, etc., the Pharmacy and Therapeutics Committee may change the tier placement of a drug.

If your doctor believes a non-preferred brand-name drug is medically necessary for you, they will need to complete the Coverage Exception Request form (available at www.osc.ct.gov) and fax it to Caremark. If approved, you will pay the preferred brand co-pay amount.



If You Choose a Brand Name When a Generic Is Available

Prescriptions will be automatically filled with a generic drug if one is available, unless your doctor completes Caremark's Coverage Exception Request form and it is approved. (It is not enough for your doctor to note "dispense as written" on your prescription; a separate form is required.) As noted on page 18, if you request a brand-name drug over a generic alternative without obtaining a coverage exception, you will pay the generic drug co-pay PLUS the difference in cost between the brand and generic drug.

If you have questions about your prescription drug benefits, contact Caremark at 1-800-318-2572.

Mandatory 90-day Supply for Maintenance Medications

If you or your family takes a maintenance medication, you will be able to get your first 30-day fill of that medication at any participating pharmacy. After that your two choices are:

- Receive your medication through the Caremark mail-order pharmacy, or
- Fill your medication at a pharmacy that participates in the state's Maintenance Drug Network (see the list of participating pharmacies on the Comptroller's website at www.osc.ct.gov).

A list of maintenance medications is posted at www.osc.ct.gov.

CVS Caremark Specialty Pharmacy

Certain chronic and/or genetic conditions require special pharmacy products (often injected or infused). The specialty pharmacy program provides these prescriptions along with the supplies, equipment and care coordination needed. Call 1-800-237-2767 for information.



Your Dental Plan Choices at a Glance

	UNITED BASIC (any dentist)	UNITED ENHANCED (network)	CIGNA DHMO® (network only)
Annual Deductible	None	\$25/individual, \$75/family	None
Annual Maximum	None (\$500 per person for periodontics)*	\$3,000 per person (excluding orthodontics)	None
Exams, Cleanings, and X-rays	Covered at 80%*	Covered at 100%*	Covered at 100%
Simple Restoration Fillings	Covered at 80%	Covered at 80%	Covered**
Oral Surgery	Covered at 67%	Covered at 67%	Covered**
Major Restoration Crowns	Covered at 67%	Covered at 67%	Covered**
Dentures, Fixed Bridges	Not covered	Covered at 50%	Covered**
Orthodontia	Not covered	Plan pays \$1,500 per person per lifetime	Covered**

* If enrolled in the Health Enhancement Program: 100% coverage for cleanings and exams (2 per year). (Use network dentists under Enhanced plan for 100% coverage.) No annual maximum on services for periodontal maintenance (2 per year) or scaling and root planing (frequency limits and cost shares may still apply).

** Contact CIGNA at 1-800-244-6224 for patient co-pay amounts.

Terms to Know

- Basic Plan** – This plan allows you to visit any dentist or dental specialist without a referral.
- Enhanced Dental PPO** – This plan offers dental services both within and outside a defined network of dentists and dental specialists without a referral. However, your out-of-pocket expenses may be higher if you see an out-of-network provider.
- DHMO Plan** – This plan provides dental services only from a defined network of dentists. You must select a Primary Care Dentist (PCD) to coordinate all care and referrals are required for all specialist services.

Before starting extensive dental procedures for which the dentist’s charges may exceed \$200, your dentist may submit a pre-treatment estimate to the Plan. You can also help to determine the amount you will be required to pay for a specific procedure by using the Plan’s website.

More details about covered expenses are available by contacting the plans by phone. (See Your Benefit Resources on page 26.)

Dental coverage ends for dependent children at age 19 (unless disabled).

Comparing Your Plans: A Message From UnitedHealthcare Dental



Overview of UnitedHealthcare Dental® benefits

Now is the Time to Live Well

Better oral health can lead to better overall health. At UnitedHealthcare, we know that the health of your teeth and gums is linked to better health overall. By brushing and flossing carefully and visiting the dentist for regular checkups, you can enjoy a healthier mouth, which plays a key role in your overall health and well-being.

How do I know which plan is best for me?

We realize that one plan does not fit all so we've created two plans to choose from: the Enhanced Plan and the Basic Plan. With both plans you have access to in- and out-of-network dentists. **However, you may have lower out-of-pocket costs when you visit a participating network dentist. To learn more, compare the options below.**

Basic Plan

- You can visit any dentist or dental specialist, without a referral
- Preventive services covered at 80%, including oral cancer screening
- HEP enrollees covered at 100% for 2 cleanings per year
- No deductibles

Enhanced Plan

- Flexibility to seek care outside of the network with higher out-of-pocket member costs. Non-network payments are paid at the maximum allowable charge (MAC)
- Realize cost savings per procedure by utilizing a network dentist or specialist
- All preventive services covered at 100% in network, including oral cancer screening
- Coverage for orthodontics, bridges and dentures for adults and children
- No referral needed.

If you have any questions, call customer service at **800-896-4834** or visit **www.myuhcdental.com/stateact**.

* For indemnity plans or PPO plans with out-of-network options, fees are set to maximum allowable charges.

Value-added programs such as wellness programs and discounts offered by the plan are not negotiated benefits and are subject to change at any time at the discretion of the plan.



Comparing the Basic and Enhanced Plans

UnitedHealthcare offers State of Connecticut members and retirees two dental plans: UnitedHealthcare Dental® Enhanced Plan or UnitedHealthcare Dental® Basic Plan.

	ENHANCED DENTAL PLAN					
	Basic Dental Plan	Basic Dental Plan with HEP	Network	Network with HEP	Out-of-Network	Out-of-Network with HEP
Calendar year deductible (waived for preventive and diagnostic); does not apply to orthodontics	Not applicable	Not applicable	\$25 individual/ \$75 family		\$25 individual/ \$75 family	
Calendar year maximum (combined for network and out-of-network); does not apply to orthodontics	Not applicable	Not applicable	\$3,000		\$3,000	
Periodontics annual maximum	\$500 per calendar year	Annual maximum waived for certain periodontal procedures	Included with calendar year maximum waived on certain procedures for HEP enrollees		Included with calendar year maximum waived on certain procedures for HEP enrollees	
Cleanings	80%	100%	100% network only	100% network only	100% of MAC	100% of MAC
Sealants	Not covered	Not covered	100% network only	100% network only	100% of MAC	100% of MAC
Orthodontics lifetime maximum (combined for network and out-of-network)	Not applicable	Not applicable	\$1,500		\$1,500	
Consumer MaxMultiplierSM	Not applicable	Not applicable	Yes		Yes	
Prenatal Dental	Yes	Yes	Yes		Yes	

IMPORTANT INFORMATION TO KNOW ABOUT YOUR HEP BENEFITS

- Full coverage for cleanings and exams (2 per year) and bitewing x-rays (1 per year) under the Basic and Enhanced plans. **Note: Under the Enhanced plan you must use an in network dentist to receive 100% coverage.**
- No annual maximum on services for periodontal maintenance (2 per year) or scaling and root planing (frequency limits and applicable cost shares still apply).

Comparing Your Plans: A Message From Cigna

Are you looking for a dental plan with the following features?

- **NO** deductibles and **NO** annual dollar maximums
- Orthodontia coverage for children *and* adults
- Teeth whitening coverage



If so, then the **Cigna Dental Care® (DHMO)** plan may be the best option for you and your family.

Visit our website designed specifically for State of CT employees at <http://www.cigna.com/stateofct>

DHMO Basics

When you sign up for the DHMO plan, you select a primary network general dentist, who will handle all of your dental care needs.

You then receive a Patient Charge Schedule, or “PCS,” that lists the specific dental procedures covered by the plan and the amount you would pay the dentist (your copays). These copays are fees that apply only when you receive treatment from the dentists or dental specialists in our large DHMO Network. If a dental procedure is not listed on your PCS, it is not covered and you will have to pay according to the dentist’s regular fees.

It’s important to remember that selecting a primary network general dentist is required before receiving care with the DHMO.

Benefits of Saying “No” with the DHMO

Highlights of the Cigna DHMO include:

- **NO** charges for most preventive services such as exams, x-rays and routine cleanings
- **NO** deductibles to pay before you can use your plan
- **NO** annual dollar maximums to limit your benefits
- **NO** claim forms to file
- **NO** referrals required for children under seven to visit a network pediatric dentist
- **NO** referrals required to receive care from a network orthodontist
- **NO** age limit on sealants, which help prevent tooth decay
- **NO** additional charge for second opinions
- **NO** ID cards required to receive care

Lower Family Premiums

While you’ll pay no premiums for Employee Only coverage for all three of your dental options, you can save in premiums with the Cigna DHMO for Employee +1, Family, and Family Less Employed Spouse (FLES) coverage.

Please review page 25 of this booklet to see how much you could save per paycheck by enrolling in the Cigna DHMO.

Enhanced Coverage Through Cigna Oral Health Integration Program

Eligible State of Connecticut employees who enroll in the Cigna DHMO plan will have access to enhanced dental coverage through the **Cigna Dental Oral Health Integration Program® (OHIP)**.

With this program, eligible participants with certain medical conditions may receive 100% reimbursement of their copays for select covered dental services.

The qualifying medical conditions for the program include:

- Heart disease
- Stroke
- Diabetes
- Head & neck cancer radiation
- Maternity
- Chronic kidney disease
- Organ transplants

Periodontal treatment and maintenance (procedures D4341, D4342 and D4910) qualifies for reimbursement for all of the medical conditions listed above. Other dental services are tied to specific medical conditions.

For additional information regarding OHIP, please visit <http://www.cigna.com/stateofct> – the website developed by Cigna just for State of CT employees.

Value-added programs such as wellness programs and discounts offered by the plan are not negotiated benefits and are subject to change at any time at the discretion of the plan.

Orthodontia Coverage

A key feature of the Cigna DHMO is that the plan offers orthodontia coverage for children *and* adults. Please refer to your PCS for the exact orthodontia procedures covered under the Cigna DHMO plan.

Below are out-of-pocket costs to think about when it comes to 24-month comprehensive orthodontia coverage for children. Please note that the Cigna copay amount and length of treatment may vary based on the individual situation.

Average cost in CT	\$6,397.00
Cigna copay amount	\$3,139.00

Finding a DHMO Dentist is Easy

For the most current information on network dental offices in your area, search our online directory at **www.Cigna.com/stateofct** or call the Dental Office Locator at **1.800.Cigna24 (1.800.244.6224)**.

Important Note: UConn Health Center is part of the Cigna DHMO Network.

Cigna and the Health Enhancement Program (HEP)

If enrolled in the HEP, remember to get your required annual preventive care cleanings.

Review your enrollment kit materials carefully before you enroll

If you have more questions, visit us online at **www.Cigna.com/stateofct** or call us for LIVE assistance 24/7 at **1.800.Cigna24 (1.800.244.6224)**.

Once you are enrolled in the Cigna DHMO

Register for our secure, easy-to-use web site, **myCigna.com/stateofct**, and get the tools to review your dental plan information, find a network dentist, and much more!

Still Undecided About Your Dental Plan?

If so, then take a look at the questions below. Your answers may help you decide which plan is the best fit for you and your family.

For each question below, check either "Yes" or "No"

Do you prefer a plan that tells you the exact dollar amount you will pay for each procedure, so you don't have to calculate percentages?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you prefer a dental plan that has no annual dollar maximums , so you don't have to worry about your benefits running out if you reach a certain amount?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you prefer a dental plan with no deductibles , so your benefits kick in right away, rather than waiting to reach a certain level of out-of-pocket expenses first?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Would you change dentists if it meant spending less out-of-pocket for your dental care costs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Would you be willing to select a primary care network dentist to manage all your dental care needs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

If you have more "Yes" checks than "No" checks, the Cigna DHMO may be the best plan for you.

All plans have exclusions and limitations. Please refer to your employer's insurance certificate, summary plan description or evidence of coverage for a complete list of plan limitations and both covered and not covered services. The term "DHMO" is used to refer to product designs that may differ by state of residence of enrollee, including but not limited to, prepaid plans, managed care plans, and plans with open access features. The Cigna Dental Care plan is underwritten by Connecticut General Life Insurance Company or Cigna HealthCare of Connecticut, Inc. and administered by Cigna Dental Health, Inc. "Cigna" and "GO YOU" are registered service marks, and the "Tree of Life" logo and "Cigna Dental" are service marks, of Cigna Intellectual Property, Inc., licensed for use by Cigna Corporation and its operating subsidiaries. All products and services are provided by such operating subsidiaries and not by Cigna Corporation. Such operating subsidiaries include Connecticut General Life Insurance Company, Cigna Health and Life Insurance Company, and HMO or service company subsidiaries of Cigna Health Corporation and Cigna Dental Health, Inc. Participating dentists are independent contractors solely responsible for treatment provided.

Your 2013-2014 Payroll Deductions

Health Enhancement Program Bi-Weekly Payroll Deductions July 1, 2013 through June 30, 2014 (26 Pay Periods)

If you do not enroll in the Health Enhancement Program, an additional \$46.16 will be deducted from your paycheck bi-weekly.

(Employees on semi-monthly pay schedules will have slightly higher deductions.)

MEDICAL PLANS	EMPLOYEE	EMPLOYEE +1	FAMILY	FLES**
Point of Enrollment - Gatekeeper Plans (POE-G)				
Anthem State BlueCare POE Plus	\$24.59	\$71.10	\$91.35	\$47.81
UnitedHealthcare Oxford HMO	\$18.29	\$52.38	\$67.30	\$35.22
Point of Enrollment Plans (POE)				
Anthem State BlueCare	\$27.01	\$81.36	\$108.31	\$54.36
UnitedHealthcare Oxford HMO Select	\$21.54	\$64.92	\$86.40	\$43.37
Point of Service Plans (POS)				
Anthem State BlueCare	\$34.83	\$120.32	\$139.01	\$62.34
Anthem State Preferred POS*	\$83.30	\$243.26	\$285.93	\$166.78
UnitedHealthcare Oxford Freedom Select	\$28.26	\$97.63	\$112.80	\$50.58
Out of Area Plans (OOA)				
Anthem OOA	\$34.83	\$120.32	\$139.01	\$62.34
UnitedHealthcare Oxford USA	\$28.26	\$97.63	\$112.80	\$50.58
DENTAL PLANS				
UnitedHealthcare Basic	\$0.00	\$14.13	\$14.13	\$7.24
UnitedHealthcare Enhanced	\$0.00	\$12.99	\$12.99	\$6.65
Cigna DHMO®	\$0.00	\$4.61	\$6.53	\$2.69

* Closed to new enrollment.

** The Family Less Employed Spouse (FLES) rate is available only when both spouses are employed by the State of Connecticut, eligible for health insurance, and enrolled in the same plan, along with at least one child.

For employees enrolled in FLES: to participate in the Health Enhancement Program, both employees must enroll.

All of the medical plans offered to State of Connecticut employees cover the same health care services. Saving a little each pay period can save you a lot each year.

- \$5 each pay period saves you..... \$130 per year
- \$10 each pay period saves you..... \$260 per year
- \$50 each pay period saves you..... \$1,300 per year
- \$75 each pay period saves you..... \$1,950 per year
- \$110 each pay period saves you..... \$2,860 per year
- \$150 each pay period saves you..... \$3,900 per year

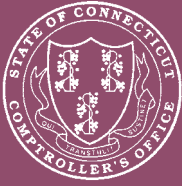
Your Benefit Resources

For details about specific plan benefits and network providers, contact the insurance carrier.
If you have questions about eligibility, enrolling in the plans or payroll deductions, contact your agency benefits office.

Health Enhancement Program (HEP) Care Management Solutions (an affiliate of ConnectiCare)	www.cthep.com	1-877-687-1448	
Anthem Blue Cross and Blue Shield <ul style="list-style-type: none"> • Anthem State Preferred POS (POS)* • Anthem State BlueCare (POS) • Anthem State BlueCare (POE) • Anthem State BlueCare POE Plus (POE-G) • Anthem Out-of-Area 	www.Anthem.com/statect	1-800-922-2232	
UnitedHealthcare (Medical) <ul style="list-style-type: none"> • Oxford Freedom Select (POS) • Oxford HMO Select (POE) • Oxford HMO (POE-G) • Oxford USA Out-of-Area 	www.welcometouhc.com/stateofct	1-800-385-9055 Call 1-800-760-4566 for questions before you enroll	
Caremark (Prescription drug benefits, any medical plan)	www.Caremark.com	1-800-318-2572	
UnitedHealthcare (Dental) <ul style="list-style-type: none"> • Basic Plan • Enhanced PPO 	www.Myuhcdental.com/statect	1-800-896-4834	
CIGNA <ul style="list-style-type: none"> • DHMO Plan 	www.Cigna.com/stateofct	1-800-244-6224	

* Closed to new enrollment.





State of Connecticut

2014
2015

Health Care Options Planner

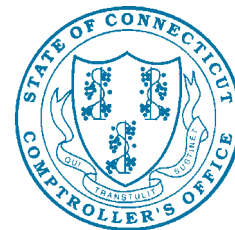
Retirees

Retirement Date October 1, 2011 or Earlier





A Message from State Comptroller Kevin Lembo



Our daily choices affect our health and what we pay out of pocket for our health care. Even if you're happy with your current coverage, it's a good idea to review the plan options each year during open enrollment.

All of the State of Connecticut medical plans cover the same services, but there are differences in each network's providers, how you access treatment and care, and how each plan helps you manage your family's health. If you decide to change your health care plan now, you may be able to keep seeing the same doctors, yet reduce your cost for health care services.

The State is pleased to announce that Cigna will now administer all three State dental plans at lower cost. This change will not alter your benefits – with the exception of some improvements – and you can continue to see your dentist under the larger network with no additional cost. The only change is that all three plans will simply be *administered* by Cigna.

Please take a few minutes to consider your options and choose the best value for you and your family. Everyone wins when you make smart choices about your health and your health care.

Kevin Lembo
State Comptroller

Table of Contents

What's New for 2014-2015

Effective July 1, 2014, Cigna will be the dental carrier for all State of Connecticut dental plans: Basic, Enhanced, and DHMO. This change will bring lower premiums and a broader network of contracted dentists for the Basic and Enhanced plans. See page 26 for details.

2014-2015 medical premium shares are listed on page 5, 11 or 15 (depending on your retirement date). Dental premiums are listed on page 27.

What You Need to Do	2
Make Sure You Cover Only Eligible Dependents	3
Qualifying Status Change	4
Medical and Prescription Drug Plan Summaries and Premium Shares	
Group 1: Retirement date prior to July 1997	5
Group 2: Retirement date July 1, 1997 - May 1, 2009 (or retired under the 2009 Retirement Incentive Program)	8
Group 3: Retirement date June 1, 2009 - October 1, 2011	12
Frequently Asked Questions	16
Making Your Decision - Medical	18
Comparing Networks	19
Comparing Plan Features	21
A Message From Anthem	22
A Message From UnitedHealthcare	24
Dental Plan Summaries and Premium Shares	26
A Message From CIGNA	28
Medicare and You	30
Enrollment Form	31
Your Benefit Resources	33





For additional details, please go to the Comptroller's website at www.osc.ct.gov or check with the Retirement Health Insurance Unit at (860) 702-3533.



How to Use This Planner

This planner is for all State of Connecticut retirees who retired October 1, 2011 or earlier. However, there are some differences depending on your retirement date. The "Your Medical Plans at a Glance," "Your Prescription Drug Coverage at a Glance," and "Your 2014-2015 Medical Premium Share" pages are customized by group.

GROUP 1:

If your **retirement date is before July 1997**, see pages 5-7 for information that applies specifically to you.

GROUP 2:

If your **retirement date is between July 1, 1997 and May 1, 2009 (or you retired under the 2009 Retirement Incentive Program)**, see pages 8-11 for information that applies specifically to you.

GROUP 3:

If your **retirement date is between June 1, 2009 and October 1, 2011**, see pages 12-15 for information that applies specifically to you.

What You Need to Do

Open Enrollment Through June 13, 2014

During open enrollment, you have the opportunity to adjust your healthcare benefit choices. It's a good time to take a fresh look at the plans, consider how your and your family's needs may have changed, and choose the best value.

During open enrollment, you may change medical and/or dental plans, add or drop coverage for your eligible family members, or enroll yourself if you previously waived coverage. If you have a question concerning your enrollment, contact the Retirement Health Insurance Unit at the address below or call (860) 702-3533.

Complete and return the form in the back of this booklet if you'd like to make a change for 2014-2015. The form must be postmarked by June 13, 2014. Any changes you make are effective July 1, 2014 through June 30, 2015 unless you have a qualifying status change. **If you don't want to make changes, you don't need to do a thing; your current coverage will continue automatically at the rates listed on page 5, 11 or 16 (as applicable).**

Return completed enrollment forms to:

**Office of the State Comptroller
Retirement Health Insurance Unit
55 Elm Street
Hartford, CT 06106
or
Fax: 860-702-3556**

What to Do When You Become Eligible for Medicare

See Medicare and You on page 30 for important information about what to do when becoming eligible for Medicare.

Make Sure You Cover Only Eligible Dependents

It's important to understand who you can cover under the plan. It's critical that the State only provide coverage for eligible dependents. **If you obtain coverage for a person who is not eligible, you will have to pay federal and State tax on the fair market value of benefits provided to that individual.**

Eligible dependents generally include: your legally married spouse or civil union partner and eligible children until age 26 for medical and age 19 for dental. Your "children" include your natural children, stepchildren, and adopted children. Children residing with you for whom you are the legal guardian may be eligible for coverage up to age 18 unless proof of continued dependency is provided. Disabled children may be covered beyond age 26 for medical or age 19 for dental. For your disabled child to remain an eligible dependent, they must be certified as disabled by your **medical** insurance carrier before their 19th birthday for dental benefits or their 26th birthday for medical benefits.

Once a judgment of divorce or legal separation is entered, your former spouse must be removed from the plan.

It is your responsibility to notify the Retirement Health Insurance Unit within 31 days when any dependent is no longer eligible for coverage.

Please refer to the Comptroller's website at www.osc.ct.gov for details about dependent eligibility.



This planner provides a brief summary of covered services. See Your Benefit Resources on page 33 to receive more detailed information.



Qualifying Status Change

Once you choose your medical and dental plans, you cannot make changes during the plan year (July 1 – June 30) unless you experience a qualifying status change. If you do have a qualifying status change, you must notify the Retirement Health Insurance Unit **within 31 days of the event**. The change you make must be consistent with your change in status.

Please call the Retirement Health Insurance Unit if you experience a qualifying status change – which include changes in:

- **Legal marital/civil union status** – Any event that changes your legal marital/civil union status, including marriage, civil union, divorce, death of a spouse and legal separation.
- **Number of dependents** – Any event that changes your number of dependents, including birth, death, adoption and legal guardianship.

- **Employment status** – Any event that changes your or your dependent's employment status, resulting in gaining or losing eligibility for coverage such as:
 - Beginning or ending employment
 - Starting or returning from an unpaid leave of absence
 - Changing from part time to full time or vice versa.
- **Dependent status** – Any event that causes your dependent to become eligible or ineligible for coverage.
- **Residence** – A significant change in your place of residence that affects your ability to access network providers.

If you experience a change in your life that affects your benefits, contact the Retirement Health Insurance Unit at (860) 702-3533. They'll explain which changes you can make and let you know if you need to send in any paperwork (for example, a copy of your marriage certificate).



Your Medical Plans at a Glance

BENEFIT FEATURES	BOTH CARRIERS	BOTH CARRIERS
	POE, POE-G, POS AND OUT-OF-AREA IN NETWORK	POS OUT-OF-NETWORK
Outpatient Physician Visits, Walk-in Centers and Urgent Care Centers	\$5 co-pay	80% ¹
Preventive Care	No copayment for preventive care visits and immunizations	80% ¹
Emergency Care	100%	100%
Diagnostic X-Ray and Lab	100%	80% ¹
Pre-Admission Testing	100%	80% ¹
Inpatient Physician	100% (prior authorization required)	80% ¹ (prior authorization required)
Inpatient Hospital	100% (prior authorization required)	80% ¹ (prior authorization required)
Outpatient Surgical Facility	100% (prior authorization required)	80% ¹ (prior authorization required)
Ambulance	100% (if emergency)	100% (if emergency)
Short-Term Rehabilitation and Physical Therapy	100%	80%, ¹ up to 60 inpatient days, 30 outpatient days per condition per year
Routine Eye Exam	\$15 co-pay, 1 exam per year	50%, 1 exam per year
Audiological Screening	\$15 co-pay, 1 exam per year	80%, ¹ 1 exam per year
Mental Health/Substance Abuse	Prior authorization required	Prior authorization required
Inpatient	100%	80% ¹
Outpatient ²	\$5 co-pay	80% ¹
Durable Medical Equipment ²	100%	80% ¹
Prosthetics ²	100%	80% ¹
Skilled Nursing Facility	100% (prior authorization required)	80%, ¹ up to 60 days/year (prior authorization required)
Home Health Care ²	100%	80%, ¹ up to 200 visits/year
Hospice	100% (prior authorization required)	80%, ¹ up to 60 days (prior authorization required)
Annual Deductible		
Each Individual	None	\$300
Family (3 or more)	None	\$900
Annual Out-of-Pocket Maximums		
Each Individual	None	\$2,000 (plus deductible)
Family	None	\$4,000 (plus deductible)
Lifetime Maximum	None	None
Pre-admission Authorization/ Concurrent Review	Through participating provider	Penalty of 20% up to \$500 for no authorization

¹ You pay 20% of the allowable charge plus 100% of any amount your provider bills over the allowable charge.

² Prior authorization may be required.

Your 2014-2015 Medical Premium Share

There are no monthly medical premium retiree shares for your medical and prescription benefits. See page 27 for dental premiums.

Your Prescription Drug Coverage at a Glance

Medicare-eligible retirees and/or dependents are automatically enrolled in a Group Medicare Part D Plan administered by SilverScript, a subsidiary of CVS/Caremark. The State of Connecticut pharmacy plan wraps around the Part D plan so you have the same level of benefits that you are used to.

If you are NOT Medicare eligible, your prescription benefits are administered by CVS/Caremark until you become Medicare eligible.

Depending on your Medicare eligibility, your prescription drug coverage is either through Caremark or SilverScript. Prescription benefits are the same no matter which medical plan you choose. The amount you pay depends on whether your prescription is for a generic drug or a brand-name drug and where you purchase your prescriptions:

NON-MEDICARE ELIGIBLE

CVS/Caremark	In-Network		Out-of-Network
	Acute Drugs	Maintenance Drugs*	
Generic	\$3	\$0	20% of prescription cost
Preferred Brand	\$6	\$0	20% of prescription cost
Non-Preferred Brand	\$6	\$0	20% of prescription cost

* You are required to fill your maintenance drugs using the maintenance drug network or CVS Mail Order. You must obtain a 90-day supply of maintenance medication, however, you have a \$0 co-pay for maintenance drugs.

MEDICARE-ELIGIBLE

Silverscript	In-Network		Out-of-Network
	Acute and Maintenance Drugs	Silverscript Mail Order/ Maintenance Drug Network	
Generic	\$3	\$0	20% of prescription cost
Preferred Brand	\$6	\$0	20% of prescription cost
Non-Preferred Brand	\$6	\$0	20% of prescription cost

When You Become Eligible for Medicare
See Medicare and You on page 30 for more details.

90-day Supply of Maintenance Medications at NO COST to You

A maintenance medication is one you take for an ongoing or chronic condition. If you or a family member takes a maintenance medication, you can get 90-day fills – **and pay no cost!** In order to receive the \$0 copay, your maintenance prescriptions must be filled in one of two ways:

- Receive your medication through the Caremark or SilverScript mail-order pharmacy, or
- Fill your medication at a pharmacy that participates in the State’s Maintenance Drug Network (see the list of participating pharmacies on the Comptroller’s website at www.osc.ct.gov).

A list of maintenance medications is posted at www.osc.ct.gov.

If You Choose a Brand Name When a Generic Is Available

Prescriptions will be automatically filled with a generic drug if one is available, unless your doctor completes Caremark's Coverage Exception Request form and it is approved. (It is not enough for your doctor to note "dispense as written" on your prescription; a separate form is required.) If you request a brand-name drug over a generic alternative without obtaining a coverage exception, you will pay the generic drug co-pay PLUS the difference in cost between the brand and generic drug. The Coverage Exception Request form is available at www.osc.ct.gov.

If you have questions about your prescription drug benefits, contact Caremark at 1-800-318-2572 or SilverScript at 1-866-693-4624.

CVS Caremark Specialty Pharmacy

Certain chronic and/or genetic conditions require special pharmacy products (often injected or infused). The specialty pharmacy program provides these prescriptions along with the supplies, equipment and care coordination needed. Call 1-800-237-2767 for information.

Your Prescription Drug
Coverage at a Glance
(continued)



Your Medical Plans at a Glance

BENEFIT FEATURES	BOTH CARRIERS	
	POE, POE-G, POS AND OUT-OF-AREA IN NETWORK	POS OUT-OF-NETWORK
Outpatient Physician Visits, Walk-in Centers and Urgent Care Centers	\$15 co-pay (\$5 if retired before July 1, 1999)	80% ¹
Preventive Care	No copayment for preventive care visits and immunizations	80% ¹
Emergency Care	100%	100%
Diagnostic X-Ray and Lab	100%	80% ¹
Pre-Admission Testing	100%	80% ¹
Inpatient Physician	100% (prior authorization required)	80% ¹ (prior authorization required)
Inpatient Hospital	100% (prior authorization required)	80% ¹ (prior authorization required)
Outpatient Surgical Facility	100% (prior authorization required)	80% ¹ (prior authorization required)
Ambulance	100% (if emergency)	100% (if emergency)
Short-Term Rehabilitation and Physical Therapy	100%	80%, ¹ up to 60 inpatient days, 30 outpatient days per condition per year
Routine Eye Exam	\$15 co-pay, 1 exam per year	50%, 1 exam per year
Audiological Screening	\$15 co-pay, 1 exam per year	80%, ¹ 1 exam per year
Mental Health/Substance Abuse	Prior authorization required	Prior authorization required
Inpatient	100%	80% ¹
Outpatient ²	\$15 co-pay (\$5 if retired before July 1, 1999)	80% ¹
Durable Medical Equipment ²	100%	80% ¹
Prosthetics ²	100%	80% ¹
Skilled Nursing Facility	100% (prior authorization required)	80%, ¹ up to 60 days/year (prior authorization required)
Home Health Care ²	100%	80%, ¹ up to 200 visits/year
Hospice	100% (prior authorization required)	80%, ¹ up to 60 days (prior authorization required)
Annual Deductible		
Each Individual	None	\$300
Family (3 or more)	None	\$900
Annual Out-of-Pocket Maximums		
Each Individual	None	\$2,000 (plus deductible)
Family	None	\$4,000 (plus deductible)
Lifetime Maximum	None	None
Pre-admission Authorization/ Concurrent Review	Through participating provider	Penalty of 20% up to \$500 for no authorization

¹ You pay 20% of the allowable charge plus 100% of any amount your provider bills over the allowable charge.

² Prior authorization may be required.

Your Prescription Drug Coverage at a Glance

Depending on your Medicare eligibility, your prescription drug coverage is either through Caremark or SilverScript. Prescription benefits are the same no matter which medical plan you choose. The amount you pay depends on whether your prescription is for a generic drug or a brand-name drug and where you purchase your prescriptions:

NON-MEDICARE ELIGIBLE

CVS/Caremark	In-Network		Out-of-Network
	Acute Drugs	Maintenance Drugs*	
Generic	\$3	\$0	20% of prescription cost
Preferred Brand	\$6	\$0	20% of prescription cost
Non-Preferred Brand	\$6	\$0	20% of prescription cost

* You are required to fill your maintenance drugs using the maintenance drug network or CVS Mail Order. You must obtain a 90-day supply of maintenance medication, however, you have a \$0 co-pay for maintenance drugs.

MEDICARE-ELIGIBLE

SilverScript	In-Network		Out-of-Network
	Acute and Maintenance Drugs	SilverScript Mail Order/ Maintenance Drug Network	
Generic	\$3	\$0	20% of prescription cost
Preferred Brand	\$6	\$0	20% of prescription cost
Non-Preferred Brand	\$6	\$0	20% of prescription cost

Medicare-eligible retirees and/or dependents are automatically enrolled in a Group Medicare Part D Plan administered by SilverScript, a subsidiary of CVS/Caremark. The State of Connecticut pharmacy plan wraps around the Part D plan so you have the same level of benefits that you are used to.

If you are NOT Medicare eligible, your prescription benefits are administered by CVS/Caremark until you become Medicare eligible.

90-day Supply of Maintenance Medications at NO COST to You

A maintenance medication is one you take for an ongoing or chronic condition. If you or a family member takes a maintenance medication, you can get 90-day fills – **and pay no cost!** Maintenance prescriptions can be filled in two ways:

- Receive your medication through the Caremark or SilverScript mail-order pharmacy, or
- Fill your medication at a pharmacy that participates in the State’s Maintenance Drug Network (see the list of participating pharmacies on the Comptroller’s website at www.osc.ct.gov).

A list of maintenance medications is posted at www.osc.ct.gov.

When You Become Eligible for Medicare
See Medicare and You on page 30 for more details.

Your Prescription Drug
Coverage at a Glance
(continued)

If You Choose a Brand Name When a Generic Is Available

Prescriptions will be automatically filled with a generic drug if one is available, unless your doctor completes Caremark's Coverage Exception Request form and it is approved. (It is not enough for your doctor to note "dispense as written" on your prescription; a separate form is required.) If you request a brand-name drug over a generic alternative without obtaining a coverage exception, you will pay the generic drug co-pay PLUS the difference in cost between the brand and generic drug. The Coverage Exception Request form is available at www.osc.ct.gov.

If you have questions about your prescription drug benefits, contact Caremark at 1-800-318-2572 or SilverScript at 1-866-693-4624.

CVS Caremark Specialty Pharmacy

Certain chronic and/or genetic conditions require special pharmacy products (often injected or infused). The specialty pharmacy program provides these prescriptions along with the supplies, equipment and care coordination needed. Call 800-237-2767 for information.



Your 2014-2015 Medical Premium Share

Monthly Medical Premiums July 1, 2014 through June 30, 2015

Medical plan options with no retiree premium share:

Point of Enrollment – Gatekeeper Plans

Anthem State BlueCare POE Plus
UnitedHealthcare Oxford HMO

Point of Enrollment Plans

Anthem State BlueCare POE
UnitedHealthcare Oxford HMO Select

Out-of-Area Plans

UnitedHealthcare Oxford USA Out of Area plan
Anthem Out-of-Area plan

Point of Service (POS) Plans for 7/1/97 – 6/1/99 Retirees

Anthem State BlueCare POS
Anthem State Preferred POS
UnitedHealthcare Oxford Freedom Select POS

COVERAGE LEVEL	ANTHEM STATE BLUECARE POS	ANTHEM STATE PREFERRED POS Closed to New Enrollment		UNITEDHEALTHCARE OXFORD FREEDOM SELECT POS
	Retirement Date 7/1/99 - 5/1/09	Non-ERIP Retirement Date 7/97 - 6/99	Retirement Date 7/1/99 - 5/1/09	Retirement Date 7/1/99 - 5/1/09
1 Person on Medicare	\$0.00	\$0.00	\$0.00	\$0.00
1 Person not on Medicare	\$12.61	\$0.00	\$12.82	\$13.00
1 Person not on Medicare and 1 on Medicare	\$12.61	\$0.00	\$12.82	\$13.00
1 not on Medicare and 2 on Medicare	\$12.61	\$0.00	\$12.82	\$13.00
2 on Medicare	\$0.00	\$0.00	\$0.00	\$0.00
2 not on Medicare	\$27.74	\$0.00	\$28.21	\$28.60
2 not on Medicare and 1 on Medicare	\$27.74	\$0.00	\$28.21	\$28.60
3 or more on Medicare	\$0.00	\$0.00	\$0.00	\$0.00
3 or more not on Medicare	\$34.04	\$0.00	\$34.62	\$35.10
3 or more not on Medicare and 1 on Medicare	\$34.04	\$0.00	\$34.62	\$35.10

See page 27 for dental premiums.

Your Medical Plans at a Glance

BENEFIT FEATURES	BOTH CARRIERS	
	POE, POE-G, POS AND OUT-OF-AREA IN NETWORK	POS OUT-OF-NETWORK
Outpatient Physician Visits, Walk-in Centers and Urgent Care Centers	\$15 co-pay	80% ¹
Preventive Care	No copayment for preventive care visits and immunizations	80% ¹
Emergency Care	100%	100%
Diagnostic X-Ray and Lab	100%	80% ¹
Pre-Admission Testing	100%	80% ¹
Inpatient Physician	100% (prior authorization required)	80% ¹ (prior authorization required)
Inpatient Hospital	100% (prior authorization required)	80% ¹ (prior authorization required)
Outpatient Surgical Facility	100% (prior authorization required)	80% ¹ (prior authorization required)
Ambulance	100% (if emergency)	100% (if emergency)
Short-Term Rehabilitation and Physical Therapy	100%	80%, ¹ up to 60 inpatient days, 30 outpatient days per condition per year
Routine Eye Exam	\$15 co-pay, 1 exam per year	50%, 1 exam per year
Audiological Screening	\$15 co-pay, 1 exam per year	80%, ¹ 1 exam per year
Mental Health/Substance Abuse	Prior authorization required	Prior authorization required
Inpatient	100%	80% ¹
Outpatient ²	\$15 co-pay	80% ¹
Durable Medical Equipment ²	100%	80% ¹
Prosthetics ²	100%	80% ¹
Skilled Nursing Facility	100% (prior authorization required)	80%, ¹ up to 60 days/year (prior authorization required)
Home Health Care ²	100%	80%, ¹ up to 200 visits/year
Hospice	100% (prior authorization required)	80%, ¹ up to 60 days (prior authorization required)
Annual Deductible		
Each Individual	None	\$300
Family (3 or more)	None	\$900
Annual Out-of-Pocket Maximums		
Each Individual	None	\$2,000 (plus deductible)
Family	None	\$4,000 (plus deductible)
Lifetime Maximum	None	None
Pre-admission Authorization/ Concurrent Review	Through participating provider	Penalty of 20% up to \$500 for no authorization

¹ You pay 20% of the allowable charge plus 100% of any amount your provider bills over the allowable charge.

² Prior authorization may be required.

Your Prescription Drug Coverage at a Glance

Depending on your Medicare eligibility, your prescription drug coverage is either through Caremark or SilverScript. Prescription benefits are the same no matter which medical plan you choose.

The plan has a 3-tier co-pay structure which means the amount you pay depends on whether your prescription is for a generic drug, a brand-name drug listed on Caremark's preferred drug list (the formulary), or a non-preferred brand-name drug.

NON-MEDICARE ELIGIBLE

CVS/Caremark	In-Network		Out-of-Network
	Acute Drugs	Maintenance Drugs*	
Generic	\$5	\$0	20% of prescription cost
Preferred Brand	\$10	\$0	20% of prescription cost
Non-Preferred Brand	\$25	\$0	20% of prescription cost

* You are required to fill your maintenance drugs using the maintenance drug network or CVS Mail Order. You must obtain a 90-day supply of maintenance medication, however, you have a \$0 co-pay for maintenance drugs.

MEDICARE-ELIGIBLE

SilverScript	In-Network		Out-of-Network
	Acute and Maintenance Drugs	SilverScript Mail Order/ Maintenance Drug Network	
Generic	\$5	\$0	20% of prescription cost
Preferred Brand	\$10	\$0	20% of prescription cost
Non-Preferred Brand	\$25	\$0	20% of prescription cost

To check which co-pay amount applies to your prescriptions, visit www.Caremark.com for the most up-to-date information. Once you register, click on "Look up Co-pay and Formulary Status." Simply type the name of the drug you want to look up and you will see the cost and co-pay amounts for that drug as well as alternatives.

Preferred and Non-Preferred Brand-Name Drugs

A drug's tier placement is determined by Caremark. Caremark's Pharmacy and Therapeutics Committee reviews tier placement each quarter. If new generics have become available, new clinical studies have been released, new brand-name drugs have become available, etc., the Pharmacy and Therapeutics Committee may change the tier placement of a drug.

If your doctor believes a non-preferred brand-name drug is medically necessary for you, they will need to complete the Coverage Exception Request form (available at www.osc.ct.gov) and fax it to Caremark. If approved, you will pay the preferred brand co-pay amount.

Medicare-eligible retirees and/or dependents are automatically enrolled in a Group Medicare Part D Plan administered by SilverScript, a subsidiary of CVS/Caremark. The State of Connecticut pharmacy plan wraps around the Part D plan so you have the same level of benefits that you are used to.

If you are NOT Medicare eligible, your prescription benefits are administered by CVS/Caremark until you become Medicare eligible.

When You Become Eligible for Medicare

See Medicare and You on page 30 for more details.

Your Prescription Drug
Coverage at a Glance
(continued)

90-day Supply of Maintenance Medications at NO COST to You

A maintenance medication is one you take for an ongoing or chronic condition. If you or a family member takes a maintenance medication, you can get 90-day fills – **and pay no cost!** Maintenance prescriptions can be filled in two ways:

- Receive your medication through the Caremark or SilverScript mail-order pharmacy, or
- Fill your medication at a pharmacy that participates in the State's Maintenance Drug Network (see the list of participating pharmacies on the Comptroller's website at www.osc.ct.gov).

A list of maintenance medications is posted at www.osc.ct.gov.

If You Choose a Brand Name When a Generic Is Available

Prescriptions will be automatically filled with a generic drug if one is available, unless your doctor completes Caremark's Coverage Exception Request form and it is approved. (It is not enough for your doctor to note "dispense as written" on your prescription; a separate form is required.) As noted on previous page, if you request a brand-name drug over a generic alternative without obtaining a coverage exception, you will pay the generic drug co-pay PLUS the difference in cost between the brand and generic drug.

If you have questions about your prescription drug benefits, contact Caremark at 1-800-318-2572 or SilverScript at 1-866-693-4624.

CVS Caremark Specialty Pharmacy

Certain chronic and/or genetic conditions require special pharmacy products (often injected or infused). The specialty pharmacy program provides these prescriptions along with the supplies, equipment and care coordination needed. Call 1-800-237-2767 for information.



Your 2014-2015 Medical Premium Share

Monthly Medical Premiums July 1, 2014 through June 30, 2015

Medical plan options with no retiree premium share:

Point of Enrollment – Gatekeeper Plans

Anthem State BlueCare POE Plus
UnitedHealthcare Oxford HMO

Point of Enrollment Plans

Anthem State BlueCare POE
UnitedHealthcare Oxford HMO Select

Out-of-Area Plans

UnitedHealthcare Oxford USA Out of Area plan
Anthem Out-of-Area plan

COVERAGE LEVEL	ANTHEM STATE BLUECARE POS	UNITEDHEALTHCARE OXFORD FREEDOM SELECT POS	ANTHEM PREFERRED Closed to New Enrollment
1 Person on Medicare	\$0.00	\$0.00	\$0.00
1 Person not on Medicare	\$12.61	\$13.00	\$12.82
1 Person not on Medicare and 1 on Medicare	\$12.61	\$13.00	\$12.82
1 not on Medicare and 2 on Medicare	\$12.61	\$13.00	\$12.82
2 on Medicare	\$0.00	\$0.00	\$0.00
2 not on Medicare	\$27.74	\$28.60	\$28.21
2 not on Medicare and 1 on Medicare	\$27.74	\$28.60	\$28.21
3 or more on Medicare	\$0.00	\$0.00	\$0.00
3 or more not on Medicare	\$34.04	\$35.10	\$34.62
3 or more not on Medicare and 1 on Medicare	\$34.04	\$35.10	\$34.62

See page 27 for dental premiums.

Frequently Asked Questions

1. *Where can I get more details about what the State health insurance plan covers?*

All medical plans offered by the State of Connecticut cover the same services and supplies. For more detailed benefit descriptions and information about how to access the plan's services, contact the insurance carriers at the phone numbers or websites listed on page 33.

2. *If I live outside Connecticut, do I need to choose an Out-of-Area Plan?*

If you live permanently outside of Connecticut, we will automatically place you in an Out of Area plan, giving you access to a national network of providers whether you are enrolled with Anthem or UnitedHealthcare Oxford. There are no retiree premium shares for enrollment in an Out-of-Area plan.

3. *What's the difference between a service area and a provider network?*

A service area is the region in which you need to live in order to enroll in a particular plan. A provider network is a list of doctors, hospitals and other providers. In a POE plan, you may use only network providers. In a POS plan, you may use providers both in- and out-of-network, but you pay less when you use providers in the network.

4. *What are my options if I want access to doctors across the U.S.?*

Both State of Connecticut insurance carriers offer extensive regional networks as well as access to network providers nationwide. If you live outside the plans' regional service areas, you may choose one of the Out-of-Area plans – both have national networks.



5. *How do I find out which networks my doctor is in?*

Contact each insurance carrier to find out if your doctor is in the network that applies to the plan you're considering. You can search online at the carrier's website (be sure to select the right network; they vary by plan option), or you can call customer service at the numbers on page 33. It's likely your doctor is covered by more than one network.

6. *Can I enroll myself in one option and my family member in another?*

No. You and the family members you enroll must all have the same medical option and/or the same dental option. However, you can enroll certain family members in medical and different family members in dental coverage. For example, you can enroll yourself and your child for medical but yourself only for dental. To enroll an eligible family member in a plan, you must enroll as well. It is also important to note that you may not double cover yourself under another State of Connecticut retiree's health benefits.

7. *Can I enroll later or switch plans mid-year?*

Generally, the elections you make now are in effect July 1 – June 30. If you have a qualifying status change, you may be able to modify your elections mid-year (see page 4). If you decline coverage now, you may enroll during any later open enrollment or if you experience certain qualifying status changes.





Making Your Decision – Medical

GROUP 1:

If your **retirement date is before July 1997**, see pages 5-7 for information that applies specifically to you.

GROUP 2:

If your **retirement date is between July 1, 1997 and May 1, 2009 (or you retired under the 2009 Retirement Incentive Program)**, see pages 8-11 for information that applies specifically to you.

GROUP 3:

If your **retirement date is between June 1, 2009 and October 1, 2011**, see pages 12-15 for information that applies specifically to you.

Each of the medical plans offered by the State of Connecticut is designed to cover the same medical benefits – the same services and supplies. And, the amount you pay out of pocket at the time you receive services is very similar. Yet, your premium share varies quite a bit from plan to plan. How do you decide?

When it comes to choosing a medical plan, there are four main areas to look at:

1. **What is covered** – the services and supplies that are covered benefits under the plan. This comparison is easy to make at the State of Connecticut because all of the plans cover the same services and supplies. (See sidebar at left for pages specific to your retirement date.)
2. **Cost** – what you pay when you receive medical care and what is deducted from your pension check. What you pay at the time you receive services is similar across the plans. However, your premium share varies quite a bit depending on the carrier and plan selected. (see sidebar at left for pages specific to your retirement date).
3. **Networks** – whether your doctor or hospital has contracted with the insurance carrier. (See pages 19 and 20.)
4. **Plan features** – how you access care and what kinds of “extras” the insurance carrier offers. Under some plans you must use network providers except in emergencies, others give you access to out-of-network providers. Finally, you may prefer one insurance carrier over the other (see pages 19 – 25).

The following pages are designed to help you compare your options.

Comparing Networks

When Was the Last Time You Compared Your Medical Plan to the Other Options?

If you're like many people, you made a choice when you first retired and haven't really looked at it since. The State of Connecticut offers a wide variety of medical plans, so you can find the one that best fits your needs. Did you know that you might be able to take advantage of one of the lower-cost plans while keeping your doctor and receiving the same healthcare services?

Many doctors belong to multiple provider networks. Check to see if your doctor is a network provider under more than one of the plan options. Then, take a fresh look at your options. You may be able to save money every month without changing doctors.

Why Networks Matter

All of the plans cover the same health care services and supplies. The provider networks are one of the main ways in which your medical plan options differ. Each insurance carrier contracts with a group of doctors and hospitals for discounted rates on health care services. Getting your care within the network provides the highest benefit level:

- If you choose a **Point of Enrollment (POE)** plan, you must use network providers for your care (except in emergencies).
- If you choose a **Point of Service (POS)** plan or one of the Out of Area plans, you have the choice to use in-network or out-of-network providers each time you receive care – but, you'll pay more for out-of-network services.

Is a National Network Important to You?

All State of Connecticut plans have a national provider network. That means they contract with doctors and hospitals across the country – and you have nationwide access to the highest level of benefits.

- Planning to live or travel out of the region?
- Have a college student attending school hours away from home?
- Wish to get care at a specialty hospital that's not in Connecticut or the coverage region?

The State of Connecticut offers affordable options with great coverage within the region and nationwide. Take a look at your options before you decide.



How the Plans Work

Point of Service (POS) Plans – These plans offer health care services both within and outside a defined network of providers. No referrals are necessary to receive care from in-network providers. Health care services obtained outside the network may require prior authorization and are reimbursed at 80% of the allowable cost (after you pay the annual deductible).

Point of Enrollment (POE) Plans – These plans offer health care services only from a defined network of providers. (Out-of-network care is covered in emergencies.) No referrals are necessary to receive care from in-network providers. Health care services obtained outside the network may not be covered.

Point of Enrollment – Gatekeeper (POE-G) Plans – These plans offer health care services only from a defined network of providers. (Out-of-network care is covered in emergencies.) You must select a Primary Care Physician (PCP) to coordinate all care and referrals are required for all specialist services.

The Point of Enrollment - Gatekeeper (POE-G) plans generally require the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider. Until you make this designation, the medical insurance carrier designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the medical insurance carrier (see Your Benefit Resources on page 33).

You do not need prior authorization from the medical insurance carrier or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the network who specializes in obstetrics or gynecology. The health care professional, however, may be required to

comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the medical insurance carrier (see Your Benefit Resources on page 33).

Using Out-of-Network Providers

When you enroll in one of the State of Connecticut POS plans, you can choose a network or out-of-network provider each time you receive care. When you use an out-of-network provider, you'll pay more – for most services, the plan pays 80% of the allowable charge after you pay your annual deductible. Plus, you pay 100% of the amount your provider bills above the allowable charge.

In the POS plans there are no referral or prior authorization requirements to use out-of-network providers – you are free to use the network or out-of-network provider of your choice. However, since certain procedures require prior authorization (see pages 5, 8 or 12 as applicable), call your plan when you anticipate significant out-of-network expenses to find out how those charges will be covered. You'll avoid an unpleasant surprise and have the information you need to make an informed decision about where to seek health care.

Where You Live or Work Affects Your Choices

You must live or work within a plan's regional service area to enroll in that plan – even though the plan has a national network. For example, if you want to enroll in the UnitedHealthcare Oxford Freedom Select Plan (POS), you must live or work within the geographic area covered by Oxford's regional provider network. If you live and work outside that area, you should choose one of the Out-of-Area plans. Both Out-of-Area plans give you access to a national provider network.

Comparing Plan Features

All State of Connecticut plans cover the same health care services and supplies. However, they differ in these ways:

- **How you access services** – Some plans allow you to see only network providers (except in the case of emergency), some give you access to out-of-network providers when you pay more of the fees, some require you to select a PCP.
- **Health promotion** – Remember, there's more to a health plan than covering doctor visits. All of the plans offer health information online; some offer additional services such as 24-hour nurse advice lines and health risk assessment tools.
- **Provider networks** – You'll want to check with each plan to see if the doctors and hospitals you want are in each network. (See Your Benefit Resources on page 33 for phone numbers and websites.)

About Value-Added Programs

Another area where the insurance carriers may differ is the value-added programs they offer. These programs are outside the contracted plan benefits – they're "extras" that each company offers in hopes of making their plan stand out, such as:

- Wellness programs
- Member discounts (for example, on weight-loss programs or health clubs)
- Online health promotion programs

Because these value-added programs are not plan benefits, they are subject to change at any time by the insurance carrier. However, you may want to see what each company offers before you decide.

	POINT OF ENROLLMENT – GATEKEEPER (POE-G) PLANS		POINT OF ENROLLMENT (POE) PLANS		POINT OF SERVICE (POS) PLANS			OUT OF AREA PLANS	
	Anthem State BlueCare POE Plus	UnitedHealthcare Oxford HMO	Anthem State BlueCare	UnitedHealthcare Oxford HMO Select	Anthem State BlueCare	Anthem State Preferred POS*	UnitedHealthcare Oxford Freedom Select	Anthem OOA	UnitedHealthcare Oxford USA
National network	X	X	X	X	X	X	X	X	X
Regional network	X	X	X	X	X	X	X	X	X
In- and out-of-network coverage available					X	X	X	X	X
In-network coverage only (except in emergencies)	X	X	X	X					
No referrals required for care from in-network providers			X	X	X	X	X	X	X
Primary care physician (PCP) coordinates all care	X	X							

* Closed to new enrollment.



Comparing Plans: A Message From Anthem

A Healthy You Starts Here

Get on the road to good health with our large network of doctors, easy-to-use wellness tools and programs, and top-notch customer service.

Value-added programs such as wellness programs and discounts offered by the plan are not negotiated benefits and are subject to change at any time at the discretion of the plan.

Exceptional Customer Service

We've been in Connecticut for more than 75 years, and we've been serving State of Connecticut employees and retirees for more than 50 of those years. This means we know your needs, and we're ready and able to help. Get answers and information through our:

- **State-dedicated Member Services Unit at 800-922-2232** — Talk with a customer service expert who is located right here in the State and is dedicated solely to State employees and retirees.
- **State-dedicated website at anthem.com/statect** — Find information geared specifically to you and other State employees and retirees.

24/7 NurseLine

You can call the toll-free number — 800-711-5947 — to talk with a nurse about your general health questions any time of the day or night. Whether it's a question about allergies, fever, types of preventive care or any other topic, nurses are always there to provide support and peace of mind. Our nurses can help you choose the right place for care if your doctor isn't available and you aren't sure what to do.

You can also listen to recorded messages on hundreds of health topics. Just call the 24/7 NurseLine number and choose the AudioHealth Library option.



Easy-to-Use Wellness Tools and Programs

Lose weight. Join a gym. Reduce stress. When it comes to our health, we all have different goals. That's why we have a full range of wellness programs, online tools and resources designed to meet your unique needs.

Anthem's Health and Wellness programs

From finding an answer to a common health question to getting one-on-one support for a chronic health condition, you can get the help you need through our Anthem Health and Wellness programs. Here's a sampling of what's available to you by accessing the State dedicated website at anthem.com/statect:

- **ComplexCare** — If you're living with multiple medical conditions, you may need a little extra support. With this program, personal nurse coaches help you create personalized goals and stay on track with your doctor's treatment plans. They can also pinpoint and refer you to other Anthem Health and Wellness programs.

SpecialOffers@Anthem

As a State employee or retiree, you can get discounts on products that encourage a healthy lifestyle. You'll get "healthy" discounts on things like:

- Weight loss programs through Weight Watchers®, Jenny Craig® and more
- Fitness club memberships, equipment and coaching
- Hearing aids
- Allergy products
- Acupuncture
- Massage therapy
- Baby safety gear
- Senior care

SpecialOffers@Anthem is a service mark of Anthem Insurance Companies, Inc. Vendors and offers are subject to change without notice. Anthem does not endorse and is not responsible for the products, services or information provided by the SpecialOffers@Anthem vendors. Arrangements and discounts were negotiated between each vendor and Anthem for the benefit of our members. All other marks are the property of their respective owners. All of the offers in the SpecialOffers@Anthem program are continually being evaluated and expanded so the offerings may change. Any additions or changes will be communicated on our website, anthem.com. These arrangements have been made to add value for our members. Value-added products and services are not covered by your health plan benefit. Available discount percentages may change or be discontinued from time to time without notice. Discount is applicable to the items referenced.

** Weight Watchers International, Inc., an independent company and owner of the WEIGHT WATCHERS trademark. All rights reserved.*

Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans, Inc. Independent licensee of the Blue Cross and Blue Shield Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

Get the Most From Your Health Plan

Your health plan should do more than just help you when you're sick. It should help you be your healthiest. That's why Anthem offers things like vision discounts and large nationwide networks. So you can get more health from your health care.

Vision

The Anthem plans for the State of Connecticut include vision coverage and discounts:

Eye Exams

Your State of Connecticut health benefits cover you for an annual routine eye exam. No matter which plan you have, you do not need a referral.

- **1-800 CONTACTS** — Get contact lenses quick and easy — plus discounts like \$20 off when you spend \$100 or more, and free shipping.
- **Glasses.com** — Try on any five of the 1,500 designer frames — at home, for free — before you buy. It's convenient, plus you get savings like \$20 off when you spend \$100 or more, and free shipping and free returns.
- **Premier LASIK** — Save 15% on LASIK with all their in-network providers and prices as low as \$695 per eye with select providers.

Network access

Anthem provides expansive coverage nationally and around the world. Through the BlueCard® program, you can use the networks of other Blue Cross and Blue Shield plans, so you can get the care you need — just about anywhere you travel. We can help you find the right care locations outside of Connecticut by calling 800-810-BLUE.

Have a question?

Call our State-dedicated Member Services Unit at 800-922-2232.

We're ready to help you. You'll also find good information at anthem.com/statect.

Comparing Plans: A Message From UnitedHealthcare



Value-added programs such as wellness programs and discounts offered by the plan are not negotiated benefits and are subject to change at any time at the discretion of the plan.

Now is the Time to Live Well.

Top Reasons UnitedHealthcare is the right decision for you and your family:

Trust

You should trust that you are making a great decision choosing UnitedHealthcare. You need to choose someone you can depend on and with an Oxford Health Plan from UnitedHealthcare you come first. We are committed to helping people live healthier lives.

We Care

UnitedHealthcare Children's Foundation (UHCCF) is a non-profit charity dedicated to enhancing the quality of children's lives. UHCCF was founded in 1999. Since 2007, UHCCF has awarded more than 6,500 grants valued at over \$20M to children and their families across the United States.

Tools and Resources

Everything you need at your fingertips, 24/7. Search for a doctor, view your claims, online health coaching and much more.

Our Network

All medical plans offer access to our local and national network

UnitedHealthcare offers a robust local and national network. Nationally, and in the tri-state area, we have a vast number of physicians, healthcare professionals and hospitals. For years, our members have relied on access to our Connecticut, New York and New Jersey tri-state network. Whichever plan you choose, you'll also have seamless access to our UnitedHealthcare Choice Plus Network of physicians and healthcare professionals outside of the tri-state area. This gives State of Connecticut employees and retirees better access to quality care whether you are in Connecticut, traveling outside the tri-state area or living somewhere else in the country.

For more information about our network, or to search for physicians participating in our local or UnitedHealthcare Choice Plus national Network, please visit welcometouhc.com/stateofct.

UnitedHealth Premium® Program

UnitedHealthcare has long recognized the direct relationship between health care quality and successful outcomes.

The Premium program recognizes doctors who meet standards for quality and cost efficiency. The quality standards are based on evidence-based medicine and national industry guidelines. The cost efficiency standards are based on local market benchmarks for cost-efficient care.

Premium Designation Display

Doctors who have met the criteria for quality and/or cost efficiency could have one of these four UnitedHealth Premium designations. These are shown when searching for a provider online, and in provider directories:

- Quality & Cost Efficiency
- Cost Efficiency & Not Enough Data to Assess Quality
- Quality & Not Enough Data to Assess Cost
- Quality & Did Not Meet Cost Efficiency

Physician designations are subject to change. Members should always visit welcometouhc.com/stateofct and check their doctor's Premium designation before making an appointment.

Introducing UnitedHealth Premium Tier 1

UnitedHealth Premium Tier 1 helps people to quickly and easily find doctors who have been recognized for providing value.

UnitedHealth Premium Tier 1 physicians have received the Premium designation for:

- Quality & Cost Efficiency OR
- Cost Efficiency & Not Enough Data to Assess Quality

For more information about the Premium program, visit welcometouhc.com/stateofct

The choice is yours.

The UnitedHealth Premium program can help you find the care you want. The program evaluates doctors in 25 different medical specialties, using national standards for quality and local benchmarks for cost efficiency. You can use this information to help you choose the care that's right for you.

Oxford On-Call®

Healthcare Guidance 24 hours a day

We realize that questions about your health can come up at any time. That's why we offer you flexible choices in health care guidance through our *Oxford On-Call*® program. Speak with a registered nurse who can offer suggestions and guide you to the most appropriate source of care, 24 hours a day, seven days a week. That's the idea behind *Oxford On-Call*.

If you are a member and you need to reach Oxford-On-Call, please call 800-201-4911. Press option 4. Oxford On-Call can give you helpful information about many topics such as:

General Health Information

Call about illness, injury, chronic conditions, prevention, healthy living, and men's, women's and children's health.

Deciding Where to Go for Care

Oxford On-Call's nurses provide information that can help you choose care that is appropriate for your situation.

Choosing Self-Care Measures

Registered nurses provide practical self-care tips to help you manage your condition at home.

Guidance for Difficult Decisions

If you or a family member has a serious medical condition, *Oxford On-Call* nurses can be a great resource. The more you know, the better prepared you'll be.

Live Web Chat

Nurses are available to chat online about a variety of health topics, and to confidentially guide you to online resources.

For additional information regarding *Oxford On-Call*, please visit welcometouhc.com/stateofct.

Healthy Bonus® Member Discounts

We understand that rising health care costs nationwide affect our members. We strive to help you stretch your health care dollar by developing programs that aim to help you improve your health.

We recognize there are ways we can help members reduce out-of-pocket health care costs. We believe in the power of prevention: that by taking a little extra time to eat better, exercise and reduce stress, individuals can do a better job of staying on the path of wellness.

Our *Healthy Bonus* program offers access to discounts and special offers on products and services that can help you make the best kind of investment: a healthy lifestyle. Please visit welcometouhc.com/stateofct to obtain information on the discounts offered to you on things like fitness/fitness equipment, diabetes/disease management, keeping kids healthy and overall wellness.

UnitedHealth Allies

This health discount program helps you, and your family, save money on many health and wellness purchases not included in your standard health benefit plan. To begin enjoying these discounts, go to **unitedhealthallies.com** and sign up. You will need your Oxford ID number and UnitedHealth Allies card. If you do not have your UnitedHealth Allies card, call Customer Care at **800-860-8773**.

Your Dental Plans at a Glance

State of Connecticut Dental Plans Administered By Cigna

Effective July 1, 2014, Cigna will be the dental carrier for all State of Connecticut dental plans: Basic, Enhanced, and Dental HMO (DHMO). If you are currently in the Basic or Enhanced plan, here's what this means to you:

- Under the Basic and Enhanced plans, the State was able to modernize and improve some benefits. For example, under the Basic plan, sealants will now be covered for children up to age 16 (the applicable cost share will apply). Under the Enhanced plan, there will now be coverage for implants, up to \$500 per year. In addition, under both the Basic and Enhanced plans you will receive discounted rates for non-covered services when utilizing a network dental provider (unless this is prohibited by state law – see page 27 for details).
- How you utilize the networks will not change. Under the Basic plan you can continue to see any dentist with no additional charge. Under the Enhanced plan you will have lower costs if you use a Cigna Dental PPO network provider.
- You still have the option to choose the Basic plan, Enhanced plan, or Dental HMO plan.
If you decide NOT to make a dental plan change during Open Enrollment, your coverage will automatically default to the same plan type administered by Cigna.

If you are enrolled in the Basic or Enhanced plan, you will receive a new ID card from Cigna.

	BASIC PLAN (any dentist)	ENHANCED PLAN (network)	DHMO® PLAN (network only)
Annual Deductible	None	\$25 individual, \$75/family	None
Annual Maximum	None (\$500 per person for periodontics)	\$3,000 per person (excluding orthodontics)	None
Exams, Cleanings, and X-rays	Covered at 100%	Covered at 100% (network only)	Covered at 100%
Simple Restoration Fillings	Covered at 80%	Covered at 80%	Covered*
Oral Surgery	Covered at 67%	Covered at 80%	Covered*
Major Restoration Crowns	Covered at 67%	Covered at 67%	Covered*
Dentures, Fixed Bridges	Not covered**	Covered at 50%	Covered*
Implants	Not covered**	Covered at 50% (up to \$500)	Not covered
Orthodontia	Not covered	Plan pays \$1,500 per person per lifetime	Covered*

* Contact CIGNA at 1-800-244-6224 for patient co-pay amounts.

** While not covered, you will get the discounted rate on these services if you visit a network dentist, unless prohibited by state law (see page 27 for details).

Terms to Know

Basic Plan – This plan allows you to visit any dentist or dental specialist without a referral.

Enhanced Plan – This plan offers dental services both within and outside a defined network of dentists and dental specialists without a referral. **However, your out-of-pocket expenses may be higher if you see an out-of-network provider.**

DHMO Plan – This plan provides dental services only from a defined network of dentists. You must select a Primary Care Dentist (PCD) to coordinate all care and referrals are required for all specialist services.

More details about covered expenses are available by contacting Cigna at 1-800-244-6224 or www.Cigna.com/stateofct.

Dental coverage ends for dependent children at age 19 (unless disabled*).

* For your disabled child to remain an eligible dependent, they must be certified as disabled by your medical insurance carrier before their 19th birthday for dental benefits or their 26th birthday for medical benefits.

Your 2014-2015 Dental Premium Share

Monthly Dental Premiums July 1, 2014 through June 30, 2015

COVERAGE LEVEL	Basic Plan	Enhanced Plan	DHMO Plan
1 Person	\$28.93	\$22.89	\$28.46
2 Persons	\$57.87	\$45.78	\$62.60
3 or More Persons	\$57.87	\$45.78	\$76.83

Savings on Non-Covered Services

Many of the Basic and Enhanced plan Cigna PPO network dentists have agreed to offer their discounted fees to you and your covered dependents for non-covered services. These savings may also apply to services that would not be covered because you reached your annual benefit maximum or due to other plan limitations such as frequency, age, or missing tooth limitations.

- You can get savings on most services not covered under the dental PPO plans
- You must visit network dentists to receive the Cigna dental PPO discounts (savings will not apply with non-participating dentists)
- You must verify that a procedure is listed on the dentist's fee schedule before receiving treatment
- You are responsible for paying the negotiated fees directly to the dentist.

** Discounts on non-covered services may not be available in all states. Certain dentists may not offer discounts on non-covered services. Be sure to check with your dental care professional or contact Cigna customer service before receiving care to determine if these discounts will apply to you.*

Frequently Asked Questions

1. How do I know which dental plan is best for me?

This is a question only you can answer. Each plan offers different advantages. To help choose which plan might be best for you, compare the plan-to-plan features in the chart on page 26 and weigh your priorities.

2. How long can my children stay on the dental plan? Can they stay covered until their 26th birthday like with the medical plans?

The Affordable Care Act extended benefits for children until age 26 only under medical and prescription drug coverage, not dental. Dental coverage ends for dependent children at age 19 (unless they are disabled*).

** For your disabled child to remain an eligible dependent, they must be certified as disabled by your medical insurance carrier before their 19th birthday for dental benefits or their 26th birthday for medical benefits.*

3. Do any of the dental plans cover orthodontia for adults?

Yes, the Enhanced Plan and DHMO both cover orthodontia for adults up to certain limits. The Enhanced Plan pays \$1,500 per person (adult or child) per lifetime. The DHMO requires a copay. The Basic Plan does not cover orthodontia for adults or children.



Value-added programs such as wellness programs and discounts offered by the plan are not negotiated benefits and are subject to change at any time at the discretion of the plan.

A Message From Cigna

Cigna will now be the dental carrier for all State of Connecticut dental plans. As a State of Connecticut employee, you and your family have the opportunity to receive quality dental care through one of the following plans:

- **Basic Plan**
- **Enhanced Plan**
- **DHMO Plan**

Terms to Know

Basic Plan

This plan allows you to visit any dentist or dental specialist without a referral.

Enhanced Plan

This plan offers dental services both within and outside of a network of dentists and dental specialists without a referral. However, your out-of-pocket expenses may be higher if you see an out-of-network provider.

If you visit a dentist who is not part of the Cigna PPO Network, he or she is considered out-of network. The Enhanced Plan pays for covered dental services based on "MAC" or "Maximum Allowable Charge." The MAC is the amount your plan would pay had you visited an in-network dentist. When you visit an out-of-network dentist, you are responsible for any and all charges above the MAC; up to that dentist's usual charge for those services.

DHMO Plan

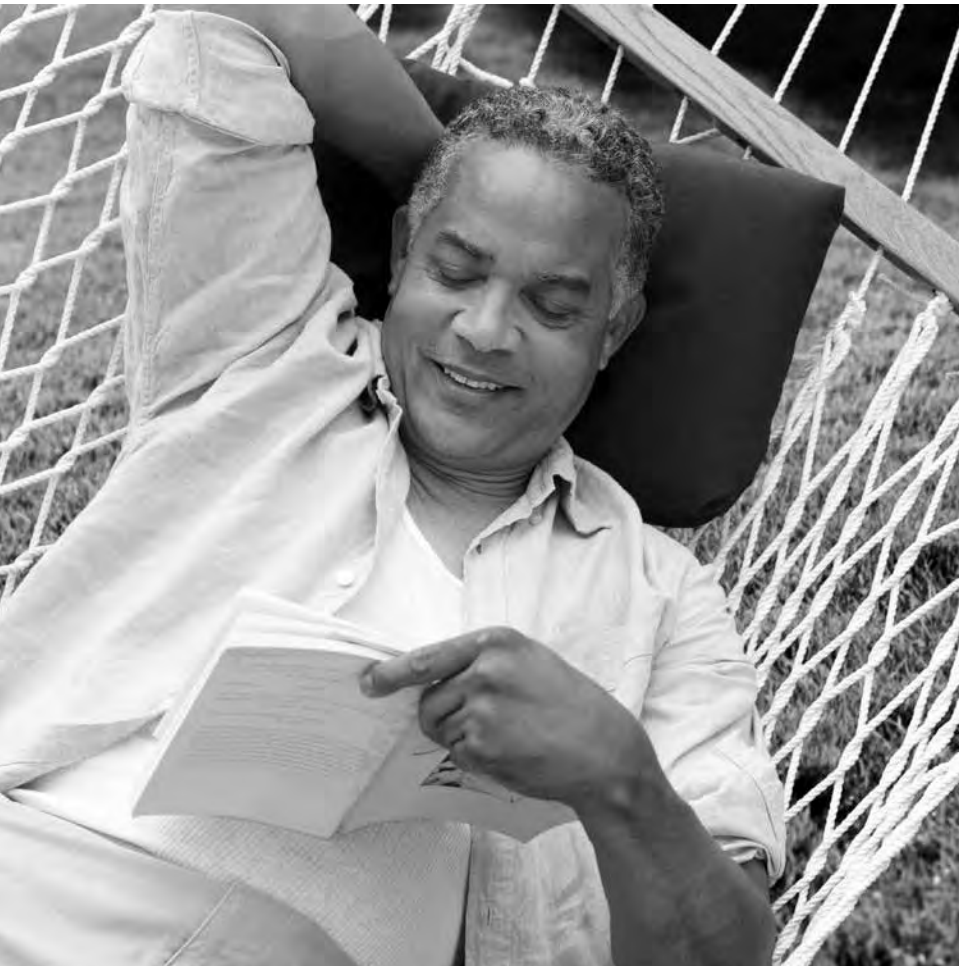
This plan provides dental services only from a defined network of dentists. You must select a Primary Care Dentist (PCD) to coordinate all care and referrals are required for all specialist services.

Pre-Enrollment Information Line & Finding a Dentist

You can speak to a knowledgeable Cigna enrollment specialist 24 hours a day, 7 days a week by calling **1.800.564.7642**.

For the most current information on network dental offices in your area, search the online directory at **www.cigna.com/stateofct** or call the Dental Office Locator at **1.800.564.7642**.

Access personalized benefit information at myCigna.com. After you enroll for coverage, you can register for an account.



Oral Health Integration Program

Eligible State of Connecticut members who enroll in dental coverage will have access to enhanced dental coverage through the Cigna Dental Oral Health Integration Program® (OHIP). With this program, eligible members with certain medical conditions may receive 100% reimbursement of their copay for select covered dental services. Please visit **www.cigna.com/stateofct** for more information.

Healthy Rewards®

Cigna's Healthy Rewards Program provides discounts of up to 60% on healthy programs and services as part of Cigna's ongoing effort to promote wellness. There's no time limit or maximum to enjoy these instant savings when you visit a participating provider or shop online. No referrals or claim forms needed. The following Healthy Rewards programs are available: weight management, fitness and nutrition, vision and hearing care, tobacco cessation, alternative medicine, and vitamins.

After you enroll in the insurance plan, you can learn more about Healthy Rewards by visiting **www.Cigna.com/rewards** (password: savings) or calling **1.800.258.3312**.

Orthodontics in Progress

If you choose the Enhanced plan which covers orthodontic care, you will have coverage for treatment in progress. The coverage will begin at the effective date of your Cigna plan. Any services incurred prior to the effective date would be paid by your previous carrier.

Your benefit amount is determined by your plan's benefit level for orthodontia and the number of months of active treatment remaining when the Enhanced plan with Cigna takes effect. For additional information, please visit **www.cigna.com/stateofct**.

Dental Treatment in Progress

Some dental procedures require several treatment dates from start to finish. For example, a root canal generally requires two visits – one for the core build-up and a second for crown placement. As a general rule, claims for a "treatment in progress" are paid by the insurance carrier you were enrolled with when the treatment began.

For example, a crown procedure that starts in June 2014 under the previous plan but is completed in July 2014 after the Cigna plan becomes effective is considered treatment in progress and is paid under the previous plan.

Other examples might include treatment for a root canal, crown and bridge, or dentures. If your treatment began before July 1, 2014, your provider should submit the claim directly to the previous plan for review. This is a standard process in the insurance industry for transition of care.

What's New

- All dental plans administered by Cigna
- 24/7 Customer Support
- Claims handled by Cigna
- Increased network of contracted dentists
- New ID Cards
- Implants covered under the Enhanced plan (up to \$500/year)

Access your dental benefit information by going to **www.cigna.com/stateofct**.



Medicare and You

Medicare is a federal healthcare insurance program for people age 65 and older. While the Social Security retirement age is creeping up, the eligibility age to start Medicare is age 65. People younger than age 65 may also qualify for Medicare due to certain disabilities or health conditions (such as permanent kidney failure or Lou Gehrig's disease). If you or a dependent becomes eligible for Medicare due to disability no matter what age, be sure to contact the Retirement Health Insurance Unit at 860-702-3533. This section covers Medicare for retirees only.

Medicare coverage is made up of various parts. If you are eligible for Medicare, you are automatically covered by Medicare Part A (hospital care) and must enroll yourself in Medicare Part B (physician services).

What to Do When You Become Eligible for Medicare

When you reach age 65, your State of Connecticut medical and prescription drug benefits will "wrap around" your Medicare benefits. Medicare will be your primary coverage and your State of Connecticut sponsored plan will pay after Medicare. This means you continue the same level of benefits that you are used to.

Do Enroll in Medicare Part A and B

Medicare Part A is free and enrollment automatic if you are at least age 65. You must enroll in Medicare Part B and pay a premium. It is essential that you enroll in Medicare Parts A and B for the first of the month you are first eligible for enrollment. Typically this is the first of the month in which you turn 65. Failing to do so will result in a "hole" in your coverage. Your State sponsored medical and prescription coverage will automatically be noted as secondary upon your 65th birthday.

Your standard premium for Medicare Part B will be reimbursed by the State effective from the date your Medicare Part B card is received by the Retirement Health Insurance Unit. (Medicare premiums paid before your card is received will not be reimbursed.) The 2014 standard Medicare Part B/Part D premium reimbursement is \$104.90, as long as you are not receiving reimbursement from any other source.

Be sure to send us a copy of your red, white and blue Medicare card as soon as you receive it. You will receive a letter from the Retirement Health Insurance Unit with more information just prior to your reaching age 65.

Additionally, you may be required to pay an Income Related Monthly Adjustment Amount (IRMAA) for Medicare Parts B and D in addition to the standard rate. Social Security will advise you by letter annually if you are required to pay a higher rate. Send a copy of this letter along with your red, white, and blue Medicare card in order to receive full reimbursement.

Do Not Enroll in Medicare Part C or Part D

The State of Connecticut prescription coverage with SilverScript (a subsidiary of Caremark) is a Medicare Part

D plan. When you or your covered dependents become eligible for Medicare, you will automatically be enrolled in the Part D prescription drug plan administered by SilverScript. You do not need to do anything except start using your SilverScript card once received.

Once enrolled, you will receive more information. However, there are four key things you need to know because SilverScript is a Medicare Part D prescription drug plan:

- **Do not opt out of the SilverScript prescription drug program.** SilverScript is required by Medicare to send you a letter giving you a chance to opt out or cancel your prescription drug enrollment, **but don't do it.** If you opt out, medical and prescription drug coverage from for you and your dependents will terminate. **Please ignore the opt out letter.**
- **Do not enroll in an individual Medicare prescription drug plan (through Medicare Part C or Part D).** You are only able to enroll in one Medicare Part D plan. Your State sponsored coverage with SilverScript is a Medicare Part D plan enrollment. Enrolling in any other Medicare Part D plan will cause your State of Connecticut medical and pharmacy coverage to end for you and your dependents.
- **Do make sure we have your street address.** If you receive your mail at a post office box, you must provide a residential street address to the Retirement Health Insurance Unit (per Center for Medicare and Medicaid Services regulations). All communication will still go to your noted mailing address.
- **Do promptly submit higher premium notices.** If your premium will be more than the standard premium rate, send a copy of your 2014/2015 IRMAA notice to the Retirement Health Insurance Unit to ensure proper reimbursement.

If Family Members Are Not Yet Eligible for Medicare

If you have covered dependents who are not yet eligible for Medicare (typically those under age 65), their current coverage through CVS Caremark will stay the same. There will be no change to their co-pay structure, and they will continue to participate in the mandatory maintenance drug network program. This means that after their first fill of a maintenance medication, refills must be filled through a pharmacy participating in the State's Maintenance Drug Network or through the CVS Caremark mail-order pharmacy. A full list of all participating pharmacies is available on the Comptroller's website at www.osc.ct.gov.

For More Information

Contact SilverScript with questions about your prescription coverage, ID cards, and participating pharmacies or the Retirement Health Insurance Unit with questions about eligibility or premiums. Contact information is at the back of the booklet.

Have Questions for SilverScript?

Call 866-693-4624



Retirement Health Insurance Open Enrollment Application



State Of Connecticut
Office of the State Comptroller
Healthcare Policy & Benefit Services Division
Retirement Health Insurance Unit
55 Elm Street
Hartford, CT 06106-1775
www.osc.ct.gov

TYPE OR PRINT AND FORWARD TO THE RETIREMENT SERVICES DIVISION
INSURANCE IS EFFECTIVE THE FIRST OF THE MONTH FOLLOWING THE RETIREMENT DATE

RETIREE NAME (Person Receiving Benefit) (Last Name, First Name, MI)	RETIREMENT DATE	EMPLOYEE NUMBER (From Active Employment)
MAILING ADDRESS		TELEPHONE NUMBER

YOUR OPTIONS

This statement lists your benefit options. Use this page to select your medical and dental coverage. Note that your choices will remain in effect throughout this plan year unless you experience a change in family status. Please keep a copy of this form for your records. Please be aware that you and any dependents who enroll in medical coverage must also enroll in prescription coverage and that prescription coverage is not available to individuals who are not enrolled in a medical plan. Check the box to the left of the plan you wish to select.

ANTHEM

- ☐ State BlueCare POS
- ☐ State BlueCare POE
- ☐ State BlueCare POE Plus POE-G
- ☐ State Preferred POS – **Currently Enrolled Only**
- ☐ Out of Area Plan – **Only if Retiree's Permanent Residence is Outside of Connecticut**

MEDICAL

OXFORD

- ☐ Oxford Freedom Select POS
- ☐ Oxford HMO Select POE
- ☐ Oxford HMO POE-G
- ☐ Oxford USA - Out of Area Plan – **Only if Retiree's Permanent Residence is Outside of Connecticut**
- ☐ Waive/Cancel Medical and Prescription Coverage

DENTAL

- ☐ Basic Dental Plan
- ☐ Enhanced Dental Plan
- ☐ Dental HMO Plan
- ☐ Waive/Cancel Dental Coverage

RETIREE/DEPENDENTS

List you and all of your dependents to be enrolled in health coverage. Note that the retiree must be enrolled in a health plan to be able to enroll eligible dependents. Attach sheets to list additional dependents. If any listed dependent age 19 or over is disabled, attach special application for covered dependent, which may be obtained from the Retirement Health Insurance Unit.

NAME	RELATIONSHIP (i.e., Spouse, Son, Daughter)	GENDER F M	DATE OF BIRTH	SOCIAL SECURITY NUMBER	MEDICAL & PRESCRIPTION	DENTAL
	Retiree	<input type="checkbox"/> <input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
	Dependent 1:	<input type="checkbox"/> <input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
	Dependent 2:	<input type="checkbox"/> <input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
	Dependent 3:	<input type="checkbox"/> <input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>

COORDINATION OF BENEFITS – APPLICATION IS INVALID UNLESS THIS SECTION IS COMPLETED

When you are covered by the Health Plan Selected will you or your dependent(s) have any other coverage? ☐ Yes ☐ No
If yes, which family member(s) will be covered by that insurance? (Check off as many that apply)
☐ Self ☐ Spouse ☐ Children (List Names):

NAME OF PLAN	ADDRESS
POLICY NUMBER	NAME OF PERSON(S) POLICY ISSUED TO
EFFECTIVE DATE	COMPANY THROUGH WHICH COVERAGE OBTAINED

Is any member listed above eligible for Medicare? ☐ Yes ☐ No

If yes give Medicare Part A (Hospital Insurance) and Medicare B (Medical Insurance) effective date(s):

RETIREE		Dependent 1		Dependent 2		Dependent 3	
PART A (MO/YR)	PART B (MO/YR)	PART A (MO/YR)	PART B (MO/YR)	PART A (MO/YR)	PART B (MO/YR)	PART A (MO/YR)	PART B (MO/YR)

I hereby apply for membership in the plan(s) above. I understand that if I am changing plans, my current coverage will be canceled when my new coverage takes effect. I understand that the services will be available subject to exclusions, limitations, and conditions described by the health plan.

I certify that all information on this form is correct to the best of my knowledge and belief, and understand that providing false and/or incomplete information may result in the rescission of coverage and/or nonpayment of claims for myself or my eligible dependent(s). I hereby authorize the State Comptroller to make deductions, if applicable, from my pension check for the medical and/or dental insurance indicated above.

RETIREE SIGNATURE (Person Receiving Benefit)	DATE
--	------

Forms must be postmarked by June 13, 2014.

To enroll or make changes, clip out this form,
complete it and return it to:

**Office of the State Comptroller
Retirement Health Insurance Unit
55 Elm Street
Hartford, CT 06106-1775**


**or
Fax: 860-702-3556**

Your Benefit Resources

For details about specific plan benefits and network providers, contact:

Anthem Blue Cross and Blue Shield <ul style="list-style-type: none"> • Anthem State BlueCare (POS) • Anthem State BlueCare (POE) • Anthem State BlueCare POE Plus (POE-G) • Anthem Out-of-Area • Anthem State Preferred POS (POS) 	www.Anthem.com/statect	1-800-922-2232	
UnitedHealthcare (Oxford) <ul style="list-style-type: none"> • Oxford Freedom Select (POS) • Oxford HMO Select (POE) • Oxford HMO (POE-G) • Oxford USA Out-of-Area 	www.welcometouhc.com/stateofct	1-800-385-9055 Call 1-800-760-4566 for questions before you enroll	
Caremark (Prescription drug benefits, any medical plan, non-Medicare eligible)	www.Caremark.com	1-800-318-2572	
SilverScript (Prescription drug benefits, any medical plan, Medicare eligible)	http://stateofconnecticut.silverscript.com	1-866-693-4624	
CIGNA <ul style="list-style-type: none"> • Basic Plan • Enhanced Plan • DHMO Plan 	www.Cigna.com/stateofct	1-800-244-6224	

For information about eligibility, enrolling in the plans, making changes to your coverage, or premium share amounts, contact:

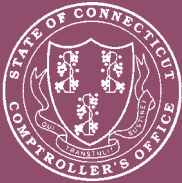
Office of the State Comptroller Retirement Health Insurance Unit 55 Elm Street Hartford, CT 06106-1775	www.osc.ct.gov	(860) 702-3533	
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Healthcare Policy & Benefit Services Division
Office of the State Comptroller
55 Elm Street
Hartford, CT 06106-1775

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State of Connecticut

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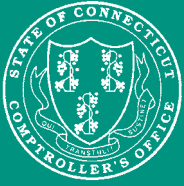
Health Care Options Planner

Retirees

**New 2014-2015
premium shares.**

See pages 5, 11 or 15
(depending on your
retirement date).





State of Connecticut

2014
2015

Health Care Options Planner

Retirees

Retirement Date October 2, 2011 or Later



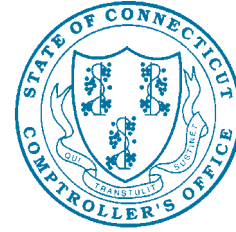
Table of Contents

Check Your HEP Status at www.cthep.com!

On the HEP website, you can check which HEP requirements you still have to complete, including for spouses and dependents. Go to www.cthep.com.

- A Message from State Comptroller Kevin Lembo.....2
- What You Need to Do 3
 - Current Retirees 3
 - New Retirees..... 3
 - Make Sure You Cover Only Eligible Dependents 4
 - Qualifying Status Change..... 4
- Health Enhancement Program (HEP) 5
- Medical Plan Summaries7
- Prescription Drug Coverage 8
- Medical Plan Premium Shares 11
- Making Your Decision – Medical.....12
 - Comparing Networks13
 - Comparing Plan Features15
 - A Message From Anthem16
 - A Message From UnitedHealthcare.....18
 - Frequently Asked Questions20
- Dental Plan Summaries and Premium Shares21
 - A Message From CIGNA23
- Enrollment Form25
- Medicare and You27
- Your Benefit Resources.....28





A Message from State Comptroller Kevin Lembo

Our daily choices affect our health and what we pay out of pocket for our health care. Even if you're happy with your current coverage, it's a good idea to review the plan options each year during open enrollment.

All of the State of Connecticut medical plans cover the same services, but there are differences in each network's providers, how you access treatment and care, and how each plan helps you manage your family's health. If you decide to change your health care plan now, you may be able to keep seeing the same doctors, yet reduce your cost for health care services.

The State is pleased to announce that Cigna will now administer all three State dental plans at lower cost. This change will not alter your benefits – with the exception of some improvements – and you can continue to see your dentist under the larger network with no additional cost. The only change is that all three plans will simply be *administered* by Cigna.

During this open enrollment, if you have not previously enrolled in the Health Enhancement Program (HEP), you must decide if you want to participate in HEP for 2014-2015. HEP is designed to help you and your family work with your medical providers to make the best decisions about your health.

Those who participated in HEP during 2013-2014 and have successfully met all of the HEP requirements will be automatically re-enrolled in HEP again and will continue to pay lower premiums for their health care coverage. Retirees eligible to participate in HEP must have retired on or after October 2, 2011.

Please take a few minutes to consider your options and choose the best value for you and your family. Everyone wins when you make smart choices about your health care.

Kevin Lembo
State Comptroller

What's New for 2014-2015

Effective July 1, 2014, Cigna will be the dental carrier for all State of Connecticut dental plans: Basic, Enhanced, and DHMO. This change will bring lower premiums and a broader network of contracted dentists for the Basic and Enhanced plans. See page 21 for details.

2014-2015 medical premium shares are listed on page 11; dental premium shares are on page 22.

What You Need to Do

Current Retirees

Open Enrollment Through June 13, 2014

During open enrollment, you have the opportunity to adjust your healthcare benefit choices. It's a good time to take a fresh look at the plans, consider how your and your family's needs may have changed, and choose the best value.

During open enrollment, you may change medical and/or dental plans, add or drop coverage for your eligible family members, or enroll yourself if you previously waived coverage. If you have a question concerning your enrollment, contact the Retirement Health Insurance Unit at the address below or call (860) 702-3533.

Complete and return the form in the back of this booklet if you'd like to make a change for 2014-2015. The form must be postmarked by June 13, 2014. Any changes you make are effective July 1, 2014 through June 30, 2015 unless you have a qualifying status change. **If you don't want to make changes, you don't need to do a thing; your current coverage will continue automatically at the rates listed on page 11 for medical and page 22 for dental.**

Return completed enrollment forms to:

**Office of the State Comptroller
Retirement Health Insurance Unit
55 Elm Street
Hartford, CT 06106**

**or
Fax: 860-702-3556**

New Retirees

To enroll for the first time, follow these steps:

1. Review this booklet and choose the medical and dental options that best meet your needs.
2. Complete the enrollment form (Form CO-744 - Choice of Health Insurance After Retirement) included in your retirement packet; this form is different from the one included in this booklet for open enrollment.
3. Return the form with your retirement packet.

If you enroll as a new retiree, your coverage begins the first day of the second month of your retirement. For example, if your retirement date is October 1, your coverage begins November 1. If you waive coverage when you're initially eligible, you may enroll within 31 days of losing other coverage, or during any open enrollment period.

**What to Do When
You Become Eligible
for Medicare**

**See Medicare and
You on page 27 for
important informa-
tion about what to
do when becoming
eligible for Medicare.**





This planner provides a brief summary of covered services. See Your Benefit Resources on page 28 to receive more detailed information.



Make Sure You Cover Only Eligible Dependents

It's important to understand who you can cover under the plan. It's critical that the State only provide coverage for eligible dependents. **If you obtain coverage for a person who is not eligible, you will have to pay federal and State tax on the fair market value of benefits provided to that individual.**

Eligible dependents generally include: your legally married spouse or civil union partner and eligible children until age 26 for medical and age 19 for dental. Your "children" include your natural children, stepchildren, and adopted children. Children residing with you for whom you are the legal guardian may be eligible for coverage up to age 18 unless proof of continued dependency is provided. Disabled children may be covered beyond age 26 for medical or age 19 for dental. For your disabled child to remain an eligible dependent, they must be certified as disabled by your **medical** insurance carrier before their 19th birthday for dental benefits or their 26th birthday for medical benefits.

Once a judgment of divorce or legal separation is entered, your former spouse must be removed from the plan.

It is your responsibility to notify the Retirement Health Insurance Unit within 31 days when any dependent is no longer eligible for coverage.

Please refer to the Comptroller's website at www.osc.ct.gov for details about dependent eligibility.

Qualifying Status Change

Once you choose your medical and dental plans, you cannot make changes during the plan year (July 1 – June 30) unless you experience a qualifying status change. If you do have a qualifying status change, you must notify the Retirement Health Insurance Unit **within 31 days of the event**. The change you make must be consistent with your change in status.

Please call the Retirement Health Insurance Unit if you experience a qualifying status change – which include changes in:

- **Legal marital/civil union status** – Any event that changes your legal marital/civil union status, including marriage, civil union, divorce, death of a spouse and legal separation.
- **Number of dependents** – Any event that changes your number of dependents, including birth, death, adoption and legal guardianship.

- **Employment status** – Any event that changes your or your dependent's employment status, resulting in gaining or losing eligibility for coverage such as:
 - Beginning or ending employment
 - Starting or returning from an unpaid leave of absence
 - Changing from part time to full time or vice versa.
- **Dependent status** – Any event that causes your dependent to become eligible or ineligible for coverage.
- **Residence** – A significant change in your place of residence that affects your ability to access network providers.

If you experience a change in your life that affects your benefits, contact the Retirement Health Insurance Unit at (860) 702-3533. They'll explain which changes you can make and let you know if you need to send in any paperwork (for example, a copy of your marriage certificate).

Health Enhancement Program

The Health Enhancement Program (HEP) has several important benefits. First, it helps you and your family work with your medical providers to get and stay healthy. Second, it saves you money on your health care. Third, it will save money for the State long term by focusing our health care dollars on prevention. It's your choice whether or not to participate, but there are many advantages to doing so.

You Save Money by Participating!

When you and all of your enrolled family members participate in HEP, you will pay lower monthly premiums and have no deductible for in-network care for the plan year. If one of you has one of the five chronic conditions identified on page 6, you may also receive a \$100 payment, provided you and all enrolled family members comply with HEP requirements. You also save money on prescription drugs to treat that condition (see page 6).

If You Do Not Enroll in HEP

Unless you enroll in HEP, your premiums will be \$100 per month higher and you will have an annual \$350 per individual (\$1,400 per family) in-network medical deductible.

HEP encourages retirees and enrolled family members to take charge of their health and health care by following health guidelines defined by getting age-appropriate wellness exams and preventive screenings.

How to Enroll in HEP

Current Retirees:

For those who are not currently participating in HEP, you can enroll during open enrollment. Forms are available from the Retirement Health Insurance Unit at www.osc.ct.gov or by calling (860) 702-3533.

Those who participated in HEP during 2013-2014 and have successfully met all of the HEP requirements will be automatically re-enrolled in HEP again for 2014-2015 and will continue to pay lower premiums for their health care coverage.

New Retirees:

If you are a new retiree, you do not have to make a new HEP election - your HEP enrollment status will follow you into retirement. If you're not currently enrolled in HEP, you must complete the HEP enrollment form upon making your benefit elections. HEP enrollment forms are available from the Retirement Health Insurance Unit at www.osc.ct.gov or by calling (860) 702-3533. If you do not wish to continue participation in HEP, you can disenroll during open enrollment.

2014 HEP PREVENTIVE CARE REQUIREMENTS

Preventive Service	Birth – age 5	Age 6 - 17	Age 18 – 24	Age 25 – 29	Age 30 – 39	Age 40 – 49	Age 50+
Preventive Visit	1 per year	1 every other year	Every 3 years	Every 3 years	Every 3 years	Every 2 years	Every year
Vision Exam	N/A	N/A	Every 7 years	Every 7 years	Every 7 years	Every 4 years	50 - 64 – Every 3 years 65 and Over – Every 2 years
Dental Cleanings*	N/A	At least 1 per year	At least 1 per year	At least 1 per year	At least 1 per year	At least 1 per year	At least 1 per year
Cholesterol Screening	N/A	N/A	Every 5 years (20+)	Every 5 years	Every 3 years	Every 2 years	Every year
Breast Cancer Screening (Mammogram)	N/A	N/A	N/A	N/A	1 screening between age 35 - 39**	As recommended by Physician	As recommended by Physician
Cervical Cancer Screening (Pap Smear)	N/A	N/A	Every 3 years (21+)	Every 3 years	Every 3 years	Every 3 years	Every 3 years
Colorectal Cancer Screening	N/A	N/A	N/A	N/A	N/A	N/A	Colonoscopy every 10 years or Annual FIT/FOBT

* Dental cleanings are required for family members who are participating in one of the State dental plans

** Or as recommended by your physician

As is currently the case under your State Health plan, any medical decisions will continue to be made by you and your physician

Health Enhancement Program Requirements

You and your enrolled family members must get age-appropriate wellness exams, early diagnosis screenings (such as colorectal cancer screenings, Pap tests, mammograms, and vision exams).

For calendar year 2014 you must complete at least one dental cleaning. All of the plans cover up to two cleanings per year. Periodontal maintenance is not subject to an annual maximum for HEP participants; however, cost shares and frequency limits may still apply. See page 21 for additional information.

Additional Requirements for Those With Certain Conditions

If you or any of your enrolled family members have **1) Diabetes (Type 1 or 2), 2) asthma or COPD, 3) heart disease/heart failure, 4) hyperlipidemia (high cholesterol), or 5) hypertension (high blood pressure)**, you and/or that family member will be required to participate in a disease education and counseling program for that particular condition. You will receive free office visits and reduced pharmacy co-pays for treatments related to your condition (see Your Prescription Drug Coverage at a Glance on page 8 for cost details).

These particular conditions are targeted because they account for a large part of our total health care costs and have been shown to respond particularly well to disease education and counseling programs. By participating in these programs, affected retirees and family members will be given additional resources to improve their health.



Administrator and Website Visit www.cthep.com

Care Management Solutions, an affiliate of ConnectiCare, is the administrator for the Health Enhancement Program (HEP). The HEP participant portal features tips and tools to help you manage your health and your HEP requirements. You can visit www.cthep.com to:

- View HEP preventive and chronic requirements and download HEP forms
- Check your HEP preventive and chronic compliance status
- Complete your chronic condition education and counseling compliance requirement
- Access a library of health information and articles
- Set and track personal health goals
- Exchange messages with HEP Nurse Case Managers and professionals

You can also call Care Management Solutions to speak with a representative.

Care Management Solutions
www.cthep.com
(877) 687-1448
Monday – Thursday, 8:00 a.m. – 6:00 p.m.
Friday, 8:00 a.m. – 5:00 p.m.

To Create a New Account

All HEP enrollees, spouses, and dependents age 18 and over need to create a new online account the first time they visit www.cthep.com. An online tutorial provides information about the site and helps you with registering if you are a newcomer. Visit www.cthep.com and click on the hyperlink to your right.

Check Your Status

You have until December 31, 2014 to complete your 2014 HEP requirements. However, right now is a great time to check your status and schedule appointments for the requirements you need to complete this year.

Your Medical Plans at a Glance

BENEFIT FEATURES	BOTH CARRIERS		BOTH CARRIERS POS OUT-OF-NETWORK
	POE, POE-G AND OUT-OF-AREA IN NETWORK	POS IN NETWORK	
Outpatient Physician Visits, Walk-in Centers and Urgent Care Centers	\$15 co-pay		80% ¹
Preventive Care	No co-payment for preventive care visits and immunizations		80% ¹
Emergency Care	\$35 co-pay ²		\$35 co-pay
Diagnostic X-Ray and Lab	100% (prior authorization required for diagnostic imaging)		80% ¹ (prior authorization required for diagnostic imaging)
Pre-Admission Testing	100%		80% ¹
Inpatient Physician	100% (prior authorization required)		80% ¹ (prior authorization required)
Inpatient Hospital	100% (prior authorization required)		80% ¹ (prior authorization required)
Outpatient Surgical Facility	100% (prior authorization required)		80% ¹ (prior authorization required)
Ambulance	100% (if emergency)		100% (if emergency)
Short-Term Rehabilitation and Physical Therapy	100%		80%, ¹ up to 60 inpatient days, 30 outpatient days per condition per year
Routine Eye Exam	\$15 co-pay, 1 exam per year ³		50%, 1 exam per year
Audiological Screening	\$15 co-pay, 1 exam per year		80%, ¹ 1 exam per year
Mental Health/Substance Abuse	Prior authorization required		Prior authorization required
	100%		80% ¹
Inpatient	100%		80% ¹
Outpatient	\$15 co-pay (prior authorization may be required)		80% ¹ (prior authorization may be required)
Durable Medical Equipment	100% (prior authorization may be required)		80% ¹ (prior authorization may be required)
Prosthetics	100% (prior authorization may be required)		80% ¹ (prior authorization may be required)
Skilled Nursing Facility	100% (prior authorization required)		80%, ¹ up to 60 days/year (prior authorization required)
Home Health Care	100% (prior authorization may be required)		80%, ¹ up to 200 visits/year (prior authorization may be required)
Hospice	100% (prior authorization required)		80%, ¹ up to 60 days (prior authorization required)
Annual Deductible	Individual: \$350 ⁴ Family: \$350 each member ⁴ (\$1,400 maximum)		Individual: \$300 Family: \$900
Annual Out-of-Pocket Maximums	Individual: \$350 ⁴ Family: \$350 each member ⁴ (\$1,400 maximum)		Individual: \$2,000 (plus deductible) Family: \$4,000 (plus deductible)
Lifetime Maximum	None		None
Pre-admission Authorization/ Concurrent Review	Through participating provider		Penalty of 20% up to \$500 for no authorization

¹ You pay 20% of the allowable charge plus 100% of any amount your provider bills over the allowable charge.

² Waived if admitted.

³ HEP participants have \$15 co-pay waived once every two years.

⁴ Waived for HEP-compliant members.

Your Prescription Drug Coverage at a Glance

Medicare-eligible retirees and/or dependents are automatically enrolled in a Group Medicare Part D Plan administered by SilverScript, a subsidiary of CVS/Caremark. The State of Connecticut pharmacy plan wraps around the Part D plan so you have the same level of benefits that you are used to. See page 27 for more details.

If you are NOT Medicare eligible, your prescription benefits are administered by CVS/Caremark until you become Medicare eligible.

Depending on your Medicare eligibility, your prescription drug coverage is either through Caremark or SilverScript. Prescription benefits are the same no matter which medical plan you choose.

The plan has a 3-tier co-pay structure which means the amount you pay depends on whether your prescription is for a generic drug, a brand-name drug listed on Caremark’s preferred drug list (the formulary), or a non-preferred brand-name drug.

NON-MEDICARE ELIGIBLE

CVS/Caremark	In-Network			Out-of-Network
	Acute Drugs	Maintenance Drugs*	HEP Enrolled (Maintenance Drugs to treat chronic condition)*	
Generic	\$5	\$5	\$0	20% of prescription cost
Preferred Brand	\$20	\$10	\$5	20% of prescription cost
Non-Preferred Brand	\$35	\$25	\$12.50	20% of prescription cost

* You are required to fill your maintenance drugs using the maintenance drug network or CVS Mail Order. You must obtain a 90-day supply of maintenance drugs.

MEDICARE-ELIGIBLE

Silverscript	In-Network			Out-of-Network
	Acute Drugs	Maintenance Drugs*	HEP Enrolled (Maintenance Drugs to treat chronic condition)	
Generic	\$5	\$5	\$0	20% of prescription cost
Preferred Brand	\$20	\$10	\$5	20% of prescription cost
Non-Preferred Brand	\$35	\$25	\$12.50	20% of prescription cost

To check which co-pay amount applies to your prescriptions, visit www.Caremark.com for the most up-to-date information. Once you register, click on “Look up Co-pay and Formulary Status.” Simply type the name of the drug you want to look up and you will see the cost and co-pay amounts for that drug as well as alternatives.

Preferred and Non-Preferred Brand-Name Drugs

A drug's tier placement is determined by Caremark. Caremark's Pharmacy and Therapeutics Committee reviews tier placement each quarter. If new generics have become available, new clinical studies have been released, new brand-name drugs have become available, etc., the Pharmacy and Therapeutics Committee may change the tier placement of a drug.

If your doctor believes a non-preferred brand-name drug is medically necessary for you, they will need to complete the Coverage Exception Request form (available at www.osc.ct.gov) and fax it to Caremark. If approved, you will pay the preferred brand co-pay amount.

When You Become Eligible for Medicare

If you are eligible for Medicare, you will be automatically enrolled in the SilverScript program. Your prescription benefits are the same but you use your SilverScript ID card for prescriptions instead.

Do not enroll in an individual Medicare Part D prescription drug plan. Doing so would cause your State of Connecticut medical and pharmacy coverage to end for you and your dependents.

See Medicare and You on page 27 for more details.



If You Choose a Brand Name When a Generic Is Available

Prescriptions will be automatically filled with a generic drug if one is available, unless your doctor completes Caremark's Coverage Exception Request form and it is approved. (It is not enough for your doctor to note "dispense as written" on your prescription; a separate form is required.) As noted on previous page, if you request a brand-name drug over a generic alternative without obtaining a coverage exception, you will pay the generic drug co-pay PLUS the difference in cost between the brand and generic drug.

If you have questions about your prescription drug benefits, contact Caremark at 1-800-318-2572 or SilverScript at 1-866-693-4624.

CVS Caremark Specialty Pharmacy

Certain chronic and/or genetic conditions require special pharmacy products (often injected or infused). The specialty pharmacy program provides these prescriptions along with the supplies, equipment and care coordination needed. Call 1-800-237-2767 for information.

90-day Supply of Maintenance Medications at NO COST to You

A maintenance medication is one you take for an ongoing or chronic condition. If you or a family member takes a maintenance medication, you can get 90-day fills – **and pay no cost!** In order to receive the \$0 copay, your maintenance prescriptions must be filled in one of two ways:

- Receive your medication through the Caremark or SilverScript mail-order pharmacy, or
- Fill your medication at a pharmacy that participates in the State's Maintenance Drug Network (see the list of participating pharmacies on the Comptroller's website at www.osc.ct.gov).

A list of maintenance medications is posted at www.osc.ct.gov.

Non-Medicare Retirees Mandatory 90-Day Refills

If you are not enrolled in Medicare, 90-day refills are mandatory for maintenance medications. The initial 30-day supply can be filled at any participating pharmacy. After that, you can fill your medication at a pharmacy that participates in the State's Maintenance Drug Network, or use Caremark's mail order service. A link to the complete list of pharmacies in the Network can be found on the Office of the State Comptroller's website at www.osc.ct.gov.



Your 2014-2015 Medical Premium Share

Monthly Medical Premiums July 1, 2014 through June 30, 2015

Medical plan options with no retiree premium share:

Point of Enrollment – Gatekeeper Plans

Anthem State BlueCare POE Plus
UnitedHealthcare Oxford HMO

Point of Enrollment Plans

Anthem State BlueCare POE
UnitedHealthcare Oxford HMO Select

Out-of-Area Plans

UnitedHealthcare Oxford USA Out of Area plan
Anthem Out-of-Area plan

COVERAGE LEVEL	ANTHEM STATE BLUECARE POS	UNITEDHEALTHCARE OXFORD FREEDOM SELECT POS	ANTHEM PREFERRED Closed to New Enrollment
1 Person on Medicare	\$0.00	\$0.00	\$0.00
1 Person not on Medicare	\$12.61	\$13.00	\$12.82
1 Person not on Medicare and 1 on Medicare	\$12.61	\$13.00	\$12.82
1 not on Medicare and 2 on Medicare	\$12.61	\$13.00	\$12.82
2 on Medicare	\$0.00	\$0.00	\$0.00
2 not on Medicare	\$27.74	\$28.60	\$28.21
2 not on Medicare and 1 on Medicare	\$27.74	\$28.60	\$28.21
3 or more on Medicare	\$0.00	\$0.00	\$0.00
3 or more not on Medicare	\$34.04	\$35.10	\$34.62
3 or more not on Medicare and 1 on Medicare	\$34.04	\$35.10	\$34.62

Important Note: Higher Premiums Without HEP

If your retirement date is October 2, 2011 or later you are eligible for the Health Enhancement Program (HEP). If you choose not to enroll, or enroll but do not meet the HEP requirements, your monthly premium share will be \$100 higher than shown above.

If you would like to change your HEP enrollment status, you may complete a form. Forms are available at www.osc.ct.gov or from the Retirement Health Insurance Unit at (860) 702-3533.

If You Retired Early

If you retired early, you may pay additional retiree premium share costs per the 2011 SEBAC agreement. For additional information, please contact the Retirement Health Insurance Unit at (860) 702-3533.



Making Your Decision – Medical

Each of the medical plans offered by the State of Connecticut is designed to cover the same medical benefits – the same services and supplies. And, the amount you pay out of pocket at the time you receive services is very similar. Yet, your premium share varies quite a bit from plan to plan. How do you decide?

When it comes to choosing a medical plan, there are four main areas to look at:

1. **What is covered** – the services and supplies that are covered benefits under the plan. This comparison is easy to make at the State of Connecticut because all of the plans cover the same services and supplies. (See page 7).
2. **Cost** – what you pay when you receive medical care and what is deducted from your pension check. What you pay at the time you receive services is similar across the plans (see page 7). However, your premium share varies quite a bit depending on the carrier and plan selected (see page 11).
3. **Networks** – whether your doctor or hospital has contracted with the insurance carrier. (See pages 13 and 14).
4. **Plan features** – how you access care and what kinds of “extras” the insurance carrier offers. Under some plans you must use network providers except in emergencies, others give you access to out-of-network providers. Finally, you may prefer one insurance carrier over the other (see pages 13 – 20).

The following pages are designed to help you compare your options.

Comparing Networks

When Was the Last Time You Compared Your Medical Plan to the Other Options?

If you're like many people, you made a choice when you first retired and haven't really looked at it since. The State of Connecticut offers a wide variety of medical plans, so you can find the one that best fits your needs. Did you know that you might be able to take advantage of one of the lower-cost plans while keeping your doctor and receiving the same healthcare services?

Many doctors belong to multiple provider networks. Check to see if your doctor is a network provider under more than one of the plan options. Then, take a fresh look at your options. You may be able to save money every month without changing doctors.

Why Networks Matter

All of the plans cover the same health care services and supplies. The provider networks are one of the main ways in which your medical plan options differ. Each insurance carrier contracts with a group of doctors and hospitals for discounted rates on health care services. Getting your care within the network provides the highest benefit level:

- If you choose a **Point of Enrollment (POE)** plan, you must use network providers for your care (except in emergencies).
- If you choose a **Point of Service (POS)** plan or one of the Out of Area plans, you have the choice to use in-network or out-of-network providers each time you receive care – but, you'll pay more for out-of-network services.

Is a National Network Important to You?

All State of Connecticut plans have a national provider network. That means they contract with doctors and hospitals across the country – and you have nationwide access to the highest level of benefits.

- Planning to live or travel out of the region?
- Have a college student attending school hours away from home?
- Wish to get care at a specialty hospital that's not in Connecticut or the coverage region?

The State of Connecticut offers affordable options with great coverage within the region and nationwide. Take a look at your options before you decide.



How the Plans Work

Point of Service (POS) Plans – These plans offer health care services both within and outside a defined network of providers. No referrals are necessary to receive care from in-network providers. Health care services obtained outside the network may require prior authorization and are reimbursed at 80% of the allowable cost (after you pay the annual deductible).

Point of Enrollment (POE) Plans – These plans offer health care services only from a defined network of providers. (Out-of-network care is covered in emergencies.) No referrals are necessary to receive care from in-network providers. Health care services obtained outside the network may not be covered.

Point of Enrollment – Gatekeeper (POE-G) Plans – These plans offer health care services only from a defined network of providers. (Out-of-network care is covered in emergencies.) You must select a Primary Care Physician (PCP) to coordinate all care and referrals are required for all specialist services.

The Point of Enrollment - Gatekeeper (POE-G) plans generally require the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider. Until you make this designation, the medical insurance carrier designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the medical insurance carrier (see Your Benefit Resources on page 28).

You do not need prior authorization from the medical insurance carrier or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the network who specializes in obstetrics or gynecology. The health care professional, however, may be required to

comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the medical insurance carrier (see Your Benefit Resources on page 28).

Using Out-of-Network Providers

When you enroll in one of the State of Connecticut POS plans, you can choose a network or out-of-network provider each time you receive care. When you use an out-of-network provider, you'll pay more – for most services, the plan pays 80% of the allowable charge after you pay your annual deductible. Plus, you pay 100% of the amount your provider bills above the allowable charge.

In the POS plans there are no referral or prior authorization requirements to use out-of-network providers – you are free to use the network or out-of-network provider of your choice. However, since certain procedures require prior authorization (see page 7), call your plan when you anticipate significant out-of-network expenses to find out how those charges will be covered. You'll avoid an unpleasant surprise and have the information you need to make an informed decision about where to seek health care.

Where You Live or Work Affects Your Choices

You must live or work within a plan's regional service area to enroll in that plan – even though the plan has a national network. For example, if you want to enroll in the UnitedHealthcare Oxford Freedom Select Plan (POS), you must live or work within the geographic area covered by Oxford's regional provider network. If you live and work outside that area, you should choose one of the Out-of-Area plans. Both Out-of-Area plans give you access to a national provider network.

Comparing Plan Features

All State of Connecticut plans cover the same health care services and supplies. However, they differ in these ways:

- **How you access services** – Some plans allow you to see only network providers (except in the case of emergency), some give you access to out-of-network providers when you pay more of the fees, some require you to select a PCP.
- **Health promotion** – Remember, there's more to a health plan than covering doctor visits. All of the plans offer health information online; some offer additional services such as 24-hour nurse advice lines and health risk assessment tools.
- **Provider networks** – You'll want to check with each plan to see if the doctors and hospitals you want are in each network. (See Your Benefit Resources on page 28 for phone numbers and websites.)

About Value-Added Programs

Another area where the insurance carriers may differ is the value-added programs they offer. These programs are outside the contracted plan benefits – they're "extras" that each company offers in hopes of making their plan stand out, such as:

- Wellness programs
- Member discounts (for example, on weight-loss programs or health clubs)
- Online health promotion programs

Because these value-added programs are not plan benefits, they are subject to change at any time by the insurance carrier. However, you may want to see what each company offers before you decide.

	POINT OF ENROLLMENT – GATEKEEPER (POE-G) PLANS		POINT OF ENROLLMENT (POE) PLANS		POINT OF SERVICE (POS) PLANS			OUT OF AREA PLANS	
	Anthem State BlueCare POE Plus	UnitedHealthcare Oxford HMO	Anthem State BlueCare	UnitedHealthcare Oxford HMO Select	Anthem State BlueCare	Anthem State Preferred POS*	UnitedHealthcare Oxford Freedom Select	Anthem OOA	UnitedHealthcare Oxford USA
National network	X	X	X	X	X	X	X	X	X
Regional network	X	X	X	X	X	X	X	X	X
In- and out-of-network coverage available					X	X	X	X	X
In-network coverage only (except in emergencies)	X	X	X	X					
No referrals required for care from in-network providers			X	X	X	X	X	X	X
Primary care physician (PCP) coordinates all care	X	X							

* Closed to new enrollment.



Comparing Plans: A Message From Anthem

A Healthy You Starts Here

Get on the road to good health with our large network of doctors, easy-to-use wellness tools and programs, and top-notch customer service.

Value-added programs such as wellness programs and discounts offered by the plan are not negotiated benefits and are subject to change at any time at the discretion of the plan.

Exceptional Customer Service

We've been in Connecticut for more than 75 years, and we've been serving State of Connecticut employees and retirees for more than 50 of those years. This means we know your needs, and we're ready and able to help. Get answers and information through our:

- **State-dedicated Member Services Unit at 800-922-2232** — Talk with a customer service expert who is located right here in the State and is dedicated solely to State employees and retirees.
- **State-dedicated website at [anthem.com/statect](https://www.anthem.com/statect)** — Find information geared specifically to you and other State employees and retirees.

24/7 NurseLine

You can call the toll-free number — 800-711-5947 — to talk with a nurse about your general health questions any time of the day or night. Whether it's a question about allergies, fever, types of preventive care or any other topic, nurses are always there to provide support and peace of mind. Our nurses can help you choose the right place for care if your doctor isn't available and you aren't sure what to do.

You can also listen to recorded messages on hundreds of health topics. Just call the 24/7 NurseLine number and choose the AudioHealth Library option.



Easy-to-Use Wellness Tools and Programs

Lose weight. Join a gym. Reduce stress. When it comes to our health, we all have different goals. That's why we have a full range of wellness programs, online tools and resources designed to meet your unique needs.

Anthem's Health and Wellness programs

From finding an answer to a common health question to getting one-on-one support for a chronic health condition, you can get the help you need through our Anthem Health and Wellness programs. Here's a sampling of what's available to you by accessing the State dedicated website at anthem.com/statect:

- **ComplexCare** — If you're living with multiple medical conditions, you may need a little extra support. With this program, personal nurse coaches help you create personalized goals and stay on track with your doctor's treatment plans. They can also pinpoint and refer you to other Anthem Health and Wellness programs.

SpecialOffers@Anthem

As a State employee or retiree, you can get discounts on products that encourage a healthy lifestyle. You'll get "healthy" discounts on things like:

- Weight loss programs through Weight Watchers®, Jenny Craig® and more
- Fitness club memberships, equipment and coaching
- Hearing aids
- Allergy products
- Acupuncture
- Massage therapy
- Baby safety gear
- Senior care

SpecialOffers@Anthem is a service mark of Anthem Insurance Companies, Inc. Vendors and offers are subject to change without notice. Anthem does not endorse and is not responsible for the products, services or information provided by the SpecialOffers@Anthem vendors. Arrangements and discounts were negotiated between each vendor and Anthem for the benefit of our members. All other marks are the property of their respective owners. All of the offers in the SpecialOffers@Anthem program are continually being evaluated and expanded so the offerings may change. Any additions or changes will be communicated on our website, anthem.com. These arrangements have been made to add value for our members. Value-added products and services are not covered by your health plan benefit. Available discount percentages may change or be discontinued from time to time without notice. Discount is applicable to the items referenced.

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Get the Most From Your Health Plan

Your health plan should do more than just help you when you're sick. It should help you be your healthiest. That's why Anthem offers things like vision discounts and large nationwide networks. So you can get more health from your health care.

Vision

The Anthem plans for the State of Connecticut include vision coverage and discounts:

Eye Exams

Your State of Connecticut health benefits cover you for an annual routine eye exam. No matter which plan you have, you do not need a referral.

- **1-800 CONTACTS** — Get contact lenses quick and easy — plus discounts like \$20 off when you spend \$100 or more, and free shipping.
- **Glasses.com** — Try on any five of the 1,500 designer frames — at home, for free — before you buy. It's convenient, plus you get savings like \$20 off when you spend \$100 or more, and free shipping and free returns.
- **Premier LASIK** — Save 15% on LASIK with all their in-network providers and prices as low as \$695 per eye with select providers.

Network access

Anthem provides expansive coverage nationally and around the world. Through the BlueCard® program, you can use the networks of other Blue Cross and Blue Shield plans, so you can get the care you need — just about anywhere you travel. We can help you find the right care locations outside of Connecticut by calling 800-810-BLUE.

Have a question?

Call our State-dedicated Member Services Unit at 800-922-2232.

We're ready to help you. You'll also find good information at anthem.com/statect.

Comparing Plans: A Message From UnitedHealthcare



Value-added programs such as wellness programs and discounts offered by the plan are not negotiated benefits and are subject to change at any time at the discretion of the plan.

Now is the Time to Live Well.

Top Reasons UnitedHealthcare is the right decision for you and your family:

Trust

You should trust that you are making a great decision choosing UnitedHealthcare. You need to choose someone you can depend on and with an Oxford Health Plan from UnitedHealthcare you come first. We are committed to helping people live healthier lives.

We Care

UnitedHealthcare Children's Foundation (UHCCF) is a non-profit charity dedicated to enhancing the quality of children's lives. UHCCF was founded in 1999. Since 2007, UHCCF has awarded more than 6,500 grants valued at over \$20M to children and their families across the United States.

Tools and Resources

Everything you need at your fingertips, 24/7. Search for a doctor, view your claims, online health coaching and much more.

Our Network

All medical plans offer access to our local and national network

UnitedHealthcare offers a robust local and national network. Nationally, and in the tri-state area, we have a vast number of physicians, healthcare professionals and hospitals. For years, our members have relied on access to our Connecticut, New York and New Jersey tri-state network. Whichever plan you choose, you'll also have seamless access to our UnitedHealthcare Choice Plus Network of physicians and healthcare professionals outside of the tri-state area. This gives State of Connecticut employees and retirees better access to quality care whether you are in Connecticut, traveling outside the tri-state area or living somewhere else in the country.

For more information about our network, or to search for physicians participating in our local or UnitedHealthcare Choice Plus national Network, please visit welcometouhc.com/stateofct.

UnitedHealth Premium® Program

UnitedHealthcare has long recognized the direct relationship between health care quality and successful outcomes.

The Premium program recognizes doctors who meet standards for quality and cost efficiency. The quality standards are based on evidence-based medicine and national industry guidelines. The cost efficiency standards are based on local market benchmarks for cost-efficient care.

Premium Designation Display

Doctors who have met the criteria for quality and/or cost efficiency could have one of these four UnitedHealth Premium designations. These are shown when searching for a provider online, and in provider directories:

- Quality & Cost Efficiency
- Cost Efficiency & Not Enough Data to Assess Quality
- Quality & Not Enough Data to Assess Cost
- Quality & Did Not Meet Cost Efficiency

Physician designations are subject to change. Members should always visit welcometouhc.com/stateofct and check their doctor's Premium designation before making an appointment.

Introducing UnitedHealth Premium Tier 1

UnitedHealth Premium Tier 1 helps people to quickly and easily find doctors who have been recognized for providing value.

UnitedHealth Premium Tier 1 physicians have received the Premium designation for:

- Quality & Cost Efficiency OR
- Cost Efficiency & Not Enough Data to Assess Quality

For more information about the Premium program, visit welcometouhc.com/stateofct

The choice is yours.

The UnitedHealth Premium program can help you find the care you want. The program evaluates doctors in 25 different medical specialties, using national standards for quality and local benchmarks for cost efficiency. You can use this information to help you choose the care that's right for you.

Oxford On-Call®

Healthcare Guidance 24 hours a day

We realize that questions about your health can come up at any time. That's why we offer you flexible choices in health care guidance through our *Oxford On-Call*® program. Speak with a registered nurse who can offer suggestions and guide you to the most appropriate source of care, 24 hours a day, seven days a week. That's the idea behind *Oxford On-Call*.

If you are a member and you need to reach Oxford-On-Call, please call 800-201-4911. Press option 4. Oxford On-Call can give you helpful information about many topics such as:

General Health Information

Call about illness, injury, chronic conditions, prevention, healthy living, and men's, women's and children's health.

Deciding Where to Go for Care

Oxford On-Call's nurses provide information that can help you choose care that is appropriate for your situation.

Choosing Self-Care Measures

Registered nurses provide practical self-care tips to help you manage your condition at home.

Guidance for Difficult Decisions

If you or a family member has a serious medical condition, *Oxford On-Call* nurses can be a great resource. The more you know, the better prepared you'll be.

Live Web Chat

Nurses are available to chat online about a variety of health topics, and to confidentially guide you to online resources.

For additional information regarding *Oxford On-Call*, please visit welcometouhc.com/stateofct.

Healthy Bonus® Member Discounts

We understand that rising health care costs nationwide affect our members. We strive to help you stretch your health care dollar by developing programs that aim to help you improve your health.

We recognize there are ways we can help members reduce out-of-pocket health care costs. We believe in the power of prevention: that by taking a little extra time to eat better, exercise and reduce stress, individuals can do a better job of staying on the path of wellness.

Our *Healthy Bonus* program offers access to discounts and special offers on products and services that can help you make the best kind of investment: a healthy lifestyle. Please visit welcometouhc.com/stateofct to obtain information on the discounts offered to you on things like fitness/fitness equipment, diabetes/disease management, keeping kids healthy and overall wellness.

UnitedHealth Allies

This health discount program helps you, and your family, save money on many health and wellness purchases not included in your standard health benefit plan. To begin enjoying these discounts, go to **unitedhealthallies.com** and sign up. You will need your Oxford ID number and UnitedHealth Allies card. If you do not have your UnitedHealth Allies card, call Customer Care at **800-860-8773**.

Frequently Asked Questions

1. *Where can I get more details about what the State health insurance plan covers?*

All medical plans offered by the State of Connecticut cover the same services and supplies. For more detailed benefit descriptions and information about how to access the plan's services, contact the insurance carriers at the phone numbers or websites listed on page 28.

2. *If I live outside Connecticut, do I need to choose an Out-of-Area Plan?*

If you live permanently outside of Connecticut, we will automatically place you in an Out of Area plan, giving you access to a national network of providers whether you are enrolled with Anthem or UnitedHealthcare Oxford. There are no retiree premium shares for enrollment in an Out-of-Area plan.

3. *What's the difference between a service area and a provider network?*

A service area is the region in which you need to live in order to enroll in a particular plan. A provider network is a list of doctors, hospitals and other providers. In a POE plan, you may use only network providers. In a POS plan, you may use providers both in- and out-of-network, but you pay less when you use providers in the network.

4. *What are my options if I want access to doctors across the U.S.?*

Both State of Connecticut insurance carriers offer extensive regional networks as well as access to network providers nationwide. If you live outside the plans' regional service areas, you may choose one of the Out-of-Area plans – both have national networks.

5. *How do I find out which networks my doctor is in?*

Contact each insurance carrier to find out if your doctor is in the network that applies to the plan you're considering. You can search online at the carrier's website (be sure to select the right network; they vary by plan option), or you can call customer service at the numbers on page 28. It's likely your doctor is covered by more than one network.

6. *Can I enroll later or switch plans mid-year?*

Generally, the elections you make now are in effect July 1 – June 30. If you have a qualifying status change, you may be able to modify your elections mid-year (see page 4). If you decline coverage now, you may enroll during any later open enrollment or if you experience certain qualifying status changes.

7. *Can I enroll myself in one option and my family member in another?*

No. You and the family members you enroll must all have the same medical option and/or the same dental option. However, you can enroll certain family members in medical and different family members in dental coverage. For example, you can enroll yourself and your child for medical but yourself only for dental. To enroll an eligible family member in a plan, you must enroll as well. It is also important to note that you may not double cover yourself under another State of Connecticut retiree's health benefits.

Your Dental Plans at a Glance

State of Connecticut Dental Plans Administered By Cigna

Effective July 1, 2014, Cigna will be the dental carrier for all State of Connecticut dental plans: Basic, Enhanced, and Dental HMO (DHMO). If you are currently in the Basic or Enhanced plan, here's what this means to you:

- Under the Basic and Enhanced plans, the State was able to modernize and improve some benefits. For example, under the Basic plan, sealants will now be covered for children up to age 16 (the applicable cost share will apply). Under the Enhanced plan, there will now be coverage for implants, up to \$500 per year. In addition, under both the Basic and Enhanced plans you will receive discounted rates for non-covered services when utilizing a network dental provider (unless this is prohibited by state law – see page 22 for details).
- How you utilize the networks will not change. Under the Basic plan you can continue to see any dentist with no additional charge. Under the Enhanced plan you will have lower costs if you use a Cigna Dental PPO network provider.
- You still have the option to choose the Basic plan, Enhanced plan, or Dental HMO plan. **If you decide NOT to make a dental plan change during Open Enrollment, your coverage will automatically default to the same plan type administered by Cigna.**

If you are enrolled in the Basic or Enhanced plan, you will receive a new ID card from Cigna.

	BASIC PLAN (any dentist)	ENHANCED PLAN (network)	DHMO® PLAN (network only)
Annual Deductible	None	\$25 individual, \$75/family	None
Annual Maximum	None (\$500 per person for periodontics)	\$3,000 per person (excluding orthodontics)	None
Exams, Cleanings, and X-rays	Covered at 100%	Covered at 100% ¹	Covered at 100%
Periodontal Maintenance	Covered at 80% ²	Covered at 80% ²	Covered ³
Simple Restoration			
Fillings	Covered at 80%	Covered at 80%	Covered ³
Oral Surgery	Covered at 67%	Covered at 80%	Covered ³
Major Restoration			
Crowns	Covered at 67%	Covered at 67%	Covered ³
Dentures, Fixed Bridges	Not covered ⁴	Covered at 50%	Covered ³
Implants	Not covered ⁴	Covered at 50% (up to \$500)	Not covered
Orthodontia	Not covered	Plan pays \$1,500 per person per lifetime	Covered ³

- 1 In the Enhanced plan, be sure to use an in-network dentist to ensure receiving 100% coverage; with out-of-network dentists, you will be subject to balance billing if your dentist charges more than the maximum allowable charge.
- 2 If enrolled in the Health Enhancement Program: No annual maximum on services for periodontal maintenance (2 per calendar year) or scaling and root planing (frequency limits and cost shares may still apply).
- 3 Contact CIGNA at 1-800-244-6224 for patient co-pay amounts.
- 4 While not covered, you will get the discounted rate on these services if you visit a network dentist, unless prohibited by state law (see page 22 for details).

Before starting extensive dental procedures for which the dentist's charges may exceed \$200, you can ask your dentist to submit a pre-treatment estimate to the Plan. You can also help to determine the amount you will be required to pay for a specific procedure by using the Plan's website. More details about covered expenses are available by contacting Cigna at 1-800-244-6224 or www.Cigna.com/stateofct.

Terms to Know

Basic Plan – This plan allows you to visit any dentist or dental specialist without a referral.

Enhanced Plan – This plan offers dental services both within and outside a defined network of dentists and dental specialists without a referral. **However, your out-of-pocket expenses may be higher if you see an out-of-network provider.**

DHMO Plan – This plan provides dental services only from a defined network of dentists. You must select a Primary Care Dentist (PCD) to coordinate all care and referrals are required for all specialist services.

Your 2014-2015 Dental Premium Share

Dental Premiums July 1, 2014 through June 30, 2015

COVERAGE LEVEL	Basic Plan	Enhanced Plan	DHMO Plan
1 Person	\$28.93	\$22.89	\$28.46
2 Persons	\$57.87	\$45.78	\$62.60
3 or More Persons	\$57.87	\$45.78	\$76.83

Savings on Non-Covered Services

Many of the Basic and Enhanced plan Cigna PPO network dentists have agreed to offer their discounted fees to you and your covered dependents for non-covered services. These savings may also apply to services that would not be covered because you reached your annual benefit maximum or due to other plan limitations such as frequency, age, or missing tooth limitations.

- You can get savings on most services not covered under the dental PPO plans
- You must visit network dentists to receive the Cigna dental PPO discounts (savings will not apply with non-participating dentists)
- You must verify that a procedure is listed on the dentist's fee schedule before receiving treatment
- You are responsible for paying the negotiated fees directly to the dentist.

** Discounts on non-covered services may not be available in all states. Certain dentists may not offer discounts on non-covered services. Be sure to check with your dental care professional or contact Cigna customer service before receiving care to determine if these discounts will apply to you.*

Frequently Asked Questions

1. How do I know which dental plan is best for me?

This is a question only you can answer. Each plan offers different advantages. To help choose which plan might be best for you, compare the plan-to-plan features in the chart on page 21 and weigh your priorities.

2. How long can my children stay on the dental plan? Can they stay covered until their 26th birthday like with the medical plans?

The Affordable Care Act extended benefits for children until age 26 only under medical and prescription drug coverage, not dental. Dental coverage ends for dependent children at age 19 (unless they are disabled*).

** For your disabled child to remain an eligible dependent, they must be certified as disabled by your medical insurance carrier before their 19th birthday for dental benefits or their 26th birthday for medical benefits.*

3. Do any of the dental plans cover orthodontia for adults?

Yes, the Enhanced Plan and DHMO both cover orthodontia for adults up to certain limits. The Enhanced Plan pays \$1,500 per person (adult or child) per lifetime. The DHMO requires a copay. The Basic Plan does not cover orthodontia for adults or children.

4. If I participate in HEP, are my regular dental cleanings 100% covered?

Yes, up to two per year. However, if you are in the Enhanced plan, you must use an in-network dentist to get the full coverage. If you go out of network, you may be subject to balance billing (if your out-of-network dentist charges more than the maximum allowable charge). And of course in the DHMO, you must use a network dentist or your exam won't be covered at all.



Value-added programs such as wellness programs and discounts offered by the plan are not negotiated benefits and are subject to change at any time at the discretion of the plan.

A Message From Cigna

Cigna will now be the dental carrier for all State of Connecticut dental plans. As a State of Connecticut employee, you and your family have the opportunity to receive quality dental care through one of the following plans:

- **Basic Plan**
- **Enhanced Plan**
- **DHMO Plan**

Terms to Know

Basic Plan

This plan allows you to visit any dentist or dental specialist without a referral.

Enhanced Plan

This plan offers dental services both within and outside of a network of dentists and dental specialists without a referral. However, your out-of-pocket expenses may be higher if you see an out-of-network provider.

If you visit a dentist who is not part of the Cigna PPO Network, he or she is considered out-of-network. The Enhanced Plan pays for covered dental services based on "MAC" or

"Maximum Allowable Charge." The MAC is the amount your plan would pay had you visited an in-network dentist. When you visit an out-of-network dentist, you are responsible for any and all charges above the MAC; up to that dentist's usual charge for those services.

DHMO Plan

This plan provides dental services only from a defined network of dentists. You must select a Primary Care Dentist (PCD) to coordinate all care and referrals are required for all specialist services.

Pre-Enrollment Information Line & Finding a Dentist

You can speak to a knowledgeable Cigna enrollment specialist 24 hours a day, 7 days a week by calling **1.800.564.7642**.

For the most current information on network dental offices in your area, search the online directory at **www.cigna.com/stateofct** or call the Dental Office Locator at **1.800.564.7642**.

Access personalized benefit information at myCigna.com. After you enroll for coverage, you can register for an account.



What's New

- All dental plans administered by Cigna
- 24/7 Customer Support
- Claims handled by Cigna
- Increased network of contracted dentists
- New ID Cards
- Implants covered under the Enhanced plan (up to \$500/year)

Access your dental benefit information by going to www.cigna.com/stateofct.



Oral Health Integration Program

Eligible State of Connecticut members who enroll in dental coverage will have access to enhanced dental coverage through the Cigna Dental Oral Health Integration Program® (OHIP). With this program, eligible members with certain medical conditions may receive 100% reimbursement of their copay for select covered dental services. Please visit www.cigna.com/stateofct for more information.

Healthy Rewards®

Cigna's Healthy Rewards Program provides discounts of up to 60% on healthy programs and services as part of Cigna's ongoing effort to promote wellness. There's no time limit or maximum to enjoy these instant savings when you visit a participating provider or shop online. No referrals or claim forms needed. The following Healthy Rewards programs are available: weight management, fitness and nutrition, vision and hearing care, tobacco cessation, alternative medicine, and vitamins.

After you enroll in the insurance plan, you can learn more about Healthy Rewards by visiting www.Cigna.com/rewards (password: savings) or calling **1.800.258.3312**.

Orthodontics in Progress

If you choose the Enhanced plan which covers orthodontic care, you will have coverage for treatment in progress. The coverage will begin at the effective date of your Cigna plan. Any services incurred prior to the effective date would be paid by your previous carrier.

Your benefit amount is determined by your plan's benefit level for orthodontia and the number of months of active treatment remaining when the Enhanced plan with Cigna takes effect. For additional information, please visit www.cigna.com/stateofct.

Dental Treatment in Progress

Some dental procedures require several treatment dates from start to finish. For example, a root canal generally requires two visits – one for the core build-up and a second for crown placement. As a general rule, claims for a "treatment in progress" are paid by the insurance carrier you were enrolled with when the treatment began.

For example, a crown procedure that starts in June 2014 under the previous plan but is completed in July 2014 after the Cigna plan becomes effective is considered treatment in progress and is paid under the previous plan.

Other examples might include treatment for a root canal, crown and bridge, or dentures. If your treatment began before July 1, 2014, your provider should submit the claim directly to the previous plan for review. This is a standard process in the insurance industry for transition of care.



Retirement Health Insurance Open Enrollment Application



State Of Connecticut
Office of the State Comptroller
Healthcare Policy & Benefit Services Division
Retirement Health Insurance Unit
55 Elm Street
Hartford, CT 06106-1775
www.osc.ct.gov

TYPE OR PRINT AND FORWARD TO THE RETIREMENT SERVICES DIVISION
INSURANCE IS EFFECTIVE THE FIRST OF THE MONTH FOLLOWING THE RETIREMENT DATE

RETIREE NAME (Person Receiving Benefit) (Last Name, First Name, MI)	RETIREMENT DATE	EMPLOYEE NUMBER (From Active Employment)
MAILING ADDRESS		TELEPHONE NUMBER

YOUR OPTIONS

This statement lists your benefit options. Use this page to select your medical and dental coverage. Note that your choices will remain in effect throughout this plan year unless you experience a change in family status. Please keep a copy of this form for your records. Please be aware that you and any dependents who enroll in medical coverage must also enroll in prescription coverage and that prescription coverage is not available to individuals who are not enrolled in a medical plan. Check the box to the left of the plan you wish to select.

ANTHEM

- ☐ State BlueCare POS
- ☐ State BlueCare POE
- ☐ State BlueCare POE Plus POE-G
- ☐ State Preferred POS – **Currently Enrolled Only**
- ☐ Out of Area Plan – **Only if Retiree's Permanent Residence is Outside of Connecticut**

MEDICAL

OXFORD

- ☐ Oxford Freedom Select POS
- ☐ Oxford HMO Select POE
- ☐ Oxford HMO POE-G
- ☐ Oxford USA - Out of Area Plan – **Only if Retiree's Permanent Residence is Outside of Connecticut**
- ☐ Waive/Cancel Medical and Prescription Coverage

DENTAL

- ☐ Basic Dental Plan
- ☐ Enhanced Dental Plan
- ☐ Dental HMO Plan
- ☐ Waive/Cancel Dental Coverage

RETIREE/DEPENDENTS

List you and all of your dependents to be enrolled in health coverage. Note that the retiree must be enrolled in a health plan to be able to enroll eligible dependents. Attach sheets to list additional dependents. If any listed dependent age 19 or over is disabled, attach special application for covered dependent, which may be obtained from the Retirement Health Insurance Unit.

NAME	RELATIONSHIP (i.e., Spouse, Son, Daughter)	GENDER F M	DATE OF BIRTH	SOCIAL SECURITY NUMBER	MEDICAL & PRESCRIPTION	DENTAL
	Retiree	<input type="checkbox"/> <input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
	Dependent 1:	<input type="checkbox"/> <input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
	Dependent 2:	<input type="checkbox"/> <input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
	Dependent 3:	<input type="checkbox"/> <input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>

COORDINATION OF BENEFITS – APPLICATION IS INVALID UNLESS THIS SECTION IS COMPLETED

When you are covered by the Health Plan Selected will you or your dependent(s) have any other coverage? ☐ Yes ☐ No
If yes, which family member(s) will be covered by that insurance? (Check off as many that apply)
☐ Self ☐ Spouse ☐ Children (List Names):

NAME OF PLAN	ADDRESS
POLICY NUMBER	NAME OF PERSON(S) POLICY ISSUED TO
EFFECTIVE DATE	COMPANY THROUGH WHICH COVERAGE OBTAINED

Is any member listed above eligible for Medicare? ☐ Yes ☐ No

If yes give Medicare Part A (Hospital Insurance) and Medicare B (Medical Insurance) effective date(s):

RETIREE		Dependent 1		Dependent 2		Dependent 3	
PART A (MO/YR)	PART B (MO/YR)	PART A (MO/YR)	PART B (MO/YR)	PART A (MO/YR)	PART B (MO/YR)	PART A (MO/YR)	PART B (MO/YR)

I hereby apply for membership in the plan(s) above. I understand that if I am changing plans, my current coverage will be canceled when my new coverage takes effect. I understand that the services will be available subject to exclusions, limitations, and conditions described by the health plan.

I certify that all information on this form is correct to the best of my knowledge and belief, and understand that providing false and/or incomplete information may result in the rescission of coverage and/or nonpayment of claims for myself or my eligible dependent(s). I hereby authorize the State Comptroller to make deductions, if applicable, from my pension check for the medical and/or dental insurance indicated above.

RETIREE SIGNATURE (Person Receiving Benefit)	DATE
--	------

Forms must be postmarked by June 13, 2014.

To enroll or make changes, clip out this form,
complete it and return it to:

**Office of the State Comptroller
Retirement Health Insurance Unit
55 Elm Street
Hartford, CT 06106-1775**

**or
Fax: 860-702-3556**

Medicare and You

Medicare is a federal healthcare insurance program for people age 65 and older. While the Social Security retirement age is creeping up, the eligibility age to start Medicare is age 65. People younger than age 65 may also qualify for Medicare due to certain disabilities or health conditions (such as permanent kidney failure or Lou Gehrig's disease). If you or a dependent becomes eligible for Medicare due to disability no matter what age, be sure to contact the Retirement Health Insurance Unit at 860-702-3533. This section covers Medicare for retirees only.

Medicare coverage is made up of various parts. If you are eligible for Medicare, you are automatically covered by Medicare Part A (hospital care) and must enroll yourself in Medicare Part B (physician services).

What to Do When You Become Eligible for Medicare

When you reach age 65, your State of Connecticut medical and prescription drug benefits will “wrap around” your Medicare benefits. Medicare will be your primary coverage and your State of Connecticut sponsored plan will pay after Medicare. This means you continue the same level of benefits that you are used to.

Do Enroll in Medicare Part A and B

Medicare Part A is free and enrollment automatic if you are at least age 65. You must enroll in Medicare Part B and pay a premium. It is essential that you enroll in Medicare Parts A and B for the first of the month you are first eligible for enrollment. Typically this is the first of the month in which you turn 65. Failing to do so will result in a “hole” in your coverage. Your State sponsored medical and prescription coverage will automatically be noted as secondary upon your 65th birthday.

Your standard premium for Medicare Part B will be reimbursed by the State effective from the date your Medicare Part B card is received by the Retirement Health Insurance Unit. (Medicare premiums paid before your card is received will not be reimbursed.) The 2014 standard Medicare Part B/Part D premium reimbursement is \$104.90, as long as you are not receiving reimbursement from any other source.

Be sure to send us a copy of your red, white and blue Medicare card as soon as you receive it. You will receive a letter from the Retirement Health Insurance Unit with more information just prior to your reaching age 65.

Additionally, you may be required to pay an Income Related Monthly Adjustment Amount (IRMAA) for Medicare Parts B and D in addition to the standard rate. Social Security will advise you by letter annually if you are required to pay a higher rate. Send a copy of this letter along with your red, white, and blue Medicare card in order to receive full reimbursement.

Do Not Enroll in Medicare Part C or Part D

The State of Connecticut prescription coverage with SilverScript (a subsidiary of Caremark) is a Medicare Part

D plan. When you or your covered dependents become eligible for Medicare, you will automatically be enrolled in the Part D prescription drug plan administered by SilverScript. You do not need to do anything except start using your SilverScript card once received.

Once enrolled, you will receive more information. However, there are four key things you need to know because SilverScript is a Medicare Part D prescription drug plan:

- **Do not opt out of the SilverScript prescription drug program.** SilverScript is required by Medicare to send you a letter giving you a chance to opt out or cancel your prescription drug enrollment, **but don't do it.** If you opt out, medical and prescription drug coverage from for you and your dependents will terminate. **Please ignore the opt out letter.**
- **Do not enroll in an individual Medicare prescription drug plan (through Medicare Part C or Part D).** You are only able to enroll in one Medicare Part D plan. Your State sponsored coverage with SilverScript is a Medicare Part D plan enrollment. Enrolling in any other Medicare Part D plan will cause your State of Connecticut medical and pharmacy coverage to end for you and your dependents.
- **Do make sure we have your street address.** If you receive your mail at a post office box, you must provide a residential street address to the Retirement Health Insurance Unit (per Center for Medicare and Medicaid Services regulations). All communication will still go to your noted mailing address.
- **Do promptly submit higher premium notices.** If your premium will be more than the standard premium rate, send a copy of your 2014/2015 IRMAA notice to the Retirement Health Insurance Unit to ensure proper reimbursement.

If Family Members Are Not Yet Eligible for Medicare

If you have covered dependents who are not yet eligible for Medicare (typically those under age 65), their current coverage through CVS Caremark will stay the same. There will be no change to their co-pay structure, and they will continue to participate in the mandatory maintenance drug network program. This means that after their first fill of a maintenance medication, refills must be filled through a pharmacy participating in the State's Maintenance Drug Network or through the CVS Caremark mail-order pharmacy. A full list of all participating pharmacies is available on the Comptroller's website at www.osc.ct.gov.








For More Information

Contact SilverScript with questions about your prescription coverage, ID cards, and participating pharmacies or the Retirement Health Insurance Unit with questions about eligibility or premiums. Contact information is at the back of the booklet.

Have Questions for SilverScript?

Call 866-693-4624

Your Benefit Resources

For details about specific plan benefits and network providers, contact:			
Health Enhancement Program (HEP) Care Management Solutions (an affiliate of ConnectiCare)	www.cthep.com	1-877-687-1448	
Anthem Blue Cross and Blue Shield <ul style="list-style-type: none"> • Anthem State BlueCare (POE) • Anthem State BlueCare POE Plus (POE-G) • Anthem Out-of-Area • Anthem State BlueCare (POS) 	www.Anthem.com/statect	1-800-922-2232	
UnitedHealthcare (Oxford) <ul style="list-style-type: none"> • Oxford Freedom Select (POS) • Oxford HMO Select (POE) • Oxford HMO (POE-G) • Oxford USA Out-of-Area 	www.welcometouhc.com/stateofct	1-800-385-9055 Call 1-800-760-4566 for questions before you enroll	
Caremark (Prescription drug benefits, any medical plan, non-Medicare eligible)	www.Caremark.com	1-800-318-2572	
SilverScript (Prescription drug benefits, any medical plan, Medicare eligible)	http://stateofconnecticut.silverscript.com	1-866-693-4624	
CIGNA <ul style="list-style-type: none"> • Basic Plan • Enhanced Plan • DHMO Plan 	www.Cigna.com/stateofct	1-800-244-6224	
For information about eligibility, enrolling in the plans, making changes to your coverage, or premium share amounts, contact:			
Office of the State Comptroller Retirement Health Insurance Unit 55 Elm Street Hartford, CT 06106-1775	www.osc.ct.gov	(860) 702-3533	



Healthcare Policy & Benefit Services Division
Office of the State Comptroller
55 Elm Street
Hartford, CT 06106-1775

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See pages 11 and 22.





STATE OF CONNECTICUT HEALTH BENEFIT PLAN

PLAN DOCUMENT

Restated as of July 1, 2014

TABLE OF CONTENTS

INTRODUCTION	5
I. PLAN DESCRIPTIONS	6
A. POE GATED —POINT OF ENROLLMENT GATEKEEPER	6
B. POE—POINT OF ENROLLMENT	6
C. POS—POINT OF SERVICE	6
D. STATE PREFERRED—POS	6
E. OUT OF AREA PLAN	7
F. HEALTH ENHANCEMENT PROGRAM	7
G. CARRIER CONTACT INFORMATION	8
II. SCHEDULE OF BENEFITS	9
POINT OF ENROLLMENT (POE)/POINT OF ENROLLMENT – GATEKEEPER (POE-G)	9
POINT OF SERVICE PLANS	12
III. DEFINITIONS	17
DEFINITIONS	17
IV. ELIGIBILITY, ENROLLMENT AND TERMINATION OF COVERAGE	35
A. ELIGIBILITY	35
Active Employees	35
Retired Employees	35
PROHIBITION OF DUAL COVERAGE	36
Dependents	36
a. Spouse or Recognized Civil Union Partner	36
b. Child of the Covered Person or Spouse	36
c. Newborn Dependent Child	37
d. Newborn Child of an Enrolled Dependent	37
e. Totally Disabled Dependent Child	37
f. Minor Child for whom a Covered Employee is Legal Guardian	38
Notice of Change in Status	38
Proof of Dependent Status	38
Penalties for Enrollment of Ineligible Individual	39
B. ENROLLMENT PROCEDURES	40
C. COVERAGE DURING LEAVES OF ABSENCE	42
Paid Leave.....	42
Unpaid Leave	42
Effect of Leave on Open Enrollment	42
D. TERMINATION OF COVERAGE	43
Change of Work Status	43
Death.....	43
Change in Marital Status.....	43
Loss of Dependent Child Status	43
V. MANAGED CARE GUIDELINES	43
A. INTRODUCTION	44
B. MEDICAL POLICY	44
C. MEMBER RESPONSIBILITIES WHEN OBTAINING HEALTH CARE—PRIOR AUTHORIZATION	44
1. Services Requiring Prior Authorization	45
2. Obtaining Prior Authorization	45
3. Who is responsible for obtaining Prior Authorization?	45
4. Prior Authorization for Inpatient Admissions	46

5.	Failure to obtain Prior Authorization.....	46
6.	Medical Emergency Admissions	46
	Medical Emergency Admissions	46
VI.	COVERED SERVICES	48
A.	PRIMARY AND PREVENTIVE CARE	48
	Well-Baby and Well-Child Care.....	48
	Adult Physical Examinations	49
	Well-Woman Routine Gynecological Examinations	49
	Immunizations	50
	Colorectal Cancer Screenings	50
	Diabetes Management (Equipment, Supplies and Education)	51
	Vision Exams.....	52
	Hearing Exams.....	52
	Naturopathic Physicians.....	52
	Laboratory Tests	52
B.	SPECIALTY CARE	52
	Surgical Services.....	52
	Reconstructive and Corrective Surgery	53
	Inpatient and Outpatient Dental Services.....	54
	Allergy Testing and Treatment	55
	Obstetrical/Maternity Care.....	55
	Newborn Care	56
	Infertility Services.....	56
	Nutritional Counseling.....	57
	Mental Health Services	57
	Substance Abuse	59
	Diagnostic Procedures	59
	Acupuncture.....	60
	Gender Identity Disorder	60
C.	HOSPITAL AND OTHER FACILITY-BASED SERVICES	61
	Inpatient Admissions	61
	Outpatient Surgery	63
	Walk-In Medical Centers or Clinics	63
	Urgent Care Centers.....	64
	Hospital Emergency Rooms—Medical Emergencies	64
	Ambulance Services.....	65
D.	THERAPY SERVICES	65
	Autism Services	65
	Chemotherapy	66
	Chiropractic	66
	Early Intervention Services	66
	Electroshock Therapy	67
	Infusion Therapy.....	67
	Kidney Dialysis.....	67
	Outpatient cardiac rehabilitation therapy	67
	Outpatient physical and occupational therapy	67
	Radiation therapy	68
	Speech therapy	68
E.	HOSPICE CARE (INPATIENT OR HOME BASED)	68
F.	HOME HEALTH CARE	69
G.	HUMAN ORGAN TRANSPLANTS	70
H.	OTHER MEDICAL SERVICES AND SUPPLIES	74
	Durable Medical Equipment	74
	Prosthetic Devices and Appliances	74
	Hearing Aid Coverage	75

Foot Orthotics	75
Ostomy Related Services	75
Specialized Formula.....	75
Medically Necessary Specialized Infant Formula.....	76
Wigs.....	76
I. OTHER COVERED SERVICES	76
Blood and blood plasma.....	76
Blood derivatives	76
Blood lead screenings	76
Intravenous and oral antibiotic therapy	76
Medically Necessary Pain Management	76
Routine Patient Care Costs in connection with Cancer Clinical Trial	76
Private Duty Nursing	77
VII. EXCLUSIONS AND LIMITATIONS	78
VIII. APPEALS AND GRIEVANCES	87
A. FIRST LEVEL APPEAL	87
B. SECOND LEVEL APPEAL	89
C. EXTERNAL APPEALS	90
Filing an External Appeal	91
Expedited External Appeals.....	93
Timeframes for Resolution	93
Binding Effect of External Appeal Decision.....	94
IX. COORDINATION OF BENEFITS	95
A. APPLICABILITY	95
B. DEFINITIONS	95
C. ORDER OF BENEFIT DETERMINATION RULES	97
D. EFFECT OF THIS BENEFIT PROGRAM ON THE BENEFITS	99
E. RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION	99
F. FACILITY OF PAYMENT	99
G. RIGHT OF RECOVERY	99
X. RIGHT OF RECOVERY	101
A. WORKERS' COMPENSATION	101
B. AUTOMOBILE INSURANCE	102
XI. CONTINUATION OF COVERAGE—COBRA	103
QUALIFYING EVENTS	103
NOTIFICATION REQUIREMENTS	104
COBRA ADMINISTRATOR	106
XII. GENERAL PROVISIONS	107
XIII. PROTECTED HEALTH INFORMATION	108

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 which 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

I. 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. 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

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. **This plan is closed to new Members.**

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.

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, 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
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 48 Monroe Turnpike Trumbull, CT 06611-1341 1-800-385-9055 http://stateofct.welcometouhc.com
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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
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*
Maternity—Prenatal services	\$15 Co-pay (first visit only) (\$5 for pre-1999 retirees)

*Non-HEP Members must satisfy deductible before being covered at “no charge” for Participating Provider (In-Network) care. Deductible does not apply to Preventive Care.

POE AND POE-G PLANS	
MEDICAL SERVICES	Cost-Share
Infertility Services	\$15 Co-pay
Office Visit	(\$5 for pre-1999 retirees)
Outpatient Hospital	No Co-pay*
Inpatient Hospital	No Co-pay*
Gender Identity Disorder Services	\$15 Co-pay
Office Visit	\$5 for pre-1999 retirees
Outpatient Hospital	No Co-pay*
Inpatient Hospital	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	No Co-pay*
Inpatient Unlimited (Prior Authorization required)	
EMERGENCY SERVICES/ URGENT CARE/WALK-IN CLINICS	Cost-Share
Emergency Room Treatment	\$35 ¹ Co-pay
Co-payment waived if Admitted to Hospital	
Emergency Ambulance Services	No Co-pay*
Urgent Care Center/ Walk-in Clinic	\$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	No Co-pay*
Maximum of 3 visits per Covered Person per Calendar Year	
Private Duty Nursing (Prior Authorization required)	No Co-pay*
Home Health Care	No Co-pay*
Maximum benefit	200 visits per year
In-Home Hospice	No Co-pay*

¹ Not required for pre-October 2, 2011 retirees

*Non-HEP Members must satisfy deductible before being covered at “no charge” for In-Network care. Deductible does not apply to Preventive Care.

POE AND POE-G PLANS	
OTHER HEALTH CARE SERVICES	Cost-Share
Infusion Therapy	No Co-pay*
Acupuncture (Coverage may vary by Carrier)	\$15 per visit
OUTPATIENT REHABILITATION SERVICES:	Cost Share
Physical or Occupational Therapy (Prior Authorization Required)	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 Physical, occupational, and speech therapy	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 Aid —Coverage limited to Dependent children 12 years of age or younger. (Limited to one hearing aid 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 (Subject to Prior Authorization)	\$15 per visit \$5 for pre-1999 retirees
Inpatient Mental Health (Subject to Prior Authorization)	No Co-pay *
Outpatient Substance Abuse (Subject to Prior Authorization)	\$15 per visit \$5 for pre-1999 retirees
Inpatient Substance Abuse (Subject to Prior Authorization)	No Co-pay

POINT OF SERVICE PLANS		
GENERAL INFORMATION	IN-NETWORK SERVICES	OUT-OF-NETWORK SERVICES
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 + 100% of billed charges in excess of allowable charges
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	Patient Share	Patient 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:	\$15 Co-pay (Waived for HEP members every other year)	Deductible plus 50% Coinsurance
Limit	1 exam per year	1 exam per year
Routine Hearing Screening: One per calendar year (when performed as part of an exam)	No 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-Surgical Services of a Physician or Surgeon (Other than medical office visit, may include after care or attending medical care)	\$15 Co-pay \$5 for pre-1999 retirees	Deductible plus Coinsurance**

POINT OF SERVICE PLANS		
GENERAL INFORMATION	IN-NETWORK SERVICES	OUT-OF-NETWORK SERVICES
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	Patient Share	Patient Share
Emergency Room Treatment Waived if patient Admitted to hospital	\$35 Co-pay 2	\$35 Co-pay 3
Urgent Care Clinic/Walk-in Clinic	\$15 Co-pay \$5 for pre-1999 retirees	Deductible plus Coinsurance**
Emergency Ambulance	No Co-pay *	No Co-pay*
OTHER HEALTHCARE SERVICES	Patient Share	Patient 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**
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	No Co-pay*	Deductible plus Coinsurance**
Utilization Limits	200 visits per year	200 visits per year
In-Home Hospice	No Co-pay*	Deductible plus Coinsurance** 200 visits per year
Acupuncture (Coverage may vary by Carrier)	\$15 Co-pay	Deductible plus Coinsurance**
Infusion Therapy Unlimited	No Co-pay*	Deductible plus Coinsurance**
MEDICAL SERVICES	Patient Share	Patient Share

² 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.

³ Not required for pre-October 2, 2011 retirees

POINT OF SERVICE PLANS		
GENERAL INFORMATION	IN-NETWORK SERVICES	OUT-OF-NETWORK SERVICES
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:	\$15 Co-pay (Waived for HEP members every other year)	Deductible + 50% Coinsurance
Limit	1 exam per year	1 exam per year
Routine Hearing Screening: One per calendar year (when performed as part of an exam)	No 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-Surgical Services of a Physician or Surgeon (Other than medical office visit, may include after care or attending medical care)	\$15 Co-pay \$5 for pre-1999 retirees	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**
Surgical Removal of breast implant	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)	Deductible plus Coinsurance**
Gender Identity Disorder Services Office Visit Outpatient Hospital Inpatient Hospital	\$15 Co-pay (\$5 for pre-1999 retirees) No Co-pay* No Co-pay*	Deductible plus Coinsurance**
HOSPITAL SERVICES	Patient Share	Patient 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

POINT OF SERVICE PLANS		
GENERAL INFORMATION	IN-NETWORK SERVICES	OUT-OF-NETWORK SERVICES
Skilled Nursing Facility (Prior authorization required)	No Co-pay*	Deductible plus Coinsurance**
Utilization limit	None	60 days per Covered Person
Inpatient Hospice Care (Prior authorization required)	No Co-pay*	Deductible plus Coinsurance**
Utilization limit	None	60 days per Covered Person
OUTPATIENT REHABILITATION SERVICES	Patient Share	Patient Share
Physical or Occupational Therapy Prior Authorization may be required⁴ Benefit limit	No Co-pay* None	Deductible plus Coinsurance** 30 visits per year
Chiropractic Therapy Benefit Limit	No Co-pay* None	Deductible plus Coinsurance** 30 visits per 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, 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	No Co-pay*	Deductible plus Coinsurance**
MEDICAL DEVICES/SUPPLIES	Patient Share	Patient 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	No Co-pay	Deductible plus Coinsurance**

⁴ 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.

** With the exception of out-of network Vision exams you will pay 20% of the Maximum Allowable Charge plus 100% of any amount your provider bills in excess of the allowable charge

POINT OF SERVICE PLANS		
GENERAL INFORMATION	IN-NETWORK SERVICES	OUT-OF-NETWORK SERVICES
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	No Co-pay	Deductible plus Coinsurance**
Medical and Ostomy Related Services	No Co-pay	Deductible plus Coinsurance**
Hearing Aid —Coverage limited to Dependent children 12 years of age or younger (Benefit limited to one hearing aid within a 24 month period_	No Co-pay	Deductible plus Coinsurance**
Outpatient Treatment for Mental Health Care (Prior Authorization required)	\$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 (Prior Authorization required)	\$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**

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.

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 the pervasive developmental disorders set forth in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders," including, but not limited to, Autistic Disorder, Rett's Disorder, Childhood Disintegrative Disorder, Asperger's Disorder, and Pervasive Developmental Disorder Not Otherwise Specified. The results of an autism spectrum 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 fifteen 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 of 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. It is waived for members of 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.

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 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 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.

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.

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 for the Maximum Allowed Amount for the Benefit Plan is 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 for 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 the 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.

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 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.

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.

PLAN SPONSOR means the State of Connecticut.

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, effective July 1, 2013, 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 employees who leave State service in deferred, vested status with sufficient actual service to qualify for retiree health benefits and which defers such individual's eligibility for coverage under the Benefit Plan until the combination of their age and State service equals 75.

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.

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

State Employees are eligible to participate in the Active Benefit Plan after completing any waiting period required by the terms of employment. Unless otherwise specified in an applicable Collective Bargaining Agreement or by the terms of employment an employee must work at least one-half ($\frac{1}{2}$) 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. Special rules apply to employees not in classified service, for part-time professional employees in higher education agencies, and for other groups participating in the State Employee plans under Section 5-259 of the General Statutes.

Position To be eligible to enroll in the health Benefit Plan an active employee must also be a:

- a. Permanent employee, or
- b. Temporary employee who has completed six (6) months in a temporary position, or
- c. Provisional appointee who has completed six (6) months of continuous service, or if service is continued in another status, following the completion of a four-month appointment without an examination being given. Coverage will be effective on the first of the month following the completion of six months continuous service, or
- d. Permanent employee in a durational position, following completion of required service as set forth in any applicable union contract.

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 recognized Civil Union Partner.

Note:

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

Exception: An individual from whom the Covered Employee is legally separated may be continued to be covered under the Plan but only if spouse was covered by the Plan immediately before (and after) entry of the judgment of legal separation and the legal separation that was reported to the Employer on or before July 1, 2012. Continuation coverage is available for the earlier of three years or the date of remarriage by either party, whichever occurs first. The fair market value of such coverage will be imputed as income to the Covered Employee.

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 for whom the

Covered Employee has been designated as the responsible party under a Qualified Medical Child Support Order) under the age of 26.

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.

d. **Newborn Child of an Enrolled Dependent**

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 and submits Proof of such legal guardianship.

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.

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 or be eligible 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 has been named the legal guardian of the person by a court of competent jurisdiction may be enrolled as a Dependent. Coverage for such child 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.

Notice of Change in Status

It is the responsibility of the Covered Employee to notify the Plan Sponsor of any change in the status of an enrolled individual within 60 days of the event or occurrence that renders such individual ineligible for continued coverage as a Dependent. Active employees should notify the personnel/payroll office of their employing agency. Retirees should notify the Office of the State Comptroller. Examples of such status changes include:

- A covered child’s attainment of age 26,
- Termination of a legal guardianship for an enrolled child as result of court order, 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: Except as provided above, a judgment of legal separation or a divorce decree that requires a Covered Person to maintain health benefit coverage for a former spouse does not make such individual eligible for enrollment or coverage under the Benefit Plan.

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 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
- Payment of income tax on the fair market value of health benefit coverage provided to an ineligible individual, which will be reported to the Internal Revenue Service as additional wages or miscellaneous income to the employee/retiree/or ineligible individual;
- 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 when you satisfy the Rule of 75, provided that you enroll within 31 days of the event. If you do not enroll during that period 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 made within thirty-one (31) days of the event that results in an individual's loss or change of coverage.

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 affects 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.

- For active employees Mid-Year Enrollment changes are processed by the payroll/personnel office of the employing agency. For retirees, Mid-Year Enrollment changes are processed by the Office of the State Comptroller.

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.

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 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. 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 of the 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, laid off, 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 event.
- 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 automatically terminate the first day of the month following the date of separation, divorce, or annulment. Failure 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 second month following the child's twenty-sixth (26) birth date, 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.

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 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, do not constitute differences in Covered Services. 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, of certain services is required so that the Carrier can review the service to verify that it is Medically Necessary and that the treatment provided is the proper level of care. Prior Authorization may be obtained by contacting the Carrier at the telephone number located on the back of the Covered Person's 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 to obtain Prior Authorization 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 for which Prior Authorization is required from a Non-Participating Provider.

1. Services Requiring Prior Authorization

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

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 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:** Effective July 1, 2013 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 radiologic 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	Drawing-up devices for visually impaired
Acetone Reagent Tablets	Equipment for use of the Pump
Alcohol or Peroxide by the pint	Glucose Acetone Reagent Strips
Alcohol Wipes	Glucose Reagent Strips
All insulin preparations	Glucose Reagent Tape
Automatic Blood Lance Kit	Injection aides
Blood Glucose Kit	Injector (Busher) Automatic
Blood Glucose Strips—Test or Reagent	Insulin Cartridge Delivery
Blood Glucose Monitor and strips	Insulin infusion devices
Cartridges for the visually impaired	Insulin Pump
Diabetes data management systems	Lancets
Disposable insulin and pen cartridges	

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:
 - 1) Evaluation;
 - 2) Radiology to evaluate extent of injury;
 - 3) Treatment of the wound, tooth fracture or evulsion;
 - 4) 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:
 - 1) 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
 - 2) 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, 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 year for individualized nutritional evaluation and counseling by a registered dietitian.

Exclusions and Limitations

- Coverage is limited to 3 visits per Covered Person per 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.

Prior Authorization may be required for Outpatient services for treatment of mental or nervous conditions according to each Carrier's requirements.

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. Prior Authorization is required in accordance with Carrier guidelines.

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 year. Prior Authorization is required for Out-of-Network services.
- b. For **Anthem** members, the use of acupuncture is considered Medically Necessary for treatment of osteoarthritis, 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:

- 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.

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 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 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. For Oxford members Outpatient Surgery includes an annual colorectal screening, colonoscopy, flexible sigmoidoscopy, for which Prior Authorization is 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.

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;
- 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.

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;
- Services under this section are subject to a maximum benefit of \$6,400 per covered Child per Plan Year and an aggregate per child maximum benefit per child of \$19,200 over a three year period.

5. Electroshock Therapy.

6. Infusion Therapy: Benefits will be provided Infusion Therapy administered in an Outpatient Hospital, Physician 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.

8. Outpatient cardiac rehabilitation therapy.

9. Outpatient physical and occupational therapy (requires Prior Authorization⁵); 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:

⁵ Prior Authorization is not required for pre-October 2, 2011 retirees.

- 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 year, prior authorization may be required.

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)
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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 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 items 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 devices 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 prosthesis 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 hearing aid per 24-month period.
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 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** medications and 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.
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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
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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:

- a. Transport for elective Hospital Admissions; and
- b. 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.

1. Utilization Management (Clinical) Appeals

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

Anthem Blue Cross and Blue Shield

First Level Appeal Review

108 Leigus Road

Wallingford, CT 06492

FAX: 203-985-7363

Verbal appeal requests: Call Member

Services at 800-922-2232

UnitedHealthcare/Oxford

Attn: Clinical Appeals Department

P.O. Box 29139

Hot Springs, AR 71903

FAX: 877-220-7537

Verbal appeal requests: 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:

Anthem Blue Cross and Blue Shield

First Level Appeal Review

108 Leigus Road

Wallingford, CT 06492

FAX: 203-985-7363

Verbal appeal requests: Call Member

Services at 800-922-2232

UnitedHealthcare/Oxford

Attn: Grievance Review Board

P.O. Box 29134

Hot Springs, AR 71903

FAX: 203-601-6893

Verbal appeal requests: Call Member

Service Associates at 800-385-9055

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.

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	20 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 in the Anthem Plans may—but are not required—to pursue a second level appeal before seeking an external review of an adverse determination before the Connecticut Department of Insurance. Members who are enrolled in UnitedHealthcare/Oxford Plans, must complete a second level appeal before seeking external review before the Connecticut Department of Insurance.

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:

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

UnitedHealthcare/Oxford
Attn: Grievance Review Board
P.O. Box 29134
Hot Springs, AR 71903
FAX: 866-352-6053
Verbal Appeals: 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:

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

FAX: 203-985-7363

Verbal Appeals: Call Member Services
800-922-2232

FAX: 203-601-6893

Verbal Appeals: Call Member Service
Associates at 800-385-9055

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.

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	15 calendar days
Utilization Review Post Service	30 calendar days	30 calendar days
Non-Utilization Review	20 calendar days	20 calendar 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 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.

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.

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.

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.

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.

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.

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 only, send the application for External Review to:

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

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:

- 30 calendar days You are or were a Member of the Plan at the time of the event that is subject of the Adverse Determination;
- The service in question reasonably appears to be a Covered Service under the 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;
- 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 appropriate), 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 provision 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, prescription drugs, or hearing aid programs. 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: State of Connecticut or its designee.

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 Plan⁶, 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

⁶ Except when the Carrier is secondary payor.

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

- 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

Under the law, 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 completed 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.

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

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 form 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)(1)(iii)(C) is included in the appropriate notice.

5. **Adequate Separation between the Plan and the Plan Sponsor.** The Plan Sponsor shall only allow employees of the Office of the State Comptroller, Healthcare Policy & Benefit Services Division, access to 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, provided the Plan Sponsor requests the Summary Health Information 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 to the level of a five-digit zip code.

State of Connecticut HEP Preventive Care Requirements 2014

Preventive Service	Birth – Age 1	Age 1-5	Age 6-17	Age 18 – 24	Age 25 – 29	Age 30 – 39	Age 40 – 49	Age 50+
Preventive Visits	At least 1 per year	At least 1 per year	Every 2 years	Every 3 years	Every 3 years	Every 3 years	Every 2 years	Every year
Vision Exam	N/A	N/A	N/A	Every 7 years	Every 7 years	Every 7 years	Every 4 years	50 -64 Every 3 years 65 and over Every 2 years
Dental Cleanings*	N/A	N/A	At least 1 per year	At least 1 per year	At least 1 per year	At least 1 per year	At least 1 per year	At least 1 per year
Cholesterol Screening	N/A	N/A	N/A	Every 5 years starting at 20	Every 5 years	Every 3 years	Every 2 years	Every year
Cervical Cancer Screening (Pap Smear)	N/A	N/A	N/A	Every 3 years starting at 21	Every 3 years	Every 3 years	Every 3 years	Every 3 years
Colorectal Cancer Screening	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Colonoscopy every 10 years or Annual FIT/FOBT

As is currently the case under the State Health plan, any medical decisions will continue to be made by you and your physician

*Dental cleanings are required for family members who are participating in one of the State dental plans

State of Connecticut

P.A. 11-58

Partnership Plan

February 21, 2012

Rules of Operations

A. Background

The State employee/retiree medical and pharmacy risk pool is large and experience is predictable. It presently has about \$1.3 billion of claims per year and covers over 200,000 persons. The State is able to achieve competitive administrative fees from its third party administrators (TPAs) and competitive pricing for its pharmacy benefits (i.e. discounts, dispensing fees, rebates). By allowing municipalities to join with the State in this risk pool, municipalities may achieve both lower costs for their benefits as well as longer term price stability.

The program must be established such that the State employee/retiree program's experience and rate levels are not significantly affected by the inclusion of municipalities in the risk pool. This will be achieved by:

1. Setting rates for each municipality based on its expected claims experience, providing medical and pharmacy coverage under a "guaranteed cost" basis, under which the municipality pays only the prescribed rates during the year and has no liability for the variation of their actual experience from what was assumed in the rate-setting during the policy year. (This approach applies to groups that are presently fully insured and those that are presently self-insured.)
2. Incorporating a "fluctuating reserve fee" (i.e. a risk charge) of, initially, 3.5% of expected claims to cover variances between actual and expected claims.
3. Requiring all the employees of a municipality or Board of Education (Note this makes language consistent with Public Act 11-58) to participate or else participation in the program will need to be approved by the Comptroller, SEBAC and OPM and the rates will be subject to a surcharge to cover uncertainties in the underlying experience of the portions of the group that will enroll.
4. Renewal rates for each group will be set based on their emerging experience, within minimum and maximum rate changes that may be promulgated.

B. Risk Management

The use of the "fluctuating reserve fee" in setting the rates charged to participating municipalities creates a buffer that protects the State employee/retiree risk pool from variances in experience of participating municipalities. The hierarchy of funds that are

available to cover the claims of participating municipalities is: expected claim charge included in rates charged to the municipality, "fluctuating reserve fee" for the year that is added to the expected claims, accumulation of gains from the municipal pool from prior years (this will be \$0 in the first year), and then the State employee/retiree risk pool. Assuming that the rates are properly set for each participating municipality, the "fluctuating reserve fee" should accumulate over time to create a "surplus account" for the municipal pool to cover year to year fluctuations in experience. The combination of the "fluctuating reserve fee" and the renewal rate guarantees work together to ensure that the municipal pool, in total, is sufficient to fund its obligations without transferring risk to the State employee/retiree program.

PA 11-58 requires that the State employee pool cannot take on substantial risk related to the Partnership Plan. To keep the risk at a modest level, the rates for municipal groups participating in the Partnership Plan will include an explicit risk charge (i.e. "fluctuating reserve fee") of 3.5% of the expected claim costs for the group. This percentage may increase or decrease over time based on the experience of the program and any surplus that may accumulate from the program. Should surplus start to accumulate, amounts in excess of what is determined appropriate will be distributed to participating municipalities in the form of reduced "fluctuating reserve fees". Changes in the "fluctuating reserve fee", either upwards or downwards, need to be approved by the Comptroller, SEBAC and OPM. Decreases may only be considered once the program reaches its target surplus established by the HCCCC. Increases may be considered if the program's experience consistently runs worse than expected such that deficits are likely to arise.

The primary risks of the program are the same as the risks that any risk pool undertakes:

- Pricing risk – the risk that the rates set for a group are not representative of the group's true underlying experience
- Severity risk – the risk that several very large amount claims arise in a group during the year, more than would typically be expected (and reflected in the rating) for a comparable group
- Incidence risk – the risk that the general use of medical services exceeds what is typically expected. For example, a very bad flu season could generate many more physician visits, prescriptions, ER visits, etc. than would typically be expected
- Selection risk – the risk that less than 100% of the current risk pool for the municipality participates in the Partnership Plan, with the least healthy lives from the groups entering the Plan. (Note: the pricing is intended to reflect the health status of the participating members, but if the group does not have experience for the segment participating, there could be an additional pricing risk due to the selection factor.)

The pricing methodology discussed above addresses these risks as follows:

- Pricing risk – rates are set based on each municipality's actual historical experience, along with reference to current and historical rate levels.
- Severity risk – the "fluctuating reserve fee" provides some protection against large amount claims. Also, the pooling of the experience of the participating municipalities

allows a balancing between groups with more than expected large amount claims against those with fewer than expected

- Incidence risk – the “fluctuating reserve fee” provides protection from such variances
- Selection risk – the surcharge added to the rates when less than a full group participates provides some protection.

C. Surplus in the Municipal Pool

The fact that the rates being charged to the participating municipalities will include a “fluctuating reserve fee” implies that, on average and over time, there should be more than sufficient funds collected from the municipalities to cover the claims and expenses of their benefits programs. At the outset of the program, this surplus is zero, since no funds have been set aside for such a purpose. Assuming that the groups are priced appropriately, such that the rates cover their claims, then the surplus will begin to accumulate. It is appropriate to develop a policy to determine the appropriate amount of surplus that will be allowed to accumulate, when and how to manage the level of that surplus, and to determine when and how certain amounts of that surplus may be returned to the municipalities participating in the Partnership Program.

- A. “Fluctuating Reserve Fee” – presently, illustrations of rate levels have assumed that a fee of 3.5% of the expected claims will be added to the rates for participating municipalities. This is the “fluctuating reserve fee”. This amount can be increased or decreased from year to year based on the performance of the program and in accordance with the provisions of Part B of these rules of operation. The higher the fee, the less attractive the rates in the Partnership Plan will be; the lower the fee, the greater the likelihood that the municipal pool may have a loss during the year. Hence, it is essential to monitor and manage this fee at a level that balances the stand-alone solvency of the municipal pool with the competitiveness of the program.
- B. Surplus in the Municipal Pool – Rules must be established to set the target surplus level in the pool. The level should be commensurate with the size of the pool, the stability of the members from year to year, and the State’s tolerance for the likelihood and amount of any charge to the State employee/retiree risk pool. Other municipal risk pools have established target surplus levels; these are typically tied to a percent of a year’s premiums or claims or a Risk-Based Capital (RBC) threshold. RBC is the measure used by the insurance industry to monitor the solvency position of insurance companies. We have seen target surplus amounts ranging from as low as 5-7% of premium to over 20% of premium. Presently, 15% of premium is the target surplus amount.
- C. “Ownership” of Surplus by participating municipalities – Surplus is accumulated by the groups that are in the program each year. There are two primary ways to manage the level of the surplus; they affect participating groups in different ways. One approach is to increase or decrease the “fluctuating reserve fee”. This approach puts the increase or decrease on the groups that are participating in the next year, which is not necessarily the groups that gave risk to the favorable or unfavorable experience. Unless a provision is made to require a retrospective additional premium contribution from groups (which is not recommended), this may be the only way to replenish a deficiency due to poor experience. The other approach for decreasing the surplus if it exceeds its target value is to issue a “dividend” to participating municipalities. Which groups are entitled to how

much must be established now before any real dollars arise. Possible approaches are to use membership, premium, and/or length of time in the program.

D. Deficit in the Municipal Pool

Consideration should be given to repaying the State pool with any gains that arise under the municipal pool starting in the year following the original charge against the State pool. Assuming that the municipal pool is properly priced, there should be a gain in the year following a loss. This puts the repayment of the State pool as the top priority of the municipal pool. It does defer the replenishment of the surplus in the municipal pool, which increases the risk that additional charges against the State employee/retiree pool may arise, but it also minimizes the total amount of the charge against the State employee/retiree pool. The two main elements of such a policy are the priority of repaying any charges against the State pool and any charges (e.g. interest and/or risk charge) that must be made in addition to the amount that the municipal pool utilized.

Notwithstanding any other provisions of these rules, if, in any year, there is an actual or projected deficit in the reserve fund for non-state public employers, as a group, equal to one quarter of one percent or more of the total claim amount for State employees and retirees, the Comptroller shall, in establishing the upcoming annual rate for each of these employers, add surcharges on such rates in an amount necessary to eliminate the deficit during the year to which these rates apply. The surcharge amounts shall be in addition to the rate or premium established in accordance with the rate setting methodology established for these employers.

E. Glossary of Terms

Entire Group: the collection of employees, and possibly retirees, that comprise the risk pool used for current rate-setting.

Segments of a group: a portion of an entire group, representing some of the persons whose experience is combined at the entire group level for purposes of current rate-setting.

HEP: Health Enhancement Plan, an arrangement that exists in the State of Connecticut Employee plan under which participants must comply with scheduled preventive screening and participants with certain medical conditions must comply with physician orders with respect to management of those conditions.

"Fluctuating Reserves Fee": a term defined in P.A. 11-58 that represents a "margin" or "risk charge" that is added to the expected cost of benefits for a group participating in the Partnership Plan to reduce the risk of loss to the State Employee health plan's experience.

F. Plan Design(s)

The State of Connecticut POS Plan, including HEP, is the standard plan design to be made available to participating municipal groups. Groups may choose to implement the

Partnership Plan with the option to be in HEP or to not be in HEP. The charges for employee classes of coverage that opt out of HEP shall be set by the Comptroller.

For groups that do not wish to participate in HEP, the State "Standard" plan version of the POS plan will be made available at a rate that reflects the expected additional costs due to exclusion of HEP.

Dental benefits need to be addressed – not yet evaluated

G. Underwriting Criteria

Municipalities or Boards of Education that enroll all of their employees will be eligible to participate in the Partnership Plan.

Municipalities or Boards of Education that enroll only certain segments of their group (e.g. police and fire only) will be eligible to participate in the Partnership Plan so long as 100% of that segment participates and rates will be established to recognize the expected costs of that segment of the total group. Participation in the plan of less than all of the employees of a municipality or Board of Education will require approval by the Comptroller, SEBAC and OPM and the rates will be subject to a surcharge to cover the uncertainties in the underlying experience of the portions of the group that will enroll. . Only retirees of participating groups can join the Partnership Plan.

H. Rating of Groups

A municipality or Board of Education that enrolls all of its employees will be charged a rate that covers the group's expected costs of medical and pharmacy benefits together with administrative fees that are equal to the State employee administrative fees and any other costs that will be incurred to manage the Partnership Plan, plus a "fluctuating reserve fee" that is initially set at 3.5% of the group's expected claim costs.

I. Rating Methodology

The following approach will be used to compute the rates for an eligible group:

1. Obtain current rates and recent experience (to the extent available) from the group. Also obtain census information showing number of employees covered by each plan of benefits currently offered by rating tier by plan. If any segment of the group is to be excluded from the Partnership Plan, group must provide rates and experience (if available) for the excluded group along with demographic composition of the excluded group and the entire group.
2. Using the information from #1 above, estimate the group's expected claim costs under their current benefit plans. Standard underwriting and actuarial practices will be used to develop these claim costs.
3. Using CORAL or Milliman Health Cost Guidelines, adjust the group's claim costs to be reflective of the State employee POS plan. Include adjustments for change of carrier if necessary.
4. Adjust the claim costs to reflect any excluded groups.
5. Adjust the claim costs to reflect non-acceptance of HEP, if required.

6. Increase the claim costs to incorporate the 3.5% "fluctuating reserve fee".
7. Add the administrative costs of the State employee program to produce the required rates.

J. Rate Guarantees

Annual renewals: rate change will be no more than three points higher or three points lower than the rate change for the State employee plan.

Each group will be re-rated at its fifth anniversary; the rate increases/decreases at that time may vary from the percentages above based on the group's actual historical experience.

These rate increase guarantees can be modified by the management of the Partnership Plan if the financial integrity of the Plan would be compromised by continuing such rate increase guarantees.

K. Exit Rules

One of the objectives of the Plan is the desire to keep groups in the Partnership Plan as long as possible. PA 11-58 requires participation for a minimum of two years. Setting the renewal rate increases to be no more than three points higher than the State employee rate change was one tactic considered to encourage groups to remain in the Plan for a long period of time. Another approach that has been raised is to create a set of exit rules that may cost groups if they leave the Plan after less than five years of continuous participation. The following presents some rules for consideration:

- If an exiting group's actual experience since inception has been worse than the rates that have been established for that group (e.g. their rate increase(s) should have been higher than the State rate increase plus three points), the group is assessed a fee as follows:
 - Exit after 2 years: lesser of the excess of the group's total costs over the rates they were charged since joining the Plan and 5% of the most recent year's Plan premium.
 - Exit after 3 years: lesser of the excess of the group's total costs over the rates they were charged since joining the Plan and 3% of the most recent year's Plan premium.
 - Exit after 4 years: lesser of the excess of the group's total costs over the rates they were charged since joining the Plan and 2% of the most recent year's Plan premium.
 - Exit after 5 years or later: no assessment.
- Groups do not benefit from any reductions in the "fluctuating reserve fee" that may take place (due to favorable experience in the Plan) until after they have participated for five years and they are presently in the Plan.

- Groups are not eligible to participate in any distributions of “surplus” in excess of the target surplus (presently we’re using 15% of annual premium as the reference point for target surplus) until after they have completed four years of continuous participation in the Plan and they are presently in the Plan.

L. Current Self-Insured Groups

Groups that are currently self-insured will have a different structure under the Partnership Plan in that they will have rates that are guaranteed for the policy period. That is, the program will look like a fully insured program, though each group is part of the self-insurance pool. Self-insured groups will have had an obligation to pay all claims incurred during the years prior to participating in the Partnership Plan. This includes claims that were incurred during such prior year(s) but that are paid during the period when the group is participating in the Partnership Plan. Since the group will also be paying a monthly “premium” to the Partnership Plan, there will be a period during the first few months of participation when the group will experience cash flows in excess of a typical month’s worth of self-insured claims and fees. The Partnership Plan can address this situation in either of two ways, depending on the group’s preference.

- A. If the group has established an IBNR reserve or comparable funds to cover the “runout” of claims from the prior year, the group can use that fund to cover the claims that are paid during the first few months of participation in the Partnership Plan but that were incurred prior to participating in the Partnership Plan. In that case, the rates for the Partnership Plan will be set to cover the claims incurred during the contract year, regardless of their payment date.
- B. If the group has not established an IBNR reserve or comparable funds to cover the “runout” of claims from the prior year, or if the group does not wish to tap into that fund to pay such claims, the rates for the Partnership Plan can be set to cover the claims that become payable during the contract year, regardless of their incurred date. The Partnership Plan will pay the runout claims from the prior contract year, meaning that the group will not be paying more than twelve months of cost during the contract year. However, the group will be responsible for the runout claims at the end of their participation in the Partnership Plan.
- C. Related to any “runout” claims to be paid by the Partnership Plan, the Comptroller’s Office and the HCCCC may impose requirements upon the municipality as may be needed to protect the State plan from extraordinary level of claims related to the runout period. In addition, municipalities shall keep any stop-loss coverage they had in place for claims associated with prior periods.

M. Other Operating Guidance Each year, HCCCC, in consultation with Non-state Public Health Care Advisory Committee, shall review and make adjustments, as needed, in structure.

1. Each year, a report will be provided to HCCCC, SEBAC and OPM of actual or projected losses for municipalities as a group and individually; annual and cumulative since inception.

2. Office of The State Comptroller and The Health Care Cost Containment Committee retain the right to change administrators or funding arrangement for plan.
3. Non-state employers participating in plan acknowledge that the plan may change from time to time upon action by the Comptroller, the HCCCC, Sebac and OPM.

- V. STATE CERTIFICATIONS/AFFIDAVITS, INTENT TO BID FORM, VERIFICATION OF ACCURACY FORM.



STATE OF CONNECTICUT

GIFT AND CAMPAIGN CONTRIBUTION CERTIFICATION

Written or electronic certification to accompany a State contract with a value of \$50,000 or more in a calendar or fiscal year, pursuant to C.G.S. §§ 4-250 and 4-252(c); Governor M. Jodi Rell's Executive Orders No. 1, Para. 8, and No. 7C, Para. 10; and C.G.S. §9-612(g)(2)

INSTRUCTIONS:

Complete all sections of the form. Attach additional pages, if necessary, to provide full disclosure about any lawful campaign contributions made to campaigns of candidates for statewide public office or the General Assembly, as described herein. Sign and date the form, under oath, in the presence of a Commissioner of the Superior Court or Notary Public. Submit the completed form to the awarding State agency at the time of initial contract execution and if there is a change in the information contained in the most recently filed certification, such person shall submit an updated certification either (i) not later than thirty (30) days after the effective date of such change or (ii) upon the submittal of any new bid or proposal for a contract, whichever is earlier. Such person shall also submit an accurate, updated certification not later than fourteen days after the twelve-month anniversary of the most recently filed certification or updated certification.

CHECK ONE: ☐ Initial Certification ☐ 12 Month Anniversary Update (Multi-year contracts only.)
 ☐ Updated Certification because of change of information contained in the most recently filed certification or twelve-month anniversary update.

GIFT CERTIFICATION:

As used in this certification, the following terms have the meaning set forth below:

- 1) "Contract" means that contract between the State of Connecticut (and/or one or more of its agencies or instrumentalities) and the Contractor, attached hereto, or as otherwise described by the awarding State agency below;
- 2) If this is an Initial Certification, "Execution Date" means the date the Contract is fully executed by, and becomes effective between, the parties; if this is a twelve-month anniversary update, "Execution Date" means the date this certification is signed by the Contractor;
- 3) "Contractor" means the person, firm or corporation named as the contractor below;
- 4) "Applicable Public Official or State Employee" means any public official or state employee described in C.G.S. §4-252(c)(1)(i) or (ii);
- 5) "Gift" has the same meaning given that term in C.G.S. § 4-250(1);
- 6) "Principals or Key Personnel" means and refers to those principals and key personnel of the Contractor, and its or their agents, as described in C.G.S. §§ 4-250(5) and 4-252(c)(1)(B) and (C).

I, the undersigned, am a Principal or Key Personnel of the person, firm or corporation authorized to execute this certification on behalf of the Contractor. I hereby certify that, no gifts were made by (A) such person, firm, corporation, (B) any principals and key personnel of the person firm or corporation who participate substantially in preparing bids, proposals or negotiating state contracts or (C) any agent of such, firm, corporation, or principals or key personnel who participates substantially in preparing bids, proposals or negotiating state contracts, to (i) any public official or state employee of the state agency or quasi-public agency soliciting bids or proposals for state contracts who participates substantially in the preparation of bid solicitations or request for proposals for state contracts or the negotiation or award of state contracts or (ii) any public official or state employee of any other state agency, who has supervisory or appointing authority over such state agency or quasi-public agency.

I further certify that no Principals or Key Personnel know of any action by the Contractor to circumvent (or which would result in the circumvention of) the above certification regarding **Gifts** by providing for any other Principals, Key Personnel, officials, or employees of the Contractor, or its or their agents, to make a **Gift** to any Applicable Public Official or State Employee. I further certify that the Contractor made the bid or proposal for the Contract without fraud or collusion with any person.

CAMPAIGN CONTRIBUTION CERTIFICATION:

I further certify that, on or after December 31, 2006, neither the Contractor nor any of its principals, as defined in C.G.S. § 9-612(g)(1), has made any **campaign contributions** to, or solicited any contributions on behalf of, any exploratory committee, candidate committee, political committee, or party committee established by, or supporting or authorized to support, any candidate for statewide public office, in violation of C.G.S. § 9-612(g)(2)(A). I further certify that **all lawful campaign contributions** that have been made on or after December 31, 2006 by the Contractor or any of its principals, as defined in C.G.S. § 9-612(g)(1), to, or solicited on behalf of, any exploratory committee, candidate committee, political committee, or party committee established by, or supporting or authorized to support any candidates for statewide public office or the General Assembly, are listed below:

Lawful Campaign Contributions to Candidates for Statewide Public Office:

<u>Contribution Date</u>	<u>Name of Contributor</u>	<u>Recipient</u>	<u>Value</u>	<u>Description</u>

Lawful Campaign Contributions to Candidates for the General Assembly:

<u>Contribution Date</u>	<u>Name of Contributor</u>	<u>Recipient</u>	<u>Value</u>	<u>Description</u>

Sworn as true to the best of my knowledge and belief, subject to the penalties of false statement.

Printed Contractor Name

Printed Name of Authorized Official

Signature of Authorized Official

Subscribed and acknowledged before me this _____ day of _____, 20____.

Commissioner of the Superior Court (or Notary Public)



STATE OF CONNECTICUT CONSULTING AGREEMENT AFFIDAVIT

Affidavit to accompany a bid or proposal for the purchase of goods and services with a value of \$50,000 or more in a calendar or fiscal year, pursuant to Connecticut General Statutes §§ 4a-81(a) and 4a-81(b). For sole source or no bid contracts the form is submitted at time of contract execution.

INSTRUCTIONS:

If the bidder or vendor has entered into a consulting agreement, as defined by Connecticut General Statutes § 4a-81(b)(1): Complete all sections of the form. If the bidder or contractor has entered into more than one such consulting agreement, use a separate form for each agreement. Sign and date the form in the presence of a Commissioner of the Superior Court or Notary Public. **If the bidder or contractor has not entered into a consulting agreement, as defined by Connecticut General Statutes § 4a-81(b)(1):** Complete only the shaded section of the form. Sign and date the form in the presence of a Commissioner of the Superior Court or Notary Public.

Submit completed form to the awarding State agency with bid or proposal. For a sole source award, submit completed form to the awarding State agency at the time of contract execution.

This affidavit must be amended if there is any change in the information contained in the most recently filed affidavit not later than (i) thirty days after the effective date of any such change or (ii) upon the submittal of any new bid or proposal, whichever is earlier.

AFFIDAVIT: [Number of Affidavits Sworn and Subscribed On This Day: ____]

I, the undersigned, hereby swear that I am a principal or key personnel of the bidder or contractor awarded a contract, as described in Connecticut General Statutes § 4a-81(b), or that I am the individual awarded such a contract who is authorized to execute such contract. I further swear that I have not entered into any consulting agreement in connection with such contract, **except for the agreement listed below:**

Consultant's Name and Title		Name of Firm (if applicable)
Start Date	End Date	Cost
Description of Services Provided:		

Is the consultant a former State employee or former public official? ☐ YES ☐ NO

If YES:
 Name of Former State Agency Termination Date of Employment

Sworn as true to the best of my knowledge and belief, subject to the penalties of false statement.

	Signature of Principal or Key Personnel	Date
	Printed Name (of above)	Awarding State Agency

Sworn and subscribed before me on this _____ day of _____, 20____.

**_____
Commissioner of the Superior Court
or Notary Public**



STATE OF CONNECTICUT

AFFIRMATION OF RECEIPT OF STATE ETHICS LAWS SUMMARY

Written or electronic affirmation to accompany a large State construction or procurement contract, having a cost of more than \$500,000, pursuant to Connecticut General Statutes §§ 1-101mm and 1-101qq

INSTRUCTIONS:

Complete all sections of the form. Submit completed form to the awarding State agency or contractor, as directed below.

CHECK ONE:

- ☐ I am a person seeking a large State construction or procurement contract. I am submitting this affirmation to the awarding State agency with my bid or proposal. [Check this box if the contract will be awarded through a competitive process.]
- ☐ I am a contractor who has been awarded a large State construction or procurement contract. I am submitting this affirmation to the awarding State agency at the time of contract execution. [Check this box if the contract was a sole source award.]
- ☐ I am a subcontractor or consultant of a contractor who has been awarded a large State construction or procurement contract. I am submitting this affirmation to the contractor.
- ☐ I am a contractor who has already filed an affirmation, but I am updating such affirmation either (i) no later than thirty (30) days after the effective date of any such change or (ii) upon the submittal of any new bid or proposal, whichever is earlier.

IMPORTANT NOTE:

Within fifteen (15) days after the request of such agency, institution or quasi-public agency for such affirmation contractors shall submit the affirmations of their subcontractors and consultants to the awarding State agency. Failure to submit such affirmations in a timely manner shall be cause for termination of the large State construction or procurement contract.

AFFIRMATION:

I, the undersigned person, contractor, subcontractor, consultant, or the duly authorized representative thereof, affirm (1) receipt of the summary of State ethics laws* developed by the Office of State Ethics pursuant to Connecticut General Statutes § 1-81b and (2) that key employees of such person, contractor, subcontractor, or consultant have read and understand the summary and agree to comply with its provisions.

* The summary of State ethics laws is available on the State of Connecticut's Office of State Ethics website.

Signature

Date

Printed Name

Title

Firm or Corporation (if applicable)

Street Address

City

State

Zip

Awarding State Agency

**STATE OF CONNECTICUT**

Written or electronic PDF copy of the written certification to accompany a large state contract pursuant to P.A. No. 13-162 (Prohibiting State Contracts With Entities Making Certain Investments In Iran)

Respondent Name: _____

INSTRUCTIONS:

CHECK ONE: ☐ Initial Certification.
☐ Amendment or renewal.

A. Who must complete and submit this form. Effective October 1, 2013, this form must be submitted for any large state contract, as defined in section 4-250 of the Connecticut General Statutes. This form must always be submitted with the bid or proposal, or if there was no bid process, with the resulting contract, regardless of where the principal place of business is located.

Pursuant to P.A. No. 13-162, upon submission of a bid or prior to executing a large state contract, **the certification portion of this form must be completed** by any corporation, general partnership, limited partnership, limited liability partnership, joint venture, nonprofit organization or other business organization **whose principal place of business is located outside of the United States**. United States subsidiaries of foreign corporations are exempt. For purposes of this form, a "foreign corporation" is one that is organized and incorporated outside the United States of America.

Check applicable box:

- ☐ Respondent's principal place of business is within the United States or Respondent is a United States subsidiary of a foreign corporation. Respondents who check this box **are not required to complete the certification portion of this form**, but must submit this form with its Invitation to Bid ("ITB"), Request for Proposal ("RFP") or contract package if there was no bid process.
- ☐ Respondent's principal place of business is outside the United States and it is not a United States subsidiary of a foreign corporation. **CERTIFICATION required.** Please complete the certification portion of this form and submit it with the ITB or RFP response or contract package if there was no bid process.

B. Additional definitions.

- 1) "Large state contract" has the same meaning as defined in section 4-250 of the Connecticut General Statutes;
- 2) "Respondent" means the person whose name is set forth at the beginning of this form; and
- 3) "State agency" and "quasi-public agency" have the same meanings as provided in section 1-79 of the Connecticut General Statutes.

C. Certification requirements.

No state agency or quasi-public agency shall enter into any large state contract, or amend or renew any such contract with any Respondent whose principal place of business is located outside the United States and is not a United States subsidiary of a foreign corporation unless the Respondent has submitted this certification.

Complete all sections of this certification and sign and date it, under oath, in the presence of a Commissioner of the Superior Court, a Notary Public or a person authorized to take an oath in another state.

CERTIFICATION:

I, the undersigned, am the official authorized to execute contracts on behalf of the Respondent. I certify that:

- ☐ Respondent has made no direct investments of twenty million dollars or more in the energy sector of Iran on or after October 1, 2013, as described in Section 202 of the Comprehensive Iran Sanctions, Accountability and Divestment Act of 2010.
- ☐ Respondent has either made direct investments of twenty million dollars or more in the energy sector of Iran on or after October 1, 2013, as described in Section 202 of the Comprehensive Iran Sanctions, Accountability and Divestment Act of 2010, or Respondent made such an investment prior to October 1, 2013 and has now increased or renewed such an investment on or after said date, or both.

Sworn as true to the best of my knowledge and belief, subject to the penalties of false statement.

Printed Respondent Name

Printed Name of Authorized Official

Signature of Authorized Official

Subscribed and acknowledged before me this _____ day of _____, 20____.

Commissioner of the Superior Court (or Notary Public)

COMMISSION ON HUMAN RIGHTS AND OPPORTUNITIES
CONTRACT COMPLIANCE REGULATIONS
NOTIFICATION TO BIDDERS

(Revised 09/17/07)

The contract to be awarded is subject to contract compliance requirements mandated by Sections 4a-60 and 4a-60a of the Connecticut General Statutes; and, when the awarding agency is the State, Sections 46a-71(d) and 46a-81i(d) of the Connecticut General Statutes. There are Contract Compliance Regulations codified at Section 46a-68j-21 through 43 of the Regulations of Connecticut State Agencies, which establish a procedure for awarding all contracts covered by Sections 4a-60 and 46a-71(d) of the Connecticut General Statutes.

According to Section 46a-68j-30(9) of the Contract Compliance Regulations, every agency awarding a contract subject to the contract compliance requirements has an obligation to “aggressively solicit the participation of legitimate minority business enterprises as bidders, contractors, subcontractors and suppliers of materials.” “Minority business enterprise” is defined in Section 4a-60 of the Connecticut General Statutes as a business wherein fifty-one percent or more of the capital stock, or assets belong to a person or persons: “(1) Who are active in daily affairs of the enterprise; (2) who have the power to direct the management and policies of the enterprise; and (3) who are members of a minority, as such term is defined in subsection (a) of Section 32-9n.” “Minority” groups are defined in Section 32-9n of the Connecticut General Statutes as “(1) Black Americans . . . (2) Hispanic Americans . . . (3) persons who have origins in the Iberian Peninsula . . . (4) Women . . . (5) Asian Pacific Americans and Pacific Islanders; (6) American Indians . . .” An individual with a disability is also a minority business enterprise as provided by Section 4a-60g of the Connecticut General Statutes. The above definitions apply to the contract compliance requirements by virtue of Section 46a-68j-21(11) of the Contract Compliance Regulations.

The awarding agency will consider the following factors when reviewing the bidder’s qualifications under the contract compliance requirements:

- (a) the bidder’s success in implementing an affirmative action plan;
- (b) the bidder’s success in developing an apprenticeship program complying with Sections 46a-68-1 to 46a-68-17 of the Administrative Regulations of Connecticut State Agencies, inclusive;
- (c) the bidder’s promise to develop and implement a successful affirmative action plan;
- (d) the bidder’s submission of employment statistics contained in the “Employment Information Form”, indicating that the composition of its workforce is at or near parity when compared to the racial and sexual composition of the workforce in the relevant labor market area; and
- (e) the bidder’s promise to set aside a portion of the contract for legitimate minority business enterprises. See Section 46a-68j-30(10)(E) of the Contract Compliance Regulations.

INSTRUCTIONS AND OTHER INFORMATION

The following BIDDER CONTRACT COMPLIANCE MONITORING REPORT must be completed in full, signed, and submitted with the bid for this contract. The contract awarding agency and the Commission on Human Rights and Opportunities will use the information contained thereon to determine the bidders compliance to Sections 4a-60 and 4a-60a CONN. GEN. STAT., and Sections 46a-68j-23 of the Regulations of Connecticut State Agencies regarding equal employment opportunity, and the bidder’s “good faith efforts to include minority business enterprises as subcontractors and suppliers for the work of the contract.

1) Definition of Small Contractor

Section 4a-60g CONN. GEN. STAT. defines a small contractor as a company that has been doing business under the same management and control and has maintained its principal place of business in Connecticut for a one year period immediately prior to its application for certification under this section, had gross revenues not exceeding ten million dollars in the most recently completed fiscal year, and at least fifty-one percent of the ownership of which is held by a person or persons who are active in the daily affairs of the company, and have the power to direct the management and policies of the company, except that a nonprofit corporation shall be construed to be a small contractor if such nonprofit corporation meets the requirements of subparagraphs (A) and (B) of subdivision 4a-60g CONN. GEN. STAT.

MANAGEMENT: Managers plan, organize, direct, and control the major functions of an organization through subordinates who are at the managerial or supervisory level. They make policy decisions and set objectives for the company or departments. They are not usually directly involved in production or providing services. Examples include top executives, public relations managers, managers of operations specialties (such as financial, human resources, or purchasing managers), and construction and engineering managers.

BUSINESS AND FINANCIAL OPERATIONS: These occupations include managers and professionals who work with the financial aspects of the business. These occupations include accountants and auditors, purchasing agents, management analysts, labor relations specialists, and budget, credit, and financial analysts.

MARKETING AND SALES: Occupations related to the act or process of buying and selling products and/or services such as sales engineer, retail sales workers and sales representatives including wholesale.

LEGAL OCCUPATIONS: In-House Counsel who is charged with providing legal advice and services in regards to legal issues that may arise during the course of standard business practices. This category also includes assistive legal occupations such as paralegals, legal assistants.

COMPUTER SPECIALISTS: Professionals responsible for the computer operations within a company are grouped in this category. Examples of job titles in this category include computer programmers, software engineers, database administrators, computer scientists, systems analysts, and computer support specialists

ARCHITECTURE AND ENGINEERING: Occupations related to architecture, surveying, engineering, and drafting are included in this category. Some of the job titles in this category include electrical and electronic engineers, surveyors, architects, drafters, mechanical engineers, materials engineers, mapping technicians, and civil engineers.

OFFICE AND ADMINISTRATIVE SUPPORT: All clerical-type work is included in this category. These jobs involve the preparing, transcribing, and preserving of written communications and records; collecting accounts; gathering and distributing information; operating office machines and electronic data processing equipment; and distributing mail. Job titles listed in this category include telephone operators, bill and account collectors, customer service representatives, dispatchers, secretaries and administrative assistants, computer operators and clerks (such as payroll, shipping, stock, mail and file).

BUILDING AND GROUNDS CLEANING AND MAINTENANCE: This category includes occupations involving landscaping, housekeeping, and janitorial services. Job titles found in this category include supervisors of landscaping or housekeeping, janitors, maids, grounds maintenance workers, and pest control workers.

CONSTRUCTION AND EXTRACTION: This category includes construction trades and related occupations. Job titles found in this category include boilermakers, masons (all types), carpenters, construction laborers, electricians, plumbers (and related trades), roofers, sheet metal workers, elevator installers, hazardous materials removal workers, paperhangers, and painters. Paving, surfacing, and tamping equipment operators; drywall and ceiling tile installers; and carpet, floor and tile installers and finishers are also included in this category. First line supervisors, foremen, and helpers in these trades are also grouped in this category..

INSTALLATION, MAINTENANCE AND REPAIR: Occupations involving the installation, maintenance, and repair of equipment are included in this group. Examples of job titles found here are heating, ac, and refrigeration mechanics and installers; telecommunication line installers and repairers; heavy vehicle and mobile equipment service technicians and mechanics; small engine mechanics; security and fire alarm systems installers; electric/electronic repair, industrial, utility and transportation equipment; millwrights; riggers; and manufactured building and mobile home installers. First line supervisors, foremen, and helpers for these jobs are also included in the category.

MATERIAL MOVING WORKERS: The job titles included in this group are Crane and tower operators; dredge, excavating, and lading machine operators; hoist and winch operators; industrial truck and tractor operators; cleaners of vehicles and equipment; laborers and freight, stock, and material movers, hand; machine feeders and offbearers; packers and packagers, hand; pumping station operators; refuse and recyclable material collectors; and miscellaneous material moving workers.

PRODUCTION WORKERS: The job titles included in this category are chemical production machine setters, operators and tenders; crushing/grinding workers; cutting workers; inspectors, testers sorters, samplers, weighers; precious stone/metal workers; painting workers; cementing/gluing machine operators and tenders; etchers/engravers; molders, shapers and casters except for metal and plastic; and production workers.

<p><u>White</u> (not of Hispanic Origin)- All persons having origins in any of the original peoples of Europe, North Africa, or the Middle East.</p> <p><u>Black</u>(not of Hispanic Origin)- All persons having origins in any of the Black racial groups of Africa.</p> <p><u>Hispanic</u>- All persons of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin, regardless of race.</p>	<p><u>Asian or Pacific Islander</u>- All persons having origins in any of the original peoples of the Far East, Southeast Asia, the Indian subcontinent, or the Pacific Islands. This area includes China, India, Japan, Korea, the Philippine Islands, and Samoa.</p> <p><u>American Indian or Alaskan Native</u>- All persons having origins in any of the original peoples of North America, and who maintain cultural identification through tribal affiliation or community recognition.</p>
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BIDDER CONTRACT COMPLIANCE MONITORING REPORT

PART I - Bidder Information

Company Name Street Address City & State Chief Executive	Bidder Federal Employer Identification Number _____ Or Social Security Number _____
Major Business Activity (brief description)	Bidder Identification (response optional/definitions on page 1) -Bidder is a small contractor. Yes__ No__ -Bidder is a minority business enterprise Yes__ No__ (If yes, check ownership category) Black__ Hispanic__ Asian American__ American Indian/Alaskan Native__ Iberian Peninsula__ Individual(s) with a Physical Disability__ Female__
Bidder Parent Company (If any)	- Bidder is certified as above by State of CT Yes__ No__
Other Locations in Ct. (If any)	

PART II - Bidder Nondiscrimination Policies and Procedures

1. Does your company have a written Affirmative Action/Equal Employment Opportunity statement posted on company bulletin boards? Yes__ No__	7. Do all of your company contracts and purchase orders contain non-discrimination statements as required by Sections 4a-60 & 4a-60a Conn. Gen. Stat.? Yes__ No__
2. Does your company have the state-mandated sexual harassment prevention in the workplace policy posted on company bulletin boards? Yes__ No__	8. Do you, upon request, provide reasonable accommodation to employees, or applicants for employment, who have physical or mental disability? Yes__ No__
3. Do you notify all recruitment sources in writing of your company's Affirmative Action/Equal Employment Opportunity employment policy? Yes__ No__	9. Does your company have a mandatory retirement age for all employees? Yes__ No__
4. Do your company advertisements contain a written statement that you are an Affirmative Action/Equal Opportunity Employer? Yes__ No__	10. If your company has 50 or more employees, have you provided at least two (2) hours of sexual harassment training to all of your supervisors? Yes__ No__ NA__
5. Do you notify the Ct. State Employment Service of all employment openings with your company? Yes__ No__	11. If your company has apprenticeship programs, do they meet the Affirmative Action/Equal Employment Opportunity requirements of the apprenticeship standards of the Ct. Dept. of Labor? Yes__ No__ NA__
6. Does your company have a collective bargaining agreement with workers? Yes__ No__ 6a. If yes, do the collective bargaining agreements contain non-discrimination clauses covering all workers? Yes__ No__ 6b. Have you notified each union in writing of your commitments under the nondiscrimination requirements of contracts with the state of Ct? Yes__ No__	12. Does your company have a written affirmative action Plan? Yes__ No__ If no, please explain. 13. Is there a person in your company who is responsible for equal employment opportunity? Yes__ No__ If yes, give name and phone number. _____ _____

Part III - Bidder Subcontracting Practices

(Page 4)

1. Will the work of this contract include subcontractors or suppliers? Yes__ No__

1a. If yes, please list all subcontractors and suppliers and report if they are a small contractor and/or a minority business enterprise. (defined on page 1 / use additional sheet if necessary)

1b. Will the work of this contract require additional subcontractors or suppliers other than those identified in 1a. above?

Yes__ No__

PART IV - Bidder Employment Information

Date:

JOB CATEGORY *	OVERALL TOTALS	WHITE (not of Hispanic origin)		BLACK (not of Hispanic origin)		HISPANIC		ASIAN or PACIFIC ISLANDER		AMERICAN INDIAN or ALASKAN NATIVE	
		Male	Female	Male	Female	Male	Female	Male	Female	male	female
Management											
Business & Financial Ops											
Marketing & Sales											
Legal Occupations											
Computer Specialists											
Architecture/Engineering											
Office & Admin Support											
Bldg/ Grounds Cleaning/Maintenance											
Construction & Extraction											
Installation , Maintenance & Repair											
Material Moving Workers											
Production Occupations											
TOTALS ABOVE											
Total One Year Ago											
FORMAL ON THE JOB TRAINEES (ENTER FIGURES FOR THE SAME CATEGORIES AS ARE SHOWN ABOVE)											
Apprentices											
Trainees											

*NOTE: JOB CATEGORIES CAN BE CHANGED OR ADDED TO (EX. SALES CAN BE ADDED OR REPLACE A CATEGORY NOT USED IN YOUR COMPANY)

1. Which of the following recruitment sources are used by you? (Check yes or no, and report percent used)				2. Check (X) any of the below listed requirements that you use as a hiring qualification (X)		3. Describe below any other practices or actions that you take which show that you hire, train, and promote employees without discrimination
SOURCE	YES	NO	% of applicants provided by source			
State Employment Service					Work Experience	
Private Employment Agencies					Ability to Speak or Write English	
Schools and Colleges					Written Tests	
Newspaper Advertisement					High School Diploma	
Walk Ins					College Degree	
Present Employees					Union Membership	
Labor Organizations					Personal Recommendation	
Minority/Community Organizations					Height or Weight	
Others (please identify)					Car Ownership	
					Arrest Record	
					Wage Garnishments	

Certification (Read this form and check your statements on it CAREFULLY before signing). I certify that the statements made by me on this BIDDER CONTRACT COMPLIANCE MONITORING REPORT are complete and true to the best of my knowledge and belief, and are made in good faith. I understand that if I knowingly make any misstatements of facts, I am subject to be declared in non-compliance with Section 4a-60, 4a-60a, and related sections of the CONN. GEN. STAT.

(Signature)	(Title)	(Date Signed)	(Telephone)
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**COMMISSION ON HUMAN RIGHTS AND OPPORTUNITIES
CONTRACT COMPLIANCE REGULATIONS
NOTIFICATION TO BIDDERS**

The contract to be awarded is subject to contract compliance requirements mandated by Sections 4a-60 and 4a-60a of the Connecticut General Statutes; and, when the awarding agency is the State, Sections 46a-71(d) and 46a-81i(d) of the Connecticut General Statutes. There are Contract Compliance Regulations codified at Section 46a-68j-21 through 43 of the Regulations of Connecticut State Agencies, which establish a procedure for awarding all contracts covered by Sections 4a-60 and 46a-71(d) of the Connecticut General Statutes.

According to Section 46a-68j-30(9) of the Contract Compliance Regulations, every agency awarding a contract subject to the contract compliance requirements has an obligation to “aggressively solicit the participation of legitimate minority business enterprises as bidders, contractors, subcontractors and suppliers of materials.” “Minority business enterprise” is defined in Section 4a-60 of the Connecticut General Statutes as a business wherein fifty-one percent or more of the capital stock, or assets belong to a person or persons: “(1) Who are active in daily affairs of the enterprise; (2) who have the power to direct the management and policies of the enterprise; and (3) who are members of a minority, as such term is defined in subsection (a) of Section 32-9n.” “Minority” groups are defined in Section 32-9n of the Connecticut General Statutes as “(1) Black Americans . . . (2) Hispanic Americans . . . (3) persons who have origins in the Iberian Peninsula . . . (4) Women . . . (5) Asian Pacific Americans and Pacific Islanders; (6) American Indians . . .” An individual with a disability is also a minority business enterprise as provided by Section 4a-60g of the Connecticut General Statutes. The above definitions apply to the contract compliance requirements by virtue of Section 46a-68j-21(11) of the Contract Compliance Regulations.

The awarding agency will consider the following factors when reviewing the bidder’s qualifications under the contract compliance requirements:

- (a) the bidder’s success in implementing an affirmative action plan;
- (b) the bidder’s success in developing an apprenticeship program complying with Sections 46a-68-1 to 46a-68-17 of the Administrative Regulations of Connecticut State Agencies, inclusive;
- (c) the bidder’s promise to develop and implement a successful affirmative action plan;
- (d) the bidder’s submission of employment statistics contained in the “Employment Information Form”, indicating that the composition of its workforce is at or near parity when compared to the racial and sexual composition of the workforce in the relevant labor market area; and
- (e) the bidder’s promise to set aside a portion of the contract for legitimate minority business enterprises. See Section 46a-68j-30(10)(E) of the Contract Compliance Regulations.

This form is **MANDATORY** and must be completed, signed, and returned with the vendor's bid.

**ACKNOWLEDGMENT OF CONTRACT COMPLIANCE
NOTIFICATION TO BIDDERS**

INSTRUCTION: Bidder must sign acknowledgment below, and return this form to the awarding agency with the bid proposal.

The undersigned duly authorized representative of the bidding vendor acknowledges receiving and reading a copy of the **NOTIFICATION TO BIDDERS**. *(Please print name under signature line.)*

Signature

Title

Date

On behalf of:

Vendor Name

Street Address

City State Zip

Federal Employee Identification Number
(FEIN/SSN)

This form is **MANDATORY** and must be completed, signed, and returned with the vendor's bid.



STATE OF CONNECTICUT
NONDISCRIMINATION CERTIFICATION – New Resolution
By Entity
For Contracts Valued at \$50,000 or More

Documentation in the form of a corporate, company, or partnership policy adopted by resolution of the board of directors, shareholders, managers, members or other governing body of a contractor that certifies the contractor complies with the nondiscrimination agreements and warranties under Connecticut General Statutes §§ 4a-60(a)(1) and 4a-60a(a)(1), as amended

INSTRUCTIONS:

For use by an entity (corporation, limited liability company, or partnership) when entering into any contract type with the State of Connecticut valued at \$50,000 or more for any year of the contract. Complete all sections of the form. Submit to the awarding State agency prior to contract execution.

CERTIFICATION OF RESOLUTION:

I, _____, _____, of _____,
Authorized Signatory Title Name of Entity

an entity duly formed and existing under the laws of _____,
Name of State or Commonwealth

certify that the following is a true and correct copy of a resolution adopted on the _____ day of

_____, 20_____ by the governing body of _____,
Name of Entity

in accordance with all of its documents of governance and management and the laws of

_____, and further certify that such resolution has not been modified
Name of State or Commonwealth

or revoked, and is in full force and effect.

RESOLVED: That the policies of _____ comply with the
Name of Entity

nondiscrimination agreements and warranties of Connecticut General Statutes

§§ 4a-60(a)(1) and 4a-60a(a)(1), as amended.

The undersigned has executed this certificate this _____ day of _____, 20_____.

Authorized Signatory

Date

Printed Name

STATE OF CONNECTICUT STATE ELECTIONS ENFORCEMENT COMMISSION

20 Trinity Street Hartford, Connecticut 06106—1628

SEEC FORM 10

NOTICE TO EXECUTIVE BRANCH STATE CONTRACTORS AND PROSPECTIVE STATE CONTRACTORS OF CAMPAIGN CONTRIBUTION AND SOLICITATION BAN

This notice is provided under the authority of Connecticut General Statutes 9-612(g)(2), as amended by P.A. 07-1, and is for the purpose of informing state contractors and prospective state contractors of the following law (italicized words are defined on page 2):

Campaign Contribution and Solicitation Ban

No *state contractor, prospective state contractor, principal of a state contractor or principal of a prospective state contractor*, with regard to a *state contract or state contract solicitation* with or from a state agency in the executive branch or a quasi-public agency or a holder, or principal of a holder of a valid prequalification certificate, shall make a contribution to, or *solicit* contributions on behalf of (i) an exploratory committee or candidate committee established by a candidate for nomination or election to the office of Governor, Lieutenant Governor, Attorney General, State Comptroller, Secretary of the State or State Treasurer, (ii) a political committee authorized to make contributions or expenditures to or for the benefit of such candidates, or (iii) a party committee;

In addition, no holder or principal of a holder of a valid prequalification certificate, shall make a contribution to, or solicit contributions on behalf of (i) an exploratory committee or candidate committee established by a candidate for nomination or election to the office of State senator or State representative, (ii) a political committee authorized to make contributions or expenditures to or for the benefit of such candidates, or (iii) a party committee.

Duty to Inform

State contractors and prospective state contractors are required to inform their principals of the above prohibitions, as applicable, and the possible penalties and other consequences of any violation thereof.

Penalties for Violations

Contributions or solicitations of contributions made in violation of the above prohibitions may result in the following civil and criminal penalties:

Civil penalties--\$2000 or twice the amount of the prohibited contribution, whichever is greater, against a principal or a contractor. Any state contractor or prospective state contractor which fails to make reasonable efforts to comply with the provisions requiring notice to its principals of these prohibitions and the possible consequences of their violations may also be subject to civil penalties of \$2000 or twice the amount of the prohibited contributions made by their principals.

Criminal penalties—Any knowing and willful violation of the prohibition is a Class D felony, which may subject the violator to imprisonment of not more than 5 years, or \$5000 in fines, or both.

Contract Consequences

Contributions made or solicited in violation of the above prohibitions may result, in the case of a state contractor, in the contract being voided.

Contributions made or solicited in violation of the above prohibitions, in the case of a prospective state contractor, shall result in the contract described in the state contract solicitation not being awarded to the prospective state contractor, unless the State Elections Enforcement Commission determines that mitigating circumstances exist concerning such violation.

The state will not award any other state contract to anyone found in violation of the above prohibitions for a period of one year after the election for which such contribution is made or solicited, unless the State Elections Enforcement Commission determines that mitigating circumstances exist concerning such violation.

Receipt acknowledged: _____
(signature) (date)

Print name: _____ Title: _____

Company Name: _____

Additional information and the entire text of P.A 07-1 may be found on the website of the State Elections Enforcement Commission, www.ct.gov/seec. Click on the link to "State Contractor Contribution Ban"

Definitions:

"State contractor" means a person, business entity or nonprofit organization that enters into a state contract. Such person, business entity or nonprofit organization shall be deemed to be a state contractor until December thirty-first of the year in which such contract terminates. "State contractor" does not include a municipality or any other political subdivision of the state, including any entities or associations duly created by the municipality or political subdivision exclusively amongst themselves to further any purpose authorized by statute or charter, or an employee in the executive or legislative branch of state government or a quasi-public agency, whether in the classified or unclassified service and full or part-time, and only in such person's capacity as a state or quasi-public agency employee.

"Prospective state contractor" means a person, business entity or nonprofit organization that (i) submits a response to a state contract solicitation by the state, a state agency or a quasi-public agency, or a proposal in response to a request for proposals by the state, a state agency or a quasi-public agency, until the contract has been entered into, or (ii) holds a valid prequalification certificate issued by the Commissioner of Administrative Services under section 4a-100. "Prospective state contractor" does not include a municipality or any other political subdivision of the state, including any entities or associations duly created by the municipality or political subdivision exclusively amongst themselves to further any purpose authorized by statute or charter, or an employee in the executive or legislative branch of state government or a quasi-public agency, whether in the classified or unclassified service and full or part-time, and only in such person's capacity as a state or quasi-public agency employee.

"Principal of a state contractor or prospective state contractor" means (i) any individual who is a member of the board of directors of, or has an ownership interest of five per cent or more in, a state contractor or prospective state contractor, which is a business entity, except for an individual who is a member of the board of directors of a nonprofit organization, (ii) an individual who is employed by a state contractor or prospective state contractor, which is a business entity, as president, treasurer or executive vice president, (iii) an individual who is the chief executive officer of a state contractor or prospective state contractor, which is not a business entity, or if a state contractor or prospective state contractor has no such officer, then the officer who duly possesses comparable powers and duties, (iv) an officer or an employee of any state contractor or prospective state contractor who has managerial or discretionary responsibilities with respect to a state contract, (v) the spouse or a dependent child who is eighteen years of age or older of an individual described in this subparagraph, or (vi) a political committee established or controlled by an individual described in this subparagraph or the business entity or nonprofit organization that is the state contractor or prospective state contractor.

"State contract" means an agreement or contract with the state or any state agency or any quasi-public agency, let through a procurement process or otherwise, having a value of fifty thousand dollars or more, or a combination or series of such agreements or contracts having a value of one hundred thousand dollars or more in a calendar year, for (i) the rendition of services, (ii) the furnishing of any goods, material, supplies, equipment or any items of any kind, (iii) the construction, alteration or repair of any public building or public work, (iv) the acquisition, sale or lease of any land or building, (v) a licensing arrangement, or (vi) a grant, loan or loan guarantee. "State contract" does not include any agreement or contract with the state, any state agency or any quasi-public agency that is exclusively federally funded, an education loan or a loan to an individual for other than commercial purposes.

"State contract solicitation" means a request by a state agency or quasi-public agency, in whatever form issued, including, but not limited to, an invitation to bid, request for proposals, request for information or request for quotes, inviting bids, quotes or other types of submittals, through a competitive procurement process or another process authorized by law waiving competitive procurement.

"Managerial or discretionary responsibilities with respect to a state contract" means having direct, extensive and substantive responsibilities with respect to the negotiation of the state contract and not peripheral, clerical or ministerial responsibilities.

"Dependent child" means a child residing in an individual's household who may legally be claimed as a dependent on the federal income tax of such individual.

"Solicit" means (A) requesting that a contribution be made, (B) participating in any fund-raising activities for a candidate committee, exploratory committee, political committee or party committee, including, but not limited to, forwarding tickets to potential contributors, receiving contributions for transmission to any such committee or bundling contributions, (C) serving as chairperson, treasurer or deputy treasurer of any such committee, or (D) establishing a political committee for the sole purpose of soliciting or receiving contributions for any committee. Solicit does not include: (i) making a contribution that is otherwise permitted by Chapter 155 of the Connecticut General Statutes; (ii) informing any person of a position taken by a candidate for public office or a public official, (iii) notifying the person of any activities of, or contact information for, any candidate for public office; or (IV) serving as a member in any party committee or as an officer of such committee that is not otherwise prohibited in this section.

INTENT TO BID FORM

*Please fill out the Intent to Bid Form and fax it to 860-702-3662 or email a PDF of the completed form to osc.rfp@ct.gov. **Note: This form must be received by 2:30PM on November 26, 2014, to be considered.***

**Attention: Employee & Retiree Medical Benefits
 Administrative Services Only**

Plan Sponsor Name: The STATE OF CONNECTICUT

Name : _____

Authorized Personnel: _____

Title: _____

This is to confirm that we have received the Request for Proposal for the State of Connecticut.
We wish to advise you that we _____ **will** _____ **will not** submit a proposal.

We are not submitting a proposal because

Signature of this form presents your intent to bid.

Signature: _____

Email address: _____

Date: _____

Upon submission of the Intent to Bid form you will be provided with contact information to obtain access to the Milliman Secure FTP Web Transfer Console to download repricing data for your proposal.

Verification of Accuracy

Your response must designate the individual responsible for coordinating proposal responses and for binding the company to the responses to this RFP.

Name: _____ Phone #: _____

Title: _____

Your response must designate the chief actuary or independent actuary retained by the proposer who certifies the method used to determine and report requested discount information.

Name: _____ Phone #: _____

Title: _____

Your response must designate proposer's Medical Director or Chief Medical Officer.

Name: _____ Phone #: _____

Title: _____

VI. STATE OF CONNECTICUT CONTRACT

OSC Standard Contract and Conditions

SECTION 1

This Agreement ("Agreement") is made and entered into as of the _____ of _____, 2014 ("Effective Date") by and between the State of Connecticut by and through the Office of the State Comptroller ("Comptroller"), and _____ ("Contractor") under the authority of Conn. Gen. Stat. Sections 3-112.

SECTION 2

CONTRACT PERIOD AND DEFINITIONS

This Agreement shall begin effective (start date) and shall expire on (end date), and the duties of the Contractor as set forth in Section 4 of this Agreement shall be completed by the Contractor no later than (hereinafter "end date").

Whenever the following terms or phrases are used in this Agreement, they shall have the following meaning unless the context clearly requires otherwise:

SECTION 3

NOTICE OF CHANGE AND TERMINATION

Unless otherwise expressly provided to the contrary, any other notice provided under this Agreement shall be in writing and may be delivered personally or by certified or registered mail. All notices shall be effective if delivered personally, or by certified or registered mail, to the following addresses:

Comptroller: Office of the Comptroller
55 Elm Street
Hartford, CT 06106
Attention: Business Office

Contractor: _____

Any request for written notice under this Agreement shall be made in the manner set forth in this section. The parties may change their respective addresses for notices under this paragraph upon prior written notification to the other.

If for any reason, the Contractor shall fail to fulfill in a timely manner and proper manner its obligations under this Agreement, the Comptroller shall thereupon have the right to terminate this Agreement by giving written notice to the Contractor of such termination and the reason therefore specifying the effective date thereof at least thirty (30) days before the effective date of such termination. In such event, all records and data prepared by the Contractor under this Agreement shall become available for audit. The Contractor shall not be relieved of liability to the Comptroller for damages sustained by the Comptroller by virtue of any breach of the Agreement by the Contractor, and the Comptroller may withhold any payments to the Contractor for the purposes of set-off until such time as the exact amount of damages to the Comptroller is determined.

The Comptroller or the Contractor may terminate this Agreement for any time by giving at least 60 days notice in writing to the other party. If the agreement is terminated by the Comptroller as provided herein, all fees earned up to the date of termination pursuant to _____ shall accrue and be paid to the Contractor.

SECTION 4 SPECIFICATION OF SERVICES

(Insert Outline of Work)

SECTION 5 COST AND SCHEDULE OF PAYMENTS

The COMPTROLLER shall pay the CONTRACTOR a total sum not to exceed _____ for services performed under this AGREEMENT.

The Contractor shall be compensated for fees based upon work performed, documented, and accepted by the Comptroller.

The Contractor shall submit invoices on a periodic basis, not less often than monthly. Invoices shall, at a minimum, include the Contractor name, the Contract Number, the Contractor's Federal Employer Identification Number, the billing period, and an itemization of expenses by line item.

Invoices for deliverables shall include an identification of the deliverable; if printed material, a copy of the deliverable; and the date that the deliverable was provided to the Comptroller.

Invoices for services billed by the hour shall include the name and title of the individual providing the services, the dates worked, the number of hours worked each day with a brief synopsis of the work performed, the rate being charged for the individual, and the total cost for that person's work during the billing period.

Invoices for expenses, if allowed, shall include a detailed account of expenses specifying the day when and purpose for which they were incurred as well as all receipts, invoices, bills and other available documentation as evidence of the actual cost of such expenses.

Such expenses may include, but are not limited to: mileage @ 50.5 cents per mile; costs of travel including airfare and hotels, and office expenses such as, phone calls, copying, postage and package delivery incurred in connection with the service pertaining to this AGREEMENT. All expenses will be reimbursed at cost.

SECTION 6 OTHER CONDITIONS

A. Entire Agreement

This Agreement embodies the entire agreement between the Comptroller and the Contractor on matters specifically addressed herein. The parties shall not be bound by or be liable for any statement, representation, promise, inducement or understanding of any kind or nature not set forth herein. This Agreement shall supersede all prior written agreements between the parties and their predecessors. No changes, amendments or modifications of any terms or conditions of the Agreement shall be valid unless reduced to writing and signed by both parties and where applicable approved by the Office of the Attorney General. The Contractor's proposal response was used as determinative in the request for proposal process that resulted in this Agreement.

B. Changes in Service

When changes in the services are required or requested by the Comptroller, Contractor shall promptly estimate their monetary effect and so notify the Comptroller. No change shall be implemented by Contractor unless it is approved by the Comptroller in writing; and, unless otherwise agreed to in writing, the provisions of this Agreement shall apply to all changes in the services. If the Comptroller determines that any change materially affects the cost or time of performance of this Agreement as a whole, Contractor and the Comptroller will mutually agree in writing to an equitable adjustment.

C. Independent Contractor

Contractor represents that it is fully experienced and properly qualified to perform the services provided for herein, and that it is properly licensed, equipped, organized, and financed to perform such services. Contractor shall act as an independent Contractor in performing this Agreement, maintaining complete control over its employees and all of its subcontractors. Contractor shall furnish fully qualified personnel to perform the services under this Agreement. Contractor shall perform all services in accordance with its methods, subject to compliance with this Agreement and all applicable laws and regulations. It is acknowledged that services rendered by the Contractor to the Comptroller hereunder do not in any way conflict with other contractual commitments with or by the Contractor.

If applicable, Contractor shall deliver copies of any and all current license(s) and registration(s) relating to the services to be performed under this Agreement to the Comptroller, at the time of the execution of this Agreement, as evidence that such are in full force and effect.

D. Laws and Regulations

The Agreement shall be deemed to have been made in the City of Hartford, State of Connecticut. Both Parties agree that it is fair and reasonable for the validity and construction of this Agreement that it shall be governed by, construed, and enforced in accordance with the laws and court decisions of the State of Connecticut without giving effect to its principles of conflicts of laws.

The Contractor agrees that the sole and exclusive means for the presentation of any claims against the State arising from this Agreement shall be in accordance with Chapter 53 of the Connecticut General Statutes (Claims Against the State) and the Contractor further agrees not to initiate legal proceedings in any State or Federal Court in addition to, or in lieu of, said Chapter 53 proceedings.

To the extent that any immunities provided by Federal law or the laws of the State of Connecticut do not bar an action against the State, and to the extent that these courts are courts of competent jurisdiction, for the purpose of venue, the complaint shall be made returnable to the Judicial District of Hartford only or shall be brought in the United States District Court for the District of Connecticut only, and shall not be transferred to any other court, provided, however, that nothing here constitutes a waiver or compromise of the sovereign immunity of the State of Connecticut. The Contractor waives any objection which it may now have or will have to the laying of venue of any Claims in any forum and further irrevocably submits to such jurisdiction in any suit, action or proceeding.

The Contractor shall provide written notice to the State of any litigation that relates to the services directly or indirectly financed under this Agreement or that has the potential to impair the ability of the Contractor to fulfill the terms and conditions of this Agreement, including but not limited to financial, legal or any other situation which may prevent the Contractor from meeting its obligations under the Agreement.

Contractor, its employees and representatives shall at all times comply with all applicable laws, ordinances, statutes, rules, regulations, and orders of governmental authorities, including those having jurisdiction over its registration and licensing to perform services under this Agreement.

E. Labor and Personnel

At all times, Contractor shall utilize approved, qualified personnel and any Comptroller approved subcontractors necessary to perform the services under this Agreement. Contractor shall advise the Comptroller promptly, in writing, of any labor dispute or anticipated labor dispute or other labor related occurrence known to Contractor involving Contractor's employees or subcontractors which may reasonably be expected to affect Contractor's performance of services under this Agreement. The Comptroller may then, at its option, ask Contractor to arrange for a temporary employee(s) or subcontractor(s) satisfactory to the Comptroller to provide the services otherwise performable by Contractor hereunder. The Contractor will be responsible to the Comptroller for any economic detriment caused the Comptroller by such subcontract arrangement.

Contractor shall, if requested to do so by the Comptroller, reassign from the Comptroller's account any employee or authorized representatives whom the Comptroller, in its sole discretion, determines is incompetent, dishonest, or uncooperative. In requesting the reassignment of an

employee under this paragraph, the Comptroller shall give ten (10) days notice to Contractor of the Comptroller's desire for such reassignment. Contractor will then have five (5) days to investigate the situation and attempt, if it so desires, to satisfy the Comptroller that the employee should not be reassigned; however, the Comptroller's decision in its sole discretion after such five (5) day period shall be final. Should the Comptroller still desire reassignment, then five days thereafter, or ten (10) days from the date of the notice of reassignment, the employee shall be reassigned from the Comptroller's account.

F. Conflicts, Errors, Omissions, and Discrepancies

In the event of any conflict between the provision of this Agreement and the provisions of Form CO-802A to which this Agreement is attached, the provisions of this Agreement shall control.

In case of conflicts, discrepancies, errors, or omissions among the various parts of this Agreement, any such matter shall be submitted immediately by Contractor to the Comptroller for clarification. The Comptroller shall issue such clarification within a reasonable period of time. Any services affected by such conflicts, discrepancies, errors, or omissions which are performed by Contractor prior to clarification by the Comptroller shall be at Contractor's risk.

G. Indemnity

Contractor hereby indemnifies and shall defend and hold harmless the State of Connecticut, the Comptroller, its officers, and its employees from and against any and all suits, actions, legal or administrative proceedings, claims, demands, damages, liabilities, monetary loss, interest, attorney's fees, costs and expenses of whatsoever kind or nature arising out of the performance of this Agreement, including those arising out of injury to or death of Contractor's employees or subcontractors, whether arising before, during, or after completion of the services hereunder and in any manner directly or indirectly caused, occasioned or contributed to in whole or in part, by reason of any act, omission, fault or negligence of Contractor or its employees, agents or subcontractors.

H. Nondisclosure

Contractor shall not release any information concerning the services provided pursuant to the Agreement or any part thereof to any member of the public, press, business entity or any official body unless prior written consent is obtained from the Comptroller.

I. Quality Surveillance and Examination of Records

All services performed by Contractor shall be subject to the inspection and approval of the Comptroller at all times, and Contractor shall furnish all information concerning the services.

The Comptroller or its representatives shall have the right at reasonable hours to examine any books, records, and other documents of Contractor or its subcontractors pertaining to work performed under this Agreement and shall allow such representatives free access to any and all such books and records. The Comptroller will give the Contractor at least twenty-four (24) hours notice of such intended examination. At the Comptroller's request, the Contractor shall provide the Comptroller with hard copies of or magnetic disk or tape containing any data or information in the possession or control of the Contractor which pertains to the Comptroller's business under

this Agreement. The Contractor shall incorporate this paragraph verbatim into any Agreement it enters into with any subcontractor providing services under this Agreement.

The Contractor shall retain and maintain accurate records and documents relating to performance of services under this Agreement for a minimum of three (3) years after the final payment by the Comptroller and shall make them available for inspection and audit by the Comptroller.

In the event that this Agreement constitutes a grant Agreement, and the Contractor is a public or private agency other than another state agency, the Contractor shall provide for an audit acceptable to the Comptroller, in accordance with the provisions of Conn. Gen. Stat. Sec. 7-396a.

J. Insurance

The Contractor, at its sole expense, agrees to secure and keep in full force and effect at all times during the term of this Agreement as defined in Section 2 above, a one million dollar (\$1,000,000) liability insurance policy or policies provided by an insurance company or companies licensed to do business in the State of Connecticut. Said policy or policies shall cover all of the Contractor's activities under this Agreement and shall state that it is primary insurance in regard to the, State of Connecticut, the Comptroller, its officers and employees. The State of Connecticut shall be named as an additional insured.

In addition, the Contractor shall at its sole expense maintain in effect at all times during the performance of its obligations hereunder the following additional insurance coverages with limits not less than those set forth below with insurers and under forms of policies approved by the State Insurance Commissioner to do business in Connecticut:

Coverage:

Minimum Amounts and Limits

- | | |
|---|---|
| 1. Workers' Compensation | Connecticut Statutory Requirements |
| 2. Employer's Liability | To the extent included under Workers' Compensation Insurance Policy |
| 3. Adequate comprehensive Vehicle Liability Insurance covering all vehicles owned or leased by Contractor and in the course of work under this Agreement: | |
| a. Bodily Injury Insurance meeting Connecticut statutory requirements; | |
| b. Property Damage Insurance meeting Connecticut statutory requirements; | |

None of the requirements contained herein as to types, limits, and approval of insurance coverage to be maintained by Contractor are intended to and shall not in any way limit or qualify the liabilities and obligations assumed by Contractor under this Agreement.

Contractor shall deliver Certificates of Insurance relating to all of the above referenced coverages to the Comptroller at the time of the execution of this Agreement as evidence that policies providing such coverage and limits of insurance are in full force and effect, which

Certificate shall provide that no less than thirty (30) days advance notice will be given in writing to the Comptroller prior to cancellation, termination or alteration of said policies of insurance.

K. Non-Waiver

None of the conditions of this Agreement shall be considered waived by the Comptroller or the Contractor unless given in writing. No such waiver shall be a waiver of any past or future default, breach, or modification of any of the conditions of this Agreement unless expressly stipulated in such waiver.

L. Promotion

Unless specifically authorized in writing by the Comptroller, the Contractor shall have no right to use, and shall not use, the name of the State of Connecticut, its officials or employees, the seal of the Comptroller, or the seal of the Comptroller:

1. In any advertising, publicity, promotion; nor
2. To express or imply any endorsement of the Contractor's products or services; nor

To use the names of the Comptroller, its officials or employees or the Comptroller seal or Comptroller's seal in any manner (whether or not similar to uses prohibited by subparagraphs 1 and 2 above), except as only to manufacture and deliver in accordance with this Agreement such items as are hereby contracted by the Comptroller, provided however, the use of the Comptroller seal shall require specific and express permission from the Secretary of the Comptroller.

M. Confidentiality

All data provided to Contractor by the Comptroller or developed internally by Contractor with regard to the Comptroller will be treated as proprietary to the Comptroller and confidential unless the Comptroller agrees in writing to the contrary. Contractor agrees to forever hold in confidence all files, records, documents, or other information as designated, whether prepared by the Comptroller or others, which may come into Contractor's possession during the term of this Agreement, except where disclosure of such information by Contractor is required by other governmental authority to ensure compliance with laws, rules, or regulations, and such disclosure will be limited to that actually so required. Where such disclosure is required, Contractor will provide advance notice to the Comptroller of the need for the disclosure and will not disclose absent consent from the Comptroller.

N. Subpoenas

In the event the Contractor's records are subpoenaed pursuant to Conn. Gen. Stat. Section 36a-43, the Contractor shall, within twenty-four (24) hours of service of the subpoena, notify the person designated for the Comptroller in Section 3 of this Agreement of such subpoena. Within thirty-six (36) hours of service, the Contractor shall send a written notice of the subpoena together with a copy of the same to the person designated for the Comptroller in Section 3 of this Agreement.

O. Survival

The rights and obligations of the parties which by their nature survive termination or completion of the Agreement, including but not limited to those set forth herein in sections relating to Indemnity, Nondisclosure, Promotion, and Confidentiality of this Agreement, shall remain in full force and effect.

P. Americans with Disabilities Act

This clause applies to those Contractors which are or will become responsible for compliance with the terms of the Americans with Disabilities Act of 1990 during the term of the contract. Contractor represents that it is familiar with the terms of this Act and that it is in compliance with the law. Failure of the Contractor to satisfy this standard either now or during the term of the contract as it may be amended will render the contract voidable at the option of the Comptroller upon notice to the Contractor. Contractor warrants that it will hold the Comptroller harmless from any liability which may be imposed upon the Comptroller as a result of any failure of the Contractor to be in compliance with this Act.

Q. Non-Discrimination and Executive Orders

This Agreement is subject to the provisions of Executive Order No. Three of Governor Thomas J. Meskill, promulgated June 16, 1971, concerning labor employment practices, Executive Order No. Seventeen of Governor Thomas J. Meskill, promulgated February 15, 1973, concerning the listing of employment openings and Executive Order No. Sixteen of Governor John G. Rowland promulgated August 4, 1999, concerning violence in the workplace, all of which are incorporated into and are made a part of the Contract as if they had been fully set forth in it. At the Contractor's request, the Client Agency shall provide a copy of these orders to the Contractor.

This Agreement may also be subject to Executive Order No. 7C of Governor M. Jodi Rell, promulgated July 13, 2006, concerning contracting reforms and Executive Order No. 14 of Governor M. Jodi Rell, promulgated April 17, 2006, concerning procurement of cleaning products and services, in accordance with their respective terms and conditions.

Non-Discrimination -The Contractor agrees to the following provisions required pursuant to 4a-60a of the Connecticut General Statutes:

For the purposes of this section, "minority business enterprise" means any small Contractor or supplier of materials fifty-one percent or more of the capital stock, if any, or assets of which is owned by a person or persons. (1) who are active in the daily affairs of the enterprise; (2) who have the power to direct the management and policies of the enterprise; and (3) who are member of a minority, as such term is defined in subsection (a) of Connecticut General Statutes section 32-9n; and "good faith" means that degree of diligence which a reasonable person would exercise in the performance of legal duties and obligations. "Good faith efforts" shall include, but not be limited to, those reasonable initial efforts necessary to comply with statutory or regulatory requirements and additional or substituted efforts when it is determined that such initial efforts will not be sufficient to comply with such requirements. For purposes of this section, "Commission" means the Commission on Human Rights and Opportunities. For purposes of this section, "Public works contract" means any agreement between any individual,

firm or corporation and the state or any political subdivision of the state other than a municipality for construction, rehabilitation, conversion, extension, demolition or repair of a public building, highway or other changes or improvements in real property, or which is financed in whole or in part by the state, including but not limited to, matching expenditures, grants, loans, insurance or guarantees.

(1) The Contractor agrees and warrants that in the performance of the Agreement such Contractor will not discriminate or permit discrimination against any person or group of persons on the grounds of race, color, religious creed, age, marital status, national origin, ancestry, sex, mental retardation or physical disability, including, but not limited to blindness, unless it is shown by such Contractor that such disability prevents performance of the work involved, in any manner prohibited by the laws of the United States or of the State of Connecticut. The Contractor further agrees to take affirmative action to insure that applicants with job related qualifications are employed and that employees are treated when employed without regard to their race, color, religious creed, age, marital status, national origin, ancestry, sex, mental retardation, or physical disability, including, but not limited to, blindness unless it is shown by the Contractor that such disability prevents performance of the work involved; (2) the Contractor agrees, in all solicitations or advertisements for employees placed by or on behalf of the Contractor, to state that it is an "affirmative action – equal opportunity employer" in accordance with regulations adopted by the Commission; (3) the Contractor agrees to provide each labor union or representative of workers with which the Contractor has a collective bargaining agreement or other contract or understanding and each vendor with which the Contractor has a contract or understanding, a notice to be provided by the Commission, advising the labor union or workers' representative of the Contractor's commitments under this section and to post copies of the notice in conspicuous places available to employees and applicants for employment; (4) the Contractor agrees to comply with each provision of this section and Connecticut General Statutes sections 46a-68e and 46a-68f and with regulation or relevant order issued by said Commission pursuant to Connecticut General Statutes sections 46a-56, 46a-68e and 46a-68f; (5) the Contractor agrees to provide the Commission on Human Rights and Opportunities with such information requested by the Commission and permit access to pertinent books, records and accounts, concerning the works contract, the Contractor agrees and warrants that he will make good faith efforts to employ minority business enterprise as subcontractors and suppliers of materials on employment practices and procedures of this Contractor as relate to the provisions of this section and section 46a-56. If the contract is a public works contract, the Contractor agrees and warrants that he will make good faith efforts to employ minority business enterprises as subcontractors and suppliers of materials on such public works projects.

Determination of the Contractor's good faith efforts shall include, but shall not be limited to, the following factors: The Contractor's employment and subcontracting policies, patterns and practices: affirmative advertising, recruiting; technical assistance activities and such other reasonable activities or efforts as the Commission may prescribe that are designed to ensure the participation of minority business enterprises in public works projects.

The Contractor shall develop and maintain adequate documentation, in a manner prescribed by the Commission, of its good faith efforts.

The Contractor shall include the provisions of subsection _____ of this section in every subcontract or purchase order entered into in order to fulfill any obligation of a contract with the State and such provisions shall be binding on a subcontractor, vendor or manufacturer unless

exempted by regulations or orders of the Commission. The Contractor shall take such action with respect to any such subcontract or purchase order as the Commission may direct as a means of enforcing such provisions including sanctions for noncompliance in accordance with Connecticut General Statutes Section 46a-56; provided, if such Contractor becomes involved in, or is threatened with, litigation with a subcontractor or vendor as a result of such direction by the Commission, the Contractor may request the State of Connecticut to enter into any such litigation or negotiation prior thereto to protect the interests of the State and the State may so enter.

The Contractor agrees to comply with the regulations referred to in this Section as they exist on the date of this Agreement and as they may be adopted or amended from time to time during the term of this Agreement and any amendments thereto.

Non-discrimination Regarding Sexual Orientation - Unless otherwise provided by Connecticut General Statutes, Section 46a-51p, the Contractor agrees to the following provisions required pursuant to Section 4a-60a of the Connecticut General Statutes:

(1) The Contractor agrees and warrants that in the performance of the Agreement such Contractor will not discriminate or permit discrimination against any person or group of persons on the grounds of sexual orientation, in any manner prohibited by the laws of the United States or the State of Connecticut, and that employees are treated when employed without regard to their sexual orientation; (2) the Contractor agrees to provide each labor union or representative of workers with which such Contractor has a collective bargaining agreement or other contract or understanding, and each vendor with which such Contractor has a contract or understanding, a notice to be provided by the Commission on Human Rights and Opportunities advising the labor union or workers' representative of the Contractor's commitments under this section, and to post copies of the notice in conspicuous places available to employees and applicants for employment; (3) the Contractor agrees to comply with each provision of this section and with each regulation or relevant order issued by said Commission pursuant to Section 46a-56 of the Connecticut General Statutes; (4) the Contractor agrees to provide the Commission on Human Rights and Opportunities with such information requested by the Commission, and permit access to pertinent books, records and accounts concerning the employment practices and procedures of the Contractor which relate to provisions of this section and Section 46a-56 of the Connecticut General Statutes.

The Contractor shall include the provisions of the foregoing paragraph in every subcontract or purchase order entered into in order to fulfill any obligation of a contract with the State and such provisions shall be binding on any subcontractor, vendor or manufacturer unless exempted by regulations or orders of the Commission. The Contractor shall take such action with respect to any such subcontract or purchase order as the Commission may direct as a means of enforcing such provisions including sanctions for non compliance in accordance with Section 46a-56 of the Connecticut General Statutes provided, if such Contractor becomes involved in, or is threatened with, litigation with a subcontractor or vendor as a result of such direction by the Commission, the Contractor may request the State of Connecticut to enter into any such litigation or negotiation prior thereto to protect the interests of the State and the State may so enter.

S. Sovereign Immunity

Notwithstanding any provisions to the contrary contained in this Agreement, it is agreed and understood that the State of Connecticut shall not be construed to have waived any rights or

defenses of sovereign immunity which it may have with respect to all matters arising out of this Agreement.

T. Assignment

This Agreement shall not be assigned by either party without the express prior written consent of the other.

U. Severability

If any part or parts of this Agreement shall be held to be void or unenforceable, such part or parts shall be treated as severable, leaving valid the remainder of this Agreement notwithstanding the part or parts found to be void or unenforceable.

V. Headings

The titles of the several sections, subsections, and paragraphs set forth in this Agreement are inserted for convenience of reference only and shall be disregarded in construing or interpreting any of the provisions of this Agreement.

W. Third Parties

The Comptroller shall not be obligated or liable hereunder to any party other than the Contractor.

X. Non Waiver

In no event shall the making by the Comptroller of any payment to the Contractor constitute or be construed as a waiver by the Comptroller of any breach of covenant, or any default which may then exist, on the part of the Contractor and the making of any such payment by the Comptroller while any such breach or default exists shall in no way impair or prejudice any right or remedy available to the Comptroller in respect to such breach or default.

Y. Contractor Certification

The Contractor certifies that the Contractor has not been convicted of bribery or attempting to bribe an officer or employee of the Comptroller, nor has the Contractor made an admission of guilt of such conduct which is a matter of record.

Z. Summary of State Ethics Laws

Pursuant to the requirements of section 1-101qq of the Connecticut General Statutes, the summary of State ethics laws developed by the State Ethics Commission pursuant to section 1-81b of the Connecticut General Statutes is incorporated by reference into and made a part of the Agreement as if the summary had been fully set forth in the Contract. (See Attachment A, attached hereto and incorporated by reference herein.)