



2026

**2026 ConnectiCare, Inc.
POS High Deductible Health Plan (HDHP)
For use with a Health Savings Account (HSA)**

SOLO Agreement

**ConnectiCare, Inc.
175 Scott Swamp Road
Farmington, Connecticut 06032**

IMPORTANT

Please read the Managed Care Rules And Guidelines section to learn this Plan's rules. Understanding the rules of this Plan will help you maximize your coverage. The Managed Care Rules And Guidelines section will explain how this Plan operates and whether your Plan requires you to use Participating Providers, as well as whether you need to obtain a Referral or Prior Authorization before receiving care. In addition, please read the Exclusions And Limitations section to find out what isn't covered under this Plan.

Right to Return: Newly enrolled Subscribers have the right to return this Agreement until midnight of the tenth day after the date on which the Subscriber receives the Agreement, by returning the Agreement to ConnectiCare or an agent of ConnectiCare. No reason needs to be stated for the return. ConnectiCare will treat this Agreement as if it had never been issued and will return all Premium Payments to the Subscriber. If the Subscriber returns this Agreement under this provision, they will be responsible for payment of any health care service they or a Dependent received before they returned the Agreement

For only HSA compatible high-deductible health plans (HDHP): This Plan has been designed to conform to Federal Internal Revenue Service (IRS) guidelines on such plans. However, the IRS has made no determination that this Plan is qualified, and ConnectiCare make no representation to such. Whether or not an HSA used with this Plan will provide a Member with tax advantages depends on a number of circumstances, including the Member's personal coverage situation, contributions to and withdrawals from their HSA account, other coverage a Member may have and changes the IRS may make to its rules. Members should consult with a qualified tax advisor in determining whether and how this option may provide them with a tax benefit. ConnectiCare cannot guarantee and we make no representations that tax benefits will accrue to anyone covered under this Plan.

Policy Form: CCI IND 01 (1/2026)

Product Option Form: CCI IND POS HDHP HSA 01 (1/2026)

WELCOME TO CONNECTICARE!

Thank you for choosing ConnectiCare. ConnectiCare looks forward to providing you with the responsive customer service that ConnectiCare's Members have come to expect from ConnectiCare and working with you and your providers to make sure you and your family make the right choices to maximize the coverage available to you under this Plan.

Renewability: This Agreement is renewable provided the following requirements are satisfied:

- The Member continues to pay the Premium due, as described in the Premium Payment section of this Agreement.

Changes in Benefits: ConnectiCare may make changes to the benefits and/or Premium rates while this Agreement is in effect:

- As described in the Termination of Coverage section of this Agreement or when renewed.

If ConnectiCare makes any changes to the benefits, the changes apply to services that start on or after the Effective Date of this Agreement. These changes (including any decrease in benefits or removal of benefits) apply to:

- Any claims or expenses,
- Services incurred, or
- Supplies furnished.

There are no vested rights to receive any benefits described in this Agreement after the date this Agreement changes or terminates. This applies even if the claim or expense took place after this Agreement changes or ends but before the Member received the changed or new plan documents.

This Plan has been designed to conform to Federal Internal Revenue Service (IRS) guidelines on such plans. However, the IRS has made no determination that this Plan is qualified, and we make no representation to such. Whether or not an HSA used with this Plan will provide a Member with tax advantages depends on a number of circumstances, including the Member's personal coverage situation, contributions to and withdrawals from their HSA account, other coverage a Member may have and changes the IRS may make to its rules. Members should consult with a qualified tax advisor in determining whether and how this option may provide them with a tax benefit. ConnectiCare cannot guarantee, and we make no representations that tax benefits will accrue to anyone covered under this Plan.

Situs: The situs of this Agreement is Connecticut.

Time Zone: Except as otherwise expressly provided herein, all references to a specific time of day refer to the specific time of day in the Eastern time zone of the United States of America.

Agreement Issuance: This ConnectiCare, Inc **POS High Deductible Health Plan (HDHP) For use with a Health Savings Account (HSA) SOLO Agreement** (also called the “Agreement”) is issued ConnectiCare (“ConnectiCare”), to the Subscriber or Member whose identification cards are issued with this Agreement. In consideration of statements made in any required application and timely payment of Premiums, ConnectiCare agrees to provide the Covered Services as outlined in this Agreement.

Incorporation by Reference: This Agreement, amendments and Riders to this Agreement, the applicable Schedule of Benefits for this plan, and any application(s) submitted to the Connecticut Insurance Department and/or ConnectiCare to obtain coverage under this Agreement, including the applicable rate sheet for this product, are incorporated into this Agreement by reference, and constitute the entire legally binding contract between ConnectiCare and the Subscriber.

No statement by the Subscriber in their Application shall void this Agreement or be used in any legal proceeding unless such Application or an exact copy thereof is included in or attached to this Agreement.

Members must read their Schedule of Benefits for details regarding particular features of their Plan, such as Coinsurance, Deductibles, exclusions, and limitations.

Words in this document that are in the upper case have special meaning and their meaning is in the Definitions section.

This Agreement replaces any agreement, contract, policy, or program of the same coverage that ConnectiCare may have issued to the Member prior to the date ConnectiCare issued this Agreement. It is written according to the laws of the State of Connecticut, including rules, regulations or other standards set forth by the State of Connecticut Insurance Department (Department). ConnectiCare has the discretion to define and interpret the terms of this Agreement and determine eligibility for plan benefits in accordance with ConnectiCare’s policies and procedures and in accordance with applicable federal or State Law.

Contract Changes: No amendment, modification, or other change to this entire legally binding contract between ConnectiCare and the Subscriber shall be valid until approved by ConnectiCare and evidenced by a written document signed by an executive officer of ConnectiCare. No agent of ConnectiCare has the authority to change this Agreement and incorporated documents or to waive any of its provisions.

Acceptance of the Agreement: With acceptance of this Agreement, the Subscriber agrees to all the provisions of this Agreement, including any Riders. By accepting this Agreement and maintaining this Agreement more than ten days after it is delivered to the Subscriber, the Subscriber and their Dependents also agree to when the Member may receive Covered Services and when to pay Premium to ConnectiCare for coverage under this Plan.

Identification Card (“ID”): Members should carry their ConnectiCare ID Card and present it whenever they receive services at a Provider’s office, in an emergency room or Urgent Care Center, or at any other health care facility or pharmacy. Members should use their ID card

when the Member receives prescriptions at Participating Pharmacies. Members should be ready to provide their ID number in communications with ConnectiCare. To replace a lost or misplaced ConnectiCare ID card, contact the Member Services Department or visit ConnectiCare's website at Connecticare.com to request a replacement.

Coverage: Members are responsible for providing ConnectiCare information about themselves and any dependents that is complete, accurate and true to the best of their knowledge and belief. Coverage is being provided to Members under this Plan on the basis that they are an applicant and the information that they have provided is truthful. If a Member makes a fraudulent or intentional misrepresentation of a material fact, coverage may be rescinded or cancelled. In the event that there is a change in the name(s), address, telephone number(s) or email address(es) that the Member has provided to ConnectiCare, the Member is responsible for telling ConnectiCare as soon as possible about the change(s).

The Enrollment Form and any other forms or statements that ConnectiCare request must be received and accepted by ConnectiCare before the applicant will be considered for Membership under this Plan. ConnectiCare reserves the right to accept or deny requested coverage based on the completion of an Enrollment Form by the applicant. If additional information is requested and is not received by ConnectiCare within 45 days of the request, the Application may be rejected by ConnectiCare.

Interpreter Services: ConnectiCare offers interpreter services to assist any Member who may require language support in understanding and obtaining health coverage under this Agreement. These services are provided by ConnectiCare at no additional cost to the Member. ConnectiCare offers both oral interpretation and written translation services for materials vital for a Member's understanding of their health care coverage. Members who are deaf or hard of hearing can also use the Telecommunications Relay Service by dialing 711.

Important ConnectiCare Member Resources

Service	Where to Go
Member Services	ConnectiCare (860) 674-5757 or 1-800-251-7722 TDD/TYY services 1-800-833-8134
	Behavioral Health Program 1-888-946-4658
	Dental 1-800-626-3205
Prior Authorization	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 1-877-607-2363
	Genetic Testing 1-888-835-2042
Self Service for your Account	<ul style="list-style-type: none"> • Make an account on ConnectiCare.com to access your Member Portal. • Go to MyConnectiCarePortal.com to make a one-time payment.
Premium Payment	ConnectiCare, Inc. PO Box 75159 Chicago, IL 60675-5159

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Definitions: Some words or terms in this Agreement may not have their usual meanings. Health plans often use these words in a specific way. If a word with a specialized meaning appears in only one section of this Agreement, it will be defined in that section. Words with special meanings used in any section of this Agreement are capitalized and are explained in this Definitions section.

Adverse Determination: The denial, reduction, termination, or 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 ConnectiCare or ConnectiCare's Delegated Program:

- That, based upon the information provided,
- Upon application of any utilization review technique, such benefit does not meet ConnectiCare'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.

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

Affordable Care Act ("ACA"): The comprehensive health care reform law enacted in March 2010, also referred to as "PPACA" or "Obamacare."

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 Out-of-Pocket Maximum: The most a Member must pay for Covered Services in a Plan year. After a Member spends this amount on Deductibles, Copayments, and Coinsurance, ConnectiCare pays 100% of the costs of Covered Services. The amounts the Subscriber or Dependents pay for services not covered by this Plan do not count towards the Annual Out-of-Pocket Maximum. The Schedule of Benefits may list an Annual Out-of-Pocket Maximum amount for each individual enrolled under this Agreement and a separate Annual Out-of-Pocket Maximum amount for the entire family when there are two or more Members enrolled. When two or more Members are enrolled under this Agreement:

1. The individual Annual Out-of-Pocket Maximum will be met, with respect to the Member, when that person meets the individual Annual Out-of-Pocket Maximum amount; or
2. The family Annual Out-of-Pocket Maximum will be met when a Member's family's Cost Sharing adds up to the family Annual Out-of-Pocket Maximum amount.

Once the total Cost Sharing for the Member adds up to the individual Annual Out-of-Pocket Maximum amount, ConnectiCare will pay 100% of the charges for Covered Services for that individual for the rest of the calendar year if they remain enrolled in this Plan. Once the Cost Sharing for two or more Member's family adds up to the family Annual Out-of-Pocket Maximum amount, ConnectiCare will pay 100% of the charges for Covered Services for the rest of the calendar year for the Member and every Member of their family if they remain enrolled in this Plan.

Appeal: A written complaint or, if the complaint involves an urgent care request, an oral complaint submitted by or on behalf of a Member regarding:

- The availability, delivery, or quality of Health Services, including a complaint regarding an Adverse Determination made pursuant to utilization review,
- Claims payment, handling, or reimbursement for Health Services, or
- Any matter pertaining to the contractual relationship between the Member and ConnectiCare.

Application: The form provided or approved ConnectiCare, used to enroll or disenroll the Member. Reference to receipt of Application/Change Form may mean either paper or electronic file provided to us.

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 a microprocessor-equipped device is determined by the Member's health care provider to be Medically Necessary.

Autism Spectrum Disorder ("ASD"): The Autism Spectrum Disorder as set forth in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders.

Balance Bill or Balance Billing: When a Provider bills a Member for the difference between the Provider's charged amount and the Member's Cost Sharing amount. A ConnectiCare Participating Provider is not permitted to Balance Bill a Member for Covered Services. Non-Participating Providers may Balance Bill Members unless there are Balance Billing protections through federal or State Law.

Behavioral Health Program: A Delegated Program under which ConnectiCare may provide for management, administration, and a network of providers for mental health, and alcohol and Substance Use services, under this Plan. In some instances, the Behavioral Health Program may be managed and administered by a Delegated Program under contract with us. In that event, when this document refers to determinations, Prior Authorizations, and other decisions made under the terms of the Behavioral Health Program, such determinations as Prior Authorizations, and other decisions are made by the Delegated Program on behalf of us.

Behavioral Therapy: Any interactive Behavioral Therapy derived from evidence-based research and consistent with the services and interventions designated by the Commissioner of Social Services pursuant to subsection (1) of section 17a-215c, 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 Reduction: A Benefit Reduction is a reduction in benefits, which applies when a Member fails to obtain Prior Authorization for certain Medically Necessary health care services that require Prior Authorization prior to the receipt of these services from or arranged by a Non-Participating Provider.

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 with the development and implementation of a plan that efficiently uses health care resources to help the Member manage his/her health.

Case Manager: An individual, usually a registered nurse, who is responsible for developing and implementing a care plan that takes into account benefit structure, accepted industry and internal standards, and cost effectiveness in order to help the Member manage their health.

Clinically Equivalent Alternative Drug or Supply: A drug or supply in the same category as an excluded drug or supply and determined by ConnectiCare to be an effective alternative.

Clinical Peer: A physician or other health care professional who:

- Holds a non-restricted license in a state of the United States in the same specialty as the treating physician or other health care professional who is managing the medical condition, procedure, or treatment under review, or
- For a review concerning a child or adolescent substance use disorder or mental disorder, holds a national board certification in child and adolescent psychiatry, or a doctoral level psychology degree with training and clinical experience in the treatment of child and adolescent substance use disorder or mental disorder as applicable, or for a review concerning an adult substance use or mental disorder, holds a national board certification in psychiatry or doctoral level psychology degree with training and clinical experience in the treatment of adult substance use or mental disorders as applicable.

Coinsurance: The percentage of the Maximum Allowable Amount that the Member is legally responsible to pay 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 charge for the Covered 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 Covered 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 the Member's fiscal responsibility.

ConnectiCare: ConnectiCare, Inc. the company insuring this Plan.

Contract Year: January 1st through December 31st. Contract Year generally aligns with the calendar year.

Copayment: A fixed amount that the Member will pay for a Covered Service. If applicable, Copayments are listed in the Schedule of Benefits.

Cosmetic Treatments: Any dental, medical, or surgical treatment for which the primary purpose is to change appearance as ConnectiCare determines.

Cost Sharing: The portion of costs that a Member is responsible for paying out of their own pocket for Covered Services. This term includes Deductibles, Coinsurance, and Copayments, but it does not include Premiums, Balance Bill amounts for Non-Participating Providers, or the cost of non-covered services.

Cost Sharing Maximum: The Member's maximum payment liability per year for Deductible, Copayment and Coinsurance as listed in the Schedule of Benefits.

Covered Service or Covered Services: Medically Necessary services, including some medical devices, equipment, and prescription drugs, that Members are eligible to receive from ConnectiCare under this Plan, unless otherwise prohibited by federal or State Law. Covered Services are diagnostic and therapeutic, medical, surgical, and mental Covered Services and supplies available under this Plan. Covered Services must be provided or rendered by a licensed health care provider within the scope of their license or authorization in accordance with the laws and regulations of the governmental authority having jurisdiction. Covered Services include preventive services.

Custodial Care: Those services and supplies furnished to a Member who has a medical condition that is chronic or non-acute in nature which 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 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 ConnectiCare will begin paying for those benefits. When a Deductible applies as a result of the In-Network Level of Benefits, except as otherwise required by law, the Deductible amount will be calculated based on the lesser of:

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

When a Deductible applies as a result of the Out-of-Network Level of Benefits, except as otherwise required by law, the Deductible 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 Deductible and shall be the Member's fiscal responsibility.

- **Benefit Deductible:** 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 ConnectiCare will begin paying for those benefits. Anything paid by a Member for those benefits does not count towards meeting the Plan Deductible (if this Plan has one).
- **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 Services before ConnectiCare will begin paying ConnectiCare's 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 a Coinsurance amount.

Delegated Program: An outside company that ConnectiCare may use to manage and administer certain categories of benefits or services provided under this Plan.

When this document refers to determinations, Prior Authorizations or other decisions made under the terms of that Delegated Program, such determinations, Prior Authorizations, or other decisions are made by the outside company on ConnectiCare's behalf.

Dental Services: Those diagnostic and therapeutic, medical, surgical services and supplies that are Medically Necessary and available to you and your covered dependents under this Plan. Dental Services must be provided or rendered by a licensed Dentist, dental hygienist, or dental assistant within the scope of his or her license or authorization in accordance with the laws and regulations of the governmental authority having jurisdiction.

Dentist: Any licensed Dentist (D.D.S., D.M.D.) who is actively engaged in the practice of Dentistry, including the following:

- **Endodontist:** A Dentist whose practice is limited to treating disease and injuries of the

pulp and associated periradicular conditions.

- **Oral and Maxillofacial Surgeon:** A dental specialist whose practice is limited to the diagnosis, surgical and adjunctive treatment of diseases, injuries, deformities, defects, and esthetic aspects of the oral and maxillofacial regions.
- **Orthodontist:** A dental specialist whose practice is limited to the interception and treatment of malocclusion of the teeth and surrounding structures.
- **Periodontist:** A Dentist whose practice is limited to the treatment of diseases of the supporting and surrounding tissues of the teeth.
- **Prosthodontist:** A Dentist whose practice is limited to the restoration of the natural teeth and/or the replacement of missing teeth with artificial substitutes.

Dentistry (Dental Care): The diagnosis and treatment of diseases or lesions of the mouth and surrounding and associated structures,

- Replacement of lost teeth by artificial ones,
- The diagnosis or correction of malposition of the teeth, or
- The furnishing, supplying, constructing, reproducing, or repairing any prosthetic denture, bridge appliance or of any other structure to be worn in the mouth; or the placement or adjustment of such appliance or structure in the human mouth.

Dependent: A Member who meets the eligibility criteria as a Dependent, as outlined in this Agreement.

Diabetes Devices: A device, including, but not limited to, a blood glucose test strip, glucometer, continuous glucometer, lancet, lancing device, or insulin syringe, which 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 non-legend device and used to screen for or prevent diabetic ketoacidosis.

Drug Therapy: A product administered by a health care professional for use in diagnosis, cure, treatment, or prevention of disease.

Distant Site: This is the location where a physician or other licensed Provider delivering a professional service is physically located when providing the service through telemedicine.

Drug Formulary or Formulary: A list of prescription drugs this ConnectiCare Plan covers. The Drug Formulary also puts drugs in different Cost Sharing levels or tiers.

Durable Medical Equipment or DME: Equipment and supplies that a Provider orders for everyday or extended use. DME may include medically necessary oxygen equipment, wheelchairs, crutches, or blood testing strips for diabetics.

Effective Date: The date that coverage under this Agreement became effective. The Effective Date is subject to the payment of Premium and ConnectiCare's receipt and approval of a complete Enrollment Form.

Emergency or Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of medical attention to result in:

1. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

With respect to a pregnant woman who is having contractions, an emergency medical condition means that there isn't adequate time to affect a safe transfer to another hospital before delivery, or that transfer may pose a threat to the health or safety of the woman or child.

Emergency Transportation Services: Ambulance transfers undertaken before stabilizing an Emergency Medical Condition.

Emergency Services: Services to evaluate, treat or stabilize an Emergency Medical Condition. These services may be provided in a licensed emergency room or other facility that provides treatment of Emergency Medical Conditions.

