2024
FIXED FUNDING SOLUTIONS
LARGE GROUP
FLEXPOS

HEALTH PLAN DESCRIPTION

AS ADMINISTERED BY CONNECTICARE INSURANCE COMPANY, INC.

This Plan is a self-funded health benefit plan provided by your Employer. It is not an insurance policy. ConnectiCare Insurance Company, Inc., (sometimes referred to as "ConnectiCare" or "CICI") provides administrative services under an agreement with your Employer with respect to the Plan. ConnectiCare does not fund or insure benefits of this Plan.

This document is called a Health Plan Description ("Plan Description") as it describes the benefits your Employer has decided to provide to you and your covered dependents and includes the Benefit Summaries and any amendments. Your Employer is responsible for whether this Plan Description completely or accurately describes the Plan. The effective date of this Plan Description can be found in the *Additional Information* document provided by your Employer.

This replaces any agreement, contract, policy or program of the same coverage that ConnectiCare or its affiliates may have provided prior to this Plan Description's effective date.

Words in this Plan Description that are in "Upper Case" (like this) have special meaning. You can find their meaning in the "Definitions" section at the end of this Plan Description.

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Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the Pre-Authorization And Pre-Certification (Prior Approval) Addendum to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

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IMPORTANT RULES, TELEPHONE NUMBERS AND ADDRESSES

IMPORTANT RULES

Here are some quick suggestions to help you get the most from this Plan.

Please note that this summary doesn't include everything you need to know, but it will help get you started.

- Read the "Managed Care Rules And Guidelines" section of this Plan Description, so you can find out right now if this Plan requires you to only use Participating Providers and obtain Referrals.
- **You should also refer to the "Pre-Authorization And Pre-Certification (Prior Approval) Addendum" to find out what services require Pre-Authorization (prior approval). Make sure you read this addendum prior to receiving services. There are several other places in the Plan Description that discuss prior approval requirements, but the addendum lists all services subject to prior approval.**
- Select a Primary Care Provider (PCP) to act as your "health care manager" and be your first resource for medical information.
- Except in an Emergency, **always** use physicians and facilities that are Participating Providers for ***every*** service or supply you receive in order to get the highest level of benefits.
- If you think you are in an Emergency situation or in need of Urgent Care, try to call your PCP first to find out what to do, if you have time. If you do not have time to call, go to an emergency room or an Urgent Care Center, as appropriate. If it is possible, go to an emergency room or Urgent Care Center that is a Participating Provider.
- ***Always*** present your ID Card whenever obtaining health care services, durable medical equipment or supplies (including prescription drugs).

IMPORTANT TELEPHONE NUMBERS AND ADDRESSES

Because it's hard to find the phone numbers and mailing addresses you need when you're in a hurry, here's a list to have on hand.

Member Services

ConnectiCare
1-800-846-8578

TDD/TYY services
1-800-833-8134

Behavioral Health Program
1-888-946-4658

Pre-Authorization or Pre-Certification

ConnectiCare
1-800-562-6833 Utilization management questions can be asked from 8:00 a.m. to 5:00 p.m. Monday through Friday and after hours, you may leave a voicemail message.

Behavioral Health Program
1-888-946-4658

Radiology Services Program (Outpatient Diagnostic X-rays And Therapeutic Procedures, Spine Surgery And Interventional Pain Management)
1-877-607-2363

Submitting Claims From Non-Participating Providers

ConnectiCare (all claims except Behavioral Health Program)
ConnectiCare Claims
PO Box 546
Farmington, CT 06034-0546

Behavioral Health Program
OptumHealth Behavioral Solutions
PO Box 30757
Salt Lake City, UT 84130-0757

Questions and Complaints

ConnectiCare (all questions and complaints except Behavioral Health Program)

ConnectiCare Member Services
175 Scott Swamp Road
Farmington, CT 06032
Or www.connecticare.com

Behavioral Health Program

Optum-Appeals
P.O. Box 30512
Salt Lake City, UT 84130-0512
Fax: 1-855-312-1470
Phone: 1-866-556-8166

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OTHER IMPORTANT INFORMATION

1. **Some Care Is Not Covered**. Managed care companies decide what care is or isn't covered by the plan. That's part of a managed care company's job in trying to control costs. But these decisions aren't made in a vacuum. CICI's decisions are made by doctors and nurses with input from Members, physicians and other health care providers. Sometimes, even services you think should be covered are not paid for by this Plan, for example, if this Plan excludes them or if CICI determines they are not Medically Necessary. This Plan's exclusions are listed in the "Exclusions And Limitations" section of this Plan Description. And, if CICI has determined that a service is not Medically Necessary and is therefore denied, you can use the Plan's Appeal process.
2. **The Cost Of Care Matters**. Because managed care companies are in the business of trying to control health care costs, the cost of a service is considered when making coverage decisions. For example, if there is a less expensive but equally effective or more reasonable treatment available than the treatment that is being proposed, then the CICI will consider the cost in determining whether the proposed treatment is covered. Cost is never the **only** criterion that is used and, again, input from Members, physicians and other health care providers is obtained to make these decisions.
3. **Drug Costs Matter**. You no doubt are aware that prescription drug costs are skyrocketing. So, as with other health care services, the cost of a medication is a factor when CICI decides where medications will go in the Plan's "tiered system" of Cost-Shares. The Plan's tiered system places medications in categories that tell you what your Cost-Share will be for that medication. Under your Plan, if a covered medication is in a higher tier, that doesn't mean it's not a good medication or that you shouldn't get it. It just means that you will have to pay a higher amount for it. Sometimes there might be an equally effective generic or alternative medication on a lower tier that you can use. Other times you and your doctor will decide that you need to have the medication on the higher tier. But in any case, you can get the medication – you may just have to pay a higher amount for it.
4. **In This Plan You Get A Higher Level Of Benefits If You Use Participating Providers, Or Network Providers When You Are Out Of The Network Access Area.** In this Plan, you must use Participating Providers, or Network Providers when you are out of the Network Access Area, to get the higher level of benefits. This is true even if you feel that a Non-Participating Provider is a "better" doctor or you prefer to use a Non-Participating Provider. If you use a Network Provider when you are in the Network Access Area, you will get a lower level of benefits.
5. **Participating Provider Or Network Provider Networks Can Change.** CICI maintains networks of Participating Providers that you should use to get your care covered. But those networks can change at any time. Sometimes, doctors can even leave in the middle of the year, after you have enrolled in a plan, so you might have to switch your doctor to get your care covered at the higher level of benefits. In those cases, CICI makes sure there are enough alternative doctors available to provide your care, and CICI has transition of care programs to ensure that your transition to a new doctor is as smooth as possible. The same is true of any of CICI's vendors who contract with Network Providers.
6. **In This Plan You Get A Lower Level Of Benefits If You Use Non-Participating Providers**. In this Plan, you have the option of using Non-Participating Providers and still get your care covered. That's one reason people enroll in a plan like this – so they will have the option of using a doctor that's not in the plan's provider network. But that care will always be paid at the lower level of benefits. This is true even if you feel that a Non-Participating Provider is a "better" doctor or you prefer to use a Non-Participating Provider. If you want the higher level of benefits, you always have to use a Participating Provider, or a Network Provider when you are out of the Network Access Area.
7. **Confidential Information Is Shared With Others To Administer The Plan**. CICI takes its privacy obligations **very** seriously. CICI collects a lot of very sensitive medical and other personal information about Members that needs to be kept strictly confidential. Therefore, CICI has very extensive policies about who can and cannot see your private information. But you should know that CICI has to share your private information with others in order to administer your Plan. As a result, companies that perform services for CICI to administer your Plan, and, sometimes even your Employer, and its other service providers, depending on what function they serve in administering this Plan, will have access to your private medical information. But these companies **all** sign confidentiality agreements and they are strictly prohibited from using the private information for anything other than administering this Plan. CICI **never** sells your private information to anyone.

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the Pre-Authorization And Pre-Certification (Prior Approval) Addendum to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

8. **Confidential Information Is Used In Educational Programs**. One of the main roles managed care companies play is to provide information concerning appropriate care. To accomplish this, CICI has several health education programs for chronic diseases, like asthma, diabetes and heart failure. CICI also sends reminders and specially directed educational information about medications and specific treatments to Plan Members and their doctors. In some of CICI's programs, directed information is sent to you and/or your doctors to tell them about what care you and they might consider getting for your diagnosis. The programs CICI runs are developed with input from practicing physicians and use well-documented, established facts about treatment and care. CICI uses claim information about you that is in CICI's system to figure out which members and doctors should be sent educational information from CICI.
9. **The Plan's Rules Must Be Followed**. There are a lot of rules to follow. CICI is making efforts to simplify things, but you really can't get around the fact there are rules you have to follow if you are going to get your care covered by this Plan. Some of the rules require you to notify CICI before getting care, some of them require you to get your care only from certain providers, some of the rules put limits on the care you can get, and some require you to only get certain types of care. The rules are in this Plan Description. You should also feel free to call CICI's Member Services Department at the appropriate telephone number listed in the "Important Telephone Numbers And Addresses" subsection of the "Important Information" section of this Plan Description or to contact CICI at www.connecticare.com to ask any questions you might have or if you are unsure about whether you have to follow any particular rule before getting your care.

MEMBERS' RIGHTS AND RESPONSIBILITIES

YOUR RIGHTS

You have a right to:

- Receive information about CICI, CICI's services, CICI's Participating Providers, and CICI's **Member's Rights and Responsibilities**.
- Be treated with respect and recognition of your dignity and right to privacy.
- Participate with practitioners in decision-making regarding your health care.
- A candid discussion of appropriate or Medically Necessary treatment options for your condition, regardless of cost or benefit coverage.
- Refuse treatment and to receive information regarding the consequences of such action.
- Voice complaints or Appeals about CICI or the care you are provided.
- Make recommendations regarding CICI's **Member's Rights and Responsibilities** policies.

YOUR RESPONSIBILITIES

You have a responsibility to:

- Select a Primary Care Provider (PCP).
- Provide, to the extent possible, information providers need to render care and CICI needs to administer coverage.
- Follow the plans and instructions for care that you have agreed on with practitioners.
- Keep scheduled appointments or give sufficient advance notice of cancellation.
- Pay applicable Copayments, Deductibles and/or Coinsurance.
- Follow the rules of this Plan and assume financial responsibility for not following the rules.
- Understand your health problems and participate in developing mutually agreed upon treatment goals to the degree possible.
- Be considerate of providers, and their staff and property, and respect the rights of other patients.
- Be considerate of CICI's employees by treating them with respect and dignity.
- Read this document describing this Plan's benefits and rules.

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the Pre-Authorization And Pre-Certification (Prior Approval) Addendum to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

THE CONNECTICARE ID CARD

Your ConnectiCare ID card gives medical and pharmacy providers the information they need to bill CICI directly for services for payment by your Plan. In addition to your name and other information, the card may include your ID number, your Employer's group number, and information about your coverage.

Be sure to always carry your ConnectiCare ID Card and present it whenever you receive services at the doctor's office, in an emergency room or Urgent Care Center, at your pharmacy and at any other health care facility. Your ID card should also be used when you receive prescriptions at Participating Pharmacies, Preferred Pharmacies or Non-Preferred Participating Pharmacies. And if you call or write CICI's Member Services Department, please give the representative your ID number.

If you lose your ConnectiCare ID card, contact CICI's Member Services Department by calling the appropriate telephone number listed in the "Important Telephone Numbers And Addresses" subsection of the "Important Information" section or visit CICI at www.connecticare.com to request a replacement. It generally will take about 10 business days for you to receive the replacement ID Card. If your coverage terminates, please destroy the card and do not attempt to use it. **Any attempt to use the card when you are not a Member in this Plan is against the law. You will be responsible for any claims incurred when you are not eligible for coverage.**

If you use the card after your coverage terminates and benefits are paid, you will have to reimburse CICI for the cost of the benefits paid.

COVERAGE

You are responsible for providing to your Employer information about yourself and your dependents that is complete, accurate and true to the best of your knowledge and belief. Coverage is being provided to you under this Plan on the basis of the information that is provided to your Employer. In the event that there is a change in the name(s), address, telephone number(s) or email address(es) that you have provided, you are responsible for telling your Employer as soon as possible about the change(s).

EFFECTIVE DATE GENERAL RULE

This Plan Description is effective as of the date listed in the *Additional Information* document. This Plan will take effect for you and your Eligible Dependents on the date you become eligible under your Employer's standard eligibility requirements. The following rules also apply:

Once you enter an eligible class, you will need to complete the probationary period before your coverage under this Plan begins.

Determining When You Become Eligible

You become eligible for the Plan on your eligibility date, which is determined as follows.

On the Effective Date Of The Plan

If you are in an eligible class on the effective date of your Plan, your eligibility date is the effective date of this Plan or, if later, the date you complete the period of continuous service required by your employer. Your Employer determines the criteria that is used to define the eligible class for coverage under this Plan. Such criteria are based solely upon conditions related to your employment. See your Employer for details.

After The Effective Date Of The Plan

If you are in an eligible class on the date of hire, your eligibility date is the effective date of this Plan or, if later, the date you complete the period of continuous service required by your employer. Your Employer determines the criteria that is used to define the eligible class for coverage under this Plan. Such criteria are based solely upon conditions related to your employment. See your Employer for details.

EFFECTIVE DATE OF COVERAGE WHEN A MEMBER IS AN INPATIENT AT THE TIME OF ELIGIBILITY

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

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APPLICATION OF AGREEMENT TO HEALTH SERVICES

This Plan Description replaces the prior health plan document or policy, if any, received by you describing this Plan. This Plan Description applies to health care services rendered on and after the effective date of this Plan Description. Medically Necessary health services and supplies are not covered if the patient is not enrolled as a Member under this Plan at the time the service or supply is rendered or received.

If this Plan Description specifically excludes a multi-staged health care procedure that was covered by a prior SPD/plan document or policy issued to you covering this Plan, then any Member who had completed the initial covered procedure of that multi-staged procedure prior to the effective date of this Plan Description will continue to be covered for that procedure until it is completed. Coverage will be available as long as the Member continues to be covered by this Plan and the procedure is rendered in accordance with the terms (including timing) of Pre-Authorization or Pre-Certification given by CICI, if any.

ELIGIBILITY AND ENROLLMENT

CICI will rely upon your Employer to determine whether or not a person meets the definition of a dependent for coverage under this plan. This determination will be conclusive and binding upon all persons for the purposes of this plan.

ELIGIBILITY RULES:

1. You, the Employee, must work full-time for your Employer (or part-time, if allowed by your Employer as indicated on the *Additional Information* document); and must be able to sign up under your Employer's coverage rules, including having to satisfy a probationary a period.
2. You and your spouse must have a legally valid existing marriage license and your spouse must live with you.
3. Your domestic partner if allowed by your Employer as indicated on the *Additional Information* document as long as all of the following conditions are met:
   - You have been residing together continuously for at least twelve months prior to the date indicated below as each other's sole domestic partner.
   - You intend to live together in accordance with your exclusive mutual interpersonal commitment.
   - You are not related by blood to a degree that would legally prohibit a marriage in the state in which you live.
   - You are not married to, a party to a civil union with, or in a domestic partnership with any person other than the person with whom you agree to execute a domestic partner affidavit.
   - You are legally and mentally competent to enter a contract in the state in which you reside.
   - You are jointly responsible for your common welfare and financial obligations and intend to continue to do so.

   In addition, your Employer will require that a signed "Domestic Partner Affidavit" or other satisfactory certification as your Employer determines, be returned with the Application/Change Form to your Employer as a condition of enrollment. "Proof," as described in the Domestic Partner Affidavit, must be provided annually. If it is not, coverage under this Plan will terminate as described in this Plan Description.

   When your domestic partner is covered under this Plan, replace the term "spouse" found in this Plan with "domestic partner."
4. Your child may be eligible for coverage under this Plan until the end of the last day of the Plan Year that is after his/her 26th birthday as long as his/her birthday is not the same day as the first day of the Plan Year. If your child's 26th birthday is the first day of the Plan Year, eligibility for coverage will end on that day.

   The following rules apply to children:
   - **Natural Children**. Your natural children can be covered.
   - **Adopted Children**. Children legally adopted by you can be covered if they meet the rules for natural children once the adoption is final. Before the adoption becomes final, a child can be signed up for coverage when you become legally responsible for at least partial support for the child.
   - **Step-Children**. Your step-children who are the natural or adopted children of your spouse/partner, or children for whom your spouse/partner is appointed legal guardian, can be covered.
   - **Guardianship**. Children for whom you are appointed the legal guardian can be covered.
   - **Handicapped Children**. To continue to be covered beyond the allowable age for dependent children, the child must:
     - Be unable to support himself/herself by working because of a mental or physical handicap, as certified by the child's physician or advanced practice registered nurse, and
     - Be dependent on you or your spouse/partner for support and care because he/she has a mental or physical handicap, and

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- ♦ Have become handicapped and must have always been handicapped while he/she would have been able to be signed up for dependent children coverage if he/she were not disabled.

  Proof of the handicap and the child's financial dependence must be given to your Employer within 31 days of the date when the child's coverage would end under another plan, or when you enrolled under this Plan if the handicap existed before you enrolled for coverage under this Plan. You must give your Employer proof that the child's handicap and financial dependence continue if your Employer asks for such proof.

- **Qualified Medical Child Support Orders (QMCSO)**. Special rules apply when a court issues a QMCSO requiring you to provide health insurance for your child. Your Employer decides whether you may sign up the child because of this QMCSO, and CICI will follow your Employer's decision. Your child does not have to live with you or in the Service Area in order to be covered under this Plan.

ADDING DEPENDENTS

Adding a Spouse. You must add your spouse to a Plan through your Employer within 31 days of the marriage to be effective on the date of the marriage. Otherwise, you must wait until the next Annual Enrollment Period to add your spouse to this Plan.

Adding a Domestic Partner. You must add your domestic partner to a Plan through your Employer within 31 days of the eligibility date. Otherwise, you must wait until the next Annual Enrollment Period to add your partner to this Plan.

If your marriage or domestic partnership ends, you must tell your Employer immediately, in writing and on a form acceptable to your Employer.

If your domestic partnership ends, you must tell your Employer immediately, in writing and on a form acceptable to your Employer.

Adding a Child. Your newborn natural child is enrolled for coverage for the first 91 days after birth when we are notified or receive a claim for the newborn. You may be responsible for any additional premium.

When our initial notification is a claim, your child's coverage will end on day 92, unless you notify us that you want to continue the newborn's coverage. When additional Premium is due, your notification to continue your child's coverage **MUST** be made to us within 91 days of his or her birth. You may be responsible for any additional Premium, for the first 91 days, regardless of your decision to continue coverage beyond day 91.

If the newborn natural child is not signed up under this Plan within 91 days of the child's birth and the requested contribution, if required, is not paid to us, any services provided to that child after the 91-day period are not covered, and you must wait until the next Annual Enrollment Period or Special Enrollment Period to sign up the child under this Plan.

If your daughter is covered under this Plan, her newborn child can receive coverage **ONLY** for the first 91 days after the child's birth, unless you or your covered spouse/partner becomes the child's legal guardian and you are signed up under this Plan.

A newly adopted child, a child for whom you become the legal guardian, and step-child must apply for coverage within 31 days of the date of the adoption (or the date on which you or your spouse become at least partially legally responsible for the adopted child's support and maintenance), or the date of your marriage to the step-child's parent, or the date you became the legal guardian. If the newly adopted child, a child for whom you become the legal guardian or step-child is not signed up within this 31-day period, you must wait until the next Annual Enrollment Period or special enrollment period to sign up the child under this Plan.

CHANGES AFFECTING ELIGIBILITY

You must tell your Employer right away about any change that may affect you or your dependents covered under this Plan. Examples of such changes are:

- Marriage.
- Divorce.
- End of domestic partnership.
- Birth of your child or of a child of your daughter.
- Child reaching maximum age limit for coverage under this Plan.
- Your employment ends, or you have a reduction in work hours.
- Loss of eligibility for other reasons specified in this document.

Changes should be indicated on an Enrollment Form, which you can obtain from your Employer. You should return the Enrollment Form to your Employer, even if what you pay for coverage does not change.

SPECIAL ENROLLMENT PERIOD

End of Other Group Health Coverage. You may be able to sign up yourself or your Eligible Dependent(s) for coverage under this Plan if you ask to sign up within 31 days after the date on which you or your dependent's other group health insurance coverage ends.

For you or a dependent to qualify for coverage during this Special Enrollment Period, the other group health creditable coverage must have been lost because COBRA benefits ended, non-COBRA coverage ended due to loss of eligibility for coverage or employer contributions for the coverage ended.

Medicaid or Children's Health Insurance Program (CHIP). If you, your spouse/partner or your child(ren) should lose eligibility for coverage under a state Medicaid or Children's Health Insurance Program (CHIP), you may sign up yourself, your spouse/partner and your child(ren) in this Plan as long as you ask to sign up within 60 days after the date Medicaid or CHIP coverage ends.

If you, your spouse/partner or your child(ren) should become eligible for health plan premium help under a state Medicaid or Children's Health Insurance Program (CHIP) plan, you may sign up yourself, your spouse/partner and your child(ren) in this Plan as long as you ask to sign up within 60 days after the day you are eligible for health plan premium help under Medicaid or CHIP.

Important: You cannot receive coverage under this Plan as: both an employee and a dependent, or A dependent of more than one employee.

MANAGED CARE RULES AND GUIDELINES

SELECTION OF A PRIMARY CARE PROVIDER (PCP)

Each Member should pick a PCP for routine physicals and to help when you are ill or need follow-up care after you receive Emergency Services.

Each Member can pick a different PCP.

If a Member does not pick a PCP at enrollment, CICI will pick one.

A Member can change PCPs at any time by calling or writing CICI's Member Services Department or by visiting CICI at their web site at www.connecticare.com.

If your current PCP leaves CICI's network or will no longer treat patients at a certain office where you may have received care, CICI will tell you about that change 30 days before it happens, if possible, or as soon as possible after CICI becomes aware of the change. You will then have to pick a new PCP.

WHEN YOU NEED SPECIALIZED CARE

Members **ARE NOT** required to get a pre-approval (referral) to see a specialist.

When you or your covered dependents are seeing a Specialist Physician regularly and that Specialist Physician is no longer participating with CICI as a part of CICI's network, CICI will tell you about that change 30 days before it happens, if possible, or as soon as possible after CICI becomes aware of the change. Please call your PCP or check CICI's Provider Directory for help in selecting a new Specialist Physician.

CONTINUITY OF CARE

If a Participating Provider changes network status, Members with complex care needs have up to a 90-day period of continued coverage at the In-Network Level Of Benefits to allow for a transition of care to another Participating Provider. In this circumstance, CICI will notify each "continuing care patient" with respect to the Participating Provider at the time of termination, notice of termination and your right to elect transitional care from such Participating Provider.

For the purpose of this provision, a "**continuing care patient**" means a Member who, with respect to a Participating Provider, is:

- Undergoing a course of treatment for a serious and complex condition,
- Undergoing a course of institutional or inpatient care,
- Scheduled to undergo non-elective surgery, including receipt of postoperative care,
- Pregnant and undergoing a course of treatment for the pregnancy; or
- Determined terminally ill and is receiving treatment for such illness.

For the purpose of this provision, the term "**terminated**" includes with respect to a Participating Provider contract, the expiration or nonrenewal, but does not include a termination of the contract for failure to meet applicable quality standards or fraud.

If the Non-Participating Provider's services are allowed as described in this provision, his or her services will only be covered if he or she agrees to accept what CICI would pay other Participating Providers; does not impose cost-sharing with respect to the Member in an amount that would exceed the cost-sharing that could have been imposed if the provider was a Participating Provider under this Plan; adheres to CICI's quality standards and provides CICI with the medical information CICI requests; and adheres to CICI's policies and practices, including obtaining any necessary Pre-Authorizations and or Pre-Certifications.

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the Pre-Authorization And Pre-Certification (Prior Approval) Addendum to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

SERVICES REQUIRING PRE-AUTHORIZATION OR PRE-CERTIFICATION

The Pre-Authorization Or Pre-Certification Process

When Being Treated By A Participating Provider

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

When Being Treated By A Non-Participating Provider

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

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

You can find the list of Health Services, including prescription drugs that need Pre-Certification or Pre-Authorization in the "Pre-Authorization And Pre-Certification (Prior Approval) Addendum."

Changes To The Pre-Authorization Or Pre-Certification Lists

Our Pre-Authorization or Pre-Certification lists may change at any time. Read the member electronic newsletter to learn about the changes. You can also contact CICI's Member Services Department or visit CICI's web site at www.connecticare.com.

When Pre-Authorization Or Pre-Certification Is Denied

No benefits will be provided under this Plan if you or your covered dependents receive services or supplies after Pre-Authorization or Pre-Certification has been denied.

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

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

Benefit Reduction

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

Your benefits will be denied if the services you or your covered dependents obtained without Pre-Authorization or Pre-Certification were not Medically Necessary or were not covered by this Plan.

If the services you obtained without the Pre-Authorization or Pre-Certification were Medically Necessary and otherwise covered by this Plan, then your benefits will be reduced as described below. CICI calls this a "Benefit Reduction."

Benefit Reduction Amounts

When a Non-Participating Provider arranges an admission to a Hospital or other facility for you or your covered dependents, or any of the services or supplies listed in the "Pre-Authorization And Pre-Certification (Prior Approval) Addendum" are rendered by a Non-Participating Provider, coverage for that admission and/or those services or supplies will be reduced as follows if you did not obtain Pre-Certification or Pre-Authorization:

- The lesser of $500 or 50% of the Maximum Allowable Amount CICI will pay per admission and/or service or supply, as applicable.

Note: These Benefit Reductions are in addition to the benefits that would normally be paid if proper Pre-Certification or Pre-Authorization was obtained. Benefit Reductions do not apply to Emergency Services.

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the Pre-Authorization And Pre-Certification (Prior Approval) Addendum to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

Benefit Reductions apply to the Out-Of-Network Level Of Benefits. All Benefit Reductions are your financial responsibility.

Benefit Reduction Exception

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

USING PARTICIPATING PROVIDERS AND NON-PARTICIPATING PROVIDERS

Terms You Should Know:

The **Network Access Area** consists of those geographic areas where contracted health care facilities, practitioners, and pharmacies provide benefits for covered Health Services under this Plan. To locate contracted health care facilities, practitioners, and pharmacies that are in the Network Access Area, visit our web site at https://secured.connecticare.com/providerdirectory/, or call the appropriate telephone number listed in the "Important Telephone Numbers And Addresses" section.

A **Participating Provider** is a provider or facility who has a contract to provide health care services in the Network Access Area and is listed in CICI's current Provider Directory. Certain other providers or facilities who are contracted with CICI or CICI's affiliates or subcontractors to provide health care services in areas near the Network Access Area are also Participating Providers.

A **Network Provider** is a provider or facility who has a contract to provide health care services through a designated network vendor outside the Network Access Area.

The In-Network Level Of Benefits

In order to obtain the higher level of benefits available under this Plan, you and your covered dependents need to use the In-Network Level of Benefits option of this Plan.

Here is how you and your covered dependents obtain the In-Network Level Of Benefits.

If You Are In The Network Access Area

Using Participating Providers

When a Member uses Participating Providers to order, arrange or provide care when he or she is in the Network Access Area, that Member will be eligible for the higher level of benefits under this Plan. This is called the In-Network Level Of Benefits. The amount of these benefit levels is listed on your Benefit Summary.

To locate a Participating Provider, Members can refer to CICI's Provider Directory, visit CICI at their web site at https://secured.connecticare.com/providerdirectory/, or call CICI.

IMPORTANT: Except in a few VERY LIMITED CIRCUMSTANCES, ALL health care services and supplies must be ordered, rendered and supplied by a Participating Provider when you are in the Network Access Area, or the service or supply will not be covered at the In-Network Level Of Benefits, even if you use a Network Provider or you believe that a Non-Participating Provider is a "better" doctor.

If You Are Out Of The Network Access Area

Using Network Providers

When a Member uses Network Providers when he or she is out of the Network Access Area, that Member will also be eligible for a higher level of benefits under this Plan. This is, again, the In-Network Level Of Benefits. The amount of these benefit levels is listed on your Benefit Summary.

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

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

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

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

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

- You make a request to see a Non-Participating Provider, due to the Member's unreasonable travel to or delay in obtaining an appointment from the nearest Participating Provider (or a Network Provider when you are outside of the Network Access Area).

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the Pre-Authorization And Pre-Certification (Prior Approval) Addendum to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

- CICI or, as appropriate, CICI's Delegated Program have determined, at their discretion, Medically Necessary services are not available from a Participating Provider or a Network Provider without unreasonable travel or delay to the Member.

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

1-800-562-6833

Or by writing:

ConnectiCare
Clinical Review Department
175 Scott Swamp Road
Farmington, Connecticut 06032

For mental health or alcohol or substance abuse care, you must call 1-888-946-4658 to request Pre-Authorization before obtaining care.

The Out-Of-Network Level Of Benefits

Members will receive a lower level of benefits when he or she uses the Out-Of-Network Level Of Benefits option.

If You Are In The Network Access Area

Using Non-Participating Providers

When a Member uses Non-Participating Providers to order, arrange or provide care when he or she is in the Network Access Area, that Member will be eligible for a lower level of benefits under this Plan. This is called the Out-Of-Network Level Of Benefits. The amount of these benefit levels is listed on your Benefit Summary.

IT IS YOUR RESPONSIBILITY to request Pre-Authorization or Pre-Certification before you or your covered dependents obtain care when using Non-Participating Providers. Please refer to the "Pre-Authorization And Pre-Certification (Prior Approval) Addendum" and "Benefit Reduction" subsection of this section for more details.

Services rendered by a Non-Participating Provider are not covered at the In-Network Level Of Benefits, even if the Member is referred to the Non-Participating Provider by a Participating Provider or a Network Provider.

Using Network Providers, Instead Of A Participating Provider

When a Member uses Network Providers to order, arrange or provide care when he or she is in the Network Access Area, instead of choosing to use Participating Providers, that Member will only be eligible for the lower level of benefits, called the Out-Of-Network Level Of Benefits.

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

If You Are Out Of The Network Access Area

Using Non-Participating Providers

When a Member uses Non-Participating Providers when he or she is out of the Network Access Area, that Member will receive coverage at the Out-Of-Network Level Of Benefits, except in an Emergency and as noted later in the "After Hours Care" subsection of this section.

Participating Provider And Network Provider General Rules

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

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

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

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

The rate the Plan pays Participating Providers or Network Providers for covered Health Services, before any deduction of any applicable risk withholds, may include:

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

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the Pre-Authorization And Pre-Certification (Prior Approval) Addendum to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

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

You should also know that Participating Providers or Network Providers are not prohibited from disclosing, to a Member who inquires the method that CICI uses to compensate them on behalf of the Plan.

You may obtain the professional qualifications of Participating Providers or Network Providers by calling the appropriate telephone number listed in the "Important Telephone Numbers And Addresses" subsection of the "Important Information" section or by visiting CICI's web site at www.connecticare.com.

BENEFITS FOR STUDENTS, WHILE TRAVELING AND AFTER-HOURS CARE

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

Students

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

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

In those instances, covered Health Services include:

- **Allergy shots**

  Your child can arrange to have allergy shots while at school. When a Participating Provider provides the allergy extracts, your child can bring them to a Non-Participating Provider near school who will give the shots.

- **Emergency Services or Urgent Care**

  Emergency Services or Urgent Care are covered. If your child needs follow up care related to that Emergency or Urgent Care, call CICI for Pre-Authorization, even if the follow up care is given in the emergency room.

- **Behavioral Health (Mental Health, alcohol and substance abuse services)**

  Mental health, alcohol and substance abuse services are coordinated by CICI's Behavioral Health Program Delegated Program. If your child needs these services while at school, call CICI's Behavioral Health Program at the telephone number listed on the back of his/her ID card. Representatives are always available to coordinate this care. CICI's Behavioral Health Program maintains a national network of providers and will try to find a provider in your child's area. If necessary, it will authorize appropriate care rendered by a Non-Participating Provider.

- **Physical therapy**

  When your child's doctor orders physical therapy treatment as a result of an accident or surgical procedure the therapy is covered.

- **Radiology services**

  Radiology services are covered when your child is at school, including CT scans and MRI/MRA exams.

- **Prescription drugs**

  Prescriptions are covered at Participating Pharmacies throughout the United States. If you have prescription drug coverage with us, your child needs to present his/her ID card to the pharmacy, along with a prescription, and pay the applicable Cost-Share amount.

While Traveling

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

- Emergency Services.
- Urgent Care.

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

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

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the Pre-Authorization And Pre-Certification (Prior Approval) Addendum to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

After Hours Care

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

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

COST-SHARES YOU ARE REQUIRED TO PAY

Examples of Cost-Sharing arrangements are "Copayments," "Deductibles" and "Coinsurance."

Review your Benefit Summary for the applicable Cost-Share amounts of this Plan, any maximums this Plan may have, and per calendar year or per Plan Year coverage.

Amount Of In-Network Level Of Benefits

Your Benefit Summary lists the amount of the In-Network Level Of Benefits that you or your covered dependents will receive when Participating Providers (or Network Providers when you are out of the Network Access Area) render Medically Necessary care. In general, you are required to pay a Copayment for the In-Network Level Of Benefits before the In-Network Level Of Benefits is paid, but some benefits require you to pay a Benefit Deductible first.

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

Amount Of Out-Of-Network Level Of Benefits

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

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

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

Deductibles

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

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

Plan Deductibles

In-Network Level Of Benefits Plan Deductible

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

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

Out-Of-Network Level Of Benefits Plan Deductible

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

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

How Plan Deductibles Are Met

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

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

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the Pre-Authorization And Pre-Certification (Prior Approval) Addendum to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

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

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

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

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

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

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

More About Deductibles

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

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

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

Copayments

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

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

Copayments vary by Plan. Your Benefit Summary will describe your Copayments, if any.

A Member does not have to pay Emergency room (ER) Copayments if the Member:

- Is admitted directly to the Hospital from the (ER), or
- Was treated at an Urgent Care Center and told by the treating provider that he/she should go immediately to an ER because the ER was better equipped to handle his/her medical problem.

Coinsurance

Coinsurance is the Member's share of a percentage of the cost of covered Health Services after any applicable Deductible is met.

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

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

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

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

Review your Benefit Summary for Coinsurance amount details.

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the Pre-Authorization And Pre-Certification (Prior Approval) Addendum to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

More Information About Deductibles And Coinsurance

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

Maximums

Out-Of-Pocket Maximum

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

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

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

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

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

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

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

- Amounts a Member pays toward any non-covered Health Services, or
- Amounts a Member pays toward any Out-Of-Network Level Of Benefits, or
- Amounts a Member pays toward any penalties or Benefit Reductions, or
- Charges by a provider in excess of the Maximum Allowable Amount.

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

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

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

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

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

- Amounts a Member pays toward any non-covered Health Services, or
- Amounts a Member pays toward any In-Network Level Of Benefits, or
- Amounts a Member pays toward any penalties or Benefit Reductions, or
- Charges by a provider in excess of the Maximum Allowable Amount.

Your Benefit Summary describes any Out-Of-Pocket Maximum.

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the Pre-Authorization And Pre-Certification (Prior Approval) Addendum to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

MEDICAL NECESSITY AND APPROPRIATE SETTING FOR CARE

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

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

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

"Medically Necessary" health care services are those Health Services that are required diagnostic or therapeutic treatments for an illness or injury.

Health care treatments, medications and supplies that are not Medically Necessary are not covered under this Plan. CICI determines if a treatment, medication or supply is Medically Necessary. These determinations are made through various Utilization Management processes, including pre-service review, concurrent review, post service review, discharge planning and Case Management.

A health care practitioner determines medical care, but coverage for that care under this Plan is subject to Medical Necessity as determined by CICI. CICI uses input from physicians, including specialists, to approve, and in some cases develop, CICI's Medical Necessity protocols.

Case Managers help to arrange and coordinate Medically Necessary care. At CICI's discretion, development of alternative individual plans may include coverage of otherwise non-covered services or supplies.

UTILIZATION MANAGEMENT

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

QUALITY ASSURANCE

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

- Systematically monitors, evaluates and suggests improvements for both the process of care and the outcome of care delivered to Members.
- Identifies and implements opportunities for improvement in the quality of care and services delivered to Members, both administrative and clinical, including behavioral health.
- Evaluates and improves Members' access to and satisfaction with clinical and administrative services.
- Facilitates Members' access to appropriate medical care.
- Encourages Members to become more knowledgeable, active participants in their own medical and preventative care by implementing initiatives that focus on member education and health management wellness programs.
- Carries out systematic data collection related to plan and practitioner performance and communicates, in the aggregate, these data and their interpretation to internal and peer review committees for analysis and action.
- Monitors whether the care and service provided meets or exceeds established local, state, and national managed care standards.
- Develops innovative approaches to facilitating the delivery of care to diverse populations.

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

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the Pre-Authorization And Pre-Certification (Prior Approval) Addendum to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

NEW TREATMENTS

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

When CICI receives a request for coverage for a New Treatment, CICI reviews the New Treatment to determine whether it should be covered under this Plan.

Generally, New Treatments, other than drugs with FDA approval for the use for which they are prescribed, are not covered. However, during CICI's review phase of a New Treatment, CICI may, in some limited circumstances and in CICI's discretion, cover a New Treatment for Members in the same or similar circumstances before CICI's determination is made. Once CICI completes their review, if CICI determines the New Treatment should be covered, those New Treatments rendered **AFTER** CICI's determination will be covered. There will be no retroactive coverage of a New Treatment.

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

In the case where a New Treatment is a prescription drug with FDA approval for the use for which it is being prescribed, the medication will be covered at the highest tier Copayment level until CICI's Pharmacy and Therapeutics (P&T) Committee has had an opportunity to review it, unless it is in a class of medication that is specifically excluded as described in the "Exclusions And Limitations" section or in "Supplemental Prescription Drug" subsection, if applicable.

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

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

EXPERIMENTAL OR INVESTIGATIONAL

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

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

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

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

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

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the Pre-Authorization And Pre-Certification (Prior Approval) Addendum to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

INSUFFICIENT EVIDENCE OF THERAPEUTIC VALUE

Any service, supply, device, procedure or medication (collectively called "Treatment") for which there is Insufficient Evidence Of Therapeutic Value for the use for which it is being prescribed is not covered. There is insufficient evidence of therapeutic value when CICI determines, in their sole discretion, that either:

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

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

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

DELEGATED PROGRAMS

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

Delegated Programs may be added or removed from this Plan at any time at CICI's discretion.

BENEFITS

Benefits for Medically Necessary Health Services provided under this Plan are subject to all the rules of this document.

Not all services are covered under this Plan. While some exclusions and limitations are listed throughout the "Benefits" section, you should also read through the "Exclusions And Limitations" section to ensure you fully understand what is not covered under this Plan.

Please review your Benefit Summary for the amounts you have to pay (Copayment, Deductible, Coinsurance amounts), and the benefit maximums of this Plan.

PREVENTIVE AND WELLNESS CARE

Some Participating Provider preventive and wellness services, as defined by the United States Preventive Service Task Force, including immunizations recommended by the Advisory Committee on Immunizations Practices at the Centers for Disease Control (CDC), and preventive care and screenings for infants, children, adolescents, and women supported by the Health Resources and Services Administration (HRSA) are exempt from all Member Cost Shares (Deductible, Copayment and Coinsurance) under the federal Patient Protection and Affordable Care Act (ACA). These services are identified by the specific coding your Participating Provider submits to ConnectiCare. The service coding must match ConnectiCare's coding list to be exempt from all Cost Sharing under ACA.

You should visit CICI's website at www.connecticare.com to view a list of the preventive and wellness services that are exempt from Member Cost-Shares or call CICI's Member Services Department at the telephone number listed in the "Important Telephone Numbers And Addresses" section for assistance.

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the Pre-Authorization And Pre-Certification (Prior Approval) Addendum to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

PREVENTIVE SERVICES

The following **preventive services are covered when provided in the doctor's office**:

Routine Exams And Preventive Care

Adult Preventive Care Services

Office visits for adult preventive care services (routine exams and preventive care) are **covered**.

Gynecological Preventive Exam Office Services

Office visits for gynecological preventive exam office services (routine exams and preventive care) are **covered**.

The Member's doctor decides the number of times she should get periodic health evaluations and checkups.

Infant/Pediatric Preventive Care Services

Office visits for infant/pediatric preventive care services (routine exams and preventive care) are **covered**.

Other Preventive Services

Blood Lead Screening Exams And Risk Assessments

If the Member's Primary Care Provider decides that blood lead screenings and risk assessments are needed, they are **covered** as follows:

Lead Screening Exams

- At least annually for a child from 9- 35 months of age, and
- For a child 3-6 years of age who has not been previously screened or is at risk.

Risk Assessments:

- For lead poisoning at least annually for a child 3-6 years of age, and
- At any time in accordance with state guidelines for a child age 36 months or younger.

Cervical Cancer Screening (Pap Tests)

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

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

Cervical cancer screenings are only exempt from any Cost-Share amounts as defined by the United States Preventive Service Task Force and the Health Resources and Services Administration (HRSA).

Colorectal Cancer Screenings

Colorectal cancer screenings, using fecal occult blood testing, sigmoidoscopy, colonoscopy, or radiological imaging, are **covered** in accordance with the recommendations established by the American Cancer Society.

- If the screening is coded as preventive, a Member can get one screening per year, and
- If the screening is not preventive, the Member's doctor decides the number of times he/she should get colorectal cancer screenings.

You may have to pay a Cost-Share for these screenings. The amount depends on where the procedure is received and your Plan. For example, if you have a procedure done at a doctor's office, you may be required to pay an office services Copayment, but if you get the service on an outpatient basis, either in a Hospital or in an ambulatory surgery facility, you may be required to pay an ambulatory services Cost-Share amount.

This Plan will not require the Member to pay:

- A Deductible amount for a procedure that his/her doctor initially performs as a screening colonoscopy or a screening sigmoidoscopy in accordance with the American Cancer Society recommendations, or
- Any Cost-Share amount for repeat colonoscopies ordered by a doctor in a benefit year, unless the Member is enrolled in one of CICI's HSA-compatible high deductible health plans (HDHPs).

Hearing Screenings

Hearing screenings are **covered**:

- As a part of a physical examination if a Member is under age 19.
- If Medically Necessary to evaluate the sudden onset of severe symptoms of an injury or illness. No coverage is available if the Member is already diagnosed with a permanent hearing loss.

Immunizations

Immunizations (vaccine and injection of vaccine) are **covered.**

The following immunizations are **NOT** covered:

- Immunizations a Member gets only because someone else says he/she needs them (for example, to get a job or to go to camp),
- Immunizations received for travel,
- Immunizations and vaccinations for cholera, plague or yellow fever,
- Routine immunizations received at an Urgent Care Center, and
- Vaccinations an employer is legally required to provide because of an employment risk.

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the Pre-Authorization And Pre-Certification (Prior Approval) Addendum to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

Mammogram Screenings

Mammogram screenings are **covered**.

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

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

In addition to the mammogram screenings noted above, comprehensive ultrasound screening of an entire breast or breasts is also **covered at the applicable Cost-Share as shown on your Benefit Summary**.

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

- A mammogram demonstrates heterogeneous or dense breast tissue based on the Breast Imaging Reporting and Data System established by the American College of Radiology; or
- A woman is believed to be at increased risk for breast cancer due to family history or prior personal history of breast cancer, positive genetic testing or other indications as determined by her physician or advanced practice registered nurse.

Magnetic resonance imaging (MRI) of an entire breast or breasts in accordance with guidelines established by the American Cancer Society is **covered at the applicable advanced radiology Cost-Share as shown on your Benefit Summary**.

Some types of breast cancer screenings (e.g., when a Member has or is thought to have a clinical genetic disorder) require Pre-Authorization.

Newborn Care

Newborn children are **covered for the first 91 days following birth**.

Please refer to the "Adding Dependents" subsection of the "Eligibility And Enrollment" section for more information and rules regarding coverage for newborn children.

Prostate Screening

Laboratory and diagnostic tests to screen for prostate cancer are **covered** for a Member who:

- Is at least 50 years old, or
- Is any age and is also symptomatic, or
- Is any age and has a biological father or brother who has been diagnosed with prostate cancer.

In addition, treatment for prostate cancer will also be **covered** in accordance with national guidelines established by the National Comprehensive Cancer Network, the American Cancer Society or the American Society of Clinical Oncology.

Routine Vision Exams

Vision Care Services

1. Services will be provided at the frequency described in your Benefit Summary.
2. A Participating Vision Care Provider who is an Ophthalmologist or Optometrist must provide the routine eye exam. The exam is **covered after the applicable Cost-Share amount. Please refer to your Benefit Summary to find out the Cost-Share amount.**

A **Non-Participating Vision Care Provider** is a provider who is not a Participating Vision Care Provider. Note that a Non-Participating Vision Care Provider may be a Participating Provider under the other terms and provisions of the Plan.

A **Participating Vision Care Provider** is a Participating Provider who has entered into an agreement with CICI (directly or through a vision care Participating Vendor) to provide Vision Care Services and/or Optical Care Services and that is eligible to be listed in the Vision Care Provider Listing, as updated from time to time.

If the eye exam is provided by a Non-Participating Vision Care Provider, no Optical Care Services, as described on the next page, are available under this Plan.

Optical Care Services

Optical Care Services means the eyewear materials that are subject to a discount described in this Plan.

1. You and your covered dependents may obtain discounts, as described in the following table, on Optical Care Services. In order to receive the discount, you must purchase the eyewear from the Participating Vision Care Provider.
2. If that Participating Vision Care Provider does not have eyewear dispensing facilities on his or her premises, then you must purchase the eyewear from the Participating Vision Care Provider with whom the Participating Vision Care Provider has made arrangements to dispense the Optical Care Services in his or her behalf.
3. When you or your covered dependents are eligible for covered Optical Care Services Discounts from a Participating Vision Care Provider, the Participating Vision Care Provider will subtract the appropriate discount from the total amount that is due. You do not have to submit a claim form.

Not all of CICI's contracted eye care providers participate in the Optical Care Services Discounts program. Please contact your eye care provider to confirm if he or she does participate.

OPTICAL CARE SERVICES DISCOUNTS TABLE:

OPTICAL CARE	DISCOUNT AVAILABLE	
FRAMES & LENSES Lens options include, but are not limited to: • Polycarbonate • Scratch resistant coating • Ultra-violet coating • Anti-reflective coating • Solid tint • Gradient tint • Photochromatic	A 25% discount on the total purchase price of frames and lenses that cost $250 or less. A 30% discount on the total purchase price of frames and lenses that cost more than $250.	
PRESCRIPTION CONTACT LENSES* Options include: • Hard or soft contact lenses • Initial disposable contact lens package for you and your covered dependents who have never worn disposable contact lenses	**IF THE CONTACT LENS CHARGE:**	**THEN:**
	Includes both the purchase price for the contact lenses and the charge for the Participating Vision Care Provider's professional services,	• A 25% discount on the total purchase price of contact lenses and professional services that cost $250 or less. • If total purchase price of contact lenses and professional services cost more than $250, then 25% discount on professional services, and 30% discount on contact lenses only.
	Does not include the purchase price for both the contact lenses **AND** the Participating Vision Care Provider's professional services,	• A 25% discount on professional services. • A 25% discount on the total purchase price of contact lenses that cost $250 or less. • A 30% discount on the total purchase price of contact lenses that cost more than $250.
OTHER DISCOUNTS Options include: • Replacement Lenses/Frames	A 25% discount on entire purchase price.	
*** Discount only available if required professional services for fittings and follow-up are purchased.**		

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the Pre-Authorization And Pre-Certification (Prior Approval) Addendum to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

There is no coverage, or discounts where applicable, for the following vision care services and optical care services:

- Contact lenses, frames, and lenses for cosmetic or convenience purposes.
- Optical Care Services Discounts when a Non-Participating Vision Care Provider provides the routine exam.

  In addition, Optical Care Services Discounts that are provided through a Non-Participating Vision Care Provider are also excluded, even if a Participating Vision Care Provider provides the routine eye exam.
- Services, frames, and lenses provided through a medical department, clinic, or similar service provided or maintained by an employer, or provided under any other group coverage furnished by or arranged through any employer.
- Tinted glasses or industrial safety glasses, unless they are prescription lenses obtained at your option and would otherwise be covered as Optical Care Services.
- Vision Care Services or Optical Care Services rendered after the date you or your covered dependents cease to be covered under this Plan, except for lenses and frames ordered prior to such termination.

CICI does not coordinate benefits for any routine vision or optical care services under this Plan.

OUTPATIENT SERVICES

This Plan **covers** Medically Necessary services provided in the doctor's office, including consultations. It also **covers** Medically Necessary services in the Member's home to treat an illness or injury.

Allergy Testing

Allergy testing with allergenic extract (or RAST allergen specific testing) is typically **covered after the applicable Cost-Share up to the maximum benefit as shown on your Benefit Summary.** In addition, allergy testing for medicine, biological or venom sensitivity is typically **covered after the applicable Cost-Share up to the maximum benefit as shown on your Benefit Summary**.

Benefit maximums apply to the total allergy testing benefits, whether at the In-Network Level Of Benefits or at the Out-Of-Network Level Of Benefits.

Chiropractic Services

Medically Necessary short-term chiropractic services include office visits and manipulation. These services are **covered after the applicable Cost-Share up to the benefit maximum as shown on your Benefit Summary** if they are expected to return function to the same level the Member had before he/she became injured or ill.

There is no coverage for chiropractic therapy that is long term or maintenance in nature.

Gynecological Office Services

Gynecological services in a doctor's office are **covered.**

Laboratory Services

Outpatient laboratory services, including services a Member receives in a Hospital or laboratory facility, are **covered after the applicable Cost-Share amount as shown on your Benefit Summary**.

You should use laboratories that are Participating Providers to reduce your out-of-pocket expenses.

Some laboratory services require Pre-Authorization to be **covered**.

Maternity Care Office Services

Maternity services (pre-natal and post-partum) in a doctor's office are **covered.** There may be a Cost-Share that the Member will have to pay for care related to pregnancy for each visit, even after the initial pre-natal office visit. The Cost-Share amount depends on where the services are received.

Preventive maternity care office services are exempt from all Member Cost-Shares under the federal Patient Protection and Affordable Care Act (ACA). Some diagnostic laboratory or radiology services provided in relation to maternity care may not be covered as preventive and will be subject to Cost Sharing (e.g., ultrasounds).

You should visit CICI's website at www.connecticare.com to view a list of the preventive and wellness services that are exempt from Member Cost-Shares or call CICI's Member Services Department at the telephone number listed in the "Important Telephone Numbers And Addresses."

Outpatient Rehabilitative Therapy, Including Physical, Occupational and Speech Therapy

Medically Necessary short-term outpatient rehabilitative therapy (including those services a Member receives at a day program facility or in an office) is **covered up to the benefit maximum, as shown on your Benefit Summary.**

Physical, occupational, and speech therapy coverage is **covered** as follows:

- Services must be ordered by a physician, a physician assistant or advanced practice registered nurse.
- Services are limited to short-term physical, occupational and speech therapy.
- Treatment must be necessary to restore a function lost through, or to eliminate an abnormal function that has developed due to, injury or illness. For speech therapy, coverage is limited to therapy when speech has been achieved and then lost as a result of illness or injury.

Services are no longer covered once therapeutic goals have been met or when a home exercise program is appropriate to achieve further gains.

There is no coverage for physical and occupational therapy:

- For the treatment of temporomandibular joint (TMJ) dysfunction.
- To treat developmental delays or other non-injury or non-illness related disorders, except as described in the "Autism Services" or "Birth to Three Program (Early Intervention Services)" subsections of the "Benefits" section.
- That is long term or maintenance in nature, where long term or maintenance in nature means that the treatment period for a specific condition or diagnosis is greater than a 60-day period.

There is no coverage for speech therapy:

- To treat developmental speech delays, stuttering, lisps or other non-injury or non-illness related speech impediments, except as described in the "Autism Services" or "Birth to Three Program (Early Intervention Services)" subsections of the "Benefits" section, or
- For therapy that is long term or maintenance in nature, where long term or maintenance in nature means that the treatment period for a specific condition or diagnosis is greater than a 60-day period.

Primary Care Provider Office Services

When a Member has an injury or illness that does not require a special doctor to treat it and the care can be obtained in a Primary Care Provider's office, the services are **covered** subject to the Primary Care Provider Office Services Cost-Share amount.

Radiological Services

Outpatient diagnostic x-rays and therapeutic procedures may be **covered**. CICI may use an outside company to manage and administer this program.

The services performed in a Hospital or radiological facility are **covered after the applicable Cost-Share amount.** The Cost-Share amount depends on where the Member receives the services.

Some radiology services require Pre-Authorization to be covered. Covered radiology services are:

- Computerized Axial Tomography (CAT).
- Magnetic Resonance Imaging (MRI).
- Positron Emission Tomography (PET).
- Nuclear cardiology.
- Bone densitometry scans.
- Ultrasound.
- X-rays (e.g., chest x-rays).

Specialist Office Services

When a Member has an injury or illness that requires a special doctor to treat it and the care can be obtained in a Specialty Physician's office, the services are **covered** subject to the Specialist Office Services Cost-Share amount.

EMERGENT/URGENT CARE

Ambulance/Medical Transport Services

Emergency Services

Emergency land or air ambulance/medical transport services are **covered** only for Medically Necessary Emergency transportation if the Member requires Emergency Services and the Member's medical condition prevents the Member from getting to a health care facility safely by any other means, as determined by CICI.

Non-Emergency Services

Non-Emergency land or air ambulance/medical transport services for non-routine care visits will be **covered** only when Medically Necessary and with Pre-Authorization if the Member's medical condition prevents safe transport to a health care facility by any other means.

Ambulance/medical transportation services will also be **covered**, if the Member is in-patient at an acute care facility and needs air transportation to another acute care facility because Medically Necessary services to help the Member are not available in the facility where the Member is confined.

There is no coverage for ambulance services that are non-Emergency medical transport services to and from a provider's office for routine care or if the transport services are for a Member's convenience.

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the Pre-Authorization And Pre-Certification (Prior Approval) Addendum to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

Emergency Services

Emergency Services provided both within and outside of the Network Access Area, as applicable, are **covered at the In-Network Level Of Benefits for Cost-Sharing**, whether a Member receives Emergency Services from a Participating Provider or Non-Participating Provider. You may be responsible to pay a bill submitted to you by Non-Participating Providers for their charges over and above the amount paid by the Plan.

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

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

  If possible, you or your representative should contact your Primary Care Provider (PCP) **or, for mental health care or alcohol and substance abuse Emergencies, your practitioner or CICI's Behavioral Health Program** prior to obtaining care, so your PCP, your practitioner or CICI's Behavioral Health Program can be involved in the management of your health care.

Determination of whether a condition is an Emergency rests with CICI.

Walk-In/Urgent Care Centers

Walk-in/Urgent Care is **covered** when a Member receives it in an Urgent Care Center. The following rules apply to the use of an Urgent Care Center:

- Use an Urgent Care Center only when your doctor is unable to provide or arrange for the treatment of an illness or injury.
- If you want the follow up care to be covered at the highest level of benefits that this Plan offers, then you must use a Participating Provider.

  Continuing care and follow-up care in an Urgent Care Center are not covered, even if the center is a Participating Provider. However, the removal of stitches is covered, if the same Urgent Care Center used to obtain the stitches is used to take them out.

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

AMBULATORY SERVICES (OUTPATIENT)

Medically Necessary ambulatory services (outpatient) are **covered.** Ambulatory services include procedures performed by a doctor on an outpatient basis, whether in a Hospital, at a Hospital Outpatient Surgical Facility, or at an Ambulatory Surgery Center. To locate a Participating Provider that is a Hospital Outpatient Surgical Facility or an Ambulatory Surgery Center, you can refer to CICI's Provider Directory, visit CICI at their web site at https://secured.connecticare.com/providerdirectory/, or call CICI.

There may be a Cost-Share that you will have to pay for Medically Necessary ambulatory surgery or certain radiological diagnostic procedures.

Some of these services require Pre-Authorization from CICI.

INPATIENT SERVICES

Hospital Services

Pre-Certification Rules For Non-Emergencies

All non-Emergency Inpatient admissions must be Pre-Certified at least five business days before the Member is admitted.

Special Pre-Authorization rules apply to transplant services. Pre-Authorization must be obtained ten business days before any evaluative transplant services are performed.

General Hospitalizations

Medically Necessary inpatient Hospital services generally performed and usually provided by acute care general Hospitals with Pre-Certification from CICI are **covered.**

Examples of covered inpatient Hospital Health Services are:

- Administration of whole blood, blood plasma and derivatives,
- Anesthesia and oxygen services,
- Autologous blood transfusions (self-donated blood),
- Doctor services,
- Drugs and biologicals,
- Intensive care unit and related services,
- Laboratory, x-ray and other diagnostic tests,
- Nursing care,
- Operating room and related facilities,
- Room and board in a semi-private room, and
- Therapy: cardiac rehabilitation, inhalation, occupational, physical, pulmonary, radiation and speech.

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the Pre-Authorization And Pre-Certification (Prior Approval) Addendum to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

Mastectomy Services

Health Services for a mastectomy or lymph node dissection are **covered**.

- If the Member is admitted to a Hospital, the Plan will cover a minimum of a 48-hour length of stay following the mastectomy or lymph node dissection. The Plan will cover a longer stay if the Member's doctor recommends it.
- If medically appropriate, and if the Member and his/her attending doctor approve, the Member may choose a shorter Hospital length of stay or have the services performed in an outpatient facility.

Maternity Services

Inpatient Services

Any Member who is admitted to a Hospital to have her baby will be covered for a minimum of a 48-hour length of stay for a vaginal delivery and a minimum of a 96-hour length of stay for a caesarean delivery.

The time periods begin at the time the baby is delivered.

Post-Discharge Benefits

If the Member and her newborn baby stay in the Hospital for the 48 or 96-hour period, the following post-discharge home health services will be **covered**:

- Vaginal Delivery (48-Hour Length of Stay)

  One skilled nursing visit by a maternal child health nurse from a Home Health Agency (requires Pre-Authorization from us).

  Medically Necessary comprehensive lactation visits at home after the delivery.
- Caesarean Delivery (96-Hour Length of Stay):

  Medically Necessary comprehensive lactation visits at home after the delivery.

Optional Early Discharge Programs

If medically appropriate, and if the Member and her attending doctor both approve, a Member may choose a shorter Hospital length of stay. In these situations, the following home health services will be **covered**:

- Vaginal Delivery with Less than 48-Hour Length of Stay; or Caesarean Delivery with Less than 96-Hour Length of Stay.

  Two skilled nursing visits by a maternal child health nurse from a Home Health Agency within two weeks of the delivery (requires Pre-Authorization from us).

  Medically Necessary comprehensive lactation visits at home after the delivery.

Solid Organ Transplants And Bone Marrow Transplants

Medically Necessary transplants are **covered after the applicable Cost-Share amount**. The Cost-Share amount depends on where the procedures are rendered.

The following organ transplants are **covered**:

- Bone marrow.
- Cornea.
- Heart.
- Heart-lung.
- Intestinal.
- Kidney.
- Liver.
- Lung.
- Pancreas.
- Pancreas-kidney.

Bone marrow procedures such as autologous or allogeneic transplants, or peripheral stem cell rescue, or any procedure similar to these, are considered "organ transplants" under this Plan and are subject to its provisions.

Transplant Pre-Authorization Rules

Except for cornea transplants, all requests for transplants and related services require Pre-Authorization at the time of diagnosis. **Pre-Authorization must be obtained at least ten business days before any evaluative services have been received.**

If Pre-Authorization has not been obtained, payment for the transplant and related services, as well as for medical diagnosis and evaluation, will be reduced or denied as described in this document.

A Member may use any provider for transplants. However, to obtain the In-Network Level Of Benefits, you must use Participating Providers. By using Participating Providers, you reduce your out-of-pocket expenses.

Donor Benefits

Medically Necessary expenses of organ donation are **covered after the applicable Cost-Share amount**. The Cost-Share amount depends on where the procedures are received.

Donor coverage is only available if the transplant recipient is CICI's Member and Pre-Authorization for evaluation has been obtained.

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the Pre-Authorization And Pre-Certification (Prior Approval) Addendum to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

Transportation, Lodging And Meal Expenses For Transplants

Expenses for transportation, lodging and meals for the Member receiving the transplant and for one companion of the Member are **covered** as described below**.**

The transplant facility must be located outside of Connecticut and Massachusetts and be more than 50 miles from where the Member receiving the transplant lives for this reimbursement to apply.

- Expenses may be submitted beginning with the date the transplant evaluation began through 90 days after the transplant was received.
- Transportation costs for travel to and from a transplant facility for the Member receiving the transplant and one companion are **covered**.

  If air transportation is chosen, coverage includes round trip coach class air fare for the Member receiving the transplant and one companion **up to two round trips per person**.

  If a personal car is used, mileage will be paid based on the federal Internal Revenue Code mileage reimbursement rate at the time the travel was taken **for a maximum of two round trips to and from where the Member receiving the transplant lives to the transplant facility**.
- Lodging expenses for up to ten nights for the Member receiving the transplant and one companion are **covered up to the standard average room rate in the city where the transplant is performed**.
- Meal expenses (excluding alcoholic beverages) for the Member receiving the transplant and one companion are **covered up to two meals per day for a maximum of ten days.**

In order for CICI to approve payment, transportation, lodging and meal receipts must be sent to CICI at the appropriate address listed in the information you will receive from CICI.

Skilled Nursing And Rehabilitation Facilities

Medically Necessary skilled nursing care is **covered up to the benefit maximum as shown in your Benefit Summary** if such care is provided:

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

The following limitations and conditions apply to the Skilled Nursing Facility/Rehabilitation Facility benefits:

- In order to be covered, the skilled nursing care must be for intense rehabilitation or sub-acute medical services, or a substitution for inpatient Hospitalization.
- The care must be ordered by a doctor. The doctor's order must specify the skills of qualified health professionals such as registered nurses, physical therapists, occupational therapists, or speech pathologists, required for the Member's care in the facility.

  Admissions and continued stay requests will be reviewed by CICI by using nationally recognized measures to determine if the skilled nursing care will result in significant functional gain or improvement to the Member's medical condition.
- The services in the Skilled Nursing Facility/Rehabilitation Facility must be provided directly by, or under the supervision of, a skilled health professional.
- Admission must be Pre-Certified by CICI.

BEHAVIORAL HEALTH (MENTAL HEALTH SERVICES)

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

Inpatient Mental Health Services

Medically Necessary inpatient mental Health Services, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), received in an acute care Hospital or a Residential Treatment Facility, are **covered** just as they would be for any other illness or injury as described in the "Hospital Services" section.

Inpatient Alcohol And Substance Abuse Disorder Services

Medically Necessary, medically monitored inpatient detoxification services and Medically Necessary, medically managed intensive inpatient detoxification services are **covered** just as they would be for any other illness or injury as described in the "Hospital Services" section. Benefits also include coverage for Medically Necessary inpatient services, supplies and medicine to treat substance abuse. These treatments have the same meanings as described in the most recent edition of the American Society of Addiction Medicine Treatment Criteria for Addictive, Substance-Related and Co-Occurring Conditions.

Substance abuse disorder includes both alcohol dependency, defined as meeting the criteria for moderate to severe alcohol use disorder in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) and drug dependency, defined as meeting the criteria for moderate or severe Substance Abuse Disorder in the most recent edition of DSM.

Outpatient Mental Health And Alcohol And Substance Abuse Disorder Treatment

Medically Necessary outpatient services for the diagnosis and treatment of mental illnesses, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) are **covered** just as they would be for any other illness or injury as described in the "Outpatient Services" section. Benefits also include coverage for treatment for alcohol and substance abuse. The services must be provided by a licensed mental health provider.

Pre-Authorization is required for some outpatient treatment for mental health and alcohol and substance abuse services, including office visits, subsequent to an evaluation. Please refer to the "Pre-Authorization And Pre-Certification (Prior Approval) Addendum" to find out what services require Pre-Authorizations.

Other Behavioral Health Benefits

Chemical Maintenance Treatment

Chemical maintenance treatment is **covered after the applicable Cost-Share amount**, as prescribed by applicable law.

Evidence-Based Maternal, Infant And Early Childhood Home Visitation Services

Evidence-based maternal, infant and early childhood home visitation services that are designed to improve health outcomes for pregnant women, postpartum mothers and newborns and children, including but not limited to services for maternal substance use disorders or depression and relationship-focused interventions for children with mental or nervous conditions or substance abuse disorders are **covered after the applicable Cost-Share amount**.

Extended Day Treatment Programs

Extended day treatment programs are **covered after the applicable Cost-Share amount**, as prescribed by applicable law.

Intensive, Family-Based And Community-Based Treatment Programs

Intensive, family-based and community-based treatment programs that focus on addressing environmental systems that impact chronic and violent juvenile offenders are **covered after the applicable Cost-Share amount**.

Other Home-Based Therapeutic Interventions For Children

Home-based therapeutic interventions for children are **covered after the applicable Cost-Share amount.**

OTHER SERVICES

Home Health Services

Medically Necessary home health services must be provided by a Home Health Agency and Pre-Authorized. Home health services are **covered after the applicable Cost-Share amount, if any, up to the benefit maximum as shown on the Benefit Summary**, if:

- CICI determines that Hospitalization or admission to a Skilled Nursing Facility would otherwise be required; or
- The Member is diagnosed as terminally ill and his/her life expectancy is six months or less, or
- A plan of home health care is ordered by a physician, a physician assistant or advanced practice registered nurse and approved by CICI.

  The home health services must be medical and therapeutic health services provided in the Member's home, including:

  - Nursing care by a registered nurse or licensed practical nurse,
  - Social services by a Masters-prepared social worker provided to, or on behalf of, a terminally ill Member,
  - Physical, occupational or speech therapy,
  - Hospice care for a terminally ill patient (i.e., having a life expectancy of six months or less), or
  - Certain medical supplies, medications and laboratory services.

There is no coverage for:

- Custodial Care,
- Convalescent care,
- Domiciliary care,
- Rest home care, or
- Home health aide care that is not patient care of a medical or therapeutic nature.

The benefit maximum does not apply to Hospice care.

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

Disposable Medical Supplies

Some, but not all, disposable medical supplies, which are used with covered durable medical equipment or covered medical treatment received in the home, are **covered after the applicable Cost-Share amount**.

The following limitations and conditions apply:

- Disposable medical supplies must be ordered by a physician.

  Note: Having a doctor's order is not a guarantee that the disposable supplies are covered.
- Disposable medical supplies may be obtained from either a Participating Provider or a Non-Participating Provider by presenting the physician's order to the vendor.
- Disposable medical supplies will also be covered if they are dispensed in:

  - A physician's office as part of the physician services, or
  - An emergency room as part of Emergency Services, or
  - An Urgent Care Center as part of Urgent Care.

  In these cases, the disposable medical supplies will be covered as part of the Disposable Medical Supplies, Emergency Room or Walk-In/Urgent Care Centers benefit, as applicable.
- CICI has the right to change the list of covered disposable medical supplies from time to time.

Durable Medical Equipment (DME), Including Prosthetics

Durable Medical Equipment (DME) including prosthetics, consists of non-disposable equipment which is primarily used to serve a medical purpose and is appropriate for use in the home. DME is **covered after the applicable Cost-Share amount**.

The following limitations and conditions apply:

- DME must be ordered by a physician.

  Note: Having a doctor's order is not a guarantee that the DME is covered.
- The equipment must be provided by a DME Participating Provider in order for the DME to be covered at the highest level of benefits.
- If a Participating Provider does not carry the covered DME, the DME may be purchased at a Non-Participating Provider as long the DME is prescribed by a doctor and Pre-Authorized by CICI.

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the Pre-Authorization And Pre-Certification (Prior Approval) Addendum to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

- Some DME requires Pre-Authorization before it will be covered. The DME that requires Pre-Authorization is listed in the "Services Requiring Pre-Authorization Or Pre-Certification Addendum."
- DME may be authorized for rental or purchase based on the expected length of medical need and the cost/benefit of a purchase or rental. CICI will decide whether DME is to be rented or purchased. If a rental item is converted to a purchase, the Coinsurance the Member pays for the purchase will be based on only the balance remaining to be paid in order to purchase the equipment.
- DME will be covered without Pre-Authorization if it is dispensed in:
  - ♦ A physician's office as part of physician services,
  - ♦ An emergency room as part of Emergency Services, or
  - ♦ An Urgent Care Center as part of Urgent Care.

  In these cases, DME will be covered as part of the DME, Emergency Room or Walk-In/Urgent Care Centers benefit, as applicable.
- A wig prescribed by an oncologist for a Member suffering hair loss as a result of chemotherapy or radiation therapy are **covered without Pre-Authorization up to one wig per year**.
- To be covered, DME must not duplicate the function of any previously obtained equipment, unless it is covered as replacement equipment as described below:

  The replacement equipment is Pre-Authorized by CICI and the original device is no longer capable of serving its original function due to:
  - ♦ A changed medical condition.
  - ♦ The normal growth of Member child, or
  - ♦ The normal wear and tear of the equipment.

ADDITIONAL SERVICES

Autism Services

Medically Necessary diagnosis and treatment of Autism Spectrum Disorders (ASDs), identified and ordered in a treatment plan developed by a licensed doctor, psychologist or clinical social worker pursuant to a comprehensive evaluation are **covered**:

- Behavioral Therapy, when provided or supervised by a behavioral analyst who is certified by the Behavioral Analyst Certification Board, or by a licensed doctor, or by a licensed psychologist.
- Direct psychiatric or psychological services and consultations provided by a licensed psychiatrist or by a psychologist.
- Occupational, physical and speech/language therapy provided by a licensed therapist.

  This occupational, physical and speech/language therapy benefit is not subject to any benefit maximum for outpatient rehabilitative therapy listed on your Benefit Summary.
- Prescription drugs when prescribed by a physician, by a doctor's assistant or by an advanced practice registered nurse for the treatment of symptoms and comorbidities of ASD, as covered under the "Prescription Drugs" subsection.

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

Birth To Three Program (Early Intervention Services)

Early intervention services consist of care as part of an Individualized Family Service Plan as prescribed by State law and are **covered** for a Member from his/her birth until his/her third birthday.

The Cost-Share amount depends on where the procedures are rendered and will only apply if the Member is enrolled in one of our HSA-compatible high deductible health plans (HDHPs).

Any benefit amount paid for early intervention services does not:

- Count towards any benefit maximums this Plan may have, except as permitted under applicable law, or
- Negatively affect the eligibility of coverage under this Plan to the child, the child's parent or the child's family members who are Members under this Plan, or
- Constitute a reason for us to rescind or cancel the Member's coverage under this Plan.

Cardiac Rehabilitation

Phase I cardiac rehabilitation is **covered**.

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

Coverage for Phase III cardiac rehabilitation is only available for Members who are actively case managed. See the "Health Management Programs" section.

Phase IV Cardiac rehabilitation is **not covered**.

Casts And Dressing Application

Application of casts and dressings is **covered after the applicable Cost-Share amount**. The Cost-Share amount depends on where the services are provided.

Clinical Trials

Certain routine care for a Member who is a patient in a disabling or Life-Threatening chronic diseases clinical trial, such as for cancer, is **covered** just as routine care would be covered under this Plan if the Member were not involved in a disabling or Life-Threatening chronic diseases clinical trial. All of the terms and conditions of this document apply.

For the purposes of this clinical trials benefit, **Life-Threatening means** any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

In order for the Member to be eligible for coverage, the trial must be Pre-Authorized and must take place under an independent peer-reviewed protocol approved or funded by:

- One of the National Institutes of Health,
- The Centers for Disease Control and Prevention,
- The Agency for Health Care Research and Quality,
- The Centers for Medicare & Medicaid Services,
- A National Cancer Institute affiliated cooperative group or the federal Department of Defense, Department of Energy, or Department of Veterans Affairs, or
- The federal Food and Drug Administration (FDA) as part of an investigational new medication or device application or exemption.

Coverage includes Health Services at Non-Participating Providers, if the treatment is not available at Participating Providers and is not paid for by the clinical trial sponsor. Payments made to Non-Participating Providers for clinical trials will be made at no greater cost to the Member than if the treatment were provided at Participating Providers.

CICI may require the following in order for a Member to be considered for coverage:

- Evidence that the Member meets all of the selection criteria for the trial,
- Evidence that the Member has given appropriate informed consent to the trial,
- Copies of any medical records, rules, test results or other clinical information used to enroll the Member in the trial,
- A summary of how the expected routine care costs would exceed the costs for standard treatment,
- Information about any items or services (including routine care) that may be paid for by another entity, including the name of the company paying for the trial, and/or
- Any other information CICI may reasonably need to review the request.

Corneal Pachymetry

Medically Necessary corneal pachymetry (measurement of the thickness of the cornea) is **covered after the applicable Cost-Share amount**. The Cost-Share amount depends on where the test is rendered.

Diabetes Services

The following Medically Necessary diabetes services, including treatment for all types of diabetes are **covered**, including but not limited to:

- Laboratory and diagnostic testing and screening, including, but not limited to hemoglobin A1c testing and retinopathy screening.
- Insulin drugs:
- Noninsulin drugs, if the noninsulin drug is a glucagon drug:
- Diabetes Devices and Diabetes Ketoacidosis Devices in accordance with the Member's diabetes treatment plan.

  Please refer to your Benefit Summary for the diabetic equipment and supplies Cost-Share amount.

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

Education

Outpatient self-management training for the treatment of diabetes, if the training is prescribed by a licensed health care professional, is **covered**. The training must be provided by a certified, registered or licensed health care professional trained in the care and management of diabetes. The Cost-Share amount depends on where the training is provided.

Benefits cover:

- Up to ten hours of initial training for a Member who is first diagnosed with diabetes for the care and management of diabetes, including counseling in nutrition and proper use of equipment and supplies for the treatment of diabetes, and
- Up to four hours for Medically Necessary training and education as a result of an additional diagnosis by a doctor of a major change in the Member's symptoms or condition that requires a change of his/her program of self-management of diabetes, and
- Up to four hours for Medically Necessary training and education as a result of new techniques and treatment for diabetes.

Prescription Drugs And Supplies

If a Member obtains prescription drugs and supplies for the treatment of diabetes, the rules of the "Prescription Drugs" subsection, including its Cost-Share provisions, apply. If a Member obtains these same supplies for the treatment of diabetes from a supplier that is not a Participating Pharmacy, the supplies are covered as described in the "Disposable Medical Supplies" section.

Drug Ingestion Treatment (Accidental)

Medically Necessary services needed to treat the accidental ingestion or consumption of a controlled drug are **covered**. The Cost-Share amount depends on where the services are provided.

Drug Therapy (Outpatient/Home)

Medically Necessary Drug Therapy is **covered after the applicable Cost-Share amount**. The Cost-Share amount depends on where the Drug Therapy is rendered.

Some Drug Therapy requires Pre-Authorization.

Drug Therapy services include all drugs administered by a licensed provider.

Eye Care

Diseases And Abnormal Conditions Of The Eye

Medically Necessary medical and surgical diagnosis and treatment of diseases or other abnormal conditions of the eye and structures next to the eye are **covered after the applicable Cost-Share amount**. This coverage includes annual retinal eye exams for Members with an existing condition of the eye, such as glaucoma or diabetic retinopathy. The Cost-Share amount depends on where the services are received.

Genetic Testing

Standard chromosome analysis is **covered after the applicable Cost-Share amount** with no Pre-Authorization. The Cost-Share amount depends on where the analysis is provided.

Some molecular genetic testing is **covered after the applicable Cost-Share amount** when a Member has or is thought to have a clinical genetic condition and when the genetic testing is Pre-Authorized. The Cost-Share amount depends on where the tests are provided.

Coverage for molecular genetic testing will be available only:

1. When the Member has obtained genetic counseling and
2. An appropriate evaluation has been performed consisting of:
   - A complete history.
   - A physical examination.
   - Conventional diagnostic studies.
   - Pedigree analysis.
3. When a diagnosis cannot be made using routine diagnostic testing and there remains the possibility of a genetic condition that will affect the Member's health, and,
4. When the result of the genetic testing will directly impact the Member's treatment

Only the following molecular genetic tests and/or Fluorescein In-Situ Hybridization (FISH) tests will be covered.

Unless otherwise noted, molecular genetic testing and FISH testing for any of these conditions requires Pre-Authorization.

1. Specific molecular genetic screening or FISH testing recommended by the American College of Medical Genetics (ACMG) or the American Congress of Obstetricians and Gynecologists (ACOG),
2. Specific molecular cancer genetic testing or FISH testing recommended by either the American Society of Clinical Oncology (ASCO) or the National Comprehensive Cancer Network (NCCN),
3. Molecular genetic testing or FISH testing to guide medication therapy for the treatment of lymphoma, leukemia, and inflammatory bowel disease,
4. Prenatal molecular genetic testing or FISH testing associated with chorionic villus sampling and/or amniocentesis and consistent with standard of care,

5. One of the following genetic conditions:
    - CADASIL.
    - Colorectal Cancer Susceptibility.
    - Cystic Fibrosis - **Pre-Authorization not required.**
    - Factor V Leiden - **Pre-Authorization not required.**
    - Fragile X - **Pre-Authorization not required.**
    - Hemoglobinopathies.
    - Hereditary Breast and Ovarian Cancer Syndrome (BRCA).
    - Hereditary Hemochromatosis - **Pre-Authorization not required.**
    - Hypertrophic Cardiomyopathy.
    - Long QT Syndrome.
    - Medullary thyroid cancer and multiple endocrine neoplasia type 2, MEN2 (RET).
    - Prothrombin - **Pre-Authorization not required.**
    - Retinoblastoma.

There is no coverage for:

- All other genetic testing services, as well as genetic testing panels not endorsed by ACOG, ASCO ACMG, or NCCN.
- Genetic testing kits available either direct to the consumer or via a physician prescription.
- Genetic testing only for the benefit of another family member.
- Repeat genetic testing.
- Whole genome or whole exome genetic testing.

Health Management And Incentive Programs

Health Management Programs

Health management programs are set up to help Members manage their long-term health conditions.

Members in this Plan may be eligible to enroll in one or more of CICI's health management programs. In addition, Members may be contacted and managed by CICI or CICI's Delegated Programs.

Depending on the programs that are available at the time, a Member may receive the following items or services as value added services or covered benefits:

- Educational mailings or visits.
- Nicotine replacement therapy (NRT).
- Pillboxes.
- Special medical equipment such as a blood pressure monitor/cuff, a peak flow meter, a glucose monitor or a scale to assist during convalescence or to monitor a special medical condition.

When these items are covered benefits, they will not be subject to standard claim processing and Cost-Sharing rules.

If you are enrolled in one of CICI administered HSA-compatible high deductible health plans (HDHP), the health management program items or services that are covered benefits are subject to the Plan Deductible. However, those items or services may not be subject to the other Cost Share amounts that do apply after the Plan Deductible is satisfied.

You can call CICI's Member Services Department to find out more about CICI's current health management programs.

Incentive Programs

CICI may offer incentives from time to time under this Plan in order to introduce you to covered programs and services available, incent you to access certain medical services, and use online tools that enhance your coverage and services.

The purpose of these incentives includes, but are not limited to, making you aware of cost effective benefit options or services, helping you achieve your best health, and encouraging you to update member-related information.

These incentives may be offered in various forms, including but not limited to:

- Contributions to health savings accounts,
- Fitness center membership and reimbursement,
- Gift cards,
- Health related merchandise,
- Modification to Cost-Share amounts,
- Discounts or rebates,
- Retailer coupons, or
- Any combination of these.

Acceptance of these incentives is voluntary as long as CICI offers the incentives program. CICI may discontinue an incentive for a particular covered program or service at any time. If you have any questions about whether receipt of an incentive or retailer coupon results in taxable income to you, it is recommended that you consult your tax advisor.

The award of any such incentive shall not depend upon the result of a wellness or health improvement activity or upon a Member's health status.

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the Pre-Authorization And Pre-Certification (Prior Approval) Addendum to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

Hospice Care

Medically Necessary Hospice care is **covered at the applicable Inpatient Hospital Services, Including Room & Board or Home Health Services Cost-Share amounts as shown on your Benefit Summary**, if the Member has a life expectancy of six months or less and if the care is Pre-Authorized or Pre-Certified by CICI. The Member's doctor must contact CICI to arrange Hospice care. Hospice care does not apply to any specific benefit maximums your Plan may have. The Cost-Share amount depends on where the services are provided.

Hospital Care

Visits a doctor makes to examine or treat a Member who is hospitalized are **covered**.

Infertility Services

Benefits

Medically Necessary diagnostic and testing procedures and therapy needed to treat diagnosed Infertility are **covered at the applicable Cost-Share amounts as shown on your Benefit Summary, up to the limits described below**:

- Ovulation induction (to a maximum of four cycles no matter what the reasons are for the ovulation induction).
- Intrauterine insemination (to a maximum of three cycles per recipient, no matter the source, where one cycle equals one intrauterine insemination (IUI) within a 30-day period).
- Uterine embryo lavage, in-vitro fertilization (IVF), gamete intra-fallopian transfer (GIFT), zygote intra-fallopian transfer (ZIFT) or low tubal ovum transfer, including the use of gonadotropins and other medicines designed to stimulate ovulation (to a maximum of two cycles **combined for all procedures**, with not more than two embryo implantations per cycle). These cycles are only covered when the Member has been unable to conceive or produce conception or sustain a successful pregnancy through the less expensive and medically appropriate treatments covered by this Plan.

  A particular Infertility treatment or procedure does not have to be tried first if the Member's treating Board Eligible or Board Certified Reproductive Endocrinologist certifies that the treatment or procedure is unlikely to be successful.
- Pre-implantation genetic testing only when Medically Necessary and covered IVF, GIFT, ZIFT or low tubal ovum transfer procedure, if embryos are at risk for known genetic mutations. Pre-implantation genetic testing to determine the gender of an embryo is covered only when there is a documented risk of an x-linked disorder.
- Prescription drugs (medicines) to treat Infertility.

  These drugs or medications are only covered for the gender indicated by the federal Food and Drug Administration (FDA) and must be covered under the "Prescription Drugs" subsection.

Rules

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

1. For certain Infertility services, a Member must be treated by a board eligible or board certified reproductive endocrinologist at a facility that meets the standards and rules of the American Society of Reproductive Medicine or the Society of Reproductive Endocrinology and Infertility.
2. All services must be provided by the providers noted above in order to be covered.

   In addition, oral medicines needed to treat Infertility must be prescribed by the treating provider to be covered.

There is no coverage for:

- All Infertility services following voluntary sterilization where no successful reversal has been made,
- Banking of eggs, embryos, or sperm.
- Cryopreservation (freezing) of eggs, or sperm,
- Genetic analysis and testing, except as otherwise described above or in the "Genetic Testing" section,
- Medicines for sexual dysfunction,
- Recruitment, selection and screening of donors or gestational carriers,
- Reversal of surgical sterilization, and
- Surrogacy and all charges associated with surrogacy arrangements such as prescription drugs, fertilization or implantation, except if provided to a Member.

Lyme Disease Services

Medically Necessary treatment of Lyme Disease is **covered** as follows:

- Up to a maximum of 30 days of intravenous antibiotic therapy or 60 days of oral antibiotic therapy, or both.
- Further antibiotic treatment if it is recommended by a board-certified rheumatologist, by an infectious disease specialist, or by a neurologist.

Antibiotic drugs are covered under the rules of this document, subject to the Cost-Shares in your Benefit Summary.

If your Benefit Summary **DOES NOT** include Cost-Shares for prescription drugs, then those antibiotic drugs prescribed for Lyme Disease are covered as described in the "Prescription Drugs And Supplies" provisions of the "Diabetes Services" subsection.

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the Pre-Authorization And Pre-Certification (Prior Approval) Addendum to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

Neuropsychological Testing

Medically Necessary psychological, neuropsychological or neurobehavioral testing is **covered**.

Nutritional Counseling

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

Observation Beds

Observation beds are **covered after the applicable Outpatient Services Cost-Share amount described in your Benefit Summary** when a Member is placed in a bed attached to an emergency department, outpatient department or operating facility for less than 24-hours at a time. Observation beds are not staffed overnight and are not part of a Hospital's bed complement.

Pain Management Services

Medically Necessary pain management services provided by a doctor (including evaluation and therapy) for short or long-term pain conditions are **covered after the applicable Cost-Share amount**. The Cost-Share amount depends on where the services are provided.

Some pain management services require Pre-Authorization. The pain management services that require Pre-Authorization are listed in the "Pre-Authorization And Pre-Certification (Prior Approval) Addendum."

Prescription Drugs

NOTE: Under federal law, the Plan will permit certain medications, certain over-the-counter (OTC) contraceptives and vitamins, as defined by the United States Preventive Service Task Force, to be exempt from Member Cost Shares (Deductible, Copayment and Coinsurance). As a result, there may be times when you will not be required to pay the applicable Cost-Shares you usually pay for covered medications under your Plan.

Benefits

Subject to all of the provisions of this Plan Description, including the guidelines, and exclusions and limitations, benefits under this section, benefits consist of the following prescription drugs, medications, and supplies.

- For the treatment of diabetes.
- All federal Food and Drug Administration (FDA) approved prescription drugs.
- All prescription contraceptive methods approved by the federal FDA, including, but not limited to:
  - Cervical caps.
  - Diaphragms.
  - Intrauterine Devices (IUDs).
  - Oral contraceptives.

NOTE: Covered at no Cost-Share when they are obtained at a Participating Pharmacy.

- For the treatment of Lyme Disease: up to 30 days of intravenous antibiotic therapy or up to 60 days of oral antibiotic therapy, or both, and further antibiotic treatment if recommended by a board-certified rheumatologist specialist, infectious disease specialist or neurologist.
- Injectable drugs, provided that they are obtained at a pharmacy and all of the other rules of this subsection are followed.
- Insulin and the following supplies:
  - Acetone/ketone testing agents.
  - Blood and urine glucose testing agents.
  - Injectable syringes and needles.
  - Lancets.

To be covered, prescription drugs must:

- Be Medically Necessary;
- Be marketed in the United States at the time of purchase; and
- In most cases, bear the label: "Caution: Federal law prohibits dispensing without prescription." (Please see the "Over-The-Counter (OTC) Medications" subsection to find out when OTC medications are covered under this subsection.)

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the Pre-Authorization And Pre-Certification (Prior Approval) Addendum to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

Additional Benefits

Over-The-Counter (OTC) Medications

Certain over-the-counter (OTC) medications, subject to terms and conditions of this subsection and the following:

1. The OTC medication must be an OTC medication that is required to be covered under the ACA. The OTC medications that the Plan will cover are listed on CICI's web site at www.connecticare.com.
2. You must obtain a prescription for the OTC medication from your doctor.
3. The OTC medication must be filled as a prescription at a pharmacy by the pharmacist; otherwise it will not be covered.
4. When such OTC medications are covered, they will be covered based upon age, gender and/or disease required to be covered under the ACA.

The list of OTC medications may change at any time. When the list does change, you will be notified in CICI's member electronic newsletter. You should call CICI's Member Services Department (or visit CICI at their web site at www.connecticare.com) to find out if an OTC medication is covered under this subsection. CICI has the right to change the OTC medications on the list in their discretion.

Specialty Drugs

Specialty drugs are those prescription drugs that are not needed immediately to treat a sudden medical condition, and that require:

- A higher level of pharmacy expertise.
- Increased patient knowledge to administer.
- Special handling.

In addition, specialty drugs are not typically stocked in a retail pharmacy.

Certain specialty prescription drugs require Pre-Authorization and should be filled through specialty pharmacies.

You can find the list of specialty drugs that need Pre-Authorization at the back of this document.

Updates to the list of specialty drugs requiring Pre-Authorization are also published from time to time in CICI's member electronic newsletter. You should call CICI's Member Services Department at the telephone number listed in the "Important Telephone Numbers And Addresses" section (or visit CICI at CICI's web site at www.connecticare.com) to find out if a specialty drug requires Pre-Authorization. CICI has the right to change the specialty drugs on the list in CICI's discretion.

Specialty drugs that require Pre-Authorization should be filled through the specialty pharmacy CICI advises you of.

When you or your provider contacts CICI for Pre-Authorization of a specialty drug, if Pre-Authorization is granted, you or your provider will be notified of the telephone number to call to contact the specialty pharmacy. Specialty drugs, when Pre-Authorized by CICI, will be dispensed for a maximum of 30-day supply per fill. The drugs will be shipped to your doctor's office, your home, or other location based on the type of drug or treatment.

NOTE: Even though up to a 30-day supply of a specialty drug may be delivered by mail to you, or your provider's office or some other location, specialty drugs DO NOT have the same Cost-Share that applies to the Mandatory Maintenance Program. Instead, specialty drugs have the applicable retail pharmacy Cost-Share amount listed on your Benefit Summary.

Specialized counseling and education are available to you from the specialty pharmacy regarding proper administration, storage, dosage, drug interactions, and side effects of these specialty drugs.

If the specialty drug is not available at the specialty pharmacy CICI advised you of, or you are out of a specialty drug or if the specialty drug ordered by your provider does not arrive in time, CICI will authorize the specialty drug for up to a 30-day supply at an alternate specialty pharmacy, so you can obtain the needed medication. In this instance, you will not be required to pay any additional amounts above the normal Cost-Share amounts you would typically pay for a specialty drug under this Plan.

Guidelines

In addition, to be covered by this subsection, all prescription drugs and supplies must meet the following rules and guidelines.

When you bring your prescription to the pharmacy to be filled, that submission of the prescription to the pharmacy does not represent a "claim" for coverage under this Plan. Requests for coverage or Pre-Authorization must be made directly to CICI to be considered a claim under the Plan.

Certain Prescription Drugs/Supplies Require Pre-Authorization

Certain prescription drugs and supplies require Pre-Authorization from CICI before they will be covered under this subsection. In addition, any drug that is newly available to the market will also require Pre-Authorization until such time that CICI re-publishes their list of drugs that require Pre-Authorization. You should refer to the "Pre-Authorization And Pre-Certification (Prior Approval) Addendum" to find out what drugs require Pre-Authorizations (prior approvals).

Updates to the list of drugs or supplies requiring Pre-Authorization is also published from time to time in CICI's member electronic newsletter. You should call CICI's Member Services Department to find out if a prescription drug or supply requires Pre-Authorization.

CICI has the right to change the drugs or supplies on the list in their discretion.

When A Participating Provider Writes A Prescription

When a Participating Provider writes the prescription for the drug or supply, it is the responsibility of the Participating Provider to obtain the Pre-Authorization, but you should check with your health care practitioner to make sure he or she has obtained Pre-Authorization **BEFORE** you go to the pharmacy. When a prescription drug or supply requiring Pre-Authorization is not Pre-Authorized, it will be rejected by the pharmacy. If the prescription drug or supply is filled, benefits available under this Plan will not be reduced or denied if the Participating Provider fails to request Pre-Authorization. However, when you submit that claim for reimbursement, CICI will review it for Medical Necessity. If CICI determines that the prescription drug or supply was not Medically Necessary, re-fills of that prescription drug or supply will not be covered.

When A Non-Participating Provider Writes A Prescription

It is your responsibility to obtain Pre-Authorization from CICI if a Non-Participating Provider writes your prescription.

When a prescription drug or supply requiring Pre-Authorization is not Pre-Authorized, it will be rejected by the pharmacy. If the prescription drug or supply is filled and you submit a claim to CICI for reimbursement by the Plan, you should request your Non-Participating Provider to ask CICI for Pre-Authorization. When that occurs CICI will review the claim for Medical Necessity. If CICI determines that the prescription drug or supply was Medically Necessary and Pre-Authorization is then granted, the Plan will reimburse you for the prescription drug or supply, which may be subject to the Benefit Reduction provisions described in the "Managed Care Rules And Guidelines" section of the Plan Description. If CICI determines that the prescription drug or supply was not Medically Necessary, that prescription drug or supply will not be covered.

When Pre-Authorization is obtained, it is your responsibility to make sure the authorization is still applicable when you go to the pharmacy to have your prescription filled. If the authorization was for a time period that expired, you will have to pay for the prescription. If the authorization was for an amount of drugs that is less than your prescription, your prescription will be filled at the amount of drugs that was Pre-Authorized.

Always Use Your ID Card

You and your covered dependents are required to use the ConnectiCare ID card when obtaining a prescription drug or covered supply under this subsection. In the event you do not use your ID card, you will be charged the discount lost because the prescription drug or covered supply was processed without the ID card, in addition to any Cost-Share amount or other charge due under this subsection.

Pharmacy Networks

Some Plan options include a pharmacy network of Participating Pharmacies and other Plan options include a pharmacy network of Preferred Participating Pharmacies and Non-Preferred Participating Pharmacies.

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

Participating Pharmacies Network

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

We will provide you and each family member with a choice of pharmacy networks to fill your prescriptions. If you do not choose a pharmacy network, one will be assigned to you. Any pharmacies not in your network will be considered non-participating for you. You may use any pharmacy listed in your pharmacy network for non-maintenance prescriptions (less than 90 day supply). You may switch your choice between networks once a year.

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

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

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the Pre-Authorization And Pre-Certification (Prior Approval) Addendum to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

Using A Participating Pharmacy

When you and your covered dependents use a Participating Pharmacy, the out-of-pocket Cost-Share amount you pay is lower than what you would have pay if you were to use a Non-Participating Pharmacy.

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

To locate a Participating Pharmacy, you can refer to CICI's Provider Directory, visit CICI at their web site at www.connecticare.com, or call CICI.

Using A Non-Participating Pharmacy

When you use a Non-Participating Pharmacy for prescriptions, you and your covered dependents will still have coverage, but the out-of-pocket costs will be higher than they would be if you were to use a Participating Pharmacy.

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

Preferred Participating Pharmacies And Non-Preferred Participating Pharmacies Network

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

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

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

Using A Preferred Participating Pharmacy

When you and your covered dependents use a Preferred Participating Pharmacy, the out-of-pocket Cost-Share amount you pay is lower than what you would have to pay if you were to use a Non-Preferred Participating Pharmacy or Non-Participating Pharmacy.

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

To locate a Preferred Participating Pharmacy, you can refer to CICI's Provider Directory, visit CICI at their site at www.connecticare.com, or call CICI.

Using A Non-Preferred Participating Pharmacy

When you and your covered dependents use a Non-Preferred Participating Pharmacy, the out-of-pocket Cost-Share amount you pay is higher than what you would have to pay if you were to use a Preferred Participating Pharmacy.

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

To locate a Non-Preferred Participating Pharmacy, you can refer to CICI's Provider Directory, visit CICI at their site at www.connecticare.com, or call CICI.

Using A Non-Participating Pharmacy

When you use a Non-Participating Pharmacy for prescriptions, you and your covered dependents will still have coverage, but the out-of-pocket costs will be higher than they would be if you were to use a Preferred Participating Pharmacy or a Non-Preferred Participating Pharmacy.

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

Prescription Drug Programs

The following provisions apply to CICI's Prescription Drug Programs. To determine which programs apply to your Plan, consult your Benefit Summary.

Advanced Opioid Management Program

This Plan has an "Advanced Opioid Management Program."

This program applies to prescriptions written for opioid medications.

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

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the Pre-Authorization And Pre-Certification (Prior Approval) Addendum to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

Generic Substitution Program

1. Most plans have the "Generic Substitution Program." To determine whether your Plan uses this program, consult your Benefit Summary. This program applies to prescriptions filled at Participating Pharmacies, Preferred Participating Pharmacies or Non-Preferred Participating Pharmacies (retail or specialty pharmacies), CICI's designated mail order vendor and retail maintenance networks.
2. This Plan covers Generic Drugs Or Supplies when they are available.

   Even if you request a covered Brand Name Drug, Or Supply and/or even if your provider deems a covered Brand Name Drug, Or Supply to be Medically Necessary and therefore prescribes a covered Brand Name Drug, Or Supply, where a Generic Equivalent drug or supply is available, you will pay the difference in the cost between the Brand Name Drug, Or Supply and the Generic Equivalent drug or supply, plus any applicable Cost Share amount.

   In some plans, the Cost-Share amount for a Brand Name Drug Or Supply is the same as the Cost-Share amount for a Generic Drug Or Supply.

Participating Pharmacies, Preferred Participating Pharmacies or Non-Preferred Participating Pharmacies have information about Brand Name Drugs Or Supplies with Generic Equivalents that are required to be substituted. You should call CICI's Member Services Department (or visit their web site at www.connecticare.com) to find out if a drug or supply is covered. CICI has the right to change the drugs or supplies that are required to be substituted in their discretion.

Tiered Cost-Share Program

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

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

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

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

CICI on behalf of the Plan has the right to change the drugs (including certain OTC medications) or supplies in each tier in CICI's discretion, even in the middle of the year. You should call CICI's Member Services Department (or visit their web site at www.connecticare.com) to find out which tier (if any) a prescription drug or supply is in.

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the Pre-Authorization And Pre-Certification (Prior Approval) Addendum to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

Mandatory Drug Substitution Program

1. Most plans have the "Mandatory Drug Substitution Program." To determine whether your Plan uses this program, consult your Benefit Summary. This program applies to prescriptions filled at Participating Pharmacies, Preferred Participating Pharmacies or Non-Preferred Participating Pharmacies (retail pharmacies), CICI's designated mail order vendor and retail maintenance networks.
2. Prescription drugs that are on CICI's "Mandatory Drug Substitution" list are not covered by this prescription drug coverage, except as described below. Instead, another drug that has the same active ingredient as the excluded drug, but which is made by a different manufacturer or sold by a different distributor, will be covered by this prescription drug coverage. (The inactive ingredients may differ in the drugs. Active ingredients are those ingredients with a therapeutic effect. Inactive ingredients are those ingredients with no therapeutic effect.)
3. If your physician prescribes the excluded drug that is on the "Mandatory Drug Substitution" list, the Participating Pharmacy, Preferred Participating Pharmacy or Non-Preferred Participating Pharmacy will switch the prescription or call your physician to receive authorization, if needed, to make the change to the covered drug from the excluded drug that was prescribed for you.
4. In certain cases, this prescription drug coverage will cover the excluded drug on the "Mandatory Drug Substitution" list if CICI determines, in their discretion that, because of your or your covered dependent's adverse reaction to the covered drug or the covered drug's ineffectiveness for the Member, the excluded drug is Medically Necessary. CICI will make this determination based on clinical evidence presented by your physician to CICI.
5. The Plan will also cover excluded drugs which are added to the "Mandatory Drug Substitution" list, if the following conditions are met:
   - You were obtaining, through your coverage under the Plan, the excluded drug for the treatment of a chronic illness prior to it being added to the "Mandatory Drug Substitution" list; and
   - Your doctor provides to CICI a written statement that the excluded drug is Medically Necessary and includes the reasons why the excluded drug is more medically beneficial in treating your chronic illness than the drugs that are covered under the Plan.

The drugs on the "Mandatory Drug Substitution" list are published from time to time in CICI's member electronic newsletter. You should call CICI's Member Services Department or visit CICI at their web site at www.connecticare.com) to find out if a prescription drug is on this list. CICI has the right to change the drugs on this list in their discretion.

Mandatory Drug Limitations Program

For some drugs, the Plan will cover only a limited number of dosages per prescription and/or time period for the drug. These are drugs where CICI has determined, in their discretion, that the number of dosages available for the drug should be limited in accordance with the proper medical use of the drug. CICI will make these determinations based on the drug manufacturer's suggestions, federal FDA guidelines and medical literature, with input from physicians.

In certain cases, this subsection will cover additional units above the limited number of dosages per prescription and/or time period for the drug if CICI determines, in their discretion, that, because of your or your covered dependent's condition, these additional units are Medically Necessary. CICI will make this determination based on clinical evidence presented by your physician to CICI. When this occurs, you may be required to pay the applicable Cost-Share amount.

In addition, CICI reserves the right to designate that certain prescriptions be filled or refilled for no more than a 30-day supply at a time, regardless of whether your Benefit Summary has a fill or refill limit. When coverage is limited to a 30-day supply at a time for a drug, you will not be able to purchase that drug through CICI's Mandatory Maintenance Program.

Mandatory Maintenance Program

1. This Plan has a "Mandatory Maintenance Program."
2. Under the Mandatory Maintenance Program, you and your covered dependents must fill your maintenance prescriptions at CICI's designated mail order vendor or a pharmacy in one of the retail maintenance networks.

   You and your covered dependents have a choice of retail maintenance networks. Once chosen you and your covered dependents may only change the retail maintenance network once per benefit year.

   You and your covered dependents may obtain up to a 90 or 100-day supply of prescription maintenance drugs or covered supplies through the Mandatory Maintenance Program at the applicable benefit level. Please refer to your Benefit Summary to see the day supply limit and Cost-Share amounts, including whether your Plan has a Plan Deductible or Benefit Deductible.

3. To obtain these benefits, your physician must prescribe the 90 or 100-day supply of the prescription maintenance drugs or covered supplies. Detailed information about how to use CICI's designated mail order vendor or retail maintenance network is provided to you in a separate flyer.

CICI has the right to change or limit the drugs eligible for dispensing through this program in their discretion, even in the middle of the year. You should call CICI's Member Services Department to receive a list of drugs or drug classes ineligible for dispensing through this program.

Clinically Equivalent Alternative Drugs Or Supplies Program

1. Some plans have the "Clinically Equivalent Alternative Drug Or Supplies Program." This program applies to prescriptions filled at retail or specialty pharmacies, CICI's designated mail order vendor and retail maintenance networks. To determine whether your Plan uses this program, consult your Benefit Summary.
2. The Clinically Equivalent Alternative Drugs Or Supplies Program includes a limited list of drugs and supplies that are covered under this Plan that have been reviewed and recommended for use based on their quality and cost effectiveness.

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

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

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

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

The covered drugs and supplies are displayed on CICI's web site. You should call CICI's Member Services Department at the telephone number in the "Important Telephone Numbers And Addresses" subsection of the "Important Information" section of this Plan Description (or visit CICI at their web site at www.connecticare.com) to find out if a prescription drug or supply is on this list. CICI, on behalf of the Plan, has the right to change the drugs or supplies on the list in their discretion.

Cost-Share Waiver Programs

From time to time, CICI may offer programs to support the use of more cost-effective or clinically effective prescription drugs, including Generic Drugs, home delivery drugs over the counter drugs and preferred products. Those programs may reduce or waive Cost-Shares for a limited time that you would otherwise pay under the terms of this Plan.

Member Cost-Sharing

You and your covered dependents are required to pay a Cost-Share amount for covered prescription drugs and supplies obtained under this subsection. The Cost-Share amounts you are required to pay for prescriptions are found on your Benefit Summary.

1. If you have a Plan that requires a prescription drug benefit Copayment, you will be required to pay the lesser of the following:
   - The applicable Copayment amount for the drug or supply, or
   - The amount your Plan would pay for the drug or supply, or
   - The amount you would pay for the drug or the supply if you had purchased it without using the benefits of this Plan.
2. If you have a Plan that requires a prescription drug Benefit Deductible, the Deductible amount must be met in any calendar year or Plan Year for prescriptions subject to the prescription drug Benefit Deductible before the Plan will begin paying for those prescriptions. Under certain options, you will not be required to meet the Deductible amount if you obtain Generic Drugs Or Supplies.

   A Benefit Deductible is considered to be met for a Member if the individual Deductible is met by the amounts paid for that Member for prescriptions covered by the Deductible.

   A family Benefit Deductible amount (two Members) is met for each Member when each Member separately meets the individual Deductible amount.

A family Benefit Deductible amount (three or more Members) is met by combining the total expenses for prescriptions contributed by each family member, whereby no one family member incurs more than the individual Member Deductible amount, up to the family Deductible amount.

The Deductible does not apply to any other Deductible amount you may be required to pay for Health Services under the Plan.

3. When a Deductible and Copayment or Coinsurance apply, you must pay Copayment amount, as described in paragraph 1, above or the Coinsurance amount up to your Deductible amount. Then once the Deductible has been met, you will be responsible to pay applicable Cost-Share amount listed on your Benefit Summary for each prescription, plus any applicable cost difference. The Coinsurance amount is based on the rate CICI would pay for the prescription on behalf of the Plan.

   If you have a Plan with a drug Benefit Deductible and then a Copayment where you fulfill the Deductible requirement in a particular claim, you will pay the remaining Deductible amount for that year in addition to the remaining drug cost up to the drug's applicable Copayment amount, described in paragraph 1, above.

4. In some plans, a different type of Cost-Share applies depending on which tier a drug or supply is in. For example, you may have to pay a Copayment for a tier one drug or supply and a Coinsurance for drugs or supplies on a different tier.

5. Amounts paid by Members as their Coinsurance responsibility, or due to any reduction in benefits do not count towards meeting the Benefit Deductible.

6. Amounts paid by Members because they must pay a price difference for a Brand Name Drug do not count towards meeting any Deductible, Coinsurance, Copayment, or Pharmacy Coinsurance Maximum.

7. In no case will the Cost-Share amount for insulin drugs, noninsulin drugs, Diabetes Devices and Diabetes Ketoacidosis exceed:

   - $25 for each 30-day supply of a Medically Necessary covered insulin drug.
   - $25 for each 30-day supply of a Medically Necessary covered noninsulin drug, if the noninsulin drug is a glucagon drug.
   - $100 for a 30-day supply of all Medically Necessary covered Diabetes Devices and Diabetes Ketoacidosis Devices for the Member that are in accordance with the Member's diabetes treatment plan. This $100 cap will be applied only to those Diabetes Devices and Diabetic Ketoacidosis Devices that can be prescribed and dispensed in a 30-day supply. In addition, this $100 cap for applicable Diabetes Devices or Diabetes Ketoacidosis Devices will be applied as a 30-day supply cumulative cap for all such devices.

   All covered insulin and noninsulin drugs, if the noninsulin drug is a glucagon drug, are exempt from the Plan Deductible.

   All covered Diabetes Devices and Diabetes Ketoacidosis are exempt from the Plan Deductible, unless the Member is enrolled in one of our HSA-compatible high deductible health plans (HDHPs).

   Exception: A glucometer is considered preventive care and will remain exempt from the Plan Deductible.

Fills For Contraceptive Drugs

A 12-month supply of an FDA-approved contraceptive drug, device, or product when prescribed by a licensed physician, physician assistant, or advanced practice registered nurse (APRN) is available. The supply may be dispensed at one time or at multiple times, but a Member cannot receive a 12-month supply more than once per Plan Year.

Lyme Disease Treatment Limit

Antibiotic therapy for the treatment of Lyme disease is limited to 30 days of intravenous antibiotic therapy and 60 days of oral antibiotic therapy, unless further antibiotic treatment is recommended by a board-certified rheumatologist, infectious disease specialist or neurologist.

Prescription Drug Exclusions And Limitations

There is no coverage for the following:

- All drugs or medications in a therapeutic drug class if one of the drugs in that therapeutic drug class is not a prescription drug, unless the drugs or medications are Medically Necessary.
- Antibacterial soap/detergent, shampoo, toothpaste/gel, or mouthwash/rinse.
- Any treatment, device, drug or supply to increase or decrease height or alter the rate of growth, including devices to stimulate growth, and growth hormones.
- Appliances or devices, except to be consistent with applicable law.
- Certain prescription drugs and supplies are no longer covered when clinically equivalent alternatives are available unless otherwise required by law or are otherwise determined by CICI to be Medically Necessary. In order for that drug or supply to be considered Medically Necessary, the provider who wrote the prescription must substantiate to us, in writing, a statement that includes the reasons why use of the drug or supply is more medically beneficial that the clinically equivalent alternative.

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the Pre-Authorization And Pre-Certification (Prior Approval) Addendum to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

- Compounded prescriptions, unless at least one ingredient in the compounded prescription is FDA approved and the FDA component(s) of the compound is covered.
- Drugs or medications if they include the same active ingredient or a modified version of an active ingredient and they are:
  - ♦ Therapeutically equivalent or therapeutically an alternative to a covered prescription drug, or
  - ♦ Therapeutically equivalent or therapeutically an alternative to an over-the-counter (OTC) product.
- Drugs or preparations, devices and supplies to enhance strength, physical condition, endurance or physical performance, including performance enhancing steroids.
- Drugs that are lost, stolen, or damaged after they are dispensed by the pharmacy.
- Drugs that may be purchased without a prescription, including prescription drugs with non-prescription OTC equivalents, unless the prescription version of the over the counter equivalent is determined to be Medically Necessary or as otherwise described in this subsection.
- Infant formulas, dietary or food supplements, prescription medical foods and nutritional supplies.
- Medications for sexual dysfunction.
- Prescription drugs or supplies:
  - ♦ Covered by Workers' Compensation law or similar laws, or covered by Workers' Compensation coverage, even if you choose not to claim those benefits.
  - ♦ Dispensed before the Member's effective date or after his or her termination date.
  - ♦ Dispensed in a Hospital or other inpatient facility.
  - ♦ Dispensed or prescribed in a manner contrary to normal medical practice.
  - ♦ Furnished by the United States Veterans' Administration.
  - ♦ Not required for the treatment or prevention of illness or injury.
  - ♦ Obtained for the use by another individual.
  - ♦ Obtained from outside of the United States by any means.
  - ♦ Provided in connection with treatment of an occupational injury or occupational illness.
  - ♦ Refilled in excess of the number the prescription calls for or refilled after one year from the date of the order for the prescription drug.
  - ♦ Re-packaged in unit dose form.
  - ♦ Unless the drug is included on the preferred drug guide (formulary) or a medical exception is granted.
  - ♦ Used for or in preparation of Infertility treatment.
  - ♦ Used for the purpose of weight gain or reduction, obesity, including but not limited to stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, appetite suppressants and other medications.
  - ♦ Used for travel.
  - ♦ Used in connection with or for a Cosmetic Treatment or hair loss, including but not limited to health and beauty aids, chemical peels, dermabrasion treatments, bleaching, creams, ointments or other treatments or supplies, to remove tattoos, scars or to alter the appearance or texture of the skin.
  - ♦ Not suggested for use by manufacturers or not approved by the federal FDA or CICI's Pharmacy and Therapeutic Committee, unless they are Medically Necessary.
- Smoking cessation products, except as described in your Benefit Summary, if applicable, or.to treat nicotine addiction.

  For nicotine addiction treatment, the product must be obtained with a prescription and Pre-Authorized by CICI.

  In addition, this Plan may also cover smoking cessation products if:
  - ♦ The Member is being actively case managed, and
  - ♦ The use of the smoking cessation product is approved by CICI.

  When those conditions are met, smoking cessation products may be provided as part of a health management program value-added service or as a benefit.
- Prescription drugs associated with surrogacy arrangements (see the general **EXCLUSIONS AND LIMITATION** section for other benefit exclusions related to surrogacy).
- Vitamins, minerals, hematinics and supplements, except prescription pre-natal vitamins or as otherwise described in this subsection.

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the Pre-Authorization And Pre-Certification (Prior Approval) Addendum to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

General Conditions

1. CICI will not be liable for any injury, claim, or judgment resulting from the dispensing of any prescription drug covered by this subsection.
2. CICI may use another administrator to administer the benefits available by this subsection.
3. All claims must be submitted to CICI within 180 days from the date the drug or supplies were received with the appropriate claim form and as described in the Plan Description, "Claims Filing, Questions And Complaints, And Appeal Process" section, "Claims Filing" subsection.

   You can call CICI's Member Services Department to obtain the appropriate claim form.
4. Covered prescription drugs will not be denied as Experimental Or Investigational if the drug has successfully completed a Phase III clinical trial conducted by the federal Food and Drug Administration (FDA).
5. CICI may require the Member's treating physician to furnish CICI with any information about the diagnosis or prognosis of any injury or illness related to a prescription drug and about the nature, quality, and quantity of the prescription drug prescribed in order to determine its Medical Necessity.
6. Upon approval of new medications by the federal FDA, CICI reserves the right to implement Pre-Authorization criteria and to set quantity limits to promote appropriate use and to avoid abuse.
7. CICI does not generally coordinate benefits under this subsection. However, CICI will coordinate benefits under this subsection with the Medicare Part D program for any covered drugs that are included in the Part D program if you or your covered dependents have other coverage for those drugs through a Part D plan.
8. CICI reserves the right to designate that certain prescriptions be filled or refilled for no more than a 30-day supply at a time, regardless of whether your Benefit Summary has a fill or refill limit. When coverage is limited to a 30-day supply at a time for a drug, you will not be able to purchase that drug through CICI's Mandatory Maintenance Program.

Renal Dialysis

Medically Necessary renal dialysis for the treatment of kidney disease is **covered**.

Sleep Studies

Medically Necessary sleep studies are **covered after the applicable Cost-Share amount**. The Cost-Share amount depends on where the services are provided. Coverage is available for **one complete study per lifetime** when provided by a sleep facility or out-of-center sleep organization that is accredited by the American Academy of Sleep Medicine (AASM) under the supervision of a board-eligible or board-certified practitioner of Sleep Medicine. A complete sleep study may include more than one session.

Sleep studies and the treatment of sleep apnea require Pre-Authorization.

Surgery And Other Care Related To Surgery

Medically Necessary surgery provided by a doctor is **covered after the applicable Cost-Share amount**. The Cost-Share amount depends on where the services are provided. Some surgical procedures require Pre-Authorization. The surgical procedures that require Pre-Authorization are listed in the "Services Requiring Pre-Authorization And Pre-Certification Addendum."

Anesthesia Services

Anesthesia services as part of a covered inpatient or outpatient surgical procedure provided by a doctor are **covered**.

Breast Implants

The surgical removal of any breast implant which was implanted on or before July 1, 1994, no matter what the purpose of the implantation, is **covered** if the services are provided by a doctor. The surgical implantation of a prosthetic device required in connection with the surgical removal of a breast due to a tumor is **covered**.

Oral Surgery Services

Medically Necessary oral surgical services for the treatment of tumors, cysts, injuries of the facial bones and for the treatment of fractures and dislocations involving the face and jaw provided by a doctor are **covered**. Oral surgery requires Pre-Authorization.

There is no coverage for surgical and non-surgical treatment of temporomandibular joint (TMJ) dysfunction or temporomandibular disease (TMD) syndrome, including but not limited to appliances, behavior modification, physiotherapy and prosthodontic therapy.

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the Pre-Authorization And Pre-Certification (Prior Approval) Addendum to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

Reconstructive Surgery

The following reconstructive surgery provided by a doctor and when Pre-Authorized is **covered**:

- Procedures to correct a serious disfigurement or deformity resulting from:
  - Illness or injury,
  - Surgical removal of tumor, or
  - Treatment of leukemia.
- Medically Necessary reconstructive surgery for the correction of a congenital anomaly restoring physical or mechanical use to that part of the Member's body.

  Other reconstructive surgery for the correction of congenital malformation is excluded. See the "Exclusions And Limitations" section.
- Breast reconstructive surgery on each breast on which a mastectomy has been performed and on a non-diseased breast (in conjunction with reconstruction after mastectomy) to produce a symmetrical appearance.

Sterilization

Sterilization services provided by a doctor are **covered as follows:**

- Male sterilization services are **covered after the applicable Cost-Share amount.**
- Female sterilization services are **covered without any Cost-Sharing amount.**

The Cost-Share amount a Member pays depends on where the procedures are provided.

Please refer to your Benefit Summary for more information about "Preventive And Wellness" provisions.

Telemedicine Services

Pursuant to Public Act 21-9, Telemedicine services for medical advice, diagnosis, care or treatment are **covered** to the same extent coverage is provided for an in-person visit.

Telemedicine services are **covered after the Cost-Share amount, as shown on your Benefit Summary**. The Cost-Share amount will be the same amount you would pay if the service was provided through an in-person service between you and your provider.

Wound Care Supplies

Medically Necessary wound care supplies (including wound vacs) are covered when:

- Prescribed by a physician.
- Supplied by a participating health care provider or Home Care Agency.
- Pre-Authorized by CICI.
- Provided in conjunction with authorized home care services.

If wound care supplies are **not** being provided in conjunction with authorized home care services, then the applicable Cost-Share amount will apply. Refer to the "Disposable Medical Supplies" section.

EXCLUSIONS AND LIMITATIONS

The following is a list of services, supplies, etc., that are excluded and/or limited under this Plan. These exclusions and limitations supersede and override the "Benefits" section, so that, even if a health care service, supply, etc. seems to be covered in the "Benefits" section, the following provisions, if applicable, will exclude or limit it.

1. All assistive communication devices.
2. Ambulance services that are non-Emergency medical transport services to and from a provider's office for routine care or if the transport services are for a Member's convenience.
3. Any Treatment for which there is Insufficient Evidence Of Therapeutic Value for the use for which it is being prescribed.
4. Any treatment or service related to the provision of a non-covered benefit, including educational and administrative services related to the use or administration of a non-covered benefit, as well as evaluations and medical complications resulting from receiving services that are not covered ("Related Services"), unless both of the following conditions are met:
   - The Related Services are Medically Necessary acute inpatient care services needed by the Member to treat complications resulting from the non-covered benefit when such complications are life threatening at the time the Related Services are rendered, as determined by CICI, and
   - The Related Services would be a Health Service if the non-covered benefit were covered by the Plan.
5. Artificial Limbs designed exclusively for athletic purposes.
6. Attorney fees.

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the Pre-Authorization And Pre-Certification (Prior Approval) Addendum to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

7. Mental health care and substance-related and addictive disorders:
    - Services performed in connection with conditions not classified in the current edition of the "International Classification of Diseases section on Mental and Behavioral Disorders" or "Diagnostic and Statistical Manual of the American Psychiatric Association."
    - Outside of an assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention, but are specifically noted not to be mental disorders within the current edition of the "Diagnostic and Statistical Manual of the American Psychiatric Association."
    - Outside of an assessment, services as treatments for the primary diagnoses of learning disabilities, pyromania, kleptomania, gambling disorder, and paraphilic disorders.
    - Services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes.
    - Tuition or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the Individuals With Disabilities Education Act.
    - Outside of an assessment, unspecified disorders for which the provider is not obligated to provide clinical rationale as defined in the current edition of the "Diagnostic and Statistical Manual of the American Psychiatric Association."
    - Transitional living, sober living and halfway house services.
    - Non-medical 24-hour withdrawal management.
    - High intensity residential care, including American Society of Addiction Medicine (ASAM) criteria, for Members with substance-related and addictive disorders who are unable to participate in their care due to significant cognitive impairment.
    - Wilderness, adventure, outdoor programming which include equine and other animal assisted services.
    - Services provided in unlicensed, and, or non-accredited program. treatment or services that are non-professionally directed.
8. Benefits for services rendered before the Member's effective date under this Plan or after the Plan has been rescinded, suspended, canceled, interrupted or terminated, except as otherwise required by applicable law.
9. Blood and related expenses as follows:
    - Blood plasma, including other blood derivatives,
    - Cord blood retrieval or storage,
    - Donation expenses of the Member's relatives or friends for their blood donated for use by the Member,
    - Donor services, which are provided by the Red Cross, or
    - Whole blood.
10. Body piercing.
11. Cardiac rehabilitation for Phase III, unless the Member:
    - Is being actively case managed, and
    - The rehabilitation is approved by CICI.

    Phase III Cardiac Rehabilitation may be covered as part of a health management program value-added service or benefit. Phase IV cardiac rehabilitation is excluded.
12. Care, treatment, services or supplies to the extent the Member has obtained benefits under:
    - Applicable law,
    - Government program,
    - Public or private grant, or
    - Any plan or program for which there would be no charge to the Member in the absence of this Plan

    However, services obtained in a Veteran's Home or Hospital for a non-service connected disability, or as required by applicable law, are covered. Also covered are care, treatment or services that are otherwise Medically Necessary and provided in a Veteran's Hospital.
13. Chiropractic therapy that is long term or maintenance in nature.

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the Pre-Authorization And Pre-Certification (Prior Approval) Addendum to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

14. Clinical trial services as follows:
    - Costs of Experimental Or Investigational medicines or devices that are not exempt from new medicine or device application by the Food and Drug Administration,
    - Costs for non-Health Services,
    - Costs that would not be covered by this Plan for a non-Experimental Or Investigational treatment,
    - Facility, ancillary, professional services and medicine costs paid for by grants or funding for the trial,
    - Routine costs that are:
        - ♦ Experimental Or Investigational,
        - ♦ Provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the Member, or
        - ♦ Services that are clearly inconsistent with widely accepted and established standards of care for a particular diagnosis, and
    - Transportation, lodging, food or other travel expenses for the Member or any family member or companion of the Member.
15. Cosmetic Treatments and procedures, including but not limited to:
    - Any medical or Hospital services related to Cosmetic Treatments or procedures.
    - Abdominoplasty, lipectomy, panniculectomy or excision of loose or redundant skin and/or fat after the Member has had a substantial weight loss, unless documented in photographs with skin breakdown, ulcer that persist despite alternative treatments.
    - Repair of diastasis recti, abdominal liposuction or suction assisted lipectomy of the abdomen.
    - Benign nevus or any benign skin lesion removal (except when the nevus or skin lesion causes significant impairment of physical or mechanical function).
    - Blepharoplasty, unless the upper eye lid obstructs the pupil, and blepharoplasty would result in significant improvement of the upper field of vision.
    - Breast augmentation, (except as described in the "Reconstructive Surgery" or "Durable Medical Equipment (DME) Including Prosthetics" subsections of the "Benefits" section or as otherwise required by the law).
    - Dermabrasion or other procedures to plane the skin, including, but not limited to:
        - ♦ Acne related services such as blue light treatment of acne, injections to raise acne scars, and removal of acne cysts.
        - ♦ Electrolysis.
        - ♦ Scar revision following surgery or injury (except when the scar causes significant impairment of a physical or mechanical function).
        - ♦ Skin tag removal.
        - ♦ Tattooing or removal, unless covered under reconstructive surgery policy.
    - Liposuction.
    - Phototherapy or laser therapy for the treatment of skin conditions, except for the treatment of psoriasis.
    - Reduction mammoplasty for Members under age 18 (except or as described in the "Reconstructive Surgery" or "Durable Medical Equipment (DME) Including Prosthetics" subsections of the "Benefits" section or as otherwise required by applicable law).
    - Reversal of inverted nipples unless described in reconstructive surgery policy.
    - Sclerotherapy for varicose veins, reticular veins and spider veins.
    - Septoplasty, septorhinoplasty or rhinoplasty unless Medically Necessary.
    - Varicose vein treatment, except when there is a history of ulcers or bleeding from a varicose vein.
    - Vascular birthmark removal unless serious life-threatening complications including infection, bleeding, and dependent on the location by interfere with ADLs.
16. Craniofacial disorder treatment.
17. Custodial Care, convalescent care, domiciliary care, long term care or rest home care, except for Custodial Care in connection with extended day treatment programs as required by applicable federal or state law. Also care provided by home health aides that is not patient care of a medical or therapeutic nature and care provided by non-licensed professionals.

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the Pre-Authorization And Pre-Certification (Prior Approval) Addendum to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

18. Dental services, including but not limited to:
    - Anesthesia, except as otherwise described in the "Oral Surgery" subsection of the "Benefits" section.
    - Bite appliances or night guards.
    - Bone grafts.
    - Correction of congenital malformation, including genial, mandibular or maxillary osteotomies; or vestibuloplasty.
    - Correction of oral malocclusion.
    - Crowns.
    - Dental implants.
    - Prosthetic devices, except as otherwise provided herein.
    - Repair, restoration or re-implantation of teeth following an injury.
    - Tooth extractions, including impacted teeth.
19. Educational services, except for educational services in connection with extended day treatment program as required by applicable federal or state law and except as described in the "Autism Services" or "Birth To Three Program (Early Intervention Services)" subsections of the "Benefits" section:
    - Screening and treatment associated with learning disabilities,
    - Special education and related services, and
    - Testing, training, rehabilitation for educational purposes.
20. Experimental Or Investigational treatment, except as otherwise described in the "Bypassing The Internal Appeal Process" subsection of the "Claims Filing, Questions And Complaints, And Appeal Process" section.
21. Facelift surgery, or rhytidectomy
22. Family planning, including but not limited to:
    - Contraceptive drugs and devices, except to the extent applicable law requires coverage for these items. When they are covered, they are covered under the "Prescription Contraception" subsection of the "Benefits" section.
    - Home births (except that complications of home births are covered).
    - Infertility services not specifically covered under the "Infertility Services" subsection of the "Benefits" section or the "Prescription Drugs" subsection and/or as described in any additional Amendment you receive from us, if you are a resident of the state of Massachusetts, including but not limited to the following:
        - ♦ All Infertility services following voluntary sterilization where no successful reversal has been made,
        - ♦ Banking of eggs, embryos, or sperm,
        - ♦ Cryopreservation (freezing) of eggs, or sperm,
        - ♦ Genetic analysis and testing, except as otherwise described above or in the "Genetic Testing" section,
        - ♦ Medications for sexual dysfunction, unless your Plan includes CICI's Supplemental Sexual Dysfunction Prescription Drug Amendment,
        - ♦ Recruitment, selection and screening of donors or gestational carriers,
        - ♦ Reversal of surgical sterilization, and
        - ♦ Surrogacy and all charges associated with surrogacy arrangements such as prescription drugs, fertilization or implantation, except if provided to a Member, and
    - Labor doulas and labor coaches.
23. Foot orthotics, except if the member is diabetic.
24. Gender reassignment surgery and all related services.
25. Genetic analysis and testing "Genetic Testing" subsections of the "Benefits" section, including:
    - All other genetic testing services, as well as genetic testing panels not endorsed by ACOG, ASCO ACMG, or NCCN.
    - Genetic testing kits available either direct to the consumer or via a physician prescription.
    - Genetic testing only for the benefit of another family member.
    - Repeat genetic testing.
    - Whole genome or whole exome genetic testing.

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the Pre-Authorization And Pre-Certification (Prior Approval) Addendum to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

26. Health club membership and exercise equipment.
27. Hearing aids.
28. Home health aide care that is not patient care of a medical or therapeutic nature.
29. Hypnosis, biofeedback (except when ordered by a physician to treat urinary incontinence) and acupuncture, except when acupuncture is provided as part of pain management.
30. Infant formulas, food supplements, nutritional supplements and enteral nutritional therapy.
31. Infertility services, including prescription drugs for diagnosis or treatment.
32. Injection of collagen or other fillers or bulking agents to enhance appearance.
33. Massage, except when part of a prescribed physical or occupational therapy program, if that program is a covered benefit.
34. Medical supplies or equipment that are not considered to be durable medical equipment or disposable medical supplies or that are not on CICI's covered list of such equipment or supplies. Examples of excluded medical supplies or equipment include:
    - Wigs, hair prosthetics, scalp hair prosthetics and cranial prosthetics, except as described in the "Benefits" section.
    - Bed related equipment such as over the bed tables, bed wedges, pillows, custom mattresses and posturepedic mattresses.
    - Hygiene related equipment such as: bath lifts, bathtub rails, bath benches, bath chairs, adaptive equipment.
    - Wheelchair lifts, stair gliders, wheelchair ramps and modifications to cars or vans.
    - Non-durable equipment such as orthopedic or prosthetic shoes or foot orthotics (unless diabetic), prophylactic anti-embolism stockings and compression stockings/garments except when a Member has a history of deep vein thrombosis and varicose veins, lymphedema, lymphedema related to cancer or a cancer related procedure.
    - Compression and cold therapy devices.
    - DME that duplicates the function of any previously obtained equipment.
35. New Treatments for which CICI has not yet made a coverage policy, except for drugs with FDA approval for the use for which they are prescribed.
36. Non-licensed professionals.
37. Non-Medically Necessary services or supplies, except as required by applicable federal law.
38. Non-medical supportive counseling services (individual or group) for alcohol or substance abuse (e.g., Alcoholics Anonymous).
39. Non-surgical treatment of temporomandibular joint (TMJ) dysfunction or temporomandibular disease (TMD) syndrome, including but not limited to:
    - Appliances,
    - Behavior modification,
    - Physiotherapy, and
    - Prosthodontic therapy.
40. Ostomy equipment and supplies.
41. Otoplasty.
42. Overnight or day camps focused on illness or disability.
43. Over-the-counter (OTC) items of any kind, including but not limited to home testing or other kits and products, except as provided in the "Benefits" section.
44. Peak flow meters.

    However, peak flow meters may be covered if:
    - The Member is enrolled in CICI's asthma health management program,
    - The member is being actively case managed, and
    - The use of the peak flow meter is approved by CICI.

    When the above conditions are met, peak flow meters may be provided as part of an asthma health management program value-added service or as a benefit.
45. Personal convenience or comfort items of any kind.
46. Physical therapy, occupational therapy, or speech therapy that is long term or maintenance in nature, where long term or maintenance in nature means that the treatment period for a specific condition or diagnosis is greater than a 60-day period.
47. Platelet-rich-plasma for bone, wound or tendon healing.

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the Pre-Authorization And Pre-Certification (Prior Approval) Addendum to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

48. Prescription drugs or supplies, including infant formulas, dietary or food supplements, prescription medical foods and nutritional supplies, as follows:

- All drugs or medications in a therapeutic drug class if one of the drugs in that therapeutic drug class is not a prescription drug, unless the drugs or medications are Medically Necessary.
- Antibacterial soap/detergent, shampoo, toothpaste/gel, or mouthwash/rinse.
- Any treatment, device, drug or supply to increase or decrease height or alter the rate of growth, including devices to stimulate growth, and growth hormones.
- Appliances or devices, except to be consistent with applicable law.
- Certain prescription drugs and supplies are no longer covered when clinically equivalent alternatives are available unless otherwise required by law or are otherwise determined by CICI to be Medically Necessary. In order for that drug or supply to be considered Medically Necessary, the provider who wrote the prescription must substantiate to us, in writing, a statement that includes the reasons why use of the drug or supply is more medically beneficial that the clinically equivalent alternative.
- Compounded prescriptions, unless at least one ingredient in the compounded prescription is FDA approved and the FDA component(s) of the compound is covered.
- Drugs or medications are excluded if they include the same active ingredient or a modified version of an active ingredient and they are:
  - ♦ Therapeutically equivalent or therapeutically an alternative to a covered prescription drug, or
  - ♦ Therapeutically equivalent or therapeutically an alternative to an over-the-counter (OTC) product.
- Drugs or preparations, devices and supplies to enhance strength, physical condition, endurance or physical performance, including performance enhancing steroids.
- Drugs that are lost, stolen, or damaged after they are dispensed by the pharmacy.
- Drugs that may be purchased without a prescription, including prescription drugs with non-prescription OTC equivalents, unless the prescription version of the over the counter equivalent is determined to be Medically Necessary or as otherwise described in the "Prescription Drugs" subsection of the "Benefits" section.
- Medications for sexual dysfunction.
- Prescription drugs or supplies:
  - ♦ Covered by Workers' Compensation law or similar laws, or covered by Workers' Compensation coverage, even if you choose not to claim those benefits.
  - ♦ Dispensed before the Member's effective date or after his or her termination date.
  - ♦ Dispensed in a Hospital or other inpatient facility.
  - ♦ Dispensed or prescribed in a manner contrary to normal medical practice.
  - ♦ Furnished by the United States Veterans' Administration.
  - ♦ Not required for the treatment or prevention of illness or injury.
  - ♦ Obtained for the use by another individual.
  - ♦ Obtained from outside of the United States by any means.
  - ♦ Provided in connection with treatment of an occupational injury or occupational illness.
  - ♦ Refilled in excess of the number the prescription calls for or refilled after one year from the date of the order for the prescription drug.
  - ♦ Re-packaged in unit dose form.
  - ♦ Unless the drug is included on the preferred drug guide (formulary) or a medical exception is granted.
  - ♦ Used for or in preparation of Infertility treatment that is not specifically covered under in the "Infertility Services" subsection of the "Benefits" section, including but not limited to Experimental or Investigational Infertility procedures.
  - ♦ Used for the purpose of weight gain or reduction, obesity, including but not limited to stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, appetite suppressants and other medications.
  - ♦ Used for travel.
  - ♦ Used in connection with or for a Cosmetic Treatment or hair loss, including but not limited to health and beauty aids, chemical peels, dermabrasion treatments, bleaching, creams, ointments or other treatments or supplies, to remove tattoos, scars or to alter the appearance or texture of the skin.
  - ♦ Not suggested for use by manufacturers or not approved by the federal FDA or CICI's Pharmacy and Therapeutic Committee, unless they are Medically Necessary.

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the Pre-Authorization And Pre-Certification (Prior Approval) Addendum to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

- Smoking cessation products, except as described in your Benefit Summary, if applicable, or to treat nicotine addiction.

  For nicotine addiction treatment, the product must be obtained with a prescription and Pre-Authorized by CICI.

  In addition, CICI may also cover smoking cessation products if:

  - The Member is being actively case managed, and
  - The use of the smoking cessation product is approved by CICI.

  When those conditions are met, smoking cessation products may be provided as part of a health management program value-added service or as a benefit.

- Vitamins, minerals, hematinics and supplements, except prescription pre-natal vitamins or as otherwise described in the "Prescription Drugs" subsection of the "Benefits" section.

49. Private room accommodations or private duty nursing in a facility.
50. Routine foot care and treatment.
51. Routine physical exams or immunizations at an Urgent Care Center.
52. Screening and/or testing required for public health surveillance, travel, education, employment, or returning to employment, except as required by law.
53. Sensory and auditory integration therapy, unless covered under the "Autism Services" or "Birth To Three Program (Early Intervention Services)" subsections of the "Benefits" section.
54. Services and supplies exceeding the applicable benefit maximums.
55. Services and supplies not specifically included in this document.
56. Services, drugs, medications or supplies obtained outside of the United States, except for Emergency Services.
57. Services or supplies rendered by a physician or provider to himself/herself, or rendered to his/her family members, such as parents, grandparents, spouse, children, step-children, grandchildren or siblings.
58. Services required by or received at a Wilderness Camp or a boarding school, including:
    - Medications, including prophylactic.
    - Physical examinations, blood tests.
    - Supplies.
    - Vaccinations/immunizations.
59. Services required by third parties or pursuant to a court order, including:
    - Blood tests.
    - Medications, including prophylactic.
    - Physical examinations.
    - Supplies.
    - Vaccinations/immunizations.
60. Services obtained for foreign or domestic travel, including:
    - Camp.
    - Employment.
    - Insurance.
    - Licensing.
    - Pursuant to a court order.
    - School.
61. Smoking cessation products, except as described in your Benefit Summary, if applicable, or to treat nicotine addiction.
    For nicotine addiction treatment, the product must be obtained with a prescription and Pre-Authorized.

    In addition, your Plan may also cover smoking cessation products if:

    - The Member is being actively case managed, and
    - The use of the smoking cessation product is approved by CICI.

    When the above conditions are met, smoking cessation products may be provided as part of a health management program value-added service or as a benefit.
62. Solid organ transplant and bone marrow transplant transportation costs, including:
    - Any expenses for anyone other than the transplant recipient and the designated traveling companion.
    - Any expenses other than the transportation, lodging and meals described in the "Benefits" section.
    - Expenses over those described in the "Benefits" section.
    - Local transportation costs while at the transplant facility.
    - Rental car costs.
    - Testing for bone marrow.
63. Speech therapy for stuttering, lisp correction, or any speech impediment not related to illness or injury, except as described in the "Benefits" section.

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the Pre-Authorization And Pre-Certification (Prior Approval) Addendum to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

64. Surrogacy and all charges associated with surrogacy arrangements such as prescription drugs, fertilization or implantation and any maternity charges incurred for the pregnancy of a surrogate or gestational carrier.
65. Telemedicine consultation services not specifically covered under the "Telemedicine Services" subsection of the "Benefits" section, including but not limited to:
    - Costs for asking for Pre-Authorizations or Pre-Certifications.
    - Costs for diet counseling or prescriptions for Drug Enforcement Administration (DEA) controlled substances or lifestyle drugs, such as sexual dysfunction, diet drugs or hair growth drugs.
    - Costs for furnishing and/or receiving medical records and reports.
    - Costs for getting answers to billing, coverage or payment questions.
    - Costs for provider to provider discussions.
    - Costs for Referrals to providers outside the online care panel.
    - Costs for reporting normal lab or other test results.
    - Costs for requesting office visits.
    - Costs for research services by providers not directly responsible for your care.
    - Costs for services not documented in provider records.
    - Costs from an outside laboratory or shop for services in connection with an order involving devices (e.g., prosthetics, orthotics) which are manufactured by that laboratory or shop, but which are designed to be fitted and adjusted by the attending physician.
    - Fees associated with data usage on a mobile phone or fees for short message service (SMS)/text messaging.
    - Membership, administrative, or access fees charged by physicians or other providers Examples of administrative fees include, but are not limited to:

      Fees charged for educational brochures or calling a patient to provide their test results.
    - Provider or Hospital fees for technical costs or facility fees for the provision of Telemedicine services.
    - Telemedicine services involving the use of electronic mail, facsimile, texting or audio-only telephone, except as required by Public Act 21-9.
66. Thigh, leg, hip, or buttock lift procedures.
67. Third party coverage, such as other primary insurance, workers' compensation and Medicare will not be duplicated.
68. Transportation, accommodation cost, and other non-medical expenses related to Health Services (whether they are recommended by a physician or not), except as otherwise described in the "Benefits" section.
69. Treatment of melasma.
70. Treatment of snoring in the absence of sleep apnea.
71. Treatment of temporomandibular joint (TMJ) dysfunction or temporomandibular disease (TMD) syndrome, including but not limited to:
    - Appliances.
    - Behavior modification.
    - Physiotherapy.
    - Prosthodontic therapy.
72. Vision care services and optical care services as follows:
    - Contact lenses, frames, and lenses for cosmetic or convenience purposes.
    - Eyeglasses and contact lenses, unless the contact lenses are the only mechanism available to restore visual function for a Member who has no visual function.
    - Eye surgeries and procedures primarily for the purpose of correcting refractive defects of the eyes.
    - Optical Care Services Discounts when a Non-Participating Vision Care Provider provides the routine exam.

      In addition, Optical Care Services Discounts that are provided through a Non-Participating Vision Care Provider are also excluded, even if a Participating Vision Care Provider provides the routine eye exam.
    - Services, frames, and lenses provided through a medical department, clinic, or similar service provided or maintained by an employer, or provided under any other group coverage furnished by or arranged through any employer.
    - Tinted glasses, sunglasses or industrial safety glasses.
    - Vision and hearing examinations (except as described in the "Eye Care" and "Hearing Screenings" subsections of the "Benefits' section).
    - Vision Care Services or Optical Care Services rendered after the date you or your covered dependents cease to be covered under this Plan, except for lenses and frames ordered prior to such termination.
    - Vision therapy and vision training.
73. War related treatment or supplies, whether the war is declared or undeclared.
74. Weight loss/control treatment, programs, clinics, medications, or surgical treatment for morbid obesity.
75. Wound care supplies for epidermolysis bullosa.

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the Pre-Authorization And Pre-Certification (Prior Approval) Addendum to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

COORDINATION OF BENEFITS (COB) AND SUBROGATION AND REIMBURSEMENT

Benefits provided under this Plan are subject to the Coordination of Benefits ("COB") and Subrogation provisions as described in this section. CICI does not coordinate benefits for prescription drugs, except as expressly stated herein, or routine vision exam services or optical care services under this Plan.

COORDINATION OF BENEFITS

Definitions

As used in this section below only:

Plan: Means any group health insurance policy or other group arrangement by which health care benefits, including prescription drug coverage are provided or paid for or the basic reparation benefits of any automobile no-fault insurance policy or Medicare.

The term Plan will be interpreted separately for each policy or other arrangement for benefits; as well as that portion of any plan, which reserves the right to consider the benefits of other plans in determining its benefits and that portion which does not.

2. **Allowable Expense:** Means any expense at least a part of which is covered by at least one of the Plans covering a Member. When a Plan provides benefits, the reasonable cash value of each service that would be rendered will be deemed a benefit for the purpose of this section; any service actually provided will be deemed an Allowable Expense and a benefit paid.
3. **Coordination:** Means that, regarding a specific claim, the Plans determine among themselves:
   - Which Plans are responsible for payment.
   - Which Plan pays first, second, third, and so on.
   - How much of the claim each Plan is responsible for paying.

General

If you or your covered dependents are eligible to receive health benefits under another Plan, the benefits provided under this Plan will be coordinated with the benefits under the other Plan(s) so that neither the Member nor the provider receives the value of more than 100% of his or her medical and health care costs. In addition, in no event will this Plan be liable for more than this Plan would have paid if this Plan were the primary payor. Health benefits will be coordinated with:

- Any services that are the legal obligation of a third party or are covered by insurance or a governmental program, such as Medicare, or are provided as basic reparations benefits under any no-fault or other automobile insurance policy, or any other recovery mechanism permitted by State or Federal statutes.
- Services covered under Title XVIII and amendments (Medicare Parts A and B).

Workers' Compensation

Workers' compensation is always the primary and the only payor on the claims to which it pertains. If Health Services for a work-related injury:

1. Are covered by a workers' compensation Plan; or
2. Would be covered if the Member is required by law to be covered by workers' compensation regardless of whether he or she has workers' compensation or submitted the claim; or
3. Would be covered if the Member complied with the terms and conditions of the workers' compensation plan;

then such services are not covered by this Plan.

Medicaid

If the Member is also covered under Medicaid, this Plan is always the primary payor. This Plan does not coordinate benefits with Medicaid.

Medicare Part D

This Plan will coordinate benefits with the Medicare Part D program for any covered drugs that are included in the Part D program if you or your covered dependents have other coverage for those drugs through a Part D plan.

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the Pre-Authorization And Pre-Certification (Prior Approval) Addendum to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

Automobile Insurance Policies

Automobile insurance is always the primary payor in relation to group health coverage, unless otherwise prohibited by law. Whenever you or your covered dependents are required to purchase basic reparations or medical pay coverage under any automobile policy by any State law, or you otherwise have such coverage under any automobile insurance policy, this Plan will be entitled to charge:

- The insurer for the dollar value of those benefits to which you and your covered dependents are entitled, or
- You for that value to the extent you have received payment or would have received payment under the basic reparations coverage under the applicable automobile insurance policy.

Student Accident Or Sickness Insurance Policies

This Plan does not coordinate benefits with student accident or sickness insurance policies where the student or parent pays the entire premium.

Primary vs. Secondary Coverage

The specific order of responsibility for coverage and benefits payments among responsible Plans will be determined by using the first of the following rules which applies:

1. The Plan that covers the individual as a policyholder or subscriber pays before the Plan that covers the individual as a dependent.
2. **Birthday Rule:** When 2 or more Plans cover the same child as a dependent of different persons who are called "parents" and are not separated or divorced:
   - The benefits of the Plan of the parent whose birthday falls earlier in a calendar year are paid before those of the Plan of the parent whose birthday falls later in the year; but
   - If both parents have the same birthday, the benefits of the Plan that covered the parent longer are paid before those of the Plan that covered the other parent for a shorter period of time.

   However, if the other Plan does not have the "Birthday Rule" described above, but instead has a rule based upon the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule based upon the gender of the parent will determine the order of benefits.
3. When 2 or more Plans cover a person as a dependent child of divorced or separated parents, the order of priority for the Plans will be determined in the following manner:
   - First, the Plan of the parent with custody of the child;
   - Then, the Plan of the spouse of the parent with custody of the child; and
   - Finally, the Plan of the parent not having custody of the child.

   However, if the specific terms of a court decree state that one of the parents is more responsible for the health care expenses of the child than the other, and the Plan obligated to pay or provide the benefits of that parent has actual knowledge of those terms, the benefits of that Plan pay first. This paragraph does not apply to any Claim Determination Period during which any benefits are actually paid or provided before the Plan has that actual knowledge. For purposes of this section, "Claim Determination Period" means a calendar year but will not include any part of a year during which a person has no coverage under this Plan, or any part of a year before the date this Coordination of Benefits provision or a similar provision takes effect.
4. The Plan that covers the Member as an active Employee or covered dependent of an active Employee provides payment before a Plan that covers the Member as a former Employee or covered dependent of a former Employee.
5. When none of the above rules determine the issue, a Plan has first responsibility if the Member has been enrolled or covered under that Plan longer than in the other Plan(s).
6. When the order is determined, each Plan in turn provides payment up to the limits specified in its policy or agreement. Total payment cannot exceed 100% of actual costs.

When This Plan Is Not Primary

1. If you or your covered dependents have primary coverage through another Plan, Participating Providers, at their discretion, will be allowed to collect payment for services from you at the time services are rendered; and, you do not have to pay Copayments under this Plan.
2. You must submit the claims to your primary plan if the provider of services does not submit the claim.

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the Pre-Authorization And Pre-Certification (Prior Approval) Addendum to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

3. When this Plan is the secondary Plan, you must submit a copy of the explanation of benefits ("EOB") form you received from the primary Plan to CICI. If CICI receives a claim without an EOB from the primary Plan, the claim will be denied. The denial will explain that this Plan is the secondary payor. **IT IS YOUR RESPONSIBILITY** to ensure the claim is processed with the primary Plan. You must submit your claims to CICI with the EOB from the primary Plan within 180 days of the date the primary plan processed the claim. Claims for Health Services submitted more than 180 days after the date the primary Plan processed the claim will not be paid under this Plan, except in special circumstances, as CICI determines.
4. In no event will this Plan be liable for more than it would have been responsible if this Plan were primary.

All of the terms and conditions described in this Plan apply for both primary and secondary coverage under this Plan.

Rights To Receive And Release Necessary Information

CICI routinely sends questionnaires to Members where the order of coverage and benefits among responsible Plans is in question. CICI reserves the right to deny any or all claims until the completed questionnaire has been returned to CICI.

Any person claiming services or payments under this Plan must furnish CICI, or its agents, any information needed to implement the Coordination of Benefits and Subrogation provisions. For the purposes of implementing these provisions or a similar provision of any other Plan, CICI may, without the consent of or notice to any person, release to or obtain from any entity any information needed for such purposes to the extent permitted by law.

Facility Of Payment

If another plan makes payments for covered Health Services that this Plan is responsible for, CICI may, at its sole discretion, pay to that plan any amounts CICI determines to be warranted in order to satisfy the intent of this section. Amounts paid will be deemed to be services or payments under this Plan. To the extent of those payments, CICI will be fully released from liability.

Rights Of Recovery

When payments or services have been made or arranged by CICI in excess of the maximum for Allowable Expenses, no matter to whom paid, CICI will have the right to recover the excess from any persons, insurance companies, or other organizations. CICI's right under this section to recover any amount from you will be limited to the amount that you have received from another plan.

SUBROGATION AND REIMBURSEMENT

You or your covered dependents may receive or be eligible to receive Plan Benefits for an injury or an illness for which some third person, organization, or governmental entity is liable to pay damages. In these cases, to be consistent with applicable law, the third person, organization or governmental entity may have primary payment responsibility and not by way of limitation, may include the following sources: a third party tortfeasor or his insurer, payments under an uninsured or underinsured motorist policy, a Workers' Compensation award or settlement, a recovery made pursuant to a no-fault insurance policy, and any medical payment coverage in any automobile or homeowner's insurance policy. For claims this Plan paid in relation to that injury or illness, the Plan or its agent will have a lien upon the proceeds on behalf of the Plan of any recovery from that third person, organization or governmental entity. You and your covered dependents agree to reimburse us, in full, without any offset or reduction under any theory of attorney or common fund, made-whole, or comparative negligence. That lien will be equal to the value of any services provided or paid for under this Plan in relation to that injury or illness. The lien may, but need not, be filed with such third person, organization, or governmental entity or in any court of competent jurisdiction.

When permitted by law, the Plan may require the Member, his or her guardian, personal representative, estate, dependents or survivors, as appropriate, assign his or her claim against the third person, organization or governmental entity to the Plan to the extent of that right or claim. The Plan may further require those individuals or entities to execute and deliver those instruments and to take such other reasonable actions as may be necessary to secure the Plan's rights.

In situations where you or your covered dependent receive monetary compensation to act as a surrogate, the Plan will seek reimbursement of Plan payments made for covered Health Services you or your covered dependent receive that are associated with conception, pregnancy and/or delivery of the child, up to the monetary amount you or your covered dependent receive to act as a surrogate. A surrogate arrangement is one in which a woman agrees to become pregnant and to surrender the baby to another person or persons who intend to raise the child. You or your covered dependent will have an obligation to provide CICI with specific information related to the surrogate arrangement for the purpose of administering this subrogation provision.

MEDICARE ELIGIBILITY

You and your covered dependents who are eligible for Medicare may still remain eligible for coverage under this Plan, subject to your Employer's eligibility rules and CICI's policies regarding coverage of retirees. If you are eligible for either Part A or Part B of Medicare, because you have end stage renal disease, your coverage will be administered as though you have enrolled in Parts A and B of Medicare, even if you have not enrolled in it.

You or your covered dependents who have Medicare receive the same Plan Benefits, but the following rules determine which Plan is primary.

Members Who Have Medicare Because They Are Age 65 Or Older

1. This is the primary plan for you and your covered dependents when you are an active Employee, **if your Employer has 20 or more employees.**
2. Medicare is the primary plan for you and your covered dependents who have Medicare when you are an active Employee, **if your Employer has fewer than 20 employees.**
3. For all Employers (no matter how many employees), Medicare is the primary plan for you and your covered dependents who have Medicare when you are not an active Employee.

Members Who Have Medicare Due To End Stage Renal Disease ("ESRD")

1. When you or your covered dependents become eligible for Medicare because of ESRD, this Plan is primary for that person for a period of 30 consecutive months.

   This 30-month period begins on the earlier of the following:

   - The 1st day of the month during which a regular course of renal dialysis starts; or
   - The 1st day of the month during which that Member receives a kidney transplant.
2. After the 30-month period described above ends, Medicare is primary.

If you or your covered dependents already had Medicare as the primary Plan at the time of the initial dialysis treatment or kidney transplant, Medicare will remain as the primary plan.

Members Under Age 65 Who Have Medicare Due To A Disability, Other Than End Stage Renal Disease ("ESRD")

1. This is the primary plan for you or your covered dependents when you are an active Employee, **if your Employer has 100 or more employees.**
2. Medicare is the primary plan for you or your covered dependents when you are an active Employee, **if your Employer has 99 or fewer employees.**
3. For all Employers (no matter how many employees), Medicare is the primary plan for you or your covered dependents if you are not an active Employee.

Members Age 65 And Older Who Are Disabled

If you or your covered dependents receive Medicare benefits because of a disability other than ESRD before turning age 65, use the rules in the "Members Who Have Medicare Because They Are Age 65 Or Older" subsection of this section, to determine which Plan is the primary Plan when you or your covered dependents do turn age 65.

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the Pre-Authorization And Pre-Certification (Prior Approval) Addendum to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

CLAIMS FILING, QUESTIONS AND COMPLAINTS, AND APPEAL PROCESS

This section tells you the procedures for filing claims, registering complaints, and Appealing CICI's decisions regarding your benefits. CICI has the right to review any claims and the discretion to interpret and apply the terms of this Plan to determine whether benefits are payable.

CLAIMS FILING

Claims for Health Services must be received by CICI within 180 days from the date the services, medications or supplies were received. Claims submitted more than 180 days after the date the services, medications or supplies were received will not be reimbursed. An exception to this rule applies in situations when this Plan is not primary. (Please see **When This Plan Is Not Primary** section).

You can find out the status of your medical claims on their site at www.connecticre.com.

You can find out the status of your behavioral health claims (those for mental health and alcohol or substance abuse) on the OptumHealth Behavioral Solutions web site at www.liveandworkwell.com.

Bills From A Participating Provider

When you receive covered Health Services from a Participating Provider, you are financially responsible for any non-covered services and all the Cost-Share amounts of this Plan, including the Plan Deductible (if applicable), Copayment amounts, and any Coinsurance amounts. The Participating Provider who rendered the services will file a claim with CICI, and any payment due under this Plan will be made to the billing Participating Provider.

Special Rules For CICI Administered *HDHP Plan*

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

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

Any amount owed to the Participating Provider must be paid directly to the Participating Provider. Contact CICI if the Participating Provider does bill you for more than the EOB says you must pay.

If you have any questions about your claims, you should call the appropriate telephone number listed in the "Important Telephone Numbers And Addresses" subsection of the "Important Information" section for assistance.

Bills From A Non-Participating Provider

If you or your covered dependents receive care from a Non-Participating Provider, a claim must be submitted to CICI at the appropriate address listed in the "Important Telephone Numbers And Addresses" subsection of the "Important Information" section:

The claim should include the following information:

- Subscriber's name.
- The patient's name and ID number (including suffix).
- A complete, itemized bill for services, which includes both a description of the service and the diagnosis. **(NOTE: Charge card receipts and "balance due" statements are not acceptable.)**
- If the claim was a result of an Emergency or Urgent Care you or your covered dependents needed while outside of the United States, please be sure that the itemized bill is written or translated in English and that it shows the amount you paid in U.S. dollars. In this case, it may be helpful for you to also include your charge receipt with the itemized bill.

Generally, the Plan's payment for covered Health Services provided by a Non-Participating Provider is made directly to you, and you are responsible for paying the provider of service, unless you write on the claim form that you want CICI to process payment to the provider, with the following exceptions: TBD

- The Plan will pay an ambulance company provider directly when there is a law that permits it to do so.
- The Plan will reimburse the Non-Participating Provider directly when the covered services are rendered in Connecticut by the Non-Participating Provider for the diagnosis or treatment of a substance use disorder, if the provider is otherwise eligible for reimbursement under this Plan.

The Plan may also pay you directly, if the Non-Participating Provider does not provide CICI with information that CICI requests for claim payment.

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the Pre-Authorization And Pre-Certification (Prior Approval) Addendum to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

Special Rules For a CICI Administered *HDHP Plan*

When coverage for treatment provided by a Non-Participating Provider is allowed, you must pay the Cost-Share amounts that you would pay if the services were given by a Participating Provider. Payment will be based on the Non-Participating Provider's billed charges. Check the "Cost-Shares You Are Required To Pay" section and your Benefit Summary to find out the Cost-Share amounts you have to pay under your Plan. If you receive treatment from a Non-Participating Provider that is not covered, you will be solely responsible for paying the Non-Participating Provider, and the amount you pay will not count toward your Plan Deductible or your Coinsurance amount.

Payment To Custodial Parent

In being consistent with the law, in situations where the Plan has not paid your covered dependent children's claims directly to the provider, the Plan will send the payment directly to the custodial parent if the Plan is notified in writing, even if that parent is not a participant under this Plan.

Claims For Emergency Services

Your claims for payment for Emergency Services provided by Non-Participating Hospitals or other Non-Participating Providers should be reviewed by you before you send the claim to CICI to ensure they are complete. In some cases, emergency room claims filed by a Hospital may be initially denied if they have missing, incomplete or improperly coded information. You may Appeal denied emergency room claims as described in the "Appeal Process" subsection of this section.

If You Are Covered By Another Plan

If you or your covered dependents are covered under another plan and this Plan is the secondary plan, you have 180 days from the date the primary plan processed the claim to submit the claim to CICI. Please refer to the "Coordination Of Benefits And Subrogation" section for a description of how to determine if this Plan is the primary or secondary plan and any requirements you have in this area.

You should also tell your provider when you or your covered dependents are covered under another plan, so his or her services can be billed and paid correctly.

Refund Of Overpayments

Whenever this Plan has made payments for Health Services, including prescription drugs either in error or in excess of the maximum amount allowed under this Plan, the Plan has the right to recover these payments from: any person to or for whom the payments were made; any insurance companies; or any other person or organization. Payments made in error for a non-covered benefit do not mean that you have the right to rely on future coverage for the non-covered service, supply or drug.

This Plan's right to recover its incorrect payment may include subtracting amounts from future benefits payments. You, personally and on behalf of your covered dependents, must, upon request, execute and deliver any documents as may be required and do whatever is necessary to secure this Plan's right to recover any erroneous or excess payments.

Assignment Of Benefits

Except for dental benefits, the benefits of this Plan are not transferable to any third party. When you or your Eligible Dependents see a Participating Provider, they will usually bill CICI directly. When you or your Eligible Dependents see a Non-Participating Provider for covered Health Services, other than covered dental services, CICI may choose to pay you or to pay the provider directly. To the extent allowed by law, CICI will not accept an assignment to a Non-Participating Provider.

Questions and Appeals

You or your duly authorized representative can always ask questions or complain about benefits and other issues concerning this Plan. Since most questions or complaints can be resolved informally, CICI suggests that you contact its Member Services Department first. The appropriate telephone numbers and addresses for the Member Services Department are listed in the "Important Telephone Numbers And Addresses" subsection of the "Important Information" section.

Representatives are available Monday through Friday, during regular business hours to explain policies and procedures and answer your questions. When you call, a representative will either answer your question or forward it to the appropriate department or individual for a response. If you are calling after normal business hours, you may leave a detailed voice mail message, including your CICI ID number and your telephone number. An associate will return your telephone call during regular business hours.

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the Pre-Authorization And Pre-Certification (Prior Approval) Addendum to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

You also have the right to appeal an adverse claim determination, as outlined below.

APPEALS AND EXTERNAL REVIEW PROCESSES

If you need help having ConnectiCare materials translated from English to a different language, please call Customer Service at 877-373-1206.

Si necesita ayuda para obtener los materiales de ConnectiCare traducidos del inglés a otro idioma, comuníquese con el Servicio al Cliente llamando al 877-373-1206.

Aby uzyskać pomoc w przetłumaczeniu materiałów ConnectiCare z języka angielskiego na inny język, proszę skontaktować się z Działem Obsługi Klienta pod numerem 877-373-1206.

If you or your authorized representative are not satisfied with a decision CICI or its Delegated Programs has made regarding Health Services, benefits, Pre-Authorization, Pre-Certification, or claims, then you or your authorized representative may request an Appeal.

Of course, before pursuing the Appeal and external review processes, you should always consider seeking immediate assistance from CICI's Member Services Department, as described in the "Questions And Appeals" subsection of this section. Often, questions can be resolved quickly and informally by speaking with one of CICI's representatives. However, if you choose to make use of the Appeal and external review processes, CICI will not subject you to any sanctions or impose any penalties on you. You may also contact the Member Services Department to request reasonable access to and copies (free of charge) of all documents, records and other information relevant to your benefit request.

An Appeal or external review request may be initiated electronically, by mail or orally by either faxing, writing or calling CICI as follows:

Facsimile: 1-800-319-0089

ConnectiCare
Member Appeals
PO Box 4061
Farmington, Connecticut 06034-4061

Telephone: 1-800-846-8578

For a behavioral health Urgent Appeal or an expedited external review for behavioral health, contact CICI's behavioral health Delegated Program at:

Telephone: 1-866-556-8166

Facsimile: 1-855-312-1470

Optum-Appeals
P.O. Box 30512
Salt Lake City, UT 84130-0512

Appeal Process

The Appeal process is divided into two categories.

1. One category deals with the **Medical Necessity Appeal** of a particular Health Service, such as a denial of a request for Pre-Certification of an inpatient admission or the Pre-Authorization of a certain procedure.
2. The other category deals with the **Administrative (Non-Medical Necessity) Appeal**, such as a decision that interprets the application of Plan rules and that does not relate to Medical Necessity.

When filing an Appeal you should explain why you feel the original decision should be overturned. You may submit additional written comments, documents, records, and other material relating to your benefit request for consideration.

The Appeal must be made as soon as possible after you receive the original decision, but no later than 180 calendar days after the Pre-Authorization request was denied or 180 calendar days after the claim for benefits was denied, whichever comes first. If you fail to submit your request within the 180 calendar days, you lose your right to your Appeal.

If you do not agree with the final internal Adverse Benefit Determination on review, you have the right to bring a civil action under Section 502(a) of ERISA, if applicable.

CICI is the ERISA Claims Fiduciary for this Plan. CICI has the discretionary authority to determine whether and to what extent you and your dependents are eligible for benefits under this Plan and to define and interpret the terms of this Plan Description and the Plan. All of CICI's interpretations and decisions are final, conclusive and binding, except if overturned on external review.

Medical Necessity Appeal

Appeal Process

If you disagree with a decision regarding the **Medical Necessity** of a particular Health Service, such as a denial of a request for Pre-Certification of an inpatient admission or the Pre-Authorization of a certain procedure, you may Appeal that decision.

The Plan's Appeal process is designed to resolve Appeals quickly and impartially through the use of an Independent Review Organization (IRO) of medical practitioners (except for behavioral health expedited and urgent reviews, which are reviewed by an appropriately licensed specialist through CICI's behavioral health Delegated Program).

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the Pre-Authorization And Pre-Certification (Prior Approval) Addendum to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

1. CICI will investigate your Appeal. An CICI representative may call you or your health care provider to obtain medical records and/or other pertinent information in order to respond to your appeal. If during this investigation, CICI acquires new or additional evidence or new or additional scientific or clinical rationale that will be reviewed as part of your Appeal, CICI will provide that information to you or your representative for review. You will have two business days to respond to the new or additional information before CICI sends your Appeal to the IRO.
2. The IRO will arrange to have the Appeal reviewed by a board-certified physician specialist in the field related to the condition that is the subject of the Appeal who was not involved in the original decision. If the physician reviewer agrees with CICI's decision to deny coverage, but uses new or additional rationale for their decision, then you or your authorized representative will be provided with the new or additional rationale and will have an opportunity to respond before the decision is issued.
3. You or your authorized representative and your practitioner will be sent a written decision.
4. If you are not satisfied with the decision made by the IRO, then you or your authorized representative may request an external review. See the "External Review And Expedited External Review" subsection.

Urgent Appeal

You may file an Appeal on an urgent basis (Urgent Appeal) if CICI has issued an Adverse Benefit Determination for coverage and the time period for making a non-urgent care request determination:

- Could seriously jeopardize your or your covered dependent's life or health or ability to regain maximum function, or
- In the opinion of a health care professional with knowledge of the medical condition you or your covered dependent would be subject to severe pain that could not be adequately managed without the services or treatment related to the Appeal.

If you are not satisfied with the Urgent Appeal decision then you, your authorized representative or any provider with your consent may request an external review. Please refer to the "External Review And Expedited External Review" subsection.

External Review And Expedited External Review

If you are not satisfied with the Medical Necessity Appeal decision, then you or your authorized representative may request an external review or expedited external review.

1. You are entitled to an expedited external review if:
   - You have received an Adverse Benefit Determination involving a medical condition for which the timeframe for completion of an Urgent Appeal would seriously jeopardize you or your covered dependent's life or health or would jeopardize you or your covered dependent's ability to regain maximum function and you have filed a request for an Urgent Appeal; or
   - You have received a final Appeal decision, if you or your covered dependent have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your or your covered dependent's life or health or would jeopardize your or your covered dependent's ability to regain maximum function, or if the final Appeal decision concerns an admission, availability of care, continued stay, or health care item or service for which you or your covered dependent received Emergency Services, but have not been discharged from a facility.
2. You must file your request for an external review or expedited external review after you have completed the internal Appeal process, and within four months after receiving the final Appeal decision. You do not need a final denial letter if CICI has not strictly adhered to (except for errors that are minor and that meet other specified conditions under applicable law) the requirements under the law with respect to making utilization review and benefit determinations.
3. Upon receipt of your request for an external review or expedited external review, CICI will complete a preliminary review.
4. If your request is complete, but you are not eligible for external review or expedited external review, CICI will notify you and will include the reasons for your ineligibility in the notice. If CICI needs more information, CICI will tell you what information is missing. You will have until the end of the four months filing period, or 48 hours from receipt of the notice, whichever is longer, to provide CICI with the missing information.

5. Your external review or expedited external review request will be sent to a randomly selected IRO. For review of medical Appeals, a board-certified physician specialist in the field related to the condition that is the subject of the review who was not involved in the original decision or Appeal decision will review your request. The IRO will use legal experts where appropriate to make coverage determinations under your Plan.
6. The IRO will notify you in writing of the acceptance of your request for external review or expedited external review and next steps.
7. The IRO must review the request and is not bound by any decision or conclusion reached during CICI's claims and Appeals process.
8. The IRO will provide both you and CICI with a written decision.
9. The decision of the IRO is binding on CICI and your Employer.

External Review And Rescission Of Coverage

If you are not satisfied with the decision to rescind your coverage, then you or your authorized representative may request an external review. You must file your request for an external review to CICI within four months after receiving the decision to rescind your coverage from your Employer.

Administrative (Non-Medical Necessity) Appeal

If you disagree with an **Administrative (Non-Medical Necessity)** decision, such as a decision that interprets the application of Plan rules and that does not relate to Medical Necessity, you may Appeal that decision.

1. When the Appeal is submitted, it will be forwarded for review.
2. A staff member who was not involved in CICI's original decision will review the Appeal.
3. You or your authorized representative will be sent a written decision.

Exhaustion Of Internal Appeals Process

Generally, you are required to complete all appeal processes of the Plan before being able to obtain external review or bring an action in litigation. However, if the Plan or its designee, does not strictly adhere to all claim determination and appeal requirements under applicable federal law, you are considered to have exhausted the Plan's appeal requirements ("Deemed Exhaustion") and may proceed with external review or may pursue any available remedies under §502(a) of ERISA or under state law, as applicable.

There is an exception to the Deemed Exhaustion rule.

Your claim or internal appeal may not go straight to External Review if:

- A rule violation was minor and is not likely to influence a decision or harm you; and
- It was for a good cause or was beyond CICI's or the Plan's or its designee's control; and
- It was part of an ongoing good faith exchange between you and CICI or the Plan.
- This exception is not available if the rule violation is part of a pattern or practice of violations by CICI or the Plan.

You may request a written explanation of the violation from the Plan or CICI, and the Plan or CICI must provide such explanation within 10 days, including a specific description of its bases, if any, for asserting that the violation should not cause the internal claims and appeals process to be deemed exhausted. If an external reviewer or a court rejects your request for immediate review on the basis that the plan met the standards for the exception, you have the right to resubmit and pursue the internal appeal of the claim. In such a case, within a reasonable time after the external reviewer or court rejects the claim for immediate review (not to exceed 10 days), you will receive notice of the opportunity to resubmit and pursue the internal appeal of the claim. Time periods for re-filing the claim shall begin to run upon your receipt of such notice.

TERMINATION AND AMENDMENT

TERMINATION OF EMPLOYEE'S COVERAGE

This Plan will terminate for an Employee and the Employee's coverage under this Plan will terminate on the earliest day that any of the following events occurs:

1. On the date this Plan is discontinued.
2. You voluntarily stop your coverage.
3. You become covered under another plan offered by your Employer.
4. Your Employer notifies CICI that your employment is ended.
5. In the event the Employee has repeatedly failed to make the required cost-sharing payments to providers. (If CICI decides to terminate your coverage under this provision, termination will take effect 30 days following CICI's written notice stating its intent to terminate.)
6. In the event you fail to remit your contribution, as may be required by your Employer. Contributions are subject to change.
7. On the date your Employer is liquidated, ceases to operate, no longer employs any active employees, or no longer covers any active employees under the Plan.

8. The date you and your covered dependents are absent from the Service Area for more than 180 days, even if you still live or work in the Service Area.

   It is your Employer's responsibility to let CICI know when your employment ends. The limits above may be extended only if CICI and your Employer agree, in writing, to extend them.

TERMINATION OF A DEPENDENT'S COVERAGE

Coverage for your dependents will end if:

- You are no longer eligible for dependents' coverage,
- You do not make your contribution for the cost of dependents' coverage,
- Your own coverage ends for any of the reasons listed under Termination of Employee's Coverage,
- Your dependent is no longer eligible for coverage. Coverage ends at the end of the calendar month when your dependent does not meet the Plan's definition of a dependent, or
- As permitted under applicable federal and state law, your dependent becomes eligible for like benefits under this or any other group plan offered by your employer.

In addition, a "domestic partner" will no longer be considered to be a defined dependent on the earlier to occur of:

- The date this plan no longer allows coverage for domestic partners.
- The date of termination of the domestic partnership.

Coverage for dependents may continue for a period after your death. Coverage for handicapped dependents may continue after they reach any limiting age. See the "COBRA Continuation of Coverage" section for more information.

Suspension Or Termination of Services due to Abuse

CICI may refuse to provide administrative services to a Member upon a Member's commission of acts of physical or verbal abuse (which are unrelated to his or her physical or mental condition), which pose a threat to or create an intimidating, hostile or offensive working environment for:

- Providers,
- Other Members, or
- CICI employees, its affiliates or its subcontractors.

AMENDMENT

The provisions of this Plan may be modified or amended. Your Employer is responsible for providing notice of such changes as required by ERISA.

COBRA CONTINUATION OF COVERAGE

COBRA/Continuation administrative services are provided directly by your Employer or through a direct contract between your Employer and a third party administrator. CICI is not the COBRA administer and has no COBRA or Continuation responsibilities under this Plan. Please contact your Employer with respect to any questions regarding COBRA/Continuation.

If your Employer is subject to COBRA requirements, the health plan continuation is governed by the Federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requirements. With COBRA you and your dependents can continue health coverage, subject to certain conditions and your payment of contributions. Continuation rights are available following a "qualifying event" that would cause you or family members to otherwise lose coverage. Qualifying events are listed in this section.

CONTINUING COVERAGE THROUGH COBRA

When you or your covered dependents become eligible, your employer will provide you with detailed information on continuing your health coverage through COBRA.

You or your dependents will need to:

- Complete and submit an application for continued health coverage, which is an election notice of your intent to continue coverage.
- Submit your application within 60 days of the qualifying event, or within 60 days of your employer's notice of this COBRA continuation right, if later.
- Agree to pay the required contributions.

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the Pre-Authorization And Pre-Certification (Prior Approval) Addendum to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

WHO QUALIFIES FOR COBRA

You have 60 days from the qualifying event to elect COBRA. If you do not submit an application within 60 days, you will forfeit your COBRA continuation rights.

Below you will find the qualifying events and a summary of the maximum coverage periods according to COBRA requirements.

Qualifying Event Causing Loss of Health Coverage	Covered Persons Eligible to Elect Continuation	Maximum Contribution Periods
Your active employment ends for reasons other than gross misconduct	You and your dependents	18 months
Your working hours are reduced	You and your dependents	18 months
You divorce or legally separate and are no longer responsible for dependent coverage	Your dependents	36 months
You become entitled to benefits under Medicare	Your dependents	36 months
Your covered dependent children no longer qualify as dependents under the Plan	Your dependent children	36 months
You die	Your dependents	36 months
You are a retiree eligible for health coverage and your former employer files for bankruptcy	You and your dependents	18 months

DISABILITY MAY INCREASE MAXIMUM CONTINUATION TO 29 MONTHS

If You Or Your Covered Dependents Are Disabled

If you or your covered dependent qualify for disability status under Title II or XVI of the Social Security Act during the 18-month continuation period, you or your covered dependent:

- Have the right to extend coverage beyond the initial 18-month maximum continuation period.
- Qualify for an additional 11-month period, subject to the overall COBRA conditions.
- Must notify your employer within 60 days of the disability determination status and before the 18-month continuation period ends.
- Must notify the employer within 30 days after the date of any final determination that you or a covered dependent is no longer disabled.
- Are responsible to pay the contributions after the 18th month, through the 29th month.

If There Are Multiple Qualifying Events

A covered dependent could qualify for an extension of the 18 or 29-month continuation period by meeting the requirements of another qualifying event, such as divorce or death. The total continuation period, however, can never exceed 36 months.

DETERMINING YOUR CONTRIBUTIONS FOR CONTINUATION COVERAGE

Your contributions are regulated by law, based on the following:

- For the 18 or 36-month periods, contributions may never exceed 102 percent of the Plan costs.
- During the 18 through 29-month period, contributions for coverage during an extended disability period may never exceed 150 percent of the Plan costs.

WHEN YOU ACQUIRE A DEPENDENT DURING A CONTINUATION PERIOD

If through birth, adoption or marriage, you acquire a new dependent during the continuation period, your dependent can be added to the Plan for the remainder of the continuation period if:

- He or she meets the definition of an eligible dependent,
- Your Employer is notified about your dependent within 31 days of eligibility, and
- Additional contributions for continuation are paid on a timely basis.

Note For more information about dependent eligibility, see the "Eligibility And Enrollment" section.

OTHER CONTINUATION

If your Employer is not subject to COBRA requirements, you may be eligible for Other Continuation if provided by your Employer. Please see the *Additional Information* document for more information.

WHEN YOUR COBRA CONTINUATION OR OTHER CONTINUATION COVERAGE ENDS

Your COBRA coverage or Other Continuation will end when the first of the following events occurs:

- You or your covered dependents reach the maximum COBRA continuation period – the end of the 18, 29 or 36 months. (Coverage for a newly acquired dependent who has been added for the balance of a continuation period would end at the same time your continuation period ends, if he or she is not disabled nor eligible for an extended maximum). For Other Continuation, if applicable and offered by your Employer, you or your covered dependents reach the maximum Other Continuation period – the end of 18 months.
- You or your covered dependents do not pay required contributions.
- You or your covered dependents become covered under another group plan that does not restrict coverage for preexisting conditions. If your new plan limits preexisting condition coverage, the continuation coverage under this Plan may remain in effect until the preexisting clause ceases to apply or the maximum continuation period is reached under this Plan.
- The date your employer no longer offers a group health plan.
- The date you or a covered dependent becomes enrolled in benefits under Medicare. This does not apply if it is contrary to the Medicare Secondary Payer Rules or other federal law.
- You or your dependent dies.

YOUR RIGHT TO CONTINUE BENEFITS WHEN CALLED UP TO ACTIVE MILITARY SERVICE

If coverage under this Plan Description terminates due to your absence from work because you were called up to active military service, you and your covered dependents may elect to continue coverage under terms similar to COBRA for **up to 24 months** after your absence from work begins or for your period of active duty service, whichever is shorter. The contributions you must pay to continue coverage will be determined by your Employer consistent with the law. The COBRA rules for payment of contributions and termination of coverage procedures will apply to this continuation coverage.

In order for you to be eligible for this continued coverage, you, or your commanding officer, must give your Employer advance written or oral notice of your call up to active military service, unless military necessity prevents that notice or communication of that notice is not possible.

Any illnesses or injuries determined by the Secretary of Veterans Affairs to have been incurred in or aggravated during the call up to active military service will not be covered under this Plan.

GENERAL PROVISIONS

1. By being covered under this Plan, you and your covered dependents accept of all the terms, conditions and provisions of this Plan.
2. No legal action can be brought to recover payment under any benefit after three years from the deadline for filing claims.
3. CICI will have no liability for benefits under this Plan.
4. CICI may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of this Plan.
5. If any portion of this Plan is or becomes, for any reason, invalid or unenforceable, that portion will be ineffective only to the extent of the invalidity or unenforceability and the remaining portion or portions will nevertheless be valid, enforceable and of full force and effect.

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the Pre-Authorization And Pre-Certification (Prior Approval) Addendum to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

6. This Plan will be governed by and construed consistent with the applicable laws of the State of Connecticut, but only to the extent those laws are not preempted by the Employee Retirement Income Security Act ("ERISA").
7. Participating Providers are not CICI's employees or agents. They are independent contractors with the responsibility for determining and providing health care for their patients.
8. A Participating Provider may refuse to provide services or treatment to you or your covered dependents if you do not pay the required Cost-Share amounts required under this Plan.
9. CICI is not responsible for your decision to receive treatment, service or supplies provided by Participating Providers, nor is CICI responsible or liable for the treatment, services, or supplies provided by Participating Providers.
10. This Plan does not limit coverage for conditions just because you had the condition before you became covered under the Plan.
11. You agree to cooperate with CICI and to follow CICI's policies, procedures, and instructions in all administrative matters required for the orderly administration of this Plan Description.
12. If you receive a Surprise Bill, CICI may not impose a Cost-Share or other out-of-pocket expense that is greater than the Cost-Share or other out-of-pocket expense that would be imposed if those services were rendered by a Preferred Participating Provider or Participating Provider.

DEFINITIONS

The following defined terms have special meaning and are found throughout this Plan Description. They are referenced using capital letters (Upper Case).

ADMINISTRATIVE SERVICES ONLY AGREEMENT

The administrative services agreement between CICI and the Employer establishing administrative fees, remittance of paid claims, benefits to be administered, the effective date of the Plan and detailing the duties and responsibilities of CICI and the Employer. Your Employer may have agreements with other service providers to assist in the administration of the Plan.

ADVERSE BENEFIT DETERMINATION

The denial, reduction, termination or a failure to provide or make payment, in whole or in part, for a benefit under this Plan requested by a Member or a Member's treating health care professional, based on a determination by CICI or CICI's Delegated Program:

- That, based upon the information provided,
  - ♦ Upon application of any utilization review technique, such benefit does not meet CICI's requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness, or
  - ♦ Is determined to be Experimental Or Investigational.
- Of a Member's eligibility to participate in this Plan; or

Any prospective review, concurrent review or retrospective review determination that denies, reduces or terminates or fails to provide or make payment, in whole or in part, for a benefit under this Plan requested by a Member or a Member's treating health care professional.

An Adverse Determination includes a rescission of coverage determination for Appeal purposes.

AMBULATORY SURGERY CENTER

An entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients not requiring Hospitalization and whose expected stay in the center does not exceed 24 hours. It is further defined as a facility that is not owned by a Hospital and which bills for its services under its own unique tax identification number.

ANNUAL ENROLLMENT PERIOD

A period of time jointly agreed upon by CICI and the Employer during which Employees and their Eligible Dependents may enroll in this Plan. You and your Eligible Dependents may also apply for enrollment in this Plan during a "Special Enrollment Period" pursuant to applicable Federal law.

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the Pre-Authorization And Pre-Certification (Prior Approval) Addendum to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

APPEAL
A written appeal or, if the appeal involves an urgent care request, an oral appeal, submitted by or on behalf of a Member regarding an Adverse Determination.

ARTIFICIAL LIMB
An Artificial Limb is a device to replace, in whole or part, an arm or a leg, including a device that contains a microprocessor. if such microprocessor-equipped device is determined by the Member's health care provider to be Medically Necessary.

AUTISM SPECTRUM DISORDERS (ASD)
The autism spectrum disorder as set forth in the most recent edition of the "Diagnostic and Statistical Manual of Mental Disorders."

BEHAVIORAL HEALTH PROGRAM
A Delegated Program under which CICI may provide for management, administration and a network of providers for mental health, and alcohol and substance abuse services under this Plan. In some instances the Behavioral Health Program may be managed and administered by a Delegated Program under contract with CICI, when this Plan refers to determinations, Pre-Authorizations, Pre-Certifications, Referrals, and other decisions made under the terms of the Behavioral Health Program, such determinations, Pre-Authorizations, Pre-Certifications, referrals and other decisions are made by the Delegated Program on behalf of CICI and CICI has the ultimate authority to make these discretionary decisions.

BEHAVIORAL THERAPY
Any interactive Behavioral Therapy derived from evidence-based research and consistent with the services and interventions designated by the Commissioner of Developmental Services pursuant to subsection (1) of section 17a-215c of the Connecticut General Statutes, as amended, including but not limited to "Applied Behavioral Analysis", cognitive behavioral therapy, or other therapies supported by empirical evidence of the effective treatment of individuals diagnosed with ASD.

"Applied Behavioral Analysis" means the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, including the use of direct observation, measurement and functional analysis of the relationship between environment and behavior, to produce socially significant improvement in human behavior. Supervision requires at least one hour of face-to-face supervision of the ASD services provider for each ten hours of Behavioral Therapy.

BENEFIT SUMMARY
The document that summarizes the benefits provided under this Plan and that lists the Copayments, Deductibles and Coinsurance levels that you are required to pay for Health Services as well as benefit or Lifetime Maximums and Out-Of-Pocket Maximums.

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

CASE MANAGEMENT
The process for identifying Members with specific health care needs in order to help in the development and implementation of a plan that efficiently uses health care resources to achieve a favorable Member outcome.

CASE MANAGER
An individual, usually a registered nurse, who is responsible for developing and implementing a plan of care that takes into account the benefit structure, accepted industry and internal standards and cost effectiveness in order to achieve favorable member outcomes.

CLINICALLY EQUIVALENT ALTERNATIVE DRUG OR SUPPLY
A drug or supply in the same category as an excluded drug or supply and determined by CICI to be an effective alternative.

COBRA
The Federal Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, and regulations issued thereunder.

COINSURANCE
The percentage of the cost of benefits under this Plan that you or the Plan are legally responsible to pay.

Except to be consistent with applicable law, the Coinsurance amount will be calculated based on the lesser of:

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

COINSURANCE MAXIMUM
Generally, the Member's maximum payment liability per year for Coinsurance for Health Services covered at the In-Network Level Of Benefits or separately at the Out-Of-Network Level Of Benefits, as listed in the Benefit Summary. Please refer to the "Managed Care Rules And Guidelines" section for more information about how the Coinsurance Maximum applies to your Plan.

CONNECTICARE INSURANCE COMPANY, INC. WE, US OR OUR (CICI)
ConnectiCare Insurance Company, Inc. the company that provides the administrative and managed care services for this Plan.

COPAYMENT MAXIMUM
Generally, the Member's maximum payment liability per year for Copayments for Health Services covered at the In-Network Level Of Benefits as listed in the Benefit Summary. Please refer to the "Managed Care Rules And Guidelines" section for more information about how the Copayment Maximum applies to your Plan.

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the Pre-Authorization And Pre-Certification (Prior Approval) Addendum to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

COPAYMENTS
One flat fee you pay per day per provider (or provider group) for certain Plan Benefits under this Plan.

COSMETIC TREATMENTS
Any medical or surgical treatment for which the primary purpose is to change appearance as CICI determines in its sole discretion.

COST-SHARE
The amount which the Member is required to pay for covered Health Services. Cost-Shares can be Deductibles, Copayments and/or Coinsurance amounts.

CUSTODIAL CARE
Those services and supplies furnished to a Member who has a medical condition that is chronic or non-acute in nature which, at CICI's discretion, either:

1. Are furnished primarily to assist the patient in maintaining activities of daily living, whether or not the Member is disabled, including, but not limited to, bathing, dressing, walking, eating, toileting and maintaining personal hygiene, or
2. Can be provided safely by persons who are not medically skilled, with a reasonable amount of instruction, including, but not limited to, supervision in taking medication, homemaking, supervision of the patient who is unsafe to be left alone and maintenance of bladder catheters, tracheotomies, colostomies/ileostomies and intravenous infusions (such as TPN) and oral or nasal suctioning.

These services and supplies are considered Custodial and are not reimbursed or paid, no matter who performs them, even if you do not have a family member, friend or other person to perform them. If skilled home health care services have been Pre-Authorized, the covered Health Services may, under some circumstances, include custodial services, if provided by a home health aide in direct support of the approved skilled home health care.

DEDUCTIBLE
The total amount that you must pay during the year toward certain benefits under this Plan before the Plan will begin paying for those benefits. Please refer to your Benefit Summary to see if benefits for your Plan are covered per calendar year or per Plan Year and which benefits are subject to a Deductible.

Benefit Deductibles: This Plan may have specific Benefit Deductibles that apply separately to certain services. The specific Benefit Deductibles must be met by the Member each year before the Plan will begin paying for those benefits. Anything paid by Members for those benefits does not count towards meeting the Plan Deductible (if this Plan has one). Please refer to your Benefit Summary to see the Benefit Deductibles that may apply to this Plan.

Plan Deductible: Some Plan options require you to pay a Plan Deductible. A Plan Deductible is a specific amount each Member must pay in any year towards certain covered Health Services before the Plan will begin paying its portion of those benefits. After the Plan Deductible is met, benefits will be paid subject to the Member's payment of either a Copayment amount or Coinsurance amount. Please refer to your Benefit Summary to see if this applies to you.

DELEGATED PROGRAM
An outside company that CICI may use to manage and administer certain categories of benefits or services provided under this Plan. For example, Pre-Authorization or Pre-Certification as described in the "Pre-Authorization And Pre-Certification (Prior Approval) Addendum" may be required to be obtained from an outside company rather than from CICI. In addition, claims for Health Services might be processed by some other company other than CICI, or when you disagree with a decision regarding covered Health Services, your Appeal may also be reviewed by an outside company.

In these cases, when this Plan Description refers to determinations, Pre-Authorizations and other decisions made under the terms of that Delegated Program, such determinations, Pre-Authorizations and other decisions are made by the outside company on CICI's behalf.

DIABETES DEVICES
A device, including, but not limited to, a blood glucose test strip, glucometer, continuous glucometer, lancet, lancing device or insulin syringe, that is a legend device or nonlegend device, and used to cure, diagnose, mitigate, prevent or treat diabetes or low blood sugar.

DIABETIC KETOACIDOSIS DEVICE
A device that is a legend or nonlegend device, and used to screen for or prevent diabetic ketoacidosis.

DRUG THERAPY
A product administered by a health care professional for use in the diagnosis, cure, treatment, or prevention of disease.

ELIGIBLE DEPENDENTS
Persons, other than you (the covered Employee), who are eligible to be enrolled as Members under this Plan and as described in the "Eligibility And Enrollment" section.

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the Pre-Authorization And Pre-Certification (Prior Approval) Addendum to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

EMERGENCY
The sudden and unexpected onset of an illness or injury with severe symptoms whereby a Prudent Layperson, acting reasonably, would believe that emergency medical treatment is needed.

An Emergency related to mental health care exists when a Member is at risk of suffering serious physical impairment or death; or of becoming a threat to himself/herself or others; or of significantly decreasing his/her functional capability if treatment is withheld for greater than 24 hours.

The presenting symptoms of the patient, as coded by the provider on the appropriate claim form or the final diagnosis, whichever reasonably indicates an emergency medical condition, shall be the basis for determining whether such services are for an Emergency. Determination of whether a condition is an Emergency for purposes of this Plan rests exclusively within CICI's discretionary authority.

EMERGENCY SERVICES
Health Services required for an Emergency.

EMPLOYEE
You, if you are or were an employee of the Employer and eligible to be enrolled under this Plan as described in the "Eligibility And Enrollment" section. The term Employee also includes owners of corporations and partners of partnerships, provided the owner or partner devotes the same time to the business of the Employer that an Employee must work in order to be covered under this Plan.

EMPLOYER
A business entity that is sponsoring the Plan to provide the covered Health Services described in this Plan Description to their eligible Employees and the Eligible Dependents of those Employees.

ENROLLMENT FORM
The application form provided or approved by CICI, used to enroll or disenroll you and/or your covered dependents.

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

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

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

GENERIC DRUG OR SUPPLY (GENERICS)
A drug or supply manufactured and approved by federal FDA standards that has the same active ingredients as the original Brand Name Drug Or Supply and is classified as a generic by a nationally recognized source and recognized by CICI as a Generic Drug Or Supply.

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

HEALTH PLAN DESCRIPTION (PLAN DESCRIPTION)
This document (including Benefit Summaries and other attachments, amendments and Enrollment Forms) which describes this Plan and the conditions and limitations as administered by CICI on behalf of the Employer.

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

HOME HEALTH AGENCY

A duly licensed agency where:

1. Nursing care is provided by a registered nurse or licensed practical nurse.
2. Home health aide services consisting of patient care of a medical or therapeutic nature are provided by someone other than a registered or licensed practical nurse.
3. Physical, occupational or speech therapy is provided.
4. Certain medical supplies, drugs and medicines prescribed by a physician, a physician assistant or an advanced practice registered nurse and laboratory services to the extent such services would be covered if Medically Necessary, as CICI determines, are provided.
5. Medical social services are provided by a qualified Masters-prepared social worker to or for the benefit of a terminally ill Member (i.e., having a life expectancy of 6-months or less).

HOSPICE

An agency that provides counseling and incidental medical services for a terminally ill (i.e., having a life expectancy of 6 months or less) individual. To be a Hospice, the agency must:

1. Be licensed consistent with all applicable laws.
2. Provide 24-hour-a-day, 7-days-a-week service.
3. Be under the direction of a duly qualified physician.
4. Have a nurse coordinator who is a registered graduate nurse with clinical experience, including experience in caring for terminally ill patients.
5. Have as its main purpose the provision of hospice services.
6. Have a full-time administrator.
7. Maintain written records of services given to the patient.
8. Maintain malpractice insurance coverage.

For purposes of this Plan, a Home Health Agency that provides hospice care in the home or a hospice, which is part of a Hospital, will be considered a Hospice.

HOSPITAL

An institution duly licensed as a hospital by the governmental authority having jurisdiction and, as prescribed by State law, a mobile field hospital when isolation care and Emergency Services are provided.

HOSPITALIZATION

Health Services rendered by a Hospital as either:

Inpatient Hospitalization: Those services rendered to a patient while that patient is assigned to a specific bed and location, and registered as an "inpatient" at a Hospital; or

Partial Hospitalization/Day Treatment Program: Those covered behavioral health services which are rendered in a facility or Hospital-based program that provides services for at least 20 hours per week.

HOSPITAL OUTPATIENT SURGICAL FACILITY (HOSF)

A facility owned by a Hospital or hospital system offering a surgical procedure and related care that in the opinion of the attending physician can be safely performed without requiring overnight inpatient Hospital care. A HOSF is included within the Hospital license and the Medicare or Medicaid certification of the Hospital itself. Services rendered by the HOSF are billed utilizing the Hospital's own tax identification number or a tax identification number unique to the Hospital or hospital system.

INDIVIDUAL PRACTICE ASSOCIATION OR IPA

An individual practice association or other organization of providers, including but not limited to a physician-hospital organization (PHO) and a group practice, that has entered into a services arrangement with CICI or an affiliate or subcontractor of CICI to provide Health Services to Members under this Plan.

INFERTILITY

The condition of an individual who is unable to conceive or produce conception or sustain a successful pregnancy during a period of one year or such treatment is Medically Necessary.

IN-NETWORK LEVEL OF BENEFITS

Generally, the maximum level of benefits under this Plan available for Health Services provided to a Member directly by his or her Primary Care Provider (PCP). The In-Network Level Of Benefits under this Plan is described in the Benefit Summary.

INSUFFICIENT EVIDENCE OF THERAPEUTIC VALUE

Insufficient Evidence Of Therapeutic Value occurs when CICI determines in their sole discretion that either:

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

There may be Insufficient Evidence Of Therapeutic Value for a Treatment even when it has been approved by a regulatory body or recommended by a health care practitioner, and the Treatment will not be covered.

INTENSIVE OUTPATIENT (IOP)

The level of behavioral health care which is less intensive than Partial Hospitalization, but more intensive than outpatient services. Typically, IOP services are customized to meet the individual patient's needs but have the capacity for a maximum of three to five encounters per week of less than four hours each in duration. The range of services offered is designed to address a mental health or substance abuse disorder in a coordinated, interdisciplinary treatment modality.

MAXIMUM ALLOWABLE AMOUNT

The Maximum Allowable Amount is the maximum amount of reimbursement we will allow for services and supplies:

- That are covered Health Services.
- That are Medically Necessary.
- That are provided in accordance with all applicable Pre-Authorization and/or Pre-Certification guidelines, utilization review or other requirements set forth in this member document.

The Maximum Allowable Amount may vary depending upon whether the provider is a Preferred Participating Provider or Participating Provider or a Non-Participating Provider.

The actual payment will be reduced by applicable Deductibles(s), Coinsurance, Copayment(s), Benefit Reduction amounts and other applicable adjustments described in this document. In no case will our reimbursement exceed the maximum benefit described in this document except as required by law.

For a Preferred Participating Provider or Participating Provider covered Health Service, the Maximum Allowable Amount is the rate the provider has agreed with us to accept as reimbursement for a covered Health Service.

Except as required otherwise by law, for a Non-Participating Provider covered Health Service, the Maximum Allowable Amount may be determined, in our sole authority, by one of the following:

1. An amount based on reimbursement or cost information from the Centers for Medicare and Medicaid Services ("CMS"). When basing the Maximum Allowable Amount upon the level or method of reimbursement used by CMS, we will update such information, which is unadjusted for geographic locality, no less than annually.
2. An amount based on or derived from the total charges billed by the Non-Participating Provider.
3. We may, at our option, refer a claim for the Out-Of-Network Level of Benefits covered Health Service to a fee negotiation service to negotiate the Maximum Allowable Amount with the Non-Participating Provider. In that situation, if the Non-Participating Provider agrees to a negotiated Maximum Allowable Amount, you will not be responsible for the difference between the Maximum Allowable Amount and the billed charges. You will be responsible for any applicable Deductible(s), Coinsurance and/or Copayment(s) at the Out-Of-Network Level of Benefits, as well as any Benefit Reduction amounts.
4. We may contract with vendors that have fee arrangements with Non-Participating Providers (Third Party Networks). If you utilize a Non-Participating Provider in a Third-Party Network, the Maximum Allowable Amount will be determined based on our contract with the Third-Party Network. Where the terms of our contract with the Third-Party Network require, we will use the contract fee between the Non-Participating Provider and the Third-Party Network as the Maximum Allowable Amount. For other arrangements, we will determine the Maximum Allowable Amount as the lesser of the contract fee, or billed charges or the amount determined by one of the methods described below.

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the Pre-Authorization And Pre-Certification (Prior Approval) Addendum to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

Providers who are not contracted for a product, but are contracted for other products with us are also considered Non-Participating Providers. The Maximum Allowable Amount for services from these Non-Participating Providers will be one of the methods shown above, unless the contract between us and that provider specifies a different amount.

When a Member receives covered Health Services from a provider, we will, to the extent applicable, apply claim processing rules to the claim submitted for those covered Health Services. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the procedure and diagnosis codes included in the claim. Applying these rules may affect our determination of the Maximum Allowable Amount. Our application of these rules does not mean that the covered Health Services a Member received were not Medically Necessary. It means we have determined that the claim was submitted inconsistent with procedure coding rules and/or reimbursement policies.

For example, your provider may have submitted the claim using several procedure codes when there is a single procedure code that includes all the procedures that were performed. When this occurs, the Maximum Allowable Amount will be based on the single procedure code, rather than a separate Maximum Allowable Amount for each billed code. Likewise, when multiple procedures are performed on the same day by the same provider, we may reduce the Maximum Allowable Amounts for those secondary and subsequent procedures because reimbursement at 100% of the Maximum Allowable Amount for those procedures would represent duplicative payment for components of the primary procedure that may be considered incidental or inclusive.

Only charges that you are legally required to pay for a Health Service will count towards the Maximum Allowable Amount. So, if the physician or provider is not charging you for part or all of the Health Service and you are therefore not legally obligated to pay for that waived amount, we will not count that waived amount towards the Maximum Allowable Amount.

MEDICALLY NECESSARY OR MEDICAL NECESSITY

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

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

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

MEDICARE

Title XVIII of the Social Security Act, including amendments.

MEMBER, YOU, AND YOUR ELIGIBLE DEPENDENTS

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

NEW TREATMENTS

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

NETWORK ACCESS AREA

Those geographic areas where contracted health care facilities, practitioners, and pharmacies provide benefits for covered Health Services under this Plan. To locate contracted health care facilities, practitioners, and pharmacies that are in the Network Access Area, visit CICI's web site at https://secured.connecticare.com/providerdirectory/, or call the appropriate telephone number listed in the "Important Telephone Numbers And Addresses" section.

NETWORK PROVIDER
A provider or facility that has a contract to provide health care services through a designated network vendor outside the Network Access Area. These providers or facilities are not listed in CICI's Provider Directory. To locate a Network Provider, you can refer to the back of your ID Card to identify the Network Provider vendor and for instructions on obtaining a list of Network Providers, or visit CICI's web site at www.connecticare.com, or call the appropriate telephone number listed in the "Important Telephone Numbers And Addresses" section.

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

NON-PARTICIPATING HOSPITAL
A Hospital that is not a Participating Hospital.

NON-PARTICIPATING PHARMACY
A pharmacy that does not have a contract with CICI to provide covered prescription drugs and supplies to you and your covered dependents.

A Non-Participating Pharmacy is a pharmacy that when used by a Member typically provides the lowest level of benefits, because out-of-pocket Cost-Shares are the highest.

NON-PARTICIPATING PHYSICIAN OR NON-PARTICIPATING PROVIDER
A duly licensed physician or health care practitioner or facility that is not a Participating Physician or a Participating Provider.

NON-PREFERRED PARTICIPATING PHARMACY
A pharmacy that has entered into an agreement with CICI, an IPA or an affiliate or subcontractor of CICI's to provide covered prescription drugs, medications and supplies to you and your covered dependents.

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

A Non-Preferred Participating Pharmacy does not include a Hospital pharmacy even if the Hospital is a Participating Hospital.

OUT-OF-NETWORK LEVEL OF BENEFITS
Generally, a lesser level of benefits than the In-Network Level Of Benefits under this Plan available for Health Services provided to a Member when the Health Services are not eligible for benefit coverage at the In-Network Level Of Benefits. Except in cases of Emergencies or as otherwise provided in this Plan Description, Health Services obtained from or arranged by Non-Participating Providers (including Network Providers when you are in the Network Access Area) are payable at the Out-Of-Network Level Of Benefits. The Out-Of-Network Level Of Benefits for benefits under this Plan is the Coinsurance percentage described in the Benefit Summary multiplied by the Maximum Allowable Amount charges after any Copayments or Deductible is applied. If the Out-Of-Pocket Maximum is met for a Member in a year, then the Out-Of-Network Level Of Benefits is modified as described in the definition of Out-Of-Pocket Maximum, below, for the remainder of that year.

OUT-OF-POCKET MAXIMUM
Generally, the maximum Cost-Share amount a Member pays per year for Health Services, as listed in the Member's Benefit Summary.

PARTICIPATING HOSPITAL
A Hospital that has entered into an agreement with CICI, an IPA or an affiliate or subcontractor of CICI's to provide certain Health Services to you and your covered dependents.

PARTICIPATING PHARMACY
A pharmacy that has entered into an agreement with CICI, an IPA or an affiliate or subcontractor of CICI's to provide covered prescription drugs, medications and supplies to you and your covered dependents.

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

A Participating Pharmacy does not include a Hospital pharmacy, even if the Hospital is a Participating Hospital.

PARTICIPATING PHYSICIAN
A health care professional duly licensed to practice as a physician who has entered into an agreement with CICI, an IPA, or an affiliate or a subcontractor of CICI's to provide certain Health Services to you and your covered dependents.

PARTICIPATING PROVIDER
A health care practitioner or facility including a Participating Physician, Participating Pharmacy, Participating Hospital or other similar facility that is duly licensed to provide health care services and that has entered into an agreement with CICI, an IPA or an affiliate or a subcontractor of CICI's to provide certain Health Services to you and your covered dependents.

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

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the Pre-Authorization And Pre-Certification (Prior Approval) Addendum to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

PLAN
This Plan as administered by CICI.

PLAN BENEFITS
Health Services as specified in the Health Plan Description (Plan Description).

PLAN YEAR
A period of 12 months beginning on the effective date of this Plan, and each 12-month period following the first one. A shorter or longer period of time may be agreed upon in writing by CICI and the Employer.

PRE-AUTHORIZATION OR PRE-AUTHORIZED
The authorization, based on Medical Necessity, needed by CICI or the applicable Delegated Program in advance of the Member's receipt of certain specified Health Services and prescription drugs and supplies.

Pre-Authorization also includes the written authorization, from CICI, or the applicable Delegated Program, needed in advance of the Member's receipt of Health Services from a Non-Participating Provider in order to have those services or supplies covered at the In-Network Level Of Benefits.

PRE-CERTIFICATION OR PRE-CERTIFIED
The registration and approval process, based on Medical Necessity, needed in advance of the Member's Partial Hospitalization or inpatient admission to a Hospital, Hospice, Residential Treatment Facility, Rehabilitation Facility or Skilled Nursing Facility that is obtained from CICI, or the applicable Delegated Program.

PREFERRED PARTICIPATING PHARMACY
A select pharmacy that has entered into an agreement with CICI, an IPA or an affiliate or subcontractor of CICI's to provide covered prescription drugs, medications and supplies to you and your covered dependents.

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

A Preferred Participating Pharmacy does not include a Hospital pharmacy, even if the Hospital is a Participating Hospital.

PRIMARY CARE PROVIDER OR PCP
A physician, advanced practice registered nurse (APRN) or a nurse practitioner who is a Participating Provider selected by or assigned to the Member, who is normally engaged in one of the following primary care specialties:

- Family medicine
- Internal medicine
- Pediatrics and

who is eligible to be listed as a PCP in the Provider Directory, as updated from time to time.

PROVIDER DIRECTORY
The listing of Participating Providers compiled and prepared for CICI administered benefit plans as updated from time to time.

PRUDENT LAYPERSON
A person who is without medical training and who draws on his or her practical experience when making a decision regarding whether Emergency medical treatment is needed. A Prudent Layperson will be considered to have acted "reasonably" if other similarly situated laypersons would have believed, on the basis of observation of the medical symptoms at hand, that Emergency medical treatment was necessary.

RADIOLOGY SERVICES PROGRAM
A Delegated Program under which CICI may provide for management, administration and a network of providers for outpatient diagnostic x-rays and therapeutic procedures under this Plan. In some instances, the Radiology Services Program may be managed and administered by a Delegated Program under contract with CICI. In that event, when this Plan Description refers to determinations, Pre-Authorizations and other decisions made under the terms of the Radiology Services Program, such determinations, Pre-Authorizations and other decisions are made by the Delegated Program on behalf of CICI and CICI has the ultimate authority to make these discretionary decisions.

REFERRAL
An approval communicated to CICI by the Member's Primary Care Provider (PCP) (or the covering physician designated by the Member's PCP), which the Member must obtain prior to his/her receipt of health care services from Specialist Physicians and other Participating Providers in order to be eligible for benefits at the highest level of benefits

REHABILITATION FACILITY
A Hospital or other facility that provides restorative physical and occupational therapy treatment and licensed and accredited as a rehabilitation facility by governmental or other authority having jurisdiction.

RESIDENTIAL TREATMENT FACILITY
A treatment center for children and adolescents that provides residential care and treatment for emotionally disturbed individuals and is licensed and accredited by the governmental authority having jurisdiction.

RETAIL MAINTENANCE NETWORK
Preferred participating pharmacies that have entered into an agreement with CICI, an IPA or an affiliate or subcontractor of CICI's to provide covered maintenance prescription drugs, medications and supplies to you and your covered dependents up to a 90 or 100 day supply.

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the Pre-Authorization And Pre-Certification (Prior Approval) Addendum to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

SERVICE AREA
The State of Connecticut, including all cities and towns in the State of Connecticut.

SKILLED NURSING FACILITY
An institution or distinct part of an institution that is duly licensed as a skilled nursing facility by the governmental authority having jurisdiction.

SPECIALIST PHYSICIAN
A Participating Physician, other than the Member's PCP.

SURPRISE BILL
A bill for health care services that you receive for services rendered by a Non-Participating Provider, where those services were rendered by a Non-Participating Provider at a Participating Provider facility, during a service or procedure performed by a Participating Provider during a service or procedure previously Pre-Certified or Pre-Authorized by us and you did not knowingly elect to obtain those services from the Non-Participating Provider.

A Surprise Bill also includes a bill for clinical laboratory services, other than Emergency Services, that you receive for laboratory services rendered by a Non-Participating Provider, where those services were rendered by a Non-Participating Provider upon a referral by a Participating Provider.

A Surprise Bill does not include a bill for health care services received by you when a Participating Provider was available to render the services and you knowingly elected to obtain the services from a Non-Participating Provider.

TELEMEDICINE (TELEHEALTH)
Pursuant to Public Act 21-9, telemedicine means the mode of delivering health care or other health services via information and communication technologies to facilitate the diagnosis, consultation and treatment, education, care management and self-management of a patient's physical, oral and mental health, and includes interaction between the patient at the originating site and the telemedicine provider at a distant site, synchronous interactions, asynchronous store and forward transfers or remote patient monitoring.

Telemedicine does not include:

- Interaction through facsimile,
- Texting,
- Electronic mail, or
- Audio-only telephone, unless the telemedicine provider is a Participating Provider or a provider enrolled in the Connecticut medical assistance program providing such health care or other health services to a Connecticut medical assistance program recipient.

URGENT CARE
Health Services for the treatment of a sudden and unexpected onset of illness or injury requiring care within 24 hours that can be treated in a physician's office or in an Urgent Care Center.

URGENT CARE CENTER OR WALK-IN-CENTER
A facility distinguished from an emergency department or primary care setting, which is duly licensed as an outpatient clinic to provide Urgent Care and that offers such services without the requirement of an appointment, provides services during times of the day, weekends, or holidays when primary care provider offices are not customarily open to patients, and offers, at a minimum, the following

- Ability to employ minimal resuscitative methods.
- Administration of fluids intravenously.
- Diagnostic imaging.

UTILIZATION MANAGEMENT
The process of evaluating and determining the coverage for and the appropriateness of medical care services, as well as providing any needed assistance to the clinician or the patient in cooperation with other parties, to ensure appropriate use of resources. Utilization Management includes Pre-Authorization, Pre-Certification, concurrent review, retrospective review, discharge planning and Case Management.

WILDERNESS CAMP
A camp that provides behavioral health intervention for children and adolescents with emotional, addiction, and or psychological problems. The intervention typically involves immersion in the wilderness or wilderness like setting, group living with peers, the administration of individual and group therapy sessions, and educational/therapeutic curricula, including back country travel, wilderness living skills and horseback riding.

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the Pre-Authorization And Pre-Certification (Prior Approval) Addendum to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

FOREIGN LANGUAGE SERVICES ADDENDUM

ATTENTION: If you speak a foreign language, language assistance services, free of charge, are available to you. Call 1-800-251-7722 and TTY number 1-800-833-8134.

Spanish

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-251-7722 and TTY number 1-800-833-8134.

Portuguese

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-251-7722 and TTY number 1-800-833-8134.

Polish

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-251-7722 and TTY number 1-800-833-8134.

Chinese

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-251-7722 and TTY number 1-800-833-8134。

Italian

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-251-7722 and TTY number 1-800-833-8134.

French

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-251-7722 and TTY number 1-800-833-8134.

French Creole

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-251-7722 and TTY number 1-800-833-8134.

Russian

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-xxx-xxx-xxxx (телетайп: 1-800-251-7722 and TTY number 1-800-833-8134.

Vietnamese

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-251-7722 and TTY number 1-800-833-8134.

Arabic

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-251-7722 (رقم هاتف الصم والبكم: 1-800-833-8134).

Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-251-7722 and TTY number 1-800-833-8134번으로 전화해 주십시오.

Albanian

KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-800-251-7722 and TTY number 1-800-833-8134.

Hindi

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

Tagalog

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-251-7722 and TTY number 1-800-833-8134.

Greek

ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-800-251-7722 and TTY number 1-800-833-8134.

Mon-Khmer, Cambodian

[illegible] 1-800-251-7722 and TTY number 1-800-833-8134 ។

Gujarati

□ચુના: જો તમે □જરાતી બોલતા હો, તો િન:□લ્કુ ભાષા સહાય સેવાઓ તમારા માટ□ ઉપલબ્ધ છ. ફોન કરો 1-800-251-7722 and TTY number 1-800-833-8134.

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the Pre-Authorization And Pre-Certification (Prior Approval) Addendum to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

EXPLANATION OF BENEFITS (EOBS) DISCLOSURE ADDENDUM

CICI will issue Explanations of Benefits (EOBs) to Members covered under this Plan.

The Subscriber or a Member, if he or she is legally capable of consenting to the provision of covered Health Services, may make a written request that CICI not issue EOBs or that CICI issue EOBs solely to the Subscriber or to the Member and specify the preferred method of receipt for the EOB.

The preferred method may be:

- Mailing EOBs to the Subscriber's or Member's mailing address or another mailing address specified by the Subscriber or Member, or
- Making EOBs available to the Subscriber or Member through electronic means, provided the access is in compliance with applicable state and federal regulations pertaining to data security.

The preferred method noted above will be valid until the Subscriber or Member submits a written request for a different method.

Nothing in this disclosure will be construed to limit the Subscriber's or Member's ability to request review of an adverse determination.

NON-DISCRIMINATION DISCLOSURE AND FOREIGN LANGUAGE ACCESSIBILITY ADDENDUM

ConnectiCare complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sexual orientation, gender or gender identity. ConnectiCare does not exclude people or treat them differently because of race, color, national origin, age, disability, or sexual orientation, gender or gender identity.

ConnectiCare:

- Provides free aids and services to people with disabilities to communicate effectively with CICI including qualified interpreters and information in alternate formats.
- Provides free language services to people whose primary language is not English, including translated documents and oral interpretation.

If you need these services, contact The Committee for Civil Rights.

If you believe that ConnectiCare has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: The Committee for Civil Rights, ConnectiCare, 175 Scott Swamp Road, Farmington, CT 06034, 1-800-251-7722, and TTY number 1-800-833-8134. You can file a grievance in person at 175 Scott Swamp Road, Farmington, CT, or by mail, or fax (860) 674-2232. If you need help filing a grievance, The Committee for Civil Rights is available to help you. You can also file a civil rights complaint with the U.S., Department of Health and Human Services, Office for Civil Rights, electronically through the Office of Civil Rights Complaint Portal, available at: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human services

200 Independence Avenue, SW

Room 509F, HHH Building

Washington, DC 20201

1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at: http://www.hhs.gov/ocr/office/file/index.html.

STATEMENT OF RIGHTS UNDER THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT ADDENDUM

CICI generally allows the designation of a Primary Care Provider (PCP). You have the right to designate any PCP who participates in CICI's network and who is available to accept you or your family members. For information on how to select a PCP, and for a list of the PCP Participating Providers, please call CICI at (860) 674-5757 or 1-800-251-7722.

For children, you may designate a pediatrician as the PCP.

You do not need Pre-Authorization from ConnectiCare or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a health care professional in CICI's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining Pre-Authorization or Pre-Certification for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of Participating Providers who specialize in obstetrics or gynecology, please call CICI at (860) 674-5757 or 1-800-251-7722.

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the Pre-Authorization And Pre-Certification (Prior Approval) Addendum to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

CHOICE OF PROVIDER ADDENDUM

If CICI generally requires or allows the designation of a Primary Care Provider (PCP), you have the right to designate any PCP who participates in our network and who is available to accept you or your family members. If the Plan designates a PCP automatically, then until you make this designation, CICI designates one for you. For information on how to select a PCP, and for a list of the participating PCP, contact your Employer or CICI's Member Services Department.

If this Plan allows for the designation of a PCP for a child, you may designate a pediatrician as the PCP.

If this Plan provides coverage for obstetric or gynecological care and requires the designation of a PCP, then you do not need Pre-Authorization from CICI or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a health care professional in CICI's 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 your Employer or CICI's Member Services Department.

NOTICE REGARDING WOMENS' HEALTH AND CANCER RIGHTS ACT ADDENDUM

Under this Plan, as required by the Women's Health and Cancer Rights Act of 1998, coverage will be provided to a person who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with the mastectomy for:

1. All stages of reconstruction of the breast on which a mastectomy has been performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
3. Prostheses; and
4. Treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the attending physician and the patient and will be provided in accordance with the plan design, limitations, Copayments, Deductibles, and Referral requirements, if any, as outlined in this Plan Description.

If you have any questions about coverage of mastectomies and reconstructive surgery, please call CICI's Member Services Department.

For more information, you can visit this U.S. Department of Health and Human Services website, http://www.cms.gov/home/regsguidance.asp, and this U.S. Department of Labor website, http://www.dol.gov/ebsa/consumer_info_health.html.

CONTINUATION OF COVERAGE DURING AN APPROVED LEAVE OF ABSENCE GRANTED TO COMPLY WITH FEDERAL LAW ADDENDUM

The COBRA Continuation Of Coverage" section applies only for the period of any approved family or medical leave (approved FMLA leave) required by Family and Medical Leave Act of 1993 (FMLA). If your Employer grants you an approved leave for a period in excess of the period required by FMLA, any continuation of coverage during that excess period will be determined by your Employer.

If your Employer grants you an approved FMLA leave in accordance with FMLA, you may, during the continuance of such approved FMLA leave, continue Health Expense Benefits for you and your eligible dependents.

At the time you request FMLA leave, you must agree to make any contributions required by your Employer to continue coverage.

If any coverage your Employer allows you to continue has reduction rules applicable by reason of age or retirement, the coverage will be subject to such rules while you are on FMLA leave.

Coverage will not be continued beyond the first to occur of:

- The date you are required to make any contribution and you fail to do so.
- The date your Employer determines your approved FMLA leave is terminated.
- The date the coverage involved discontinues as to your eligible class. However, coverage for health expenses may be available to you under another plan sponsored by your Employer.

Any coverage being continued for a dependent will not be continued beyond the date it would otherwise terminate.

If Health Expense Benefits terminate because your approved FMLA leave is deemed terminated by your Employer, you may, on the date of such termination, be eligible for Continuation Under Federal Law on the same terms as though your employment terminated, other than for gross misconduct, on such date. If this Plan provides any other continuation of coverage (for example, upon termination of employment, death, divorce or ceasing to be a defined dependent), you (or your eligible dependents) may be eligible for such continuation on the date your Employer determines your approved FMLA leave is terminated or the date of the event for which the continuation is available.

If you acquire a new dependent while your coverage is continued during an approved FMLA leave, the dependent will be eligible for the continued coverage on the same terms as would be applicable if you were actively at work, not on an approved FMLA leave.

If you return to work for your Employer following the date your Employer determines the approved FMLA leave is terminated, your coverage under this Plan will be in force as though you had continued in active employment rather than going on an approved FMLA leave provided you make request for such coverage within 31 days of the date your Employer determines the approved FMLA leave to be terminated. If you do not make such request within 31 days, coverage will again be effective under this Plan only if and when this Plan gives its written consent.

If any coverage being continued terminates because your Employer determines the approved FMLA leave is terminated, any Conversion Privilege will be available on the same terms as though your employment had terminated on the date your Employer determines the approved FMLA leave is terminated.

PRE-AUTHORIZATION AND PRE-CERTIFICATION (PRIOR APPROVAL) ADDENDUM

The following services, drugs and supplies require Pre-Authorization or Pre-Certification, if covered under your Plan.

CICI's Pre-Authorization or Pre-Certification lists may change at any time. Read the member electronic newsletter to learn about the changes. You can also s CICI's Member Services Department or visit CICI web site at www.connecticare.com.

You Need Pre-Authorization Or Pre-Certification For The Following:

Admissions:

- Hospital admissions that are elective or not the result of an Emergency, including: Acute Hospitals admissions* Partial Hospitalizations Programs (PHP)* Rehabilitation Facility admissions* Residential Treatment Facilities*
- Skilled Nursing Facility admissions
- Sub-acute care admissions

Ambulance/Medical Transportation:

- Land or air ambulance/medical transport that is not due to an Emergency

Durable Medical Equipment (DME) Prosthetics, Orthotics

- DME including, but not limited to the following items (if a covered benefit): Customized wheelchairs, functional electric stimulators, high frequency chest wall oscillation devices, Bilevel (BiPAP), demand positive airway pressure (DPAP), variable positive airway pressure (VPAP), adaptive servoventilation (VPAP Adapt SV), auto-titrating positive airway pressure (AutoPap) and Continuous Positive (CPAP)
- Orthotics
- Prosthetics including, but not limited to major limbs

Elective Services & Surgical Procedures such as:

- Applied Behavioral Analysis (ABA) for the treatment of Autism Spectrum Disorder (ASD) (if a covered benefit)*
- Arthroplasty
- Arthroscopy
- Cardiac monitoring with Mobile Cardiac Outpatient Telemetry or continuous computerized daily monitoring with auto-detection (no Pre-Authorization is required for standard Holter monitors or loop event recording devices)
- Cartilage implants (autologous chondrocyte implantation)
- Clinical trials
- Cochlear and other auditory implants
- Congenital heart disease treatment
- Cosmetic surgery/services used for Medically Necessary treatment (if a covered benefit)

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the Pre-Authorization And Pre-Certification (Prior Approval) Addendum to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

- Coverage at an in-network benefit level for out-of-network provider or facility unless services are due to an Emergency.
- Deep brain stimulation
- eClipse vaginal insert for fecal incontinence treatment
- Foot surgery
- Functional endoscopic sinus surgery
- Gastric bypass surgery, including laparoscopic (if a covered benefit)
- Gastric electrical stimulation
- Gender reassignment surgery
- Genetic testing*** to include BRCA
- Interventional pain management services for chronic back pain (including, **-** facet and epidural injection, minimally invasive spine procedures and pain pumps), Sacroiliac joint injection **
- Mammoplasty (breast augmentation or reduction) (non-mastectomy for cancer)
- Oral appliances for the treatment of obstructive sleep apnea
- Oral surgery (if a covered benefit)
- Osteochondral grafting
- Reconstructive surgery (not applicable to reconstructive surgery in conjunction with a mastectomy for breast cancer)
- Sleep studies and treatment of sleep apnea
- Solid organ transplants (except cornea) and bone marrow transplants (all transplant Pre-Authorizations must be done at least ten business days prior to services being rendered)
- Spinal cord stimulators for pain management
- Spine surgery procedures (open and minimally invasive) including artificial intervertebral disc (if a covered benefit)**
- Surgical correction of chest wall deformities
- Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve
- Vagus nerve stimulation
- Varicose vein surgery (if a covered benefit)
- Ventricular assist devices

Electroconvulsive Therapy (ECT)*

Home Health Care:

- Home health services including home health aides, skilled nursing visits, PT, OT, Speech, IV infusion
- Hospice care

Infertility Services

Intensive Outpatient Treatment Programs (IOP)*

Insufficient Evidence of Therapeutic Value

- Services, supplies, devices, or procedures for which there is Insufficient Evidence Of Therapeutic Value

Interventional Cardiology

- Including, but not limited to: Implantable cardiac defibrillators, pacemakers, heart catheterizations, stress echocardiograms myocardial perfusion imaging**

Outpatient Radiological Services (except when such radiological services are done in conjunction with a biopsy or other surgical procedure) such as:**

- Radiation therapy for cancer, including proton beam therapy
- Stereotactic radiosurgery and stereotactic body radiation therapy for all diagnosis
- Bone mineral density exams ordered more frequently than every 23 months
- CT scans (all diagnostic exams)
- MRI/MRA (all examinations)
- Nuclear cardiology
- PET scans
- Stress echocardiograms
- Transesophageal echocardiology
- Transthoracic echocardiology

Outpatient Rehabilitative Services:

- Occupational therapy
- Physical therapy
- Speech therapy (including specialty Hospitals, acute care Hospitals and providers of rehabilitation services)

Psychological Testing Over 5 Hours (1 to 5 hours requires notification only)*

Transcranial Magnetic Stimulation*

Site of Service Programs:

- Pre-Authorization may be required to determine the medically appropriate place of services (e.g., in a provider's office, in a Hospital, in a Hospital Outpatient Surgical Facility, in an Ambulatory Surgery Center) for procedures such as, but not limited to:
  - Dermatology procedures
  - Gastrointestinal procedures
  - Ophthalmologic procedures
  - Orthopedic procedures
  - Urologic procedures

***Pre-Authorization is conducted by OptumHealth Behavioral Solutions - 1-888-946-4658**

****Pre-Authorization is conducted by NIA Magellan – 1-877-607-2363**

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

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the Pre-Authorization And Pre-Certification (Prior Approval) Addendum to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

Prescription medications (only applies to certain medications)

You Need Pre-Authorization For The Following Prescription Drugs:

Abiraterone Acetate
Actemra
Actemra Actpen
Actimmune
Acyclovir Cream and Ointment
Adbry
Adcetris
Adempas
Advair Hfa
Aimovig Autoinjector
Ajovy
Ajovy Autoinjector
Aldurazyme
Alecensa
Alunbrig
Alyq
Ambrisentan
Androderm
Apomorphine HCl
Arikayce
Atgam
Aubagio
Austedo
Avonex Administration Pack
Avonex Pen
Bafiertam
Balversa
Bavencio
Belbuca
Benlysta
Betaine
Betaseron
Bexarotene
Blincyto
Bosentan
Bosulif
Botox
Breo Ellipta
Buprenorphine
Buprenorphine Hydrochloride
Bydureon Bcise
Byetta
Cablivi
Cabometyx
Calquence
Camzyos
Capecitabine
Caprelsa
Carbaglu
Carbidopa
Carglumic Acid
Cayston
Ceprotin
Cerdelga
Cerezyme
Cetrorelix acetate
Cetrotide
Chemet
Chenodal
Cholbam
Cibinqo
Cinacalcet HCL
Cinryze
Clobazam
Cometriq
Cotellic
Cresemba
Cyclosporine
Cystaran
Dabigatran Etexilate
Dalfampridine Er
Darzalex
Decitabine
Deferasirox
Deferiprone
Deferiprone (3 Times A Day)
Diacomit
Diclofenac Sodium
Dimethyl Fumarate
Diskets
Donepezil Hcl
Doptelet
Dronabinol
Dulera
Dupixent
Dupixent Pen
Dutasteride
Dutasteride-Tamsulosin
Egrifta Sv
Elaprase
Eligard
Eliquis
Emgality
Emgality Syringe
Empaveli
Enbrel
Enspryng
Entyvio
Epclusa
Epidiolex
Epoprostenol Sodium
Erbitux
Erivedge
Erleada
Erlotinib Hcl
Escitalopram oxalate
Everolimus
Fabrazyme
Fasenra
Fasenra Pen

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Fentanyl
Fentanyl Citrate
Ferriprox
Fingolimod
Firdapse
Firmagon
Flolan
Fluoxetine Hcl
Fluticasone-Salmeterol
Fluvoxamine Maleate
Folotyn
Forteo
Fulvestrant
Fyremadel
Gammagard Liquid
Ganirelix Acet
Gavreto
Gazyva
Genotropin
Genotropin Miniquick
Gilotrif
Glatiramer Acetate
Glatopa
Gonal-F
Gonal-F Rff
Gonal-F Rff Redi-Ject
Grastek
Halaven
Harvoni
Humira
Humira Pediatric
Hycamtin
Hydrocodone Bitartrate Er
Hydromorphone Er
Hydroxyprogesterone Caproate
Hysingla Er
Ibandronate Sodium
Ibrance
Icatibant
Iclusig
Icosapent Ethyl
Idhifa
Ilaris
Imatinib Mesylate
Imbruvica
Imfinzi
Impavido
Inbrija
Increlex
Infed
Inflectra
Inlyta
Iressa
Ivermectin
Ixempra
Jakafi
Javygtor
Jevtana
Kadcyla
Kalydeco
Kanuma
Kerendia
Kesimpta Pen
Keytruda
Kitabis Pak
Krystexxa
Kynmobi
Lapatinib
Latanoprost
Lenalidomide
Lenvima
Leukine
Leuprolide
Lidocaine
Linezolid
Lonsurf
Lorbrena
Lumizyme
Lupron Depot
Lupron Depot-Ped
Lynparza
Mayzent
Mekinist
Menopur
Methadone Hcl
Methadose
Metyrosine
Miglustat
Mirvaso
Morphine Sulfate Er
Mounjaro
Myalept
Mydayis
Myfembree
Myobloc
Naglazyme
Natesto
Natpara
Nayzilam
Nerlynx
Nexletol
Nexlizet
Nilutamide
Ninlaro
Nitisinone
Nityr
Norditropin Flexpro
Novarel
Noxafil
Nplate
Nubeqa
Nucala
Nuedexta
Nurtec Odt

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Ocaliva
Ocrevus
Octreotide Acetate
Odactra
Odomzo
Ofev
Omega-3 Acid Ethyl Esters
Oncaspar
Opsumit
Oralair
Oriahnn
Orilissa
Orkambi
Otezla
Ovidrel
Oxervate
Oxycontin
Oxymorphone Hcl Er
Ozempic
Palynziq
Paroxetine Er
Paroxetine Mesylate
Pemazyre
Penicillamine
Perjeta
Phenoxybenzamine Hcl
Pirfenidone
Plegridy
Pomalyst
Ponvory
Posaconazole
Procrit
Proleukin
Promacta
Pulmozyme
Pyrimethamine
Qulipta
Radicava
Ragwitek
Ravicti
Rebif
Rebif Rebidose
Restasis
Restasis Multidose
Revlimid
Ribavirin
Riluzole
Rinvoq
Roflumilast
Rozlytrek
Rubraca
Ruconest
Rufinamide
Ruzurgi
Rybelsus
Rydapt
Sajazir
Sapropterin Dihydrochloride
Serostim
Signifor
Sildenafil Citrate
Simponi
Simponi Aria
Sirturo
Skyrizi
Skyrizi (2 Syringes) Kit
Skyrizi Pen
Skyrizi On-Body
Sod Ferric Gluconate Complex
Sodium Phenylbutyrate
Soliris
Solodyn
Somatuline Depot
Somavert
Sorafenib
Sprycel
Stelara
Stivarga
Strensiq
Sucraid
Sunitinib Malate
Sylvant
Symbicort
Symdeko
Symlinpen 120
Symlinpen 60
Synagis
Synarel
Synribo
Tabrecta
Tadalafil
Tafinlar
Tagrisso
Takhzyro
Taltz Autoinjector
Taltz Autoinjector (2 Pack)
Taltz Autoinjector (3 Pack)
Taltz Syringe
Talzenna
Tasigna
Tavalisse
Tazarotene
Tegsedi
Temozolomide
Testosterone
Testosterone Cypionate
Testosterone Enanthate
Tetrabenazine
Thalomid
Tibsovo
Tiopronin
Tobi Podhaler
Tobramycin Sulfate
Tolcapone

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the Pre-Authorization And Pre-Certification (Prior Approval) Addendum to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

Tolvaptan
Topotecan HCl
Tramadol HCl Er
Travoprost
Tremfya
Treprostinil
Trientine Hcl
Trikafta
Triptodur
Trulicity
Tymlos
Tysabri
Tyvaso
Ubrelvy
Unituxin
Uptravi
Valchlor
Vancomycin capsule
Vascepa
Vectibix
Veletri
Venclexta
Venclexta Starting Pack
Venofer
Verzenio
Vigabatrin
Vigadrone
Vijoice
Vilazodone
Vimizim
Vistogard
Vitrakvi
Vizimpro
Vonjo
Voriconazole
Vosevi
Votrient
Vumerity
Vyndamax
Vyndaqel
Wixela Inhub
Xalkori
Xarelto
Xeljanz
Xeljanz Xr
Xermelo
Xgeva
Xifaxan
Xiidra
Xolair
Xospata
Xtandi
Xuriden
Xyrem
Xywav
Yervoy
Yonsa
Zaltrap
Zarxio
Zejula
Zelboraf
Zepatier
Zeposia
Zoladex
Zolinza
Ztalmy
Ztlido
Zydelig
Zykadia
Zynteglo

Specialty Drugs:

Specialty drugs that require Pre-Authorization should only be filled through specialty pharmacies that are Participating Pharmacies, unless you qualify for an exception. The list of specialty drugs that have this requirement is, as follows. If you believe you should be eligible for an exception, your provider must complete a specialty pharmacy exception form and then send it to us via fax at (860) 674-2851 or via regular mail at the following address:

ConnectiCare Pharmacy Services
175 Scott Swamp Road
Farmington, CT 06032-3124

Growth Hormone including:
Genotropin
Norditropin
Serostim
Somavert

Blood Clotting Factors including:
Ceprotin
Tavalisse

Hepatitis C treatments including:
Ribavirin
Zepatier

LHRH Agonists including;
Eligard
Leuprolide Acetate
Lupron Depot
Lupron Depot-Ped
Triptodur
Zoladex

Multiple Sclerosis Treatments including:
Aubagio
Avonex
Bafiertam
Betaseron
Dimethyl Fumarate
Fingolimod
Glatiramer
Glatopa
Kesimpta
Mayzent
Ocrevus
Plegridy

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the Pre-Authorization And Pre-Certification (Prior Approval) Addendum to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

Ponvory
Rebif
Vumerity

Other Drugs including:

Abiraterone Acetate
Actemra
Actemra Actpen
Actimmune
Adbry
Adcetris
Adempas
Aldurazyme
Alecensa
Alunbrig
Alyq
Ambrisentan
Apomorphine
Arikayce
Atgam
Aubagio
Austedo
Avonex
Bafiertam
Balversa
Bavencio
Benlysta
Betaine
Betaseron
Bexerotene
Blincyto
Bosentan
Bosulif
Botox
Cablivi
Cabometyx
Calquence
Camzyos
Capecitabine
Caprelsa
Carbaglu
Carglumic Acid
Cayston
Ceprotin
Cerdelga
Cerezyme
Cetrorelix
Cetrotide
Chenodal
Cholbam
Cibinqo
Cinryze
Cometriq
Cotellic
Cystaran
Dalfampridine Er
Darzalex
Decitabine
Deferasirox
Deferiprone
Diacomit
Dimethyl Furmarate
Doptelet
Dupixent
Elaprase
Eligard
Empaveli
Enbrel
Enspryng
Entyvio
Epclusa
Epidiolex
Epoprostenol
Erbitux
Erivedge
Erleada
Erlotinib
Everolimus
Fabrazyme
Fasenra
Ferriprox
Fingolimod
Firdapse
Firmagon
Flolan
Folotyn
Forteo
Fulvestrant
Fyremadel
Gammagard Liquid
Ganirelix
Gavreto
Gentropin
Gilotrif
Glatiramer
Glatopa
Gonal-F
Gonal- F RFF
Halaven
Harvoni
Humira
Hycamtin
Hydroxyprogesterone
Ibandronate
Ibrance
Icatibant
Iclusig
Idhifa
Ilaris
Imatinib
Imbruvica
Imfinzi
Inbrija
Increlex
Inflectra

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the Pre-Authorization And Pre-Certification (Prior Approval) Addendum to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

Inlyta
Iressa
Ixempra
Jakafi
Javygtor
Jevtana
Kadcyla
Kalydeco
Kanuma
Kesimpta
Keytruda
Kitabis
Krystexxa
Lapatinib
Lenalidomide
Lenvima
Leukine
Leuprolide Acetate
Lonsurf
Lorbrena
Lumizyme
Lupron Depot
Lupron Depot-Ped
Lynparza
Mayzent
Mekinist
Menopur
Miglustat
Myalept
Myobloc
Naglazyme
Natpara
Nerlynx
Ninlaro
Nitisinone
Nityr
Norditropin
Novarel
Nplate
Nubeqa
Nucala
Ocaliva
Ocrevus
Octreotide
Odomzo
Ofev
Oncaspar
Opsumit
Oralair
Orkambi
Otezla
Ovidrel
Oxervate
Palynziq
Pemazyre
Perjeta
Pirfenidone
Plegridy
Pomalyst
Ponvory
Procrit
Proleukin
Promacta
Pulmozyme
Pyrimethamine
Radicava
Ravicti
Rebif
Revlimid
Ribavirin
Rinvoq
Rozlytrek
Rubraca
Ruconest
Rydapt
Sajazir
Sapropterin
Serostim
Signifor
Sildenafil
Simponi
Skyrizi
Soliris
Somatuline Depot
Somavert
Sorafenib
Sprycel
Stelara
Stivarga
Strensiq
Sucraid
Sunitinib
Sylvant
Symdeko
Synagis
Synribo
Tabrecta
Tadalafil
Tafinlar
Tagrisso
Takhzyro
Taltz
Talzenna
Tasigna
Tavalisse
Tegsedi
Temozolomide
Tetrabenazine
Thalomid
Tibsovo
Tiopronin
Tobi Podhaler
Tobramycin
Tolvaptan

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the Pre-Authorization And Pre-Certification (Prior Approval) Addendum to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

Topotecan
Tracleer
Tremfya
Treprostinil
Trikafta
Triptodur
Tymlos
Tysabri
Tyvaso
Unituxin
Uptravi
Valchlor
Vectibix
Veletri
Venclexta
Verzenio
Vigabatrin
Vigadrone
Vijoice
Vimizim
Vistogard
Vitrakvi
Vizimpro
Vonjo
Vosevi
Votrient
Vumerity
Vyndamax
Vyndaqel
Xalkori
Xeljanz
Xermelo
Xgeva
Xolair
Xospata
Xtandi
Xuriden
Xyrem
Xywav
Yervoy
Yonsa
Zaltrap
Zarxio
Zejula
Zelboraf
Zepatier
Zeposia
Zoladex
Zolinza
Ztalmy
Zydelig
Zykadia
Zynteglo

Oral Oncology Agents Including:

Abiraterone Acetate

Alecensa
Alunbrig
Balversa
Bexarotene
Bosulif
Cabometyx
Calquence
Capecitabine
Caprelsa
Cometriq
Cotellic
Erivedge
Erleada
Erlotinib Hcl
Everolimus
Gavreto
Gilotrif
Hycamtin
Ibrance
Iclusig
Idhifa
Imatinib Mesylate
Imbruvica
Inlyta
Iressa
Jakafi
Lapatinib
Lenalidomide
Lenvima
Lonsurf
Lorbrena
Lynparza
Mekinist
Nerlynx
Ninlaro
Nubeqa
Odomzo
Pemazyre
Pomalyst
Revlimid
Rozlytrek
Rubraca
Rydapt
Sorafenib
Sprycel
Stivarga
Sunitinib Malate
Tabrecta
Tafinlar
Tagrisso
Talzenna
Tasigna
Temozolomide
Thalomid
Tibsovo
Venclexta
Verzenio
Vijoice
Vistogard

Take a look at the "Managed Care Rules And Guidelines" section to see if you need to obtain a Referral or have to use Participating Providers and the Pre-Authorization And Pre-Certification (Prior Approval) Addendum to find out what services require Pre-Authorizations (prior approvals). Also take a look at the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

Vitrakvi
Vizimpro
Vonjo
Votrient
Xalkori
Xermelo
Xospata
Xtandi
Yonsa
Zejula
Zelboraf
Zolinza
Zykadia

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

Actimmune
Benlysta
Cibinqo
Enbrel
Humira
Ilaris
Inflectra
Otezla
Proleukin
Rinvoq
Simponi
Skyrizi
Taltz
Tremfya
Xeljanz
Xeljanz XR

Pulmonary Hypertension Drugs including:

Adempas
Alyq
Ambrisentan
Bosentan
Epoprostenol
Flolan
Opsumit
Sildenafil
Tadalafil
Tracleer
Treprostinil
Tyvaso
Uptravi
Veletri

Infertility Drugs including:

Gonal-F
Menopur

In addition, any drug that is newly available to the market will also require Pre-Authorization until such time as we re-publish our list of drugs requiring Pre-Authorization.

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