Enrollment Form: Enrollment Form provided or approved by ConnectiCare, used to enroll or disenroll the Member. Reference to receipt of Enrollment Form may mean either paper or electronic file provided to ConnectiCare and created by ConnectiCare.

Essential Health Benefits or EHB: Health care services and benefits that fall within the following categories:

- (1) Ambulatory patient services;
- (2) Emergency services;
- (3) Hospitalization;
- (4) Maternity and newborn health care;
- (5) Mental health and substance use disorder services, including, but not limited to, behavioral health treatment;
- (6) Prescription drugs;
- (7) Rehabilitative and habilitative services and devices;
- (8) Laboratory services;
- (9) Preventive and wellness services and chronic disease management; and
- (10) Pediatric services, including, but not limited to, oral and vision care.

Experimental or Investigational: Any procedure, treatment or drug, for the illness or condition being treated, or for the diagnosis for which it is being prescribed, that has successfully completed a phase III clinical trial of the federal Food and Drug Administration. This includes medical services including procedures, medications, facilities, and devices that the FDA has not approved for treatment or therapeutic use in connection with underlying medical condition for which such procedure, medication, facility, or device was prescribed.

FDA: The United States Food and Drug Administration.

Generic Drug (Generic Drug or Supply): 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 ConnectiCare 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 ConnectiCare requires be substituted for a Brand Name Drug or Supply. Not all Brand Name Drugs with Generic Equivalents are required to be substituted.

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 ConnectiCare 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 six months or less).

Hospice: An agency that provides counseling and incidental medical services for a terminally ill (i.e., having a life expectancy of six months or less) individual. To be a Hospice, the agency must:

1. Be licensed in accordance with all laws.
2. Provide 24-hour-a-day, seven day-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 the 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: A legally operated facility, licensed by the State, with the principal purpose or function of providing medical or hospital care, medical education, or medical research.

Hospitalization: Covered 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/High Intensity Outpatient Program:** A structured ambulatory program. The program may be freestanding or Hospital-based and provides services for at least 20 hours per week.

Hospital Outpatient Surgical Facility: (HSOF) 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 Hospital Outpatient Surgical Facility 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 (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 ConnectiCare or an affiliate or subcontractor of ours to provide Covered 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.

Infusion Center: A freestanding outpatient clinic that is certified to administer Infusion Therapy.

Infusion Therapy: Medication or fluids administered intravenously.

In-Network Level of Benefits: The maximum level of benefits under this Plan available for Covered Services provided to a Member directly by his/her Primary Care Provider (PCP) or a Participating Provider. The In-Network Level of Benefits under this Plan is described in the Member's Benefit Summary.

Insufficient Evidence of Therapeutic Value: When ConnectiCare determines 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 a Treatment has been approved by a regulatory body or recommended by a health care practitioner, and the Treatment will not be covered.

Intensive Outpatient: A structured outpatient treatment program 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.

- For mental health care services, the program may be freestanding or Hospital-based and provides services for at least three hours per day, two or more days per week.
- For Substance Use Disorder services, the program provides nine to nineteen hours per week of structured programming for adults and six to nineteen hours for adolescents, consisting primarily of counseling and education about addiction related and mental health problems.

Maximum Allowable Amount: The maximum amount of reimbursement ConnectiCare will allow for services and supplies:

- That are Covered Services.
- That are Medically Necessary.
- That are provided in accordance with all applicable Prior Authorization 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 Participating Provider or a Non-Participating Provider.

The actual payment will be reduced by applicable Deductible(s), Coinsurance, Copayment(s), Benefit Reduction amounts and other applicable adjustments described in this document. In no case will ConnectiCare's reimbursement exceed the maximum benefit described in this document except as required by law.

For a Participating Provider covered Health Service, the Maximum Allowable Amount is the rate the provider has agreed with ConnectiCare 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 ConnectiCare's 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, ConnectiCare 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. ConnectiCare may, at ConnectiCare's 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, the Member will not be responsible for the difference between the Maximum Allowable Amount and the billed charges. The Member 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. ConnectiCare may contract with vendors that have fee arrangements with Non-Participating

Providers (Third Party Networks). If the Member utilizes a Non-Participating Provider in a Third-Party Network, the Maximum Allowable Amount will be determined based on ConnectiCare's contract with the Third-Party Network. Where the terms of ConnectiCare's contract with the Third-Party Network require, ConnectiCare will use the contract fee between the Non-Participating Provider and the Third-Party Network as the Maximum Allowable Amount. For other arrangements, ConnectiCare 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.

Providers who are not contracted for a product but are contracted for other products with ConnectiCare 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 ConnectiCare and that provider specifies a different amount.

When a Member receives Covered Services from a provider, ConnectiCare 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 ConnectiCare's determination of the Maximum Allowable Amount. ConnectiCare application of these rules does not mean that the Covered Services a Member received were not Medically Necessary. It means ConnectiCare has determined that the claim was submitted inconsistent with procedure coding rules and/or reimbursement policies.

For example, the Member's 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, ConnectiCare 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 the charges that the Member is legally required to pay for a Health Service will count towards the Maximum Allowable Amount. So, if the physician or provider is not charging the Member for part or all of the Covered Service and the Member is therefore not legally obligated to pay for that waived amount, ConnectiCare will not count that waived amount towards the Maximum Allowable Amount.

Medicaid: A government program, sponsored by the federal government and the individual states, including Connecticut, which provides coverage for people with lower incomes, older people, people with disabilities, and some families and children.

Medical Necessity or Medically Necessary: Health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

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; and
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: An individual who is eligible and enrolled under this Agreement, and for whom ConnectiCare has received applicable first Premium payment (binder). The term includes a Dependent and a Subscriber unless the Subscriber is a responsible adult (the parent or legal guardian) who applies for Child-Only Coverage under this Agreement on behalf of a child under age 21. In such cases, the Subscriber will be responsible for making the Premium and Cost Sharing payments for the Member and will act as the legal representative of the Member under this Agreement but will not be considered a Member.

Mental Health Services: Medically Necessary outpatient and inpatient services provided to treat mental disorders covered by the diagnostic categories listed in the most current version of the Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association, and any associated federal or State Law.

Minimum Essential Coverage: Any of the following government sponsored programs:

- Medicare,
- Medicaid,
- CHIP,
- TRICARE for Life (veteran's health care program),
- Coverage under an eligible employer-sponsored plan,
- Coverage under a health plan offered in the individual market within a State, or
- Coverage under a grandfathered health plan, and such other health benefits coverage, such as a State health benefits risk pool, or as the Secretary of HHS recognizes.

Network Access Area: Those geographic areas where contracted health care facilities, practitioners, and pharmacies provide benefits for Covered Services under this Plan. To locate contracted health care facilities, practitioners, and pharmacies that are in the Network Access Area, visit ConnectiCare's website at Connecticare.com/CTFindCare, or call the appropriate telephone number listed in this Agreement.

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

Non-Participating Provider: A Provider that has not entered into a contract with ConnectiCare to provide Covered Services to Members. This includes Providers, Pharmacies, and facilities.

Other Practitioner: Participating Providers who provide Covered Services to Members within the scope of their license but are not Primary Care Providers or specialists.

Out-of-Area Service: A service provided outside of the Service Area and is therefore not a Covered Service, except as otherwise stated in this Agreement.

Out-of-Network Level of Benefits: Generally, a lesser level of benefits than the In-Network Level of Benefits under this Plan available for Covered Services provided to a Member when the Covered 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 document, Covered Services obtained from or arranged by Non-Participating Providers 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 Member's 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 for the remainder of that year.

Out-of-Plan Services: Health care services rendered by a Non-Participating Provider, when a Member is enrolled in an HMO Plan, where Participating Providers must be used.

Participating Provider: A Provider that is licensed or otherwise authorized to provide health care services. They have entered into network contracts with ConnectiCare to provide Covered Services to Members. This includes Providers, Pharmacies, and facilities.

Plan: Health insurance coverage issued to an individual and Dependents, if applicable, providing benefits for Covered Services. Depending on the services, Member Cost Sharing may apply.

Post-Stabilization Services: Items and services furnished (regardless of the department of the hospital where it occurs) after the Member has been stabilized and as part of outpatient observation or an inpatient or outpatient stay related to the visit during which Emergency Services were provided.

Primary Care Provider: A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), Certified Nurse Practitioner, clinical nurse specialist, advanced practice registered nurse or Physician Assistant, as allowed under State law and the terms of the Plan, who provides, coordinates, or assists a Member in accessing a range of health care services.

Prior Authorization: Approval from ConnectiCare that is needed before Members get a medical service or drug so that the service or drug is covered. This includes pre-certifications, which are the registration and approval process, based on Medical Necessity, needed in

advance of the services, including but not limited to a Member's Partial Hospitalization or inpatient admission to a Hospital, Hospice, Residential Treatment Facility, Rehabilitation Facility or Skilled Nursing Facility that is obtained from us, or the applicable Delegated Program.

Provider: Any health professional, Hospital, institution, organization, pharmacy, or individual that furnishes any health care services and is licensed or otherwise authorized to furnish such services.

Provider Directory: The list of Participating Providers compiled and prepared for ConnectiCare's benefit plans.

Prudent Layperson: A person who is without medical training and who draws on his/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 ConnectiCare 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 us. In that event, when this document refers to determinations, Prior Authorizations, and other decisions made under the terms of the Radiology Services Program, such determinations, Prior Authorizations, and other decisions are made by the Delegated Program on behalf of us.

Referral: An approval communicated to ConnectiCare 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 is licensed and accredited as a rehabilitation facility by the government or other authorities having jurisdiction.

Renewal Date: January 1st of each year whereby coverage under this Agreement is continued subject to the terms of this Agreement, as long as the Subscriber pays the Premium due.

Residential Treatment: Treatment in a facility established and operated as required by law, which provides mental health care services or Substance Use Disorder services. It must meet all of the following requirements:

- Provides a program of treatment, under the active participation and direction of a physician.
- Offers organized treatment services that feature a planned and structured regimen of care in a 24-hour setting and provides at least the following basic services:

- Room and board.
- Evaluation and diagnosis.
- Counseling.
- Referral and orientation to specialized community resources.

Rider: A written amendment that modifies the terms and conditions of this document.

Schedule of Benefits: A detailed list of Covered Services, along with the associated Member Cost Sharing. This document has been formerly referred to as a benefit summary.

Service Area: The geographic region where ConnectiCare is authorized by the State to offer individual products, enroll Members seeking coverage, and deliver benefits through approved individual health plans.

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: A Provider focusing on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat specific symptoms and conditions.

Stabilize: To stabilize means to provide such medical treatment of the Emergency Medical Condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or with respect to a pregnant woman who is having contractions, to deliver (including the placenta).

State Law: The body of law in Connecticut encompassing the state's constitution, statutes, regulations, sub-regulatory guidance, directives from state regulatory agencies, and common law.

Surprise Bill: A bill for health care services that the Member receives 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 Prior Authorized by ConnectiCare and the Member 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 the Member when a Participating Provider was available to render the services, and the Member knowingly elected to obtain the services from a Non-Participating Provider.

Transitional Living: Mental Health Care Services and Substance Use Disorder services provided through facilities, group homes and supervised apartments which provide 24-hour

supervision, including those defined in the American Society of Addiction Medicine (ASAM) Criteria, and are either:

- Sober living arrangements such as drug-free housing or alcohol/drug halfway houses. They provide stable and safe housing, an alcohol/drug-free environment and support for recovery. They may be used as an addition to ambulatory treatment when it does not offer the intensity and structure needed to help the Member with recovery.
- Supervised living arrangements which are residences such as facilities, group homes and supervised apartments. They provide stable and safe housing and the opportunity to learn how to manage.
- Activities of daily living. They may be used as an addition to treatment when it does not offer the intensity and structure needed to help the Member with recovery. Please note: these living arrangements are also known as supportive housing (including recovery residences).

Urgent Care or Urgent Care Services: Immediate care for an illness, injury, or condition serious enough that a reasonable person would seek care promptly, but not so severe as to require emergency room care.

Urgent Crisis Center: A center that is certified as an urgent crisis center by the Connecticut Department of Children and Families that is dedicated to treating children's urgent mental or behavioral health needs.

Urgent Crisis Center Services: Pediatric mental and behavioral health services provided at an urgent crisis center.

Enrollment and Eligibility

To access Covered Services, an individual must be enrolled as a Member of this Plan. Enrollment requires meeting the eligibility criteria set by State Law. Once the eligibility conditions are met, Premiums are paid, and ConnectiCare processes the enrollment, the individual becomes a Member of this Plan for the Contract Year.

Special Enrollment Period: If an individual does not enroll during an Open Enrollment Period, they may be able to enroll during a Special Enrollment Period. To qualify for a Special Enrollment Period, an individual must have experienced certain life changes. The effective date of a Member's coverage will be determined by ConnectiCare. For more information about Special Enrollment Periods, please visit [ConnectiCare.com](https://www.connecticare.com).

Child-Only Coverage: ConnectiCare offers Child-Only Coverage for individuals who, as of the beginning of the Plan year, have not attained the age of twenty-one. A parent or legal guardian must apply for Child-Only Coverage on behalf of the individual under the age of eighteen (18).

Dependents: Subscribers enrolling during an Open Enrollment Period or Special Enrollment Period may also apply to enroll eligible individuals as Dependents. ConnectiCare does not limit Dependent eligibility based on financial dependency, residency, student status, employment,

eligibility for other coverage, or marital status. The following individuals are considered Dependents:

- **Spouse:** The individual lawfully married to the Subscriber under State Law.
- **Child or Children:** The Subscriber's sons, daughters, adopted children, stepchildren, foster children, children for which the Subscriber is appointed legal guardian, or any of their descendants, such as grandchildren. Each child is eligible to seek enrollment as a Dependent until reaching the age of twenty-six. These Dependents can remain covered under the Subscriber's Agreement until the anniversary date after the date on which the eligible dependent turns 26. ConnectiCare also covers children for a prospective adoptive parent Subscriber, even though the adoption has not been finalized, provided the child lives in the household of such Subscriber and the child is dependent upon such person for support and maintenance.
- **Child with a Disability:** A child who reaches age 26 can remain a Dependent if they meet the following criteria:
 - The child is incapable of self-sustaining employment because of a physically or mentally disabling injury, illness, or condition; and
 - The child is primarily dependent on the Subscriber for support and maintenance, regardless of age, if the Child is permanently and totally disabled.
 - The child remains covered by ConnectiCare as long as they remain incapacitated and meet the above eligibility criteria.
- **Domestic Partner:** An individual of the same or opposite sex who lives together and shares a domestic life with the Subscriber but is not married or joined by a civil union to the Subscriber. The Domestic Partner must meet any eligibility and verification of domestic partnership requirements established by State Law.
- **Qualified Medical Child Support Orders.** Special rules apply when a court issues a qualified medical child support orders requiring the Subscriber to provide health insurance for the Subscriber's child. Enrollment may be required even in circumstances in which the child was not previously enrolled in this Plan and might not otherwise be eligible for coverage. ConnectiCare will not require the children to live with the Subscriber, but they must live in the State of Connecticut to be covered.

Adding New Dependents: An individual may become eligible to be a Dependent after the Subscriber's enrollment in this Plan. An eligible individual may be able to enroll as a Dependent in the Member's Plan. To do so, Members must contact ConnectiCare and complete any required applications, forms, and provide the requested information for the Dependent. To enroll a new Dependent, a Member's request must be submitted to ConnectiCare within 60 days from the date when the Dependent became eligible to enroll in the Plan.

- **Spouse:** A Spouse may be added as a Dependent if the Subscriber applies no later than 60 days after any event listed below:
 - Loss of minimum essential coverage, as defined by the Affordable Care Act
 - The date of marriage to the Subscriber
 - The Spouse gains status as a citizen, national, or lawfully present individual
 - The Spouse permanently moves into the Service Area.

- **Domestic Partner:** A domestic partner may be added as a dependent if the Domestic Partner meets any eligibility and verification of domestic partnership requirements established by State Law and the Subscriber applies for coverage to add the domestic partner to this Plan. Coverage for the domestic partner will begin on their Effective Date.

- **Children (Under 26 Years of Age):** Children may be added as a Dependent if the Subscriber applies no later than 60 days after any event listed below:
 - Loss of minimum essential coverage, as defined by the Affordable Care Act
 - Becomes a Dependent through marriage, birth, placement for adoption, placement in foster care, adoption, placement for adoption, child support, or other court order.
 - The Child gains status as a citizen, national, or lawfully present individual
 - The Child permanently moves into the Service Area.

- **Newborn Child:** A newborn child of a Member is eligible as a Dependent at birth. A newborn is automatically covered for 91 days, including the date of birth. When ConnectiCare's initial notification is a claim, the newborn child's coverage will end on day ninety-two, unless the Member notifies ConnectiCare that they want to continue the newborn child's coverage. When additional Premium is due, the Subscriber's notification to continue their newborn child's coverage must be made to ConnectiCare within 91 days of the newborn child's birth. The Subscriber will be responsible for any additional Premium, for the first 91 days, regardless of the Member's decision to continue coverage beyond day ninety-one. In some cases, ConnectiCare may receive a claim from another insurer that covers the newborn child. Coordination of benefit rules may require that ConnectiCare pay the newborn's claim. In that case, ConnectiCare will enroll the newborn and pay claims as appropriate. The Member will be responsible for any Premium owed for a newborn enrolled in this manner.

Claims for newborns for eligible Covered Services will be processed as part of the mother's claims. Any Deductible or Annual Out-of-Pocket Maximum amounts met through the processing of a newborn's claims will accrue as part of the mother's Deductible and Annual Out-of-Pocket Maximum. However, if ConnectiCare receives an enrollment file for the newborn within the first 91 days after birth, the newborn will be added as a Dependent with coverage starting from their date of birth. In this case, any claims incurred by the newborn will be processed separately, and any Deductible or Annual Out-of-Pocket Maximum amounts met through these claims will be considered part of the newborn's individual Deductible or Annual Out-of-Pocket Maximum, not the mother's Deductible or Annual Out-of-Pocket Maximum. A claim is considered a newborn's claim when the services are provided to the newborn child.

Discontinuation of Dependent Coverage: Coverage for Dependent will be discontinued on:

- Not earlier than the Agreement anniversary date after the date on which the dependent child attains the age of 26, unless the child has a disability and meets specified criteria (see Child with a Disability).
- The date of a final decree of divorce, annulment or dissolution of marriage is entered between the Dependent Spouse and Subscriber.
- The date of termination of the domestic partnership decree between the Subscriber and Domestic Partner is entered.
- For Child-Only Coverage, at 11:59 p.m. on the last day of the calendar year, the non-Dependent Member reaches the limiting age of twenty-one. Member and any Dependents may be eligible to enroll in other products offered by ConnectiCare.
- Date the Subscriber loses coverage under this Plan.

Continued Eligibility: If a Member becomes ineligible for coverage under this Plan, ConnectiCare will send a written notice at least 30 days before the effective date when the Member's coverage ends. The Member has the option to Appeal against the loss of eligibility.

Premium Payment

To begin and maintain coverage under this Plan, ConnectiCare requires Members to make monthly payments called Premium Payments or Premiums. Premiums for the upcoming coverage month are due no later than the date prescribed by ConnectiCare (referred to as the "Due Date"). ConnectiCare will send the Subscriber written notice before the Due Date to let them know when and how much to pay for next month's coverage.

Payment: ConnectiCare accepts Premium Payments online, by phone, by mail, and through money order. Please refer to ConnectiCare.com or contact Member Services for further information. Premium Payments are not accepted at ConnectiCare office locations. The Member must tell ConnectiCare when the Member's address changes right away. If the change to the Member's new address results in a change in Premium, that change in Premium will be effective the first day of the month after the Member moves. The Subscriber is responsible for any increase in Premium because of an address change, even if they do not tell ConnectiCare about the change until after they move.

Third Party Payment of Premiums and Cost Sharing: Premium payments from third parties, except those required by law or made by a person or entity indicated below, may not be accepted:

1. A Ryan White HIV/AIDS program under title XXVI of the Public Health Service Act.
2. An Indian tribe, tribal organization, or urban Indian organization.
3. A local, state, or Federal government program, including a grantee directed by a government program to make payments on its behalf.
4. Family of a Member; and
5. Religious institutions and other non-profits when criteria are met pursuant to ConnectiCare's policy.

Late Payment Notice: ConnectiCare will send a written notice to the Subscriber's address of record if full payment of the Premium is not received on or before the Due Date. These notifications will inform the Subscriber of the amount owed, include a statement that ConnectiCare will terminate the Agreement for nonpayment if the full amount owed is not received prior to the expiration of the Grace Period as described in the Late Payment Notice, and provide the exact time when the Membership of the Subscriber and any enrolled Dependents will end if payment is not received timely and paid in full.

Grace Period: The Grace Period is the time after the Premium Payment due date when the full payment has not been made. If a Subscriber has not paid the Premium Payment in full by the Due Date, they can do so during the Grace Period to avoid losing their coverage.

- **Grace Period for Subscribers:** When an active Subscriber misses the Premium Payment Due Date, ConnectiCare provides a one-month Grace Period. It starts on the first day of the month for which full Premium is not paid. During this time, ConnectiCare pays all appropriate claims for Covered Services. ConnectiCare will terminate the Agreement as of 11:59 p.m. Eastern Time Zone on last day of the month prior to the beginning of the Grace Period if all past due Premiums are not paid.

Termination Notification for Nonpayment: ConnectiCare will send written notice to the Subscriber informing them that their coverage, as well as coverage for their Dependents, has been terminated due to nonpayment of Premiums. Members may appeal this termination decision by ConnectiCare. For more information on how to file an appeal, please visit [ConnectiCare.com](https://www.connecticare.com), check the Appeals, Complaints, and Grievances section of this Agreement, or contact Member Services.

Reinstatement After Termination: ConnectiCare permits the reinstatement of Members, without a gap in coverage if the reinstatement corrects an erroneous termination or cancellation action.

Re-enrollment After Termination for Nonpayment: If a Subscriber is terminated for nonpayment of Premium and wants to enroll with ConnectiCare for the following plan year during the Open Enrollment Period or a Special Enrollment Period, ConnectiCare may require the Subscriber to pay any past due Premiums. ConnectiCare will also require full payment for the first month's Premium before accepting the Subscriber's enrollment. If a Subscriber pays all past due Premiums, any eligible claims that were previously denied due to nonpayment will be reprocessed for payment.

Renewability of Coverage: ConnectiCare will renew coverage for Members on the first day of each month if all due Premiums have been received. Renewal is subject to ConnectiCare's right to make changes to this Agreement and the Member's ongoing eligibility for this Plan.

Termination of Coverage

The termination date is the first day a former Member is no longer enrolled with ConnectiCare. Coverage for a former Member ends at 11:59 p.m. Eastern Time Zone on the day before the termination date. ConnectiCare will send notice of termination to the Member at least 30 days before the termination date, including the reason for termination. If ConnectiCare terminates a Member for any reason, the Member must pay all outstanding amounts related to their coverage with ConnectiCare, including Premiums, for the period before the termination date.

ConnectiCare will permit a Member to terminate coverage under this Plan, as long as the Member provides ConnectiCare with notice.

ConnectiCare will not cancel or limit this Agreement after two years from the effective date of this Agreement

Effective Dates of Termination: When a Member's coverage terminates under this Plan at their request, the last day of coverage is as follows:

- The termination date requested by the Member or another prospective date selected by the Member, as long as the Member provides notice of at least 14 days to ConnectiCare in writing.
- If the Member has not given reasonable notice of at least 14 days, the termination date will be at the end of the month in which notice was given,
- On a date determined by ConnectiCare, if we are able to terminate in less than 14 days and the Member requests an earlier termination date, or.
- The day before coverage begins when the Member is newly eligible for Medicaid, the Children's Health Insurance Program, or a Basic Health Plan.

A Member may initiate termination of coverage effective on the last day of the month the Member notifies ConnectiCare in writing. Notification to terminate coverage must be provided to ConnectiCare prior to the last day of the month in which you request termination of coverage. However, ConnectiCare will permit the Member to terminate coverage retroactively to the end of the previous month, as long as the Member lets ConnectiCare know before the end of the month after you request to terminate coverage.

For example, if the Member notifies ConnectiCare that they wish to terminate coverage on or before March 30th, ConnectiCare will allow them to terminate their coverage retroactive to February 28th. However, if they notify ConnectiCare on March 31st for termination of coverage on February 28th, ConnectiCare will not accept their request, and termination will be processed for March 31st and Premium will be due and collected for the month of March.

Unless there is fraud or intentional misrepresentation, if a Member's coverage is terminated, any Premium payments received on behalf of the terminated Member for periods after the termination date, minus any amounts owed to ConnectiCare or its Providers for Covered Services provided before the termination date, will be refunded to the Subscriber within 30 days. ConnectiCare and its Providers will have no further liability or obligation under this Plan.

In cases of fraud or intentional misrepresentation, ConnectiCare may retain portions of this amount to recover losses.

ConnectiCare may terminate or not renew a Member for any of the following reasons:

Ineligibility of Dependent and Child-Only Coverage Due to Age: When a Dependent no longer meets the age eligibility requirements for coverage set by ConnectiCare, termination will occur. For further details on the effective date of termination, please refer to the Enrollment section.

Member Ineligibility: A Member no longer meets the eligibility requirements for coverage required by ConnectiCare. ConnectiCare will send the Member notification of loss of eligibility. ConnectiCare will also send the Member written notification when informed that the Member no longer resides within the Service Area. The coverage will end at 11:59 p.m. Eastern Time Zone on the last day of the month following the month in which either of these notices are sent to the Member. The Member may request an earlier termination effective date.

Nonpayment of Premium: Please refer to the Premium Payment section of this Agreement.

Fraud or Intentional Misrepresentation: If a Member engages in fraudulent activity or intentionally misrepresents a material fact related to their eligibility or coverage, ConnectiCare will send written notice of rescission of coverage, and the Member's coverage will end at 11:59 p.m. Eastern Time Zone on the 30th day from the date notification is sent. ConnectiCare may refuse future enrollment from the Member and may report any suspected criminal acts to authorities. Members have the option to appeal the rescission of coverage.

Member Disenrollment Request: Members can request disenrollment through ConnectiCare. ConnectiCare will determine the coverage end date.

Discontinuation of a Particular Product: If ConnectiCare decides to stop offering a particular product, in accordance with State Law, ConnectiCare will provide written notice of discontinuation at least ninety calendar days before the coverage ends.

Discontinuation of All Coverage: If ConnectiCare decides to stop offering all health coverage in a State, in accordance with State Law, ConnectiCare will send Members a written notice of discontinuation at least 180 calendar days before the coverage ends.

Death of Member: Member coverage ends at the time of the Member's death.

Acts of Physical and Verbal Abuse: Member's coverage will end 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

- ConnectiCare employees, affiliates, or subcontractors.

Refusal to Comply with Treatment: Member's coverage will end for a Member's persistent refusal to comply with treatment that is prescribed and Medically Necessary as ConnectiCare will determine.

Reasonable Actions to Secure ConnectiCare Rights: For a Member's failure to take such reasonable actions as may be necessary to secure ConnectiCare rights under this Plan, Coverage will end, as ConnectiCare will determine.

Failure to Pay Cost Sharing: In the event the Member repeatedly fails to make the required Cost Sharing payments to providers, coverage will end, as ConnectiCare will determine.

Access to Care

For an Emergency, call 911. For an Emergency, Members may call an ambulance or go to any Emergency facility, even if it is a Non-Participating Provider or outside of the Service Area while still in the United States. Members do not need Prior Authorization for 911 calls.

24-hour Nurse Advice Line: Registered Nurses are available 24 hours a day, 365 days a year to answer questions and help Members access care.

Member ID Card: Members should always carry their Member identification (ID) card with them. Members must show their ID card every time they receive Covered Services. For a replacement ID card, visit ConnectiCare.com or contact Member Services. Digital versions of the ID card are available through ConnectiCare.com and ConnectiCare Mobile App.

Member Right to Obtain Healthcare Services Outside of Agreement: ConnectiCare allows Members the freedom to seek healthcare services outside this Agreement on any terms or conditions they choose. However, Members will be fully responsible for payment for such services, and these payments will not count toward their Deductible or Annual Out-of-Pocket Maximum for services covered under this Agreement. For exceptions, Members should review the Covered Services section of the Agreement and refer to applicable Balance Billing protections provided by federal and State Law.

Telehealth Services: Telehealth involves the use of telecommunications and information technology to provide access to health assessments, diagnoses, interventions, consultations, supervision, and information across geographical distances. Telehealth includes various technologies such as telephones, facsimile machines, electronic mail systems, and remote patient monitoring devices, which facilitate the collection and transmission of patient data for monitoring and interpretation. Covered Services are also available through Telehealth, except as specifically stated in this Agreement. Telehealth includes telepsychiatry. In-person contact with a Provider is not required for these services, and the type of setting where these services are provided is not limited. The following additional provisions apply to the use of Telehealth services:

- Are meant to be used when care is needed for non-Emergency medical issues
- Are a method of accessing Covered Services, and not a separate benefit
- Are not permitted when the Member and Participating Provider are in the same physical location.
- Do not include texting, facsimile, or email only.

For Covered Services provided through store-and-forward technology, an in-person office visit is required to establish a diagnosis or treatment plan.

Physicians and Advanced Practice Registered Nurse can certify Members use of medical marijuana and provide follow-up care through the use of telehealth.

Access to Participating Providers: Members should contact their Participating Providers or Member Services to make sure they can get the healthcare services that they are seeking. ConnectiCare will assist Members to receive requested Covered Services rendered by other Participating Providers.

Accessing Care for Members with Disabilities: The Americans with Disabilities Act (ADA) prohibits discrimination based on disability and requires that ConnectiCare and its contractors make reasonable accommodations for Members with disabilities. To request reasonable accommodation assistance, Members with disabilities can contact Member Services.

Physical Access: Every effort has been made to ensure that ConnectiCare's offices and the offices of Participating Providers are accessible to individuals with disabilities. Members with special needs should call ConnectiCare's Member Services center at the number shown on the Important ConnectiCare Member Resources page of this Agreement for assistance finding an appropriate Participating Provider.

Access for the Deaf or Hard of Hearing: Call Member Services at the TTY 711 number for assistance.

Access for Persons with Low Vision or Who Are Blind: This Agreement and other important product materials will be made available in accessible formats for people with low vision or who are blind. Large print and enlarged computer disk formats are available. This Agreement is also available in audio format. For accessible formats, or for direct help in reading the Agreement and other materials, please call Member Services.

Disability Access Grievances: If a Member believes ConnectiCare or its doctors have failed to respond to their disability access needs, they may file a grievance with ConnectiCare. Please refer to the Appeals, Complaint, and Grievances section of this Agreement for information regarding how to file a grievance.

Managed Care Rules and Guidelines

Point of Service High-Deductible Health Plan for Use with a Health Savings Account (HSA) Option

If the Member's Plan has the Point of Service High-Deductible Health Plan for use with an HSA option, the following Cost Sharing provisions apply. Members should refer to the Member's Schedule of Benefits to determine if the Member has the Point of Service High-Deductible Health Plan for use with an HSA option. This Plan has been designed to conform to Federal Internal Revenue Service (IRS) guidelines on such plans. However, the IRS has made no determination that this Plan is qualified, and ConnectiCare makes no representation of such. Whether or not an HSA used with this Plan will provide a Member with tax advantages depends on a number of circumstances, including the Member's personal coverage situation, contributions to and withdrawals from their HSA account, other coverage a Member may have and changes the IRS may make to its rules. Members should consult with a qualified tax advisor in determining whether and how this option may provide them with a tax benefit. ConnectiCare cannot guarantee, and ConnectiCare makes no representation that tax benefits will accrue to anyone covered under this Plan. Approval by the Insurance Department does not guarantee tax qualification. Please seek the counsel of a tax advisor.

Primary Care Provider (PCP): A PCP handles routine and basic healthcare needs. PCPs offer services like physical exams, immunizations, and treatment for non-urgent health issues or injuries. ConnectiCare encourages Members to select a PCP from the Provider Directory. If a PCP is not selected, one will be assigned by ConnectiCare.

Members can request to change their PCP at any time through [ConnectiCare.com](https://www.connecticare.com) or by contacting Member Services.

Each family member can select a different PCP. A doctor who specializes in pediatrics may be selected as a child's PCP. A doctor who is an OB/GYN may be selected as a Member's PCP, with no referrals required. Sometimes a Member may not be able to select the PCP from the Provider Directory they want. This may happen because:

- The PCP is no longer a Participating Provider with ConnectiCare, or
- The PCP already has all the patients he or she can take care of right now.

If the Member's current PCP leaves the Plan's network of or Participating Providers or will no longer treat patients at a certain location where the Member may have received care, ConnectiCare will tell the Member about that change 30 days before it happens, if possible, or as soon as possible after ConnectiCare become aware of the change. The Member will then have to pick a new PCP.

No Specialist Referrals: Members do not need a referral from their PCP to seek treatment from a Specialist.

When a Member sees a Specialist regularly and that Specialist is no longer participating with us as a part of our network, ConnectiCare will tell the Member about that change 30 days before it happens, if possible, or as soon as possible after ConnectiCare becomes aware of the change. The Member should contact their PCP or check the ConnectiCare Provider Directory for help in selecting a new Specialist.

Continuity of Care: Members receiving an Active Course of Treatment for Covered Services from a Participating Provider may have a right to continue receiving Covered Services from that Provider if, during an Active Course of Treatment, either of the following occurs:

The expiration or nonrenewal of the Participating Provider's agreement with ConnectiCare, except for any termination of the agreement for failure to meet applicable quality standards or fraud; or

Benefits provided under this Contract with respect to such Provider are terminated because of a change in the terms of the participation of the Provider.

In either case, Members will be timely notified of their right to elect continued care from such Provider under the same terms and conditions that would have applied if the Provider was still a Participating Provider. If the Member elects to continue the care, these terms and conditions will apply for 90 days from ConnectiCare's notice or until the Active Course of Treatment ends, whichever is shorter.

An Active Course of Treatment is when the Member:

- Is undergoing an ongoing course of treatment for a Serious and Complex Condition, which is an acute illness or condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or a chronic illness or condition that life-threatening, degenerative, potentially disabling, or congenital and requires specialized medical care over a prolonged period of time.
- Is undergoing a course of institutional or inpatient care.
- Is scheduled to undergo non-elective surgery, including post-operative care.
- Is pregnant and undergoing a course of treatment for the pregnancy; or
- Is or was determined to be terminally ill, meaning that the Member's life expectancy is 6 months or less, and is receiving treatment for the terminal illness.

ConnectiCare will provide Covered Services at in-network Cost Sharing for the Active Course of Treatment, up to the lesser of ConnectiCare's Allowed Amount or an agreed upon rate for such services. If ConnectiCare and the Provider are unable to settle on an agreed upon rate, the Member may be responsible to the Provider for any billed amounts that exceed ConnectiCare's Allowed Amount subject to federal and State Law. That would be in addition to any in-network Cost Sharing amounts that Members owe under this Agreement. In addition, any payment for the amounts that exceed the previously contracted amount will not be applied to Member's Deductible or Out-of-Pocket Maximum.

Transition of Care: If a Member is hospitalized on the effective date of this Agreement, and their previous health insurance coverage ended before this Agreement began but still covers

the hospital stay, ConnectiCare will not cover any hospital costs until the Member is either discharged or the prior coverage benefits are exhausted—whichever comes first. Discharge refers to the formal release from the hospital once inpatient care is no longer needed; a transfer between hospitals does not count as a discharge. If the prior insurance no longer covers the hospital stay after it ends, the Continuity of Care section of this Agreement will apply. If the Member has no prior coverage, or if that coverage does not extend past the effective date of this Agreement, ConnectiCare will cover applicable services starting from that date. Members must notify ConnectiCare within two days of their effective date so ConnectiCare can review and approve any Medically Necessary services. If care is received at a Non-Participating Hospital, and Balance Billing protections do not apply, the hospital may bill the Member for the difference between ConnectiCare's Allowed Amount and the hospital's charges.

Prior Authorization: ConnectiCare must approve certain medical services, supplies, and prescription drugs before covering them. This process is referred to as Prior Authorization ("PA"). Many Covered Services can be received without the need for Prior Authorization. When Prior Authorization is necessary for a particular medical service or drug, the Member's Provider will generally initiate the PA request on their behalf.

For a comprehensive list of Covered Services and information about whether they require Prior Authorization, please refer to the Prior Authorization list in the Agreement. The list specifies which services require Prior Authorization and which do not. Additionally, Members can reach out to Member Services for assistance.

ConnectiCare reviews Prior Authorization requests upon receiving all required information. In urgent cases, a Member's Provider may request expedited Prior Authorization processing. The Utilization Management department will communicate the decision to the Member's Provider within the timeframes allowed by State and Federal Law.

Members will be notified if their Prior Authorization request is denied, and they will receive information on how to appeal the denial.

Please note that Prior Authorization rules are subject to change. Members are encouraged to contact Member Services or visit [ConnectiCare.com](https://www.ConnectiCare.com) before seeking certain services. Members should read the Member electronic newsletter to learn about the changes. Members can also contact our Member Services Department or visit our web site at www.ConnectiCare.com.

In accordance with State Law, for admissions, services, procedures, or extensions of stay that require Prior Authorization, ConnectiCare will not reverse or rescind such Prior Authorization or refuse to pay for such admission, service, procedure, or extension of stay if:

- ConnectiCare failed to notify the Member's Provider at least three business days prior to the scheduled date of such admission, service, procedure, or extension of stay that such Prior Authorization has been reversed or rescinded on the basis of Medical Necessity, fraud, or lack of coverage; and
- Such admission, service, procedure, or extension of stay has taken place in reliance on such Prior Authorization.

Prior Authorizations with a Participating Provider: Participating Providers must get Prior Authorization of certain services, supplies, or drugs when they are treating a Member before the Member gets that service, supply, or drug.

Prior Authorization with a Non-Participating Provider: If a Member is being treated by a Non-Participating Provider, the Non-Participating Provider will often times send ConnectiCare a request for Prior Authorization for those services, supplies or drugs that need it, but it is the Member's responsibility to make sure that ConnectiCare has given Prior Authorization before the service has been rendered.

Emergency Medical Conditions, Medically Necessary Ambulance Services, and Post-Stabilization Services: Do not need PA. However, Post-Stabilization Services received in the inpatient department of a hospital are subject to the Inpatient Concurrent Review process discussed below.

ConnectiCare does not require Prior Authorization for an ambulance provider responding to a 9-1-1 local prehospital emergency medical service system call for transporting a Member when Medically Necessary by ambulance to a hospital.

Emergency Medical Conditions and Post-Stabilization Services: Do not need PA. However, Post-Stabilization Services received in the inpatient department of a hospital are subject to the Inpatient Concurrent Review process discussed below.

Medical Necessity: Prior Authorization determinations are based on a review of Medical Necessity for the requested service. ConnectiCare is here to help guide Members throughout this process. If a Member has questions about how a certain service may be approved, they can contact Member Services. ConnectiCare can explain how this type of decision is made.

The criteria for determining Medical Necessity for healthcare services include evaluating if the services align with the Member's diagnosis or condition concerning type, amount, frequency, level, setting, and duration. The assessment of Medical Necessity is based on generally accepted medical and scientific evidence and consistent with generally accepted practice parameters.

ConnectiCare will not grant Prior Authorization if the necessary information for review is not provided. Services that do not meet the criteria for Medical Necessity will not receive approval. If the service requested is not a Covered Service, it will not be approved. Members will receive written notice explaining the reasons for the denial of the Prior Authorization request. The Member, Member's authorized representative, or their Provider can appeal the decision for Medical Necessity determination. The decision letter will inform Members of the process to appeal the denial decision. Members can request the clinical review criteria used for assessing Medical Necessity for authorization requests by contacting Member Services.

If a Member or their Provider chooses to proceed with a service that has not been authorized by ConnectiCare, the Member will be responsible for covering the cost of those services.

Utilization Review: Licensed ConnectiCare staff process Prior Authorization requests and conducts concurrent review. Upon request, Providers and Members requesting authorization for Covered Services will be provided with the criteria used for making coverage determinations. ConnectiCare aids and informs Members of alternatives for care when a Member is not authorized for a service. ConnectiCare does not provide financial incentives to encourage Utilization Management decision-makers to deny coverage for Medically Necessary care.

Inpatient Concurrent Review: ConnectiCare conducts concurrent review on inpatient cases. For non-Emergency admissions, a Member, their Provider, or the admitting facility will need to request Prior Authorization at least 14 days before the date the Member is scheduled to be admitted. For an Emergency admission, a Member, their Provider, or the admitting facility should notify ConnectiCare within 24 hours or as soon as reasonably possible after the Member has been admitted. For outpatient and inpatient non-Emergency medical services requiring Prior Authorization, a Member, their Provider, or the admitting facility must notify ConnectiCare at least 14 days before the outpatient care is provided, or the procedure is scheduled.

Second Opinion: A Member's Provider may want another Provider to review a Member's condition, which is called a Second Opinion. This Provider may review the Member's medical record, set an appointment, and may suggest a plan of care. ConnectiCare only covers Second Opinions when furnished by a Participating Provider.

Prior Authorization Denial: No benefits will be provided if a Member receives services or supplies after Prior Authorization has been denied.

If the Member fails to comply with the Prior Authorization requirements of this Plan, there will be a Benefit Reduction or, in some cases, a denial of benefits. An exception to this potential reduction or denial is when ConnectiCare says it is the responsibility of the Participating Provider to request Prior Authorization. In those instances, benefits will not be reduced or denied if the Participating Provider fails to request Prior Authorization.

If the Member receives an explanation of benefits stating a claim was denied where it was the responsibility of the Participating Provider to request the applicable Prior Authorization, the Member should contact our Member Services Department, so ConnectiCare can help the Member resolve the issue.

Benefit Reduction: As mentioned, when the Member uses a Non-Participating Providers to render services, it is the Member's responsibility to obtain Prior Authorization for the services or benefits to be reduced or denied. Member benefits will be denied if the services the Member obtained without Prior Authorization were not Medically Necessary or were not covered by this Plan. If the services the Member obtained without the Prior Authorization were Medically Necessary and otherwise covered by this Plan, then your benefits will be reduced as described below. ConnectiCare refers to this as a Benefit Reduction.

Benefit Reduction Amounts: When a Non-Participating Provider arranges Medically Necessary admission to a Hospital or other facility for the Member or any of the services or supplies listed in the Prior Authorization Addendum of this Agreement are rendered by a Non-Participating Provider, coverage for that admission and/or those services or supplies will be reduced as follows if the Member did not obtain Prior Authorization:

- The lesser of \$500 or 50% of the Maximum Allowable Amount we 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 Prior Authorization was obtained. Benefit Reductions do not apply to Emergency Services.

All Benefit Reductions are the Member's financial responsibility.

Benefit Reduction Exception: If the Member is admitted to a Participating Hospital or other facility that is a Participating Provider by a Provider that is a Non-Participating Physician, the Member will not be responsible for the Benefit Reduction if the Member failed to obtain Prior Authorization 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 Prior Authorization was obtained. Benefit Reductions do not apply to Emergency Services.

Note: Benefit reduction amounts and benefit reduction exceptions do not apply to Medically Necessary ambulance transport.

Provider Networks: Members should refer to their ID card to determine which provider network applies to their Plan. To locate providers that participate in the Member's Plan, the Member can refer to their Provider Directory:

[Connecticare.com/CTFindCare](https://connecticare.com/CTFindCare)

or

Contact Member Services

Participating Provider Network: If the Member's Plan has the Participating Provider network, the Member is free to use either Participating Providers or Non-Participating Providers to obtain Covered Services; however, the Member will pay different levels of Cost Sharing (Copayments, Coinsurance, and/or Deductibles) depending on the practitioner or facility that provides Covered Services.

The Member's Schedule of Benefits will tell the Member the Cost Sharing amount the Member is required to pay.

- If a Member receives Covered Services from a Participating Provider, the Member will generally have lower Member cost.

- If a Member receives Covered Services from a Non-Participating Provider, the Member will generally have higher Member costs.

In-Network Level of Benefits

Using A Participating Provider: When the Member uses Participating Provider benefits are covered at the In-Network Level of Benefits and the out-of-pocket Cost Sharing amount the Member pays is lower than what the Member would have to pay if the Member were to use a Non-Participating Provider. To reduce the Member's out-of-pocket costs, use a Participating Provider.

To locate a Participating Provider, the Member can refer to our Provider Directory, visit us at our web site at ConnectiCare.com/CTFindCare, or call ConnectiCare.

Always Use Participating Providers for the Highest Level of Coverage:

Use your Provider Directory, visit us at our web site at ConnectiCare.com. Providers may end their participation with us for different reasons, so check to make sure your provider is currently participating in our network of Participating Providers before obtaining care. Members can check the professional qualifications of Participating Providers by calling ConnectiCare or by visiting our website at ConnectiCare.com/FindCare.

Member's Role and Responsibility: Members should ask their Participating Provider to refer them to receiving services at another Participating Provider when needed. Members should inquire with all Provider's that any services done on their behalf be rendered Participating Providers.

Exceptions to the Use of Participating Providers: Generally, to be covered at the In-Network Level of Benefits, the services received by the Member should be performed by a Participating Provider. ConnectiCare will only cover services rendered by a Non-Participating Provider at an In-Network Level of Benefits in limited situations, including:

- Emergency Services.
- If ConnectiCare or, as appropriate, our Delegated Program, issue(s) the Member written Prior Authorization to use a Non-Participating Provider before they obtain the service or supply.

Out-Of-Network Level of Benefits

Using A Non-Participating Provider: When the Member uses a Non-Participating Provider for Covered Services benefits are covered at the Out-Of-Network Level of Benefits and the out-of-pocket costs will be higher than they would be if the Member were to use a Participating Provider. The Member's Schedule of Benefits will tell the Member the Cost Sharing amount the Member is required to pay.

Participating Provider Network: If the Member's Plan has the Participating Provider network, the Member is free to use Participating Providers or Non-Participating Providers to obtain Covered Services; however, the Member will pay different levels of Cost Sharing

(Copayments, Coinsurance, and/or Deductibles) depending on the practitioner or facility that provides Covered Services.

This table highlights the way the Participating Provider works and the costs the Member will have. The Member's Schedule of Benefits will tell the Member the Cost Sharing amount the Member is required to pay.

- If a Member receives Covered Services from a Participating Provider, the Member will generally have a higher Member cost.
- If a Member receives Covered Services from a Non-Participating Provider, the Member will generally have the highest Member cost.

Exceptions When Members Still Receive the In-Network Level of Benefits

When a Member obtains care for an Emergency Medical Condition, they will always obtain the In-Network Level of Benefits. In addition, in very limited circumstances, if ConnectiCare determines Medically Necessary services are not available from a Participating Provider without unreasonable travel or delay for the Member, the Member can obtain the In-Network Level of Benefits for care received from a Non-Participating Provider. To receive that care, the Member will need written Prior Authorization before the Member obtains the care from the Non-Participating Provider. Prior 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:

- The Member makes 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.
- ConnectiCare or, as appropriate, our Delegated Program have determined, at our discretion, Medically Necessary services are not available from a Participating Provider without unreasonable travel or delay to the Member.

The Member, the Member's Participating Provider, must request Prior Authorization by calling, faxing, or writing to our Clinical Review Department at:

By telephone: 1-800-562-6833
or
ConnectiCare
Clinical Review Department
175 Scott Swamp Road
Farmington, Connecticut 06032

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

Participating Provider General Rules: Participating Providers generally are providers and facilities that have agreed to provide Members with professional services and supplies. A provider's listing in the Provider Directory or on the ConnectiCare website is not a guarantee the provider is still a Participating Provider at the time health care services are rendered. Members should verify a provider is currently a Participating Provider by calling ConnectiCare.

ConnectiCare 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 Covered Services authorized. The rate ConnectiCare pays Participating Providers for Covered 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.

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

Members should also know that Participating Providers are not prohibited from disclosing to a Member who inquires the method that ConnectiCare uses to compensate them. Members may obtain the professional qualifications of Participating Providers by calling the appropriate telephone number listed in the Agreement or by visiting our web site at ConnectiCare.com/FindCare.

Traveling Out of The Network Access Area: While a Member is traveling out of the Network Access Area, coverage is available for Emergency Services and Urgent Care at the In-Network Level of Benefits while in the United States. 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 Prior 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, are not covered at the In-Network Level of Benefits when the Member is out of the Network Access Area.

After-Hours Care: A Member is covered at the In-Network Level of Benefits for Emergencies during and after the normal business hours of Participating Providers. If possible, please call the Member's Primary Care Provider (PCP) in the event the Member needs medical care after hours. PCPs (or covering PCPs) are always available.

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

Cost Sharing: Examples of Cost-Sharing arrangements are Copayments, Deductibles, and Coinsurance. Members should review their Schedule of Benefits for the Member's Plan, the Cost Sharing amounts of the Member's Plan, any Out-of-Pocket Maximum the Member's Plan may have, and whether benefits are administered per calendar year or per Contract Year.

Amount of In-Network Level of Benefits: The Member's Schedule of Benefits lists the amount of the In-Network Level of Benefits that the Member will receive when a Participating Provider renders Medically Necessary care. In general, the Member is required to pay a Cost Sharing for the In-Network Level of Benefits before the In-Network Level of Benefits is paid, but some benefits require the Member to pay a Deductible first. Members should refer to their Schedule of Benefits for Cost Sharing amount details.

Amount of Out-Of-Network Level of Benefits: The Member's Schedule of Benefits lists the amount of the Out-Of-Network Level of Benefits that the Member will receive when Non-Participating Providers render Medically Necessary Covered Service. Any amount charged by the Non-Participating Provider exceeding the amount of the Out-Of-Network Level of Benefits is the Member's financial responsibility. Members should refer to their Plan's Schedule of Benefits for Cost Sharing amount details.

Deductibles: A Deductible is the total amount that each Member must pay during the year for certain benefits under a plan before ConnectiCare will begin paying for those benefits. The Member's Schedule of Benefits describes the Deductibles that apply to the Member's Plan.

In-Network Level of Benefits Plan Deductible: The Member's Plan may require that the Member meet an In-Network Level of Benefits Plan Deductible for most Covered Services that are rendered by a Participating Provider before ConnectiCare will begin paying for benefits. After the Deductible is met, benefits will be paid subject to Cost Sharing.

Please note, the In-Network Level of Benefits Plan Deductible may not apply to certain Covered Services. However, those services that are exempt from the In-Network Level of Benefits Plan Deductible may be subject to Cost Sharing. To find out the Covered Services that the In-Network Level of Benefits Plan Deductible, Members should refer to their Plan's Schedule of Benefits for details.

Out-Of-Network Level of Benefits Plan Deductible: The Member's Plan may require that the Member meet an Out-Of-Network Level of Benefits Plan Deductible for most Covered Services when they are rendered by Non-Participating Providers before ConnectiCare will begin paying our portion of Covered Services. After the Plan Deductible is met, benefits will be paid subject to the Member's Cost Share. Members should refer to their Plan's Schedule of Benefits for details.

Deductible Accumulation: 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 under their Plan, as applicable. 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 under their Plan. In-Network Level of Benefits Plan Deductible amounts do not accrue toward the Out-Of-Network Level of Benefits Plan Deductible and an Out-of-Network Level of Benefits Plan Deductible amounts do not accrue toward the In-Network Level of Benefits Plan Deductible.

The applicable individual (when the Member is the only Member covered under the Member's 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 Covered Services for their Plan. The applicable family (when the Member and one other person are covered under the Member's 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 the Member's Schedule of Benefits.

An applicable family (when the Member and at least two other persons are covered under the Member's 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 Covered Services incurred by each family member, up to the applicable family Plan Deductible amount as specified on the Member's Schedule of Benefits. 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 Services, except those that have their own Benefit Deductibles.

Benefit Deductible: This Plan may have a specific Benefit Deductible that applies separately to certain benefits. For example, there may be a Benefit Deductible for the Member's prescription drug program (if that prescription drug program has been selected as part of this Plan). When this Plan does have a prescription drug Benefit Deductible, that Benefit Deductible must be individually met by the Member or the Member's Eligible Dependents each year before ConnectiCare will begin paying for those prescription drug benefits. Anything paid by Members for prescription drugs under this Benefit Deductible does not count towards meeting any Plan Deductible amounts.

Additional Deductible Details: Any Copayment or Coinsurance amounts paid do not count towards meeting any of this Plan's Benefit Deductibles or the Plan Deductibles. In addition, amounts the Member 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 ConnectiCare will

begin paying for those benefits. However, Plan Deductibles do need to be met for all other Covered Services before ConnectiCare will begin paying our share.

Deductible and Coinsurance amounts paid for Covered 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 Services or our contracted rate.

Emergency Room Copayments: A Member does not have to pay Emergency room Copayments if the Member:

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

Benefit Maximums: Some benefits may have a benefit maximum. When a benefit does have a maximum number of visits that ConnectiCare will cover, the benefit maximum applies to the total number of visits covered, whether the Member receives the benefit at the In-Network Level of Benefits or Out-Of-Network Level of Benefits. Benefit maximums are listed on the Member's Schedule of Benefits.

Annual Out-Of-Pocket Maximums: This Plan may have an Annual Out-Of-Pocket Maximum. The Out-of-Pocket Maximum amount and the Cost Sharing categories that add up to meet the Member's Out-of-Pocket Maximum are listed on the Member's Schedule of Benefits.

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. Members should refer to their Schedule of Benefits for additional details.

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 the remainder of the year.

The following amounts the Member pay does not count towards this Plan's In-Network Level of Benefits Out-of-Pocket Maximum:

- Amounts a Member pays toward any non-Covered 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.

Members should refer to their Schedule of Benefits for additional details.

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 their 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 the Member pay does not count towards this Plan's Out-Of-Network Level of Benefits Out-of-Pocket Maximum:

- Amounts a Member pays toward any non-Covered 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.

Members should refer to their Schedule of Benefits for additional details.

Copayments: A Copayment is a Cost Sharing arrangement in which a Member pays a specific charge directly to a provider for a covered Health Service every time the service is supplied. Based on their Plan, Members may pay the In-Network Level of Benefits Plan Deductible amount as shown on the Schedule of Benefits before ConnectiCare begin paying for Covered Services. Once the In-Network Level of Benefits Plan Deductible is met, Members may receive Covered Services and pay only the applicable Copayment amounts as described on the Schedule of Benefits.

The In-Network Level of Benefits Plan Deductible does not apply to certain Covered Services, but those Covered Services are subject to the applicable Copayment amount listed on the Schedule of Benefits. Please refer to the Member's Schedule of Benefits to find out which services are not subject to the In-Network Level of Benefits Plan Deductible.

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

Copayments vary by Plan. Members should refer to their Schedule of Benefits for additional details.

- A Member does not have to pay Emergency room Copayments if the Member:
- Is admitted directly to the Hospital from the emergency room, or

- Was treated at an Urgent Care Center and told by the treating provider that he/she should go immediately to an emergency room (ER) because the ER was better equipped to handle their medical problem.

Coinsurance: Coinsurance is the Member's share of a percentage of the cost of Covered Services after any applicable Deductible is met. Members should refer to their Schedule of Benefits for additional details.

Benefit Maximums: Some benefits may have a benefit maximum. When a benefit does have a maximum number of visits that ConnectiCare will cover, the benefit maximum applies to the total number of visits covered, whether the Member receives the benefit at the In-Network Level of Benefits or Out-Of-Network Level of Benefits. Members should refer to their Schedule of Benefits for additional details.

The Out-Of-Network Level of Benefits Cost Sharing Maximum is met for a Member if their individual Out-Of-Network Level of Benefits Copayment and Coinsurance amounts paid to Non-Participating Providers adds up to the per member Out-Of-Network Level of Benefits Cost Sharing Maximum.

The family In-Network Level of Benefits Cost Sharing Maximum is met by the total Copayment and Coinsurance amounts paid by a Member and all of the members in the family who are covered by the Plan to Non-Participating Providers adds up to the per family Out-Of-Network Level of Benefits Cost Sharing Maximum. Even when the Out-Of-Network Level of Benefits Cost Sharing Maximum is met, Members are still responsible for other applicable Deductible amounts, as well as those amounts for covered Out-Of-Network Level of Benefits in excess of the Maximum Allowable Amount. Cost Sharing Maximum amounts do not include:

- Amounts a Member pays toward any penalties or Benefit Reductions.
- Charges by a provider in excess of the Maximum Allowable Amount.
- Deductibles.

Members should refer to their Schedule of Benefits for additional details.

Medical Necessity And Appropriate Setting For Care

Medically Necessary: Covered 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: 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 Covered Services that require 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. ConnectiCare 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 us. ConnectiCare use input from physicians, including specialists, to approve, and in some cases develop, our Medical Necessity protocols. Case Managers help to arrange and coordinate Medically Necessary care. Alternative individual plans may include coverage of otherwise non-covered services or supplies.

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 our Members. The QI Program helps us to better serve Members, employers, Participating Providers. Through the QI Program we:

- Systematically monitor, evaluate, and suggest improvements for both the process of care and the outcome of care delivered to Members.
- Identify and implement opportunities for improvement in the quality of care and services delivered to Members, both administrative and clinical, including behavioral health.
- Evaluate and improve Members' access to and satisfaction with clinical and administrative services.
- Facilitate Members' access to appropriate medical care.
- Encourage 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.
- Carry out systematic data collection related to plan and practitioner performance and communicate, in the aggregate, these data and their interpretation to internal and peer review committees for analysis and action.
- Monitor whether the care and service provided meets or exceeds established local, state, and national managed care standards.
- Develop 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.

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

When ConnectiCare receives a request for coverage for a New Treatment, ConnectiCare 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 our review phase of a New Treatment, ConnectiCare may, in some limited circumstances cover a New Treatment for Members in the same or similar circumstances before our determination is made. Once ConnectiCare completes our review, if ConnectiCare determines whether the New Treatment should be covered, those New Treatments rendered AFTER our determination will be covered. There will be no retroactive coverage of a New Treatment.

If ConnectiCare 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 our 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.

A New Treatment may also require Prior 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 Prior Authorization requirements or dosage limits placed on it. When the Member receives a medication that is a New Treatment, the conditions under which the Member 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 Prior Authorization, or to obtain information about whether ConnectiCare have made our determination with respect to a New Treatment, the Member should contact our Member Services Department.

Experimental Or Investigational: A service, supply, device, procedure, or medication (collectively called "Treatment") will 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.

ConnectiCare 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 us, to be Experimental Or Investigational, will be considered as a covered Health Service under this Plan until such time as the Treatment is deemed by us to be no longer Experimental Or Investigational and ConnectiCare have 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.

Certain Investigational Items Outside of Clinical Trials: For the purposes of this subsection, an investigational item means a drug, biological product or device which has successfully completed a Phase One clinical trial of the FDA, but which has not yet been approved for general use by the federal drug administration (FDA) and which remains under investigation in clinical trial approved by the FDA.

Terminal Illness: A medical condition which the patient's treating physician anticipates with reasonable medical judgment will result in a patient's death or a state of permanent unconsciousness from which recovery is unlikely within a period of one year.

Connecticut law allows patients with a Terminal Illness who meet certain qualifications to be treated with Investigational Items outside of clinical trials. The cost of such an Investigational Item is excluded under this Plan. Any costs associated with or incurred as a result of such treatment with an Investigational Item are excluded under this Plan, beginning on the date treatment with the Investigational Item begins and ending six months after the date the treatment ends. Any costs associated with or incurred as a result of treatment with an Investigational Item which has been provided outside of the requirements of Connecticut law are excluded without limitation.

The Member is required to provide us with a copy of the executed written informed consent document if the Member begins treatment with an Investigational Item. You are responsible for reimbursing ConnectiCare for any costs paid by ConnectiCare for Investigational Items, or for costs associated with or incurred as a result of treatment with an Investigational Item that are excluded as described above.

Please refer to the other provisions in this Experimental Or Investigational subsection for more information about coverage of Experimental Or Investigational treatments.

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 ConnectiCare determines 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. ConnectiCare 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 ConnectiCare has made a determination that there is sufficient evidence of therapeutic value for the Treatment and ConnectiCare 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: ConnectiCare 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 our behalf. Delegated Programs may be added or removed from this Plan at any time.

Covered Services

This section describes the Covered Services available with this Plan. Covered Services are available to current Members and may be subject to Cost Sharing, exclusions, limitations, authorization requirements, approvals and the terms and conditions of this Agreement. ConnectiCare will provide and pay for a Covered Service only if all of the following conditions are satisfied:

- The individual receiving Covered Services on the date the Covered Services are rendered is a Member.
- The Covered Services are Medically Necessary and/or approved by ConnectiCare.
- The services are identified as Covered Services in this Agreement.

ConnectiCare will not cover any services, supplies, or equipment that are either provided prior to the effective date or after the termination date of this Agreement. Members should read this Agreement completely and carefully to understand their coverage and to avoid being financially responsible for services that are not covered under this Agreement.

Members should refer to their Schedule of Benefits for additional details on Cost Sharing and limitations. Cost Sharing for Covered Services may depend on the place of service where the Member receives the services or the originating site of the services.

Essential Health Benefits: Covered Services for Members include Essential Health Benefits (EHB), as defined by the Affordable Care Act (ACA) and its corresponding federal regulations. Services that are not EHBs will be specifically described in this Agreement.

EHB coverage includes at least ten categories of benefits identified in the ACA and its corresponding federal regulations. Members cannot be excluded from coverage in any of the 10 EHB categories. Please note, Members will not be eligible for EHB pediatric Covered Services under this Agreement as of 11:59 p.m. on the last day of the month that they turn age 19, unless as otherwise outlined in this Agreement. This includes pediatric dental coverage that can be purchased separately through the Marketplace and pediatric vision coverage. Access Health CT plans cover pediatric dental and vision benefits to age 26.

Under the ACA and its corresponding federal regulations governing EHBs:

ConnectiCare is not allowed to set lifetime limits or annual limits on the dollar value of EHBs provided under this Agreement.

When EHB preventive services are provided by a Participating Provider, the Member will not have to pay any Cost Sharing. ConnectiCare must ensure that the Cost Sharing that Members pay for all EHBs does not exceed an annual limit that is determined under the ACA.

For the purposes of this EHB annual limit, Cost Sharing refers to any costs that a Member is required to pay for EHBs. Cost Sharing includes Deductibles, Coinsurance and Copayments, but excludes Premiums and Member spending on non-Covered Services.

Preventive Services: In accordance with the Affordable Care Act and as part of Member's Essential Health Benefits, ConnectiCare covers preventive services at no Cost Sharing for Members. Preventive services include:

- Those evidenced-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF). Please visit the USPSTF website for preventive services recommendations at: uspreventiveservicestaskforce.org
- Immunizations for routine use in children, adolescents, and adults as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC), including if needed, at least a twenty-minute consultation between the Member and Provider authorized to administer such immunizations to such individual.
- With respect to infants, children, and adolescents, such evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA). This also includes coverage for preventive care and screenings for individuals twenty-one years of age or younger in accordance with the most recent edition of the American Academy of Pediatrics' "Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents" or any subsequent corresponding publication.

- Preventive services and screenings provided for in comprehensive guidelines supported by HRSA, to the extent not already included in certain recommendations of the USPSTF.
- Pre-exposure prophylaxis (PrEP) for the prevention of HIV infection for people at high risk of infection without Cost Sharing. This includes:
 - PrEP medication (antiviral drugs when prescribed to prevent HIV infection)
 - Laboratory tests and other diagnostic procedures (including testing for HIV, sexually transmitted infections, renal functionality, Hepatitis B, Hepatitis C, and lipid panel)
 - Counseling about antiretroviral medication adherence

Preventive Services furnished by a Participating Provider are covered at no cost, but a Member can receive preventive services from a Non-Participating Provider at the Out-of-network Cost Sharing. Office visits associated with preventive services are covered at no Cost Sharing when the service is not billed separately (or is not tracked as individual encounter data separately) from the office visit, and the primary purpose of the office visit is the delivery of the recommended preventive service.

As new recommendations and guidelines for preventive services are published and recommended by the government agencies identified above, they will become covered under this Agreement. Coverage will start for product years that begin one year after the date the recommendation or guideline is issued or on such other date as required by the ACA and its implementing regulations. The Plan year, also known as a policy year for the purposes of this provision, is based on the calendar year.

If an existing or new government recommendation or guideline does not specify the frequency, method, treatment, or setting for the provision of a preventive service, then ConnectiCare may impose reasonable coverage limits on such preventive care. Coverage limits will be consistent with the ACA, its corresponding federal regulations, and applicable State Law. Please note: Members who are enrolled in one of ConnectiCare’s HSA-compatible high-deductible health plans (HDHPs), are still responsible for meeting their Deductible for these services.

Preventive Exams and Services: ConnectiCare covers the following as preventive services when the Member receives the service in a Provider’s office:

- Preventive care medical services (routine exams and preventive care) for children aged twenty-one and under in accordance with the most recent edition of the American Academy of Pediatrics’ “Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents” or any subsequent corresponding publication.
- Routine eye care, including refraction (a test to determine nearsightedness or farsightedness) for Members under age 26 is covered up to the maximum benefit, as shown on the Member’s Schedule of Benefits.
- Preventive care medical services (annual wellness exam and preventive care) for adults twenty-one and over.
- Gynecological preventive exam office services.
- Female sterilization services provided by a Provider are covered.

- Preventive maternity care office services. Please note, some diagnostic laboratory or radiology services in relation to prenatal care, such as an ultrasound may require Cost Sharing.
- Birth-to-Three program, including early intervention services provided as part of an individualized family service plan. Early intervention services consist of care as part of an Individualized Family Service Plan as prescribed by State law and are covered for eligible children, who are a Member. Eligible children means:
 - Children from birth to thirty-six months of age, who are not eligible for special education and related services and
 - Children thirty-six months of age or older, who are receiving early intervention services and are eligible or being evaluated for participation in preschool services pursuant to federal law and State Law until such children are enrolled in such preschool services, and who need early intervention services because such children are:
 - (i) Experiencing a significant developmental delay as measured by standardized diagnostic instruments and procedures, including informed clinical opinion, in one or more of the following areas: Cognitive development; physical development, including vision or hearing; communication development; social or emotional development; or adaptive skills; or
 - (ii) Diagnosed as having a physical or mental condition that has a high probability of resulting in developmental delay.

Birth-to-Three service coverage includes the following:

- Any benefit amount paid for early intervention services does not count towards any benefit maximums this Plan may have, except as permitted under the 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 ConnectiCare to rescind or cancel the Member's coverage under this Plan.
- Please note: For Members enrolled in an HSA-compatible high-deductible health plan (HDHP) these services will be subject to the Deductible. Members should refer to their Schedule of Benefits for additional details.

Preventive Service Screenings: ConnectiCare covers the following screenings as preventive services:

- Blood lead screening and risk assessments ordered by Primary Care Providers
- Breast Cancer Screenings, including:
 - Coverage for diagnostic and screening mammograms for Members. This includes a baseline mammogram for a Member who is (1) age 35 to 39 or (2) under age 35 and at an increased risk for breast cancer. It also includes an annual mammogram for a Member who is (1) age 40 or older or (2) under age 40 and at an increased risk for breast cancer. Please note, a Member may choose mammogram may be provided by breast tomosynthesis at their option.
 - Coverage for comprehensive diagnostic and screening ultrasounds of a Member's entire breast(s) if the Member has (1) heterogeneous or dense breast tissue or (2) an increased risk of breast cancer.

- Coverage for diagnostic and screening magnetic resonance imaging (MRI) of a Member's entire breast(s) in accordance with American Cancer Society guidelines for a Member who is (1) age 35 or older or (2) under age 35 and at increased risk for breast cancer.
- Coverage for breast biopsies, certain prophylactic mastectomies, and breast reconstructive surgery following a mastectomy.
- Please note: For Members enrolled in an HSA-compatible high-deductible health plan (HDHP), diagnostic services will be subject to the Deductible. Members should refer to their Schedule of Benefits for additional details.
- Cervical Cancer Screening defined by the United States Preventive Service Task Force (USPSTF) and the Health Resources and Services Administration (HRSA)
- Colorectal Cancer Screening. 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 they should get colorectal cancer screenings. Members may have to pay a Cost Sharing for these screenings. 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 Sharing amount for repeat colonoscopies ordered by a doctor in a benefit year, unless the Member is enrolled in an HSA-compatible high deductible health plans (HDHPs). The amount depends on where the procedure is received and the Member's Plan. Colorectal cancer screenings include:
 - Using fecal occult blood testing, sigmoidoscopy, colonoscopy, or radiological imaging, are covered in accordance with the recommendations established by the American Cancer Society, based on the ages, family histories and frequencies provided in the recommendations.
- Ovarian Screening and related services, including:
 - Genetic testing for Members with a family history of ovarian cancer.
 - Routine screening for ovarian cancer, including office visits, and annual surveillance tests for Members at risk.
 - CA125 monitoring of ovarian cancer following treatment; and
 - Genetic testing of BRCA1, BRCA2, and other gene variants that increase the risk of gynecological cancer when recommended by a healthcare provider.

Please note: For Members enrolled in an HSA-compatible high-deductible health plan (HDHP), diagnostic services will be subject to the Deductible. Members should refer to their Schedule of Benefits for additional details.

Preventive Service Mental Health Wellness Exam: ConnectiCare covers mental health wellness examinations conducted by a licensed mental health professional are covered up to two visits per year without Prior Authorization and with no Cost Sharing. A mental health wellness examination is a screening or assessment that seeks to identify any behavioral or mental health needs and appropriate treatment resources. Mental health wellness examinations may include the following:

- Observation,

- A behavioral health screening,
- Education and consultation on healthy lifestyle changes,
- Referrals to ongoing treatment, mental health services, and other necessary supports,
- Discussion of potential medication options,
- Age-appropriate screenings or observations to understand the Member's mental health history, personal history, and mental or cognitive state, and
- Relevant input from an adult through screenings, interviews, or questions if appropriate.

A licensed mental health professional is one of the following licensed professionals:

- A professional counselor or certain people practicing under supervision,
- Physicians certified in psychiatry,
- An advanced practice registered nurse (APRN) certified as a psychiatric and mental health clinical nurse specialist or practitioner,
- A psychologist,
- A marital and family therapist,
- A clinical social worker, or
- An alcohol and drug counselor.

Unless specified in this Agreement, not covered under this subsection are charges for:

- Any dental service, procedure, or treatment modality not specifically listed in Dental subsection.
- Services which are covered to any extent under any other part of this Agreement.
- Services which are for diagnosis or treatment of a suspected or identified illness or injury.
- Exams given during the Member's inpatient stay for medical care.
- Services not given by a physician or under his or her direction.
- Psychiatric, psychological, personality or emotional testing or exams.

Notice for High-Deductible Health Plans: For High-Deductible Health Plans (HDHPs), the general rule is that most Covered Services are subject to the Deductible, meaning Members pay out of pocket until they meet their deductible. However, certain preventive services are allowed to be covered without applying the deductible, to encourage preventive care.

For HDHP Plans, some Preventive Services may be subject to Deductible. If the service is diagnostic rather than preventive, even if it is the same type of procedure (e.g., colonoscopy done due to symptoms vs. routine screening), it could be subject to Deductible. Also, any service not classified as preventive under ACA or IRS guidance would still be subject to the Deductible.

ConnectiCare is here to assist Members in navigating Cost Sharing applicability.

Dental Services

Pediatric Dental Care (Members Aged 26 and Under): Important: Members may opt to receive Dental Services that are not Covered Services under this Plan, a Participating Provider, including a Participating Dentist may charge their usual and customary rate for such

services or procedures. Prior to providing the Member with Dental Services that do not cover benefits, the dental provider should provide the Member with a treatment plan that includes each anticipated service or procedure to be provided and the estimated cost of each such service or procedure.

Members should consult with their dentist and submit a request for predetermination of Covered Services. This step protects the Member and their Dentist since it advises the Member both in advance as to what portion of the dental treatment costs may be covered by ConnectiCare.

ConnectiCare covers Medically Necessary pediatric dental care for Members thorough the Calendar Year they turn 26 years of age, including the following:

- Diagnostic Services: Oral examinations, diagnostic casts, X-Rays, Full mouth x-ray series, periapical x-rays, bitewing x-rays, panoramic x-rays.
- Preventive: Prophylaxis, fluoride applications, and space maintainers.
- Restorative: Treatment of tooth decay includes the use of amalgam and/or composite restorations (fillings).
- Restorative-Crowns: The use of stainless steel, gold, semiprecious, or non-precious metals to restore a tooth or teeth which cannot be restored with amalgam or composite restorations.
- Endodontics: Treatment of the diseases of the nerve of the tooth including pulp capping, pulpotomy, root canal, apexification and apicoectomy.
- Periodontics: Treatment of the supporting tissues of the teeth, gums, and underlying bone, with either surgical or non-surgical procedures (where applicable) including gingivectomy or gingivoplasty.
- Prosthodontics -Removable: Replacement of missing teeth by the use of a removable appliance including full and cast or acrylic partial dentures.
- Prosthodontics Adjustment: Repair or modification of existing removable and/or fixed appliances so that they can continue to be serviceable including adjustments, repairs, rebasing, and relining.
- Prosthodontics Fixed: The use of gold, semi-precious, or precious metal to replace a missing tooth or teeth, which cannot otherwise be replaced with a removable appliance including fixed partial denture pontics and crowns.
- Extractions: The extraction, either simple or surgical, of either a single tooth or multiple teeth, the shaping of bone ridges, the removal of a tooth end abscess, etc. are included.
- Bony Impactions: The surgical removal of teeth partially or fully covered by bone are included.
- Orthodontics: The straightening of teeth for dental health reasons are included.
- General Services: Benefits for other adjunctive general services as described in the American Dental Association (ADA) Code on Dental Procedures and Nomenclature (CDT Code), which are not included in the specific categories listed above, include (where applicable) general anesthesia (administered by a Dentist), IV sedation, and behavior management.

Dental implants, which are devices specifically designed to be placed surgically within or on the mandibular or maxillary bone as a means of providing for dental replacement are not covered.

Routine Adult Dental Care (Members Over Age 26): Some Plan options provide adults over age 26 with coverage for the following routine dental care when provided in a dental place of service:

- Preventive examinations that help stop oral disease from occurring, including:
- Visits (two times per year).
- Consultations (one within a six-month consecutive period) and only after primary teeth erupt.
- Routine cleanings (two times per year).
- X-rays, including full mouth x-rays, or panoramic x-rays at 36-month intervals, bitewing x-rays at six-month intervals, and other x-rays, if Medically Necessary and only after primary teeth erupt.

To determine whether the Member's Plan provides these adult preventive dental benefits, and the Cost Sharing amounts Members are required to pay for those benefits, Members should refer to their Schedule of Benefits.

Dental Anesthesia: Medically Necessary anesthesia, nursing, and related Hospital services for the treatment of dental conditions are covered when:

- The services, supplies or medicines are Medically Necessary as determined by the Member's dentist or oral surgeon and his/her Primary Care Provider (PCP), and
- A licensed dentist and a doctor specializing in primary care decides the Member has a complicated dental condition that requires treatment be done in a Hospital; or
- A licensed doctor specializing in primary care decides the Member has a developmental disability that puts the Member at serious risk.

Medically Necessary anesthesia for the treatment of dental conditions may also be covered in an outpatient setting as long as both of the above conditions are met.

Outpatient facility and anesthesia charges are covered if the Member needs to have dental services performed in an outpatient facility because the Member has a serious medical condition that requires close monitoring or treatment during the procedure. In this situation, ConnectiCare does not pay for what the provider charges during the procedure.

Durable Medical Equipment, Prosthetics, and Supplies

Artificial Limbs: Medically Necessary Artificial Limbs are covered. In addition, Medically Necessary repairs or a replacement to an Artificial Limb as determined by the Member's provider are also covered, unless the repair or replacement is necessitated by misuse or loss. Benefits for Artificial Limbs are covered at the Cost Sharing amounts shown in the Benefit Summary. This benefit is separate from other prosthetic benefits described in other subsections of this Agreement. There is no coverage for Artificial Limbs designed exclusively for athletic purposes.

Disposable Medical Supplies: 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 Sharing as shown on the Member's Schedule of Benefits. The following limitations and conditions apply:

- Disposable medical supplies must be ordered by a Provider. Please note, having a Provider's order is not a guarantee that the disposable supplies are covered.
- Disposable medical supplies will also be covered if they are dispensed in a facility in relation to the rendering of a Covered Services by a Provider, including hypodermic needles and syringes.

In these cases, the disposable medical supplies will be covered as part of the services received at the facility. ConnectiCare 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 Sharing amount, as shown on the Schedule of Benefits. The following limitations and conditions apply:

- DME must be ordered by a Provider. Please note, having a Provider'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.
- ConnectiCare reserves the right to limit the payment of charges to the most cost efficient and least restrictive level of service or item which can be safely and effectively provided.
- 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. ConnectiCare 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 Prior Authorization if it is dispensed in:
 - A physician's office as part of physician services,
 - An emergency room as part of Emergency Service, or
 - An Urgent Care Center as part of Urgent Care.In these cases, DME will be covered as part of the DME, Emergency Services or Walk-In/Urgent Care Centers benefit.
- 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 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

Hearing Aids: ConnectiCare covers Hearing aids are covered up to one hearing aid per ear every 24 months.

Ostomy Supplies and Equipment: Medically Necessary disposable medical supplies and durable medical equipment for ostomy care are covered after the applicable Cost Sharing

amount described on the Member's Schedule of Benefits. Examples of covered ostomy supplies, and equipment are collection devices, irrigation equipment and supplies, skin barriers and skin protectors.

The following limitations and conditions apply to the ostomy supplies and equipment benefit:

- Ostomy supplies and equipment must be prescribed or ordered by a doctor as a result of surgery.
- To obtain the supply or equipment, the Member must present the prescription or doctor's order to the provider that is selling the supply or equipment.
- Ostomy supplies or equipment will also be covered as part of the Outpatient Services, Emergency Services or Walk-In/Urgent Care Centers benefit if dispensed in an outpatient facility, Emergency Room, or Urgent Care.

Wheelchair Repair: ConnectiCare does not require a prescription or Prior Authorization for Medically Necessary repair or replacement of a complex rehabilitation technology (CRT) wheelchair unless the original prescription is more than five years old.

Wigs: A wig prescribed by an oncologist for a Member suffering hair loss as a result of chemotherapy or radiation therapy are covered without Prior Authorization. Coverage is limited to one wig per year.

Wound Care Supplies: ConnectiCare covers Medically Necessary wound care supplies (including wound vacs) when:

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

If wound care supplies are not being provided in conjunction with the covered home care services, then the applicable Cost Sharing amount will apply.

Medically necessary wound care supplies administered under the direction of a physician for the treatment of epidermolysis bullosa are covered. Supplies will be covered after the applicable Cost Sharing amount. The Cost Sharing amount depends on where the supplies are obtained.

Emergency Services and Urgent Care:

Emergency Services are available 24 hours a day, 7 days a week for Members. Members who think they are having an Emergency should call 911 right away and go to the closest Emergency facility. When receiving Emergency Services, Members should bring their Member ID card. Members who do not believe they need Emergency Services, but who need medical help, should call the 24-hour Nurse Advice Line toll-free or contact their PCP. Members should not go to an Emergency room if the condition is not an Emergency. ConnectiCare covers benefits for isolation care and Emergency Services provided by the state's mobile field hospital.

Emergency Services When Out of Service Area: Members should go to the nearest Emergency room for care when outside the ConnectiCare Service Area when they think they

are having an Emergency. Please contact Member Services within 24 hours or as soon as possible.

ConnectiCare does not provide coverage for Emergency Services outside the United States.

Emergency Services Rendered by a Non-Participating Provider: ConnectiCare covers Emergency Services obtained from Non-Participating Providers in accordance with State and Federal Law. Emergency Services, whether from Participating Providers or Non-Participating Providers, are subject to the Cost Sharing for Emergency Services in the Schedule of Benefits at the in-network level. Members are not subject to Balance Billing for Emergency Services.

Emergency Services for Accidental Ingestion or Consumption of Controlled Drugs: Emergency medical care for the accidental ingestion or consumption of controlled drugs. Coverage is subject to a minimum of 30 days inpatient care.

Emergency Medical Transportation: Emergency Medical Transportation (ground and air ambulance), or ambulance transport services provided through the 911 emergency response system are covered when Medically Necessary. These services are covered only when other types of transportation would put the Member's health or safety at risk.

ConnectiCare covers and does not require Prior Authorization for Non-Emergency Medical Transportation by an ambulance to a Hospital when Medically Necessary.

Urgent Care Services: Urgent Care Services are those services needed to prevent the serious deterioration of one's health from an unforeseen medical condition or injury. Urgent Care Services are subject to Cost Sharing in the Schedule of Benefits. For after-hours Urgent Care Services, Members should call their PCP or the Nurse Advice Line. If the Member wants follow-up care to be covered at the highest level of benefits that their Plan offers, then the Member 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.

Walk-In Care: ConnectiCare covers Walk-In Care Clinic services only when the Member's Provider is unable to provide or arrange for the treatment of common ailments like:

- Colds, flu symptoms, sore throat, cough, or upper respiratory symptoms.
- Ear or sinus pain.
- Minor cuts, bruises, or scrapes.
- Rash, hives, stings, and bites.
- Sprains.

Walk-in care is covered after the Cost Sharing amount as shown on the Member's Schedule of Benefits. There is no coverage for routine physical exams, immunizations, or follow-up care at a Walk-In Care Clinic.

Inpatient Services

Inpatient services refer to medical care provided to patients who are admitted to a hospital or other healthcare facility and stay overnight or longer for continuous medical monitoring.

ConnectiCare covers the following inpatient services:

General Hospitalization Services: Medically Necessary inpatient Hospital services generally performed and usually provided by acute care general Hospitals are covered. Examples of covered inpatient hospital Covered Services are:

- Administration of whole blood, blood plasma and derivatives.
- Anesthesia and oxygen services. Please note: ConnectiCare does not impose arbitrary time limitation for any covered general anesthesia for a medically necessary procedure or deny, reduce, terminate or fail to reimburse for general anesthesia solely because the duration of care exceeded a predetermined time limit.
- 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.
- Therapy: cardiac rehabilitation, inhalation, occupational, physical, pulmonary, radiation and speech.
- Treatment for any injury sustained by a Member when such injury is alleged to have occurred or occurs under circumstances in which the Member has an elevated blood alcohol content, or the Member has sustained such injury while under the influence of intoxicating liquor or any drug or both.

Non-Covered Services include, but are not limited to, private duty nursing, guest trays and patient convenience items.

Hospice Services (Inpatient): ConnectiCare covers Medically Necessary hospice care at a licensed facility when a Member has a life expectancy of six months or less. The Member's rendering Provider must contact ConnectiCare to arrange hospice care. Hospice care does not apply to any specific benefit maximums to the Member's Plan may have. ConnectiCare covers inpatient hospice services in combination with home hospice services for up to six months per calendar year.

Inpatient Hospital Services: Members must have a Prior Authorization at least five business days before the Member is admitted before receiving covered hospital services, except in the case of Emergency Services and other exceptions identified in this Agreement. ConnectiCare will work with the Member and their Provider to provide medically appropriate transportation to a Participating Provider facility. If coverage with ConnectiCare terminates during a hospital stay, the services received after the Member's termination date are not Covered Services.

Mastectomy Services: Covered Services for a mastectomy or lymph node dissection are covered.

- If the Member is admitted to a Hospital, ConnectiCare will cover a minimum of a 48-hour length of stay following the mastectomy or lymph node dissection. ConnectiCare 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: ConnectiCare covers Maternity Services in an inpatient place of service. Any Member who is admitted to a Hospital to have their 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.

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.
 - 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.

ConnectiCare does not require Prior Authorization for an inter-hospital transfer of:

1. A newborn infant with a life-threatening emergency or condition or
2. The newborn's hospitalized mother to accompany

Optional Early Discharge Programs: If medically appropriate, and if the Member and her attending Provider both approve, a Member may choose a shorter Hospital length of stay. In these situations, a follow-up visit within forty-eight hours of discharge and additional follow-up visit within seven days of discharge are covered. Such follow-up services shall include, but not be limited to, physical assessment of the newborn, parent education, assistance and training in breast or bottle feeding, assessment of the home support system and the performance of any medically necessary and appropriate clinical tests.

Skilled Nursing and Rehabilitation Facility Services: Medically Necessary skilled nursing care is covered up to the maximum benefit as shown on the Member's Schedule of Benefits 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 ConnectiCare 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.

ConnectiCare covers 90 days per year total of combined Skilled Nursing Facility and Rehabilitation Facility services. There is no coverage for long-term care, private duty nursing or Custodial Care.

Transplants (Solid Organ Transplants and Bone Marrow): Medically Necessary transplants are covered after the applicable Cost Sharing amount. The Cost Sharing 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.

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

If Prior 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, the Member must use Participating Providers. By using Participating Providers, the Member can reduce the Member's out-of-pocket expenses.

Transplant Donor Benefits: Medically Necessary expenses of organ donation, including Medically Necessary services and tests to determine if the organ or the bone marrow/stem cell type is a suitable match, are covered after the applicable Cost Sharing amount. The Cost Sharing amount depends on where the procedures are received.

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

Bone Marrow Testing: Expenses arising from human leukocyte antigen testing (also known as histocompatibility locus antigen testing) for A, B or DR antigens for use in bone marrow transplantation are covered after the applicable Cost Sharing when the testing is performed in a facility both accredited by the American Society for Histocompatibility and Immunogenetics and certified under the Clinical Laboratory Improvement Act of 1967.

The Cost Sharing for the testing depends on who ordered the procedures and where the procedures are provided and shall not be more than 20% of the cost of such testing per year unless the Member is enrolled in one of ConnectiCare's HSA-compatible high-deductible health plans (HDHPs).

Coverage for the testing is limited as follows:

- To a Member who, at the time of the testing, completed and signed an informed consent form that also authorizes the results of the test to be used for participation in the National Marrow Donor Program, and
- One test per Member per lifetime.

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 fifty 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 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 ConnectiCare to approve payment, transportation, lodging, and meal receipts must be sent to ConnectiCare at the appropriate address listed in the information the Member will receive from ConnectiCare.

Mental Health Care and Substance Use Disorder Services

ConnectiCare covers Medically Necessary mental health care and substance use disorder services) under this Plan and outlined in this provision, which are administered under the

ConnectiCare Behavioral Health Program for in-network services. All services must be provided by or under the direction of a behavioral health provider who is properly licensed and qualified by law and acts within the scope of their licensure. Decisions regarding mental health coverage are made by licensed mental health professionals.

Prior Authorization will not be required for services that are provided to a Member following the Member's admission to an emergency department; upon the referral of the Member's treating physician, psychologist, or advanced practice registered nurse if there is imminent danger to the Member's health or safety or the Member poses an imminent danger to the health or safety of others; or at an urgent crisis center.

Nothing in this provision shall preclude ConnectiCare from using other forms of utilization review, including, but not limited to, concurrent and retrospective review. ConnectiCare does not deny coverage of substance use disorder services solely because such substance abuse services were provided pursuant to an order issued by a court of competent jurisdiction.

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 Inpatient Services section.

Inpatient Substance Use 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 Inpatient Services section. Benefits also include coverage for Medically Necessary residential treatment, inpatient services, supplies, and medicine to treat substance use disorders. These treatments have the same meanings as described in the most recent edition of the American Society of Addiction Medicine Treatment (ASAM) Criteria.

Substance use disorders include alcoholism and substance-related and addictive disorders that are listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM).

Outpatient Mental Health and Substance Use 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 of alcohol and substance use disorders. The services must be provided by a licensed mental health provider.

Intensive Home-Based or Evidence-Based Services: Intensive, home-based, or evidence-based services designed to address specific mental or nervous condition in a child or adolescent are covered.

Collaborative Care: Collaborative care services with specific Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes as required by applicable law and which are provided under an integrated delivery of behavioral health and primary care services by the Member's Primary Care Provider, a behavioral care manager, a

psychiatric consultant and a database used by the behavioral care manager to track patient progress are covered

Outpatient Services

Outpatient services are services that do not require an overnight stay in a facility. These services are provided in various settings like doctor's offices, clinics, ambulatory surgical centers, and even at home, but without the need for admission as an inpatient. ConnectiCare covers the following outpatient services:

Allergy Testing: ConnectiCare covers the following Medically Necessary allergy testing:

- Allergy testing with allergenic extract (or RAST allergen specific testing)
- Allergy testing for medicine, biological or venom sensitivity 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

Members should refer to their Schedule of Benefits for Cost Sharing information and limitations. Allergy testing is limited to one Medically Necessary visit with a licensed professional per calendar year.

Biomarker Testing: ConnectiCare covers biomarker testing when it is used for diagnosis, treatment, appropriate management, or ongoing monitoring of a disease or condition, provided such testing provides clinical utility as demonstrated by medical and scientific evidence. ConnectiCare required testing to be done at in-network clinical laboratories.

Chiropractic Services: ConnectiCare covers Medically Necessary short-term chiropractic services, which include office visits and manipulation. These services are covered if the Member is expected to return function to the same level the Member had before they became injured or ill. ConnectiCare covers 20 Medically Necessary chiropractic visits from a licensed professional per calendar year. There is no coverage for chiropractic therapy that is long term or maintenance in nature.

Dialysis Services: ConnectiCare covers acute and chronic Medically Necessary dialysis services for the treatment renal disease if all the following requirements are met:

- The Members satisfy all medical criteria developed by ConnectiCare.

Gynecological and Obstetrician Services: ConnectiCare covers Medically Necessary outpatient OB/GYN and maternity services (pre-natal and post-partum) in a Provider's office. Members should refer to their Schedule of Benefits for Cost Sharing and Limitations.

Habilitation Services: ConnectiCare covers habilitation services and authorized devices that help a person keep, learn, or improve skills and function for daily living. These include physical, speech, and occupational therapy and other services for people with disabilities in a variety of inpatient and/or outpatient settings. Members are limited to forty visits per year combined for habilitation services.

Home Healthcare: ConnectiCare covers Medically Necessary Home Healthcare Services, subject to the limitations identified below. Medically Necessary home health services must be

provided by a licensed Home Health Agency. Home healthcare services are covered after the applicable Cost Sharing, if there is any, as shown on the Schedule of Benefits, if:

- ConnectiCare determines that Hospitalization or admission to a Skilled Nursing Facility would otherwise be required, or,
- A plan of home healthcare is ordered by a physician, a physician assistant or advanced practice registered nurse and approved by ConnectiCare.

The home healthcare must be medical and therapeutic Covered Services and 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,
- Certain medical supplies, medications, and laboratory services.

There is no coverage for:

- Custodial Care,
- Convalescent care,
- Domiciliary care,
- Long term care,
- Rest home care, or
- Care provided by home health aides that is not patient care of a medical or therapeutic nature or care or provided by non-licensed professionals.

ConnectiCare covers a limit of one hundred days of Medically Necessary home healthcare per calendar year. The benefit maximum does not apply to Hospice care.

Hospice Services: ConnectiCare covers in-home hospice services for Members who are terminally ill (a life expectancy of six months or less). Members can choose in-home hospice care instead of the traditional services covered by this Plan. ConnectiCare covers home hospice services in combination with inpatient hospice services for up to six months per calendar year.

Infusion Therapy: ConnectiCare covers Medically Necessary outpatient infusion therapy, including infusion therapy administered by a licensed professional in an appropriate place of service, including office, clinic, hospital outpatient, the Member's home, or freestanding infusion center. Members should refer to their Schedule of Benefits for Cost Sharing amounts. The Cost Sharing amount depends on who provides the service and where the infusion therapy is rendered.

Laboratory Tests, Radiology, and Specialized Scanning Services: ConnectiCare covers outpatient laboratory, radiology (including X-rays) and scanning services. Laboratory, radiology, and specialized scanning services may require Prior Authorization. ConnectiCare can assist Members select an appropriate facility for these services. Medically Necessary covered radiology and specialized scanning services include:

- Computerized Axial Tomography (CT) (including but not limited to coronary calcium scans).
- Magnetic Resonance Imaging (MRI).
- Positron Emission Tomography (PET).

- Nuclear cardiology.
- Bone densitometry scans.
- Ultrasound.
- X-rays (e.g., chest x-rays).

Members should refer to their Schedule of Benefits for additional details on Cost Sharing and limitations.

Observation Beds: ConnectiCare covers observation beds 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.

Office Visits: ConnectiCare covered Medically Necessary office visits by licensed providers, including:

- **Primary Care Provider:** 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.
- **Specialist:** When a Member has an injury or illness that requires a special provider to treat it and the care can be obtained in a Specialty Provider office, the services are covered subject to the Specialist office Services Cost Sharing amount.

Members should refer to their Schedule of Benefits for applicable Cost Sharing details for these services.

Rehabilitation Services: Members keep, get back, or improve skills and functioning for daily living that have been lost or impaired because they were sick, hurt, or disabled. These services may include physical and occupational therapy, speech therapy, and psychiatric rehabilitation services in outpatient settings. Services are limited to short-term physical, occupational and speech therapy necessary to restore a function lost through or to eliminate an abnormal function that has developed due to injury or illness. Speech therapy for developmental speech delays, stuttering, lisps, and other non-injury or non-illness related speech impediments are not covered, except as provided in the associated with autism services or Birth-to-Three program.

Post-operative physical therapy for temporomandibular joint (TMJ) dysfunction surgery is covered when the TMJ surgery is covered under this Plan. This physical therapy must be obtained during the 90-day period beginning on the date of the covered TMJ surgery and it must be Prior Authorized by ConnectiCare as part of the surgical procedure.

Outpatient rehabilitation services are limited to forty physical, occupational and speech therapy visits per year combined.

Sleep Studies: ConnectiCare covers Medically Necessary sleep studies are covered after the applicable Cost Sharing amount. The Cost Sharing 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.

Surgical Services: Medically Necessary surgery provided by a licensed Provider is covered after the applicable Cost Sharing amount. The Cost Sharing amount depends on where the services are provided. Medically Necessary services may include:

- **Anesthesia Services:** Anesthesia services as part of a covered inpatient or outpatient surgical procedure provided by a doctor are covered.
- **Breast Implant and Removal:** 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.
- **Craniofacial Disorders:** Medically Necessary orthodontic treatment and appliances for the treatment of craniofacial disorders are covered for Members aged eighteen and younger, if the treatment and appliances are prescribed by a craniofacial team recognized by the American Cleft Palate-Craniofacial Association.
- **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, including temporomandibular joint (TMJ) dysfunction surgery (for demonstrable joint disease only) or temporomandibular disease (TMD) syndrome, provided by a doctor are covered. There is no coverage for 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.
- **Reconstructive Surgery:** The following reconstructive surgery provided by a doctor 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.
 - 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.Other reconstructive surgery for the correction of congenital malformation is excluded. Please refer to the Exclusions and Limitations section of this Agreement.
- **Sterilization:** Male sterilization services provided by a doctor are covered after the applicable Cost Sharing amount. The Cost Sharing amount depends on where the procedures are provided.

Prostate Exams and Treatment: ConnectiCare covers the following Prostate Screening, including:

- 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.

Termination of Pregnancy: Termination of pregnancy due to rape or incest, or for a pregnancy which, as certified by a physician, places the woman in danger of death unless termination of pregnancy is performed (i.e., abortions for which Federal funding is allowed) is covered. Services for elective and non-elective termination of pregnancy are covered after the applicable Cost Sharing.

The federal Patient Protection and Affordable Care Act prohibits the use of federal funds to pay for elective termination of pregnancy services. A portion of the total Premium amount owed is a separate payment for these services.

Pharmacy Benefit:

ConnectiCare covers drugs ordered by Providers, approved by ConnectiCare, and filled through pharmacies. Covered drugs include over-the-counter (OTC) and prescription drugs as listed on the Formulary. ConnectiCare also covers medical drugs ordered or given in a participating facility when provided in connection with a Covered Service. Prior Authorization may be required to have certain drugs covered. A Provider who is lawfully permitted to write prescriptions, also known as a Prescriber, may request Prior Authorization on behalf of a Member and ConnectiCare will notify the Provider if the request is either approved or denied based upon Medical Necessity review.

ConnectiCare will not remove a prescription drug from the ConnectiCare Formulary during a plan year; or move a prescription drug from a Cost Sharing ConnectiCare Formulary tier that imposes a lesser coinsurance, copayment or deductible for the prescription drug to a ConnectiCare Formulary tier that imposes a greater coinsurance, copayment or deductible for the prescription drug during a plan year, unless the prescription drug is subject to an in-network coinsurance, copayment or deductible that is not greater than forty dollars per prescription per month in any tier.

ConnectiCare Formulary: ConnectiCare establishes a list of drugs, devices, and supplies that are covered under the Plan’s pharmacy benefit. The list of covered products is referred to as the “Formulary.” The list shows all the prescription and over-the-counter products Plan Members can get from a pharmacy, along with coverage requirements, limitations, or restrictions on the listed products. The Formulary is available to Members on <http://www.Connecticare.com/CTFormulary2026>. A hard copy is also available upon request. The list of products on the Formulary are chosen by a group of medical professionals from inside and outside of ConnectiCare. This group reviews the Formulary regularly and makes changes every three months based on updates in evidence-based medical practice, medical technology, and new-to-market branded and generic drugs. ConnectiCare will not remove a covered drug from the Formulary or move a drug to a higher Cost Sharing during a Plan Year, except as allowed by State Law. ConnectiCare will not deny coverage to a Member for any drug that ConnectiCare removes from its Formulary, if:

1. The Member was using the drug for the treatment of a chronic illness prior to the removal or cessation of coverage,
2. The Member was covered under this Agreement for this Contract Year for the drug prior to the removal or cessation of coverage, and
3. The Members attending Provider states in writing, after the removal or cessation of coverage, that the drug is Medically Necessary and lists the reasons why the drug is more medically beneficial than the drugs on the list of covered drugs.

Preventive Prescriptions: Please note, under federal law, ConnectiCare 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 Sharing. As a result, there may be times when the Member will not be required to pay the applicable Cost Sharing the Member usually pays for covered medications under their Plan.

General Benefits: Subject to all of the provisions of this Agreement, including the guidelines, and exclusions and limitations, ConnectiCare covers the following prescription drugs, medications, and supplies:

- **FDA Approved:** All federal Food and Drug Administration (FDA) approved prescription drugs.
- **Contraceptives:** All prescription contraceptive methods approved by the federal FDA, including, but not limited to:
 - Cervical caps.
 - Diaphragms.
 - Intrauterine Devices (IUDs).
 - Oral contraceptives.
 - Certain over-the-counter contraceptives and vitamins as allowed by applicable law.
- **Diabetes:** For the treatment of diabetes.
- **Lyme Disease:** 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 treatment if recommended by a board-certified rheumatologist specialist, infectious disease specialist or neurologist.
- **Injectable Drugs:** Injectable drugs, provided that they are obtained at a pharmacy, and all of the other rules of this Agreement are followed.
- **Orally Administered Anticancer Drugs:** Orally administered anticancer drugs shall be covered no less favorably than the intravenous administration of injectable anticancer drugs is, where consistent with applicable federal law.
- **Refill Synchronization:** ConnectiCare will not deny coverage for the refill of any drug prescribed for the treatment of a chronic illness that is made in accordance with a plan among the Member, a practitioner, and a pharmacist to synchronize the refilling of multiple prescriptions for the Member.

Coverage Requirement: To be covered, prescription drugs must:

- Be Medically Necessary.
- Be marketed in the United States at the time of purchase.

- 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).

Over-The-Counter (OTC) Medications: Certain over-the-counter (OTC) medications are covered, subject to terms and conditions of this Agreement and the following:

- The OTC medication must be an OTC medication that is required to be covered under applicable federal law. The OTC medications that ConnectiCare will cover are listed on ConnectiCare’s website at <https://www.connecticare.com/resources/pharmacy>.
- The Member must obtain a prescription for the OTC medication from their doctor.
- The OTC medication must be filled as a prescription at a pharmacy by the pharmacist; otherwise, it will not be covered.
- When such OTC medications are covered, they will be covered based upon age, gender and/or disease required to be covered under applicable federal law.

The Cost Sharing amounts the Member is required to pay for prescriptions are found on the Member’s Schedule of Benefits. The list of OTC medications may change at any time. When the list does change, the Member will be notified in ConnectiCare’s Member electronic newsletter. The Member should call ConnectiCare’s Member Services Department at the telephone number listed in the Important ConnectiCare Member Resources section (or visit ConnectiCare at ConnectiCare’s website at <https://www.connecticare.com/resources/pharmacy> to find out if an OTC medication is covered under this Agreement. ConnectiCare has the right to change the OTC medications on the list.

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 Prior Authorization. The Member can find the list of specialty drugs that need Prior Authorization in the Prior Authorization Addendum. Specialty drugs that require Prior Authorization should be filled through the specialty pharmacy ConnectiCare advise the Member of.

When the Member or the Member’s provider contacts ConnectiCare for Prior Authorization of a specialty drug, if Prior Authorization is granted, Member or the Member’s provider will be notified of the telephone number to call to contact the specialty pharmacy. Specialty drugs, when Prior Authorized by us, will be dispensed for a maximum of 30-day supply per fill. The drugs will be shipped to the Member’s Provider’s office, their home, or other location based on the type of drug or treatment.

Please note, even though up to a 30-day supply of a specialty drug may be delivered by mail to the Member, or Members Provider’s office or some other location, specialty drugs DO NOT have the same Cost Sharing that applies to the Mandatory Maintenance Program. Instead,

specialty drugs have the applicable retail pharmacy Cost Sharing amount listed on the Member's Schedule of Benefits.

Specialized counseling and education are available to the Member 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 ConnectiCare advised the Member of, or the Member is out of a specialty drug or if the specialty drug ordered by the Member's Provider does not arrive in time, ConnectiCare will authorize the specialty drug for up to a 30-day supply at an alternate specialty pharmacy, so the Member can obtain the needed medication. In this instance, the Member will not be required to pay any additional amounts above the normal Cost Sharing amounts the Member would typically pay for a specialty drug under this Plan.

Guidelines: In addition, to be covered, all prescription drugs and supplies must meet the following rules and guidelines. When the Member brings their 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 Prior Authorization must be made directly to ConnectiCare to be considered a claim under the Plan.

Prior Authorization Requirement: Certain prescription drugs and supplies require Prior Authorization from ConnectiCare before they will be covered. In addition, any drug that is newly available to the market will also require Prior Authorization until such time that ConnectiCare re-publish ConnectiCare's list of drugs that require Prior Authorization. The Member can find the list of prescription drugs that need Prior Authorization in the Prior Authorization Addendum.

Updates to the list of drugs or supplies requiring Prior Authorization are published from time to time in ConnectiCare's Member electronic newsletter. The Member should call the ConnectiCare Member Services Department at the telephone number listed in the Important ConnectiCare Member Resources section (or visit this website at <https://www.connecticare.com/resources/pharmacy>) to find out if a prescription drug or supply requires Prior Authorization. ConnectiCare has the right to change the drugs or supplies on the list.

Prescriptions: When a Participating Provider writes the prescription for the drug or supply, it is the responsibility of the Participating Provider to obtain the Prior Authorization, but the Member should check with their provider to make sure they have obtained Prior Authorization before the Member attempts to fill their prescription.

When a prescription drug or supply requiring Prior Authorization is not Prior 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 Prior Authorization. However, when the Member submits that claim for reimbursement, ConnectiCare will review it for Medical Necessity. If ConnectiCare determines that the prescription drug or supply was not Medically Necessary, re-fills of that prescription drug or supply will not be covered.

It is the Member's responsibility to obtain Prior Authorization from ConnectiCare if a Non-Participating Provider writes their prescription. When a prescription drug or supply requiring Prior Authorization is not authorized, it will be rejected by the pharmacy. If the prescription drug or supply is filled and the Member submits a claim to ConnectiCare for reimbursement, the Member should request their Non-Participating Provider to ask ConnectiCare for Prior Authorization. When that occurs, ConnectiCare will review the claim for Medical Necessity. If ConnectiCare determines that the prescription drug or supply was Medically Necessary and Prior Authorization is then granted, ConnectiCare will reimburse the Member 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 this Agreement. If ConnectiCare determines that the prescription drug or supply was not Medically Necessary, that prescription drug or supply will not be covered.

When Prior Authorization is obtained, it is the Members responsibility to make sure the authorization is still applicable when the Member goes to the pharmacy to have their prescription filled. If the authorization was for a time period that expired the Member will have to pay for the prescription. If the authorization was for an amount of drugs that is less than their prescription, their prescription will be filled at the amount of drugs that was prior authorized.

Member ID Card: Members are required to use their ConnectiCare ID card when obtaining a prescription drug or covered supply. In the event the Member does not use their ID card, the Member will be charged the discount lost because the prescription drug or covered supply was processed without the ID card, in addition to any Cost Sharing amount or other charge due under this Plan.

Pharmacies: ConnectiCare covers drugs at retail pharmacies, specialty pharmacies, and mail order pharmacies. Members may be required to fill a drug with a contracted specialty pharmacy if the drug is subject to Food and Drug Administration (FDA) restrictions on distribution, requires special handling or Provider coordination, or if specialized patient education is required to ensure safe and effective use. To find network pharmacies, please visit <https://www.connecticare.com/resources/pharmacy>.

Under this Plan, the Member is free to use either Participating Pharmacies or Non-Participating Pharmacies to obtain covered prescription drugs, medications, and supplies; however, the Member will pay different levels of Cost Sharing (Copayments, Coinsurance, and/or Deductibles) depending on the pharmacy that dispenses the covered prescription drugs, medications, and supplies.

ConnectiCare will provide the Member with a choice of pharmacy networks to fill in their prescriptions. If the Member does not choose a pharmacy network, one will be assigned to them. Any pharmacies not in network will be considered non-participating. The Member may use any pharmacy listed in their pharmacy network for non-maintenance prescriptions (less than 90-day supply). The Member may switch their choice between networks once a year.

If the Member uses a Participating Pharmacy, they generally will have low Member cost. If the Member uses a Non-Participating Pharmacy, pharmacy benefits will have higher Member cost.

When the Member uses a Participating Pharmacy, the out-of-pocket Cost Sharing amount the Member pays is lower than what the Member would have to pay if the Member were to use a

Non-Participating Pharmacy. To reduce their out-of-pocket costs, use a Participating Pharmacy. To locate a Participating Pharmacy, the Member can refer to ConnectiCare's Provider Directory, visit ConnectiCare at ConnectiCare's website at <https://www.connecticare.com/resources/pharmacy>.

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

Prescription Drug Programs: The following provisions apply to ConnectiCare's Prescription Drug Programs:

Advanced Opioid Management Program: This Plan has an Advanced Opioid Management Program. This program applies to prescriptions written for opioid medications. The Member will be notified via letter from ConnectiCare, if the Member has been identified to be a participant in this program.

Off-Label Use: ConnectiCare does not exclude coverage of any such drug on the basis that such drug has been prescribed for the treatment of a type of cancer or a disabling or life-threatening chronic disease for which the drug has not been approved by the FDA, provided the drug is recognized for treatment of the specific type of cancer or a disabling or life-threatening chronic disease for which the drug has been prescribed in one of the following established reference compendia or in peer-reviewed medical literature generally recognized by the relevant medical community:

- The U.S. Pharmacopoeia Drug Information Guide for the Health Care Professional.
- The American Medical Association's Drug Evaluations; or
- The American Society of Health-System Pharmacists' American Hospital Formulary Service Drug Information.

Generic Substitution Program: This Plan has a Generic Substitution Program. This program applies to prescriptions filled at Participating Pharmacies (retail or specialty pharmacies), ConnectiCare's designated mail order vendor and retail maintenance networks.

This Plan covers Generic Drugs or Supplies when they are available. Even if the Member request a covered Brand Name Drug Or Supply and/or even if their 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, the Member 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 Sharing amount.

In some plans, the Cost Sharing amount for a Brand Name Drug or Supply is the same as the Cost Sharing amount for a Generic Drug or Supply.

Participating Pharmacies have information about Brand Name Drugs or Supplies with Generic Equivalents that are required to be substituted. The Member should call ConnectiCare's Member Services Department at the telephone number listed in the Important ConnectiCare Member Resources section (or visit ConnectiCare at ConnectiCare's website at

<https://www.connecticare.com/resources/pharmacy> to find out if a drug or supply is covered. ConnectiCare has the right to change the drugs or supplies that are required to be substituted.

Tiered Cost Sharing Program: This Plan has a Tiered Cost Sharing Program. This program applies to prescriptions filled at Participating Pharmacies, (retail pharmacies), ConnectiCare's designated mail order vendor, retail maintenance networks, or specialty pharmacies, as well as those OTC medications covered under this Plan.

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 Sharing. 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 drugs 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 Sharing amount for a drug that is designated on the first tier is generally the lowest amount the Member will pay for a prescription. Conversely, if a drug or supply is put into a higher tier designation, the Member will generally have to pay more for that prescription. If a covered drug is in a higher tier designation, that does not mean it is not a good drug or that the Member should not get it. It just means that the Member will have to pay more for it. If their Plan has a prescription drug Benefit Deductible this may not always be the case for particular prescriptions.

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

In some plans with this program, the Member must pay a higher amount in addition to the Cost Sharing amount, when the Member obtains a Brand Name Drug or Supply when there is a Generic Equivalent.

ConnectiCare have the right to change the drugs (including certain OTC medications) or supplies in each tier, even in the middle of the year. The Member should call ConnectiCare's Member Services Department at the telephone number listed in the Important ConnectiCare Member Resources section (or visit ConnectiCare at ConnectiCare's website at <https://www.connecticare.com/resources/pharmacy> to find out which tier (if any) a prescription drug or supply is in.

Mandatory Drug Substitution Program: This Plan has a Mandatory Drug Substitution Program. This program applies to prescriptions filled at Participating Pharmacies, (retail pharmacies), a ConnectiCare designated mail order vendor, and retail maintenance networks. It does not pertain to prescriptions the Member receives to treat pain management.

Prescription drugs that are on ConnectiCare's Mandatory Drug Substitution list are not covered, 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. (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.)

If the Member's Provider prescribes the excluded drug that is on the "Mandatory Drug Substitution" list, the Participating Pharmacy will switch the prescription or call their physician to receive authorization, if needed, to make the change to the covered drug from the excluded drug that was prescribed for the Member.

In certain cases, this Plan will cover the excluded drug on the "Mandatory Drug Substitution" list if ConnectiCare determine that, because of the Member's adverse reaction to the covered drug or the covered drug's ineffectiveness for the Member, the excluded drug is Medically Necessary. ConnectiCare will make this determination based on clinical evidence presented by their physician to us.

ConnectiCare will also cover excluded drugs which are added to the "Mandatory Drug Substitution" list, if the following conditions are met:

- The Member was obtaining, through their 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
- The Member's Provider provides to ConnectiCare a written statement that the excluded drug is Medically Necessary and includes the reasons why the excluded drug is more medically beneficial in treating their 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 ConnectiCare's Member electronic newsletter. The Member should call ConnectiCare's Member Services Department at the telephone number listed in the Important ConnectiCare Member Resources section (or visit ConnectiCare at ConnectiCare's website at <https://www.connecticare.com/resources/pharmacy>) to find out if a prescription drug is on this list. ConnectiCare have the right to change the drugs on this list.

Mandatory Drug Limitations Program: For some drugs, ConnectiCare will cover only a limited number of dosages per prescription and/or time period for the drug. These are drugs where ConnectiCare have determined, that the number of dosages available for the drug should be limited in accordance with the proper medical use of the drug. ConnectiCare 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 Plan will cover additional units above the limited number of dosages per prescription and/or time period for the drug if ConnectiCare determines, that, because of the Member's condition, these additional units are Medically Necessary. ConnectiCare will make this determination based on clinical evidence presented by their physician to us. When this occurs, the Member may be required to pay the applicable Cost Sharing amount.

In addition, ConnectiCare reserves the right to designate certain prescriptions to be filled or refilled for no more than a 30-day supply at a time, regardless of whether their Schedule of Benefits has a fill or refill limit. When coverage is limited to a 30-day supply at a time for a drug, the Member will not be able to purchase that drug through the ConnectiCare Mandatory Maintenance Program.

Mandatory Maintenance Program: This Plan has a Mandatory Maintenance Program. Under the Mandatory Maintenance Program, the Member must fill their maintenance prescriptions at ConnectiCare's designated mail order vendor or a pharmacy in one of the retail maintenance networks.

The Member has a choice of retail maintenance networks. Once chosen, the Member may only change the retail maintenance network once per benefit year. The Member may obtain up to a 90 or 100-day supply of prescription maintenance drugs or covered supplies through the maintenance program at the applicable benefit level. Members should refer to their Schedule of Benefits to see the day supply limit and Cost Sharing amounts, including whether their Plan has a Plan Deductible or Benefit Deductible.

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

ConnectiCare have the right to change or limit the drugs eligible for dispensing through this program, even in the middle of the year. The Member should call ConnectiCare's Member Services Department at the telephone number listed in the Important ConnectiCare Member Resources section to receive a list of drugs or drug classes ineligible for dispensing through this program.

Clinically Equivalent Alternative Drugs or Supplies Program: This Plan has the "Clinically Equivalent Alternative Drug or Supplies Program." This program applies to prescriptions filled in at retail or specialty pharmacies, ConnectiCare's designated mail order vendor and retail maintenance networks. 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 case, 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 ConnectiCare's Members, and were 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. 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, the Member's provider must substantiate to us, 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 ConnectiCare's website. The Member should call ConnectiCare's Member Services Department at the telephone number listed in the

Important ConnectiCare Member Resources section (or visit ConnectiCare at ConnectiCare's website at <https://www.connecticare.com/resources/pharmacy>) to find out if a prescription drug or supply is on this list. ConnectiCare has the right to change the drugs or supplies on the list.

Cost Sharing Waiver Programs: ConnectiCare 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 Sharing for a limited time that the Member would otherwise pay under the terms of this Plan.

Pharmacy Cost Sharing: Members are required to pay a Cost Sharing amount for covered prescription drugs and supplies obtained under this Plan. The Cost Sharing amounts the Members are required to pay for prescriptions are found on their Schedule of Benefits.

- **Copayment:** If the Member has a Plan that requires a prescription drug benefit Copayment, the Member will be required to pay the lesser of the following:
 - The applicable Copayment amount for the drug or supply, or
 - The amount ConnectiCare would pay for the drug or supply, or
 - The amount the Member would pay for the drug or the supply if the Member had purchased it without using the benefits of this Plan.

- **Deductible:** If the Member has a Plan that requires a prescription drug Deductible, the Deductible amount must be met in any calendar year for prescriptions subject to the prescription drug Benefit Deductible before ConnectiCare will begin paying for those prescriptions. Under certain options, the Member will not be required to meet the Deductible amount if the Member obtain Generic Drugs or Supplies.

A Deductible is 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 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 the Member may be required to pay for Covered Services under the Plan.

- **Accumulators:** When a Deductible and Copayment or Coinsurance applies, the Member must pay the Copayment amount, as described in paragraph 1, above, or the Coinsurance amount up to their Deductible amount. Then, once the Deductible has been met, the Member will be responsible to pay the applicable Cost Sharing amount listed on their Schedule of Benefits for each prescription, plus any applicable cost difference. The Coinsurance amount is based on the rate ConnectiCare would pay for the prescription. If the Member has a Plan with a drug Benefit Deductible and then a Copayment where the Member fulfills the Deductible requirement in a particular claim, the Member 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 above.

- **Tier Cost Sharing:** In some plans, a different type of Cost Sharing applies depending on which tier a drug or supply is in. For example, the Member may have to pay a Copayment for a tier one drug or supply and a Coinsurance for drugs or supplies on a different tier.
- **Coinsurance:** Amounts paid by Members as their Coinsurance responsibility, or due to any reduction in benefits do not count towards meeting the Deductible.
- **Diabetes Drugs and Devices Cost Sharing:** In no case will the Cost Sharing 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 caps 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.
- **Price Differential:** 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.

Pharmacy Benefit Limits

Fill Or Refill Limit: This Plan limits benefits for prescriptions filled or refilled at a retail pharmacy to a 30-day or 90-day supply at a time depending on their Plan. This Plan also limits benefits for prescriptions filled or refilled through the Mandatory Maintenance Program to a 90-day supply at a time.

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 treatment is recommended by a board-certified rheumatologist, infectious disease specialist or neurologist.

Access to Non-Formulary Drugs: The Formulary lets Members, and their Prescribers know which products are covered by the Plan's pharmacy benefit. The fact that a drug is listed on the Formulary does not guarantee that a Prescriber will prescribe it for a Member.

Drugs that are not on the Formulary may not be covered by the Plan. These drugs may cost Members more than similar drugs that are on the Formulary if covered on exception, as described in the next section. Members may ask for non-formulary drugs to be covered. Requests for coverage of non-formulary drugs will be considered for a medically accepted use when Formulary options cannot be used, and other coverage requirements are met. In general, drugs listed on the Formulary are drugs Providers prescribe for Members to get from a pharmacy and give to themselves. Most injectable drugs that require help from a Provider to use are covered under the medical benefit instead of the pharmacy benefit. Providers have instructions from ConnectiCare on how to get advanced approval for drugs they buy and treat Members with. Some injectable drugs can be approved to get from a pharmacy using the Plan pharmacy benefit.

Requesting an Exception: ConnectiCare has a process to allow Members, their representative, or a Prescriber to request clinically appropriate drugs that are not on the Formulary. They may request coverage for drugs that have step therapy requirements or other restrictions under the Plan benefit that have not been met. Members, their representative, or Prescribers may contact ConnectiCare's Pharmacy Department to request a Formulary exception.

If a prescription requires a Prior Authorization review for a Formulary exception, the request can be considered under standard or expedited circumstances.

- Any request that is not considered an expedited exception request is considered a Standard Exception request.
- A request is considered an expedited exception request if it is to treat a Member's health condition that may seriously jeopardize their life, health, or ability to regain maximum function, or when the Member is undergoing a current course of treatment using a non-formulary drug. Trials of pharmaceutical samples from a Prescriber or a drug manufacturer will not be considered as current treatment.

ConnectiCare will notify the Member or their representative, and the Prescriber, of the coverage determination no later than:

- 24 hours following receipt of an expedited exception request.
- 72 hours following receipt of a standard exception request.

If the request is denied, ConnectiCare will send a letter to the Member or their representative, and the Prescriber. The letter will explain why the drug or product was denied. It is within the Member's rights to purchase the drug at the full cost charged by the pharmacy. If the Member disagrees with the denial of the request, the Member, their representative, or Prescriber can Appeal ConnectiCare's decision. The Prescriber may request to talk to ConnectiCare reviewers about the denial.

If an internal appeal of the original coverage determination is requested, ConnectiCare will notify the Member, their representative, and the Prescriber, of the internal appeal decision no later than:

- 24 hours following receipt of an appeal on a denied expedited exception request.
- 72 hours following receipt of an appeal of a denied standard exception request.

The Member or their representative, or the Prescriber may also request that an Independent Review Organization (IRO) review ConnectiCare's internal appeal decision. The Member or their representative, and the Prescriber, will be notified of the IRO decision no later than:

- 24 hours following receipt of an appeal on a denied expedited exception request.
- 72 hours following receipt of an appeal of a denied standard exception request.

Please note: Any step therapy regimen will be implemented consistent with federal and State law. ConnectiCare does not apply step therapy requirements for

- Any prescribed drug for longer than thirty days,
- For a prescribed drug for cancer treatment for an insured who has been diagnosed with stage IV metastatic cancer, multiple sclerosis, or rheumatoid arthritis provided such prescribed drug is in compliance with approved federal Food and Drug Administration indications, or
- For the treatment of schizophrenia, major depressive disorder or bipolar disorder, as defined in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders".

A Member's treating provider may deem such step therapy drug regimen clinically ineffective for the Member, at which time ConnectiCare will authorize dispensation of and coverage for the drug prescribed by the Member's treating provider, provided such drug is a covered drug under this Agreement. If such provider does not deem such step therapy drug regimen clinically ineffective or has not requested an override, such drug regimen may be continued. For purposes of this section, "step therapy" means a protocol or program that establishes the specific sequence in which prescription drugs for a specified medical condition are to be prescribed.

ConnectiCare has established and will disclose to its Participating Providers a process by which a Member's treating provider may request at any time an override of the use of any step therapy drug regimen. A request will be expeditiously granted when an Member's treating provider demonstrates that the drug regimen required under step therapy (A) has been ineffective in the past for treatment of the insured's medical condition, (B) is expected to be ineffective based on the known relevant physical or mental characteristics of the insured and the known characteristics of the drug regimen, (C) will cause or will likely cause an adverse reaction by or physical harm to the insured, or (D) is not in the best interest of the insured, based on Medical Necessity.

Upon the granting of an override request, ConnectiCare will authorize dispensation of and coverage for the drug prescribed by the Member's treating provider, provided such drug is a covered drug under this Agreement.

Prescription Drug General Conditions

1. ConnectiCare will not be liable for any injury, claim, or judgment resulting from the dispensing of any prescription drug covered by this Plan.
2. ConnectiCare may use a third-party administrator to administer the benefits available under this Plan.
3. All claims must be submitted to ConnectiCare within 180 days from the date the drug or supplies were received with the appropriate claim form and as described in the Claims subsection. The Member can call ConnectiCare's Member Services Department at the telephone number listed in the Important ConnectiCare Member Resources section 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) or as required by applicable law.
5. ConnectiCare may require the Member's treating physician to furnish ConnectiCare 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, ConnectiCare reserves the right to implement Prior Authorization criteria and to set quantity limits to promote appropriate use and to avoid abuse.
7. ConnectiCare does not generally coordinate benefits under this Plan. However, If the Member or their covered dependent have the Medicare Part D Drug program or a Medicare Advantage plan with drug coverage, Medicare is the primary plan over this Plan. ConnectiCare does not reduce payments on the basis that an individual is eligible for Medicare by reason of age, disability or end-stage renal disease, unless such individual enrolls in Medicare. If such individual enrolls in Medicare, any such reduction shall be only to the extent such coverage is provided by Medicare.
8. ConnectiCare reserves the right to designate those certain prescriptions to be filled or refilled for no more than a 30-day supply at a time. When coverage is limited to a 30-day supply at a time for a drug, the Member will not be able to purchase that drug through ConnectiCare's Mandatory Maintenance Program.
9. ConnectiCare does not require a Member to make a payment at the point of sale for a covered prescription medication in an amount greater than the lesser of:
 - The applicable copayment for such prescription medication.
 - The allowable claim amount for the prescription medication; or
 - The amount a Member would pay for the prescription medication if the Member purchased the prescription medication without using ConnectiCare benefits or any other source of prescription medication benefits or discounts.
10. Prescription Drug Copayment Accumulators: Drug manufacturer coupons, rebates, and copayment assistance count towards the Member's Cost Sharing responsibility, in accordance with this Agreement.

Out-of-Pocket Calculation: ConnectiCare gives credit toward a Members in-network liability (Coinsurance, Copayment, or Deductible) for any out-of-pocket expense paid by the Member directly to a pharmacy as long as:

1. No claim was submitted to the insurance, and
2. The amount paid by the insured is less than the average discounted rate for the prescription drug paid to an in-network health care provider

This is limited to the total amount credited toward Members annual out of pocket expense for prescription drugs purchased from an out of network health care provider:

1. Shall not exceed their total out-of-pocket liability or
2. Carry over to a new policy period.

Vision Services: If the Member opts to receive optometric services or procedures that are not covered benefits under this Plan, a Participating Provider optometrist may charge the Member their usual and customary rate for such services or procedures. Prior to providing the Member with optometric services or procedures that do not cover benefits, the optometrist should provide the Member with a treatment plan that includes each anticipated service or procedure to be provided and the estimated cost of each such service or procedure. To fully understand the Member's coverage, they may wish to review this document.

Pediatric Routine Eye Care: Routine eye care, including refraction (a test to determine whether the Member is near-sighted or far-sighted) for Members under age 26, is covered up to the maximum benefit, as shown on their Schedule of Benefits.

Adult Routine Eye Care: Routine eye care for Members over age 26 is covered up to the maximum benefit, as shown on their Schedule of Benefits.

Corneal Pachymetry: ConnectiCare will cover Medically Necessary corneal pachymetry (measurement of the thickness of the cornea). The Cost Sharing amount depends on where the test is rendered.

Diseases And Abnormal Conditions of the Eye: ConnectiCare covers 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 Sharing 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.

Eyeglasses And Contact Lenses: Standard Medically Necessary prescription lenses, frames, and prescription contact lenses for Members under age 26 are covered up to the maximum benefit, as shown on their Schedule of Benefits, as follows:

- One pair of eyeglasses (lenses and frames) per year, or
- Contact lenses include one fitting and a set of lenses per year.

Members over the age of twenty-six should consult their Schedule of Benefits to understand if this service is covered under their plan. In addition, there is also no coverage for any non-standard prescription lenses, frames, and prescription contact lenses, including tinted lenses, no matter the age of the Member.

Additional Services

Autism Services: Medically Necessary diagnosis and treatment of Autism Spectrum Disorders (ASDs) as described below, are covered:

- Mental health care services (including intensive behavioral therapies such as Applied Behavior Analysis (ABA) that are the following:
 - Focused on the treatment of core deficits of Autism Spectrum Disorder.
 - Provided by a Board-Certified Behavior Analyst (BCBA) or other qualified provider under the appropriate supervision.
 - Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property, and impairment in daily functioning.
- 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 their Schedule of Benefits.
- 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, are covered as described in the under ConnectiCare's Pharmacy Benefits subsection of the Agreement.

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

Cancer Treatment: ConnectiCare provides the following coverages for cancer care and treatment, including, but not limited to:

- Preventive cancer screening and testing (please refer to the Preventive Services section of this Agreement for more information)
- Diagnostic screening, laboratory, and procedures
- Dental evaluation, X-rays, fluoride treatment, and extractions necessary to prepare the Member's jaw for radiation therapy of cancer and other neoplastic diseases in the Member's head or neck.
- Mastectomies (removal of breast) and lymph node dissections for the treatment of breast cancer
- Mastectomy-related services (please refer to the reconstructive surgery and prosthetic of this Agreement for more information)
- Routine patient care costs for Members who are participating in a Clinical Trial for cancer (please refer to the Clinical Trial section of this Agreement for more information)
- Prescription medications to treat cancer (please refer to the Pharmacy Benefit section of this Agreement for more information)
- For children diagnosed with cancer, neuropsychological testing ordered by a licensed physician, to assess the extent of any cognitive or developmental delays in such child due to chemotherapy or radiation treatment.

Cardiac Rehabilitation: Cardiac rehabilitation is covered after the applicable Cost Sharing amount described on the Members Schedule of Benefits.

- 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. Please refer to the Health Management Programs section of this Agreement.
- Phase IV Cardiac rehabilitation is not covered.

Cast and Dressing Application: ConnectiCare covers cast and dressing application when the services are Medically necessary and provided by a licensed Provider.

Clinical Trials: ConnectiCare will cover 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 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 Covered 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.

The Connecticut Insurance Department has issued a standardized form that must be used when a Member asks ConnectiCare to cover routine care costs in a clinical trial.

Denials are subject to the State of Connecticut utilization review external Appeal program. ConnectiCare 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 ConnectiCare may reasonably need to review the request.

Diabetes Services: ConnectiCare covers Medically Necessary diabetes services, including treatment for all types of diabetes are covered, when prescribed and dispensed pursuant to applicable law, 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.

Members should refer to their Schedule of Benefits for diabetic equipment and supplies Cost Sharing. The Cost Sharing amount depends on where the services or devices are provided.

ConnectiCare also covers outpatient self-management training for the treatment of diabetes if the training is prescribed by a licensed health care professional. The training must be provided by a certified, registered, or licensed health care professional trained in the care of and management of diabetes. The Cost Sharing 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.
- 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.
- Up to four hours for Medically Necessary training and education as a result of new techniques and treatment for diabetes.

Prescription drugs and supplies for the treatment of diabetes are covered as described in the Pharmacy Benefits subsection of the Covered Services section. 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 this Covered Services section.

Prescription drugs administered by a needle, which are not obtained from a doctor or from a Home Health Agency are covered as described in the Pharmacy Benefits subsection of the Covered Services section.

Drug Ingestion Treatment (Accidental): ConnectiCare covers Medically Necessary services needed to treat the accidental ingestion or consumption of a controlled drug are covered. The Cost Sharing amount depends on where the services are provided.

Drug Therapy (Outpatient/Home): ConnectiCare covers Medically Necessary drug therapy is covered after the applicable Cost Sharing amount. The Cost Sharing amount depends on where the drug therapy is rendered. Drug therapy services include all drugs administered by a licensed provider.

Infertility Services: ConnectiCare covers Medically Necessary diagnostic and testing procedures, and therapy needed to treat diagnosed infertility are covered at the applicable Cost Sharing amounts, up to the limits described below.

- Ovulation induction (to a maximum of four cycles).
- Intrauterine insemination (to a maximum of three cycles per recipient, regardless of source).
- Uterine embryo lavage, in-vitro fertilization (IVF), gamete intra-fallopian transfer (GIFT), zygote intra-fallopian transfer (ZIFT) or low tubal ovum transfer (to a maximum of two cycles combined for all procedures, with no 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 need not be tried first if the Member's treating Board Eligible or Board-Certified Reproductive Endocrinologist certifies that such treatment or procedure is unlikely to be successful.
- Pre-implantation genetic testing is covered when Medically Necessary and as part of a 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 (medications) to treat Infertility. These drugs or medications are only available for the gender indicated by the federal Food and Drug Administration (FDA) and are covered as described in the Pharmacy Benefits subsection of the Covered Services section.

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. If the Member is enrolled in one of ConnectiCare's HMO products (a plan that requires the Member use Participating Providers), then the Member must use Participating Providers for coverage.

In addition, oral medicines needed to treat Infertility must be prescribed by the treating provider to be covered. ConnectiCare does not discriminate on the coverage of Infertility services or diagnosis on the basis of gender identity or expression, sexual orientation, or age.

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 in this Agreement.
- Medicines for sexual dysfunction,
- Recruitment, selection and screening of donors or gestational carriers.
- Reversal of surgical sterilization.
- Surrogacy and all charges associated with surrogacy arrangements such as prescription drugs, fertilization, or implantation, except if provided to a Member.

Lyme Disease Services: ConnectiCare covers Medically Necessary treatment of Lyme Disease including the following:

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

Antibiotic drugs are covered as described in the Pharmacy Benefit subsection of the Covered Services section.

Neuropsychological Testing: ConnectiCare covers Medically Necessary psychological, neuropsychological, or neurobehavioral testing.

Nutritional Counseling: ConnectiCare provides coverage of nutritional counseling services, 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. The benefit maximum does not apply to behavioral health diagnoses, including but not limited to autism and eating disorders.

Nutritional Supplements and Food Products

Enteral Or Intravenous Nutritional Therapy: ConnectiCare covers Medically Necessary enteral (tube feeding) or intravenous nutritional products are covered at the applicable Cost-Share amount when ordered by a doctor if they are needed for a medical illness or injury and are to be used for the total caloric needs of the Member.

Oral nutritional products (except for Modified Food Products for Inherited Metabolic Diseases and Other Specialized Formulas) that are specially changed to allow them to be taken through an irregular gastrointestinal tract are covered when:

- A doctor orders them.
- They are needed due to a gastrointestinal illness or injury preventing them from being taken normally.
- They are to be used for the total caloric needs of a Member.

Modified Food Products For Inherited Metabolic Diseases: ConnectiCare covers Medically Necessary modified food products (low protein), and amino acid modified preparations are covered at the Modified Food Products and Specialized Formulas Drug Cost-Share amount listed on their Schedule of Benefits.

Modified food products and amino acid preparations are covered for the treatment of the following inherited metabolic diseases:

- Biotinidase deficiency.
- Congenital adrenal hyperplasia.
- Cystic fibrosis.
- Galactosemia.
- Homocystinuria.
- Hypothyroidism.
- Inborn errors of metabolism, as described by the Department of Public Health.
- Maple syrup urine disease,
- Phenylketonuria (for which newborn screening is required).
- Sickle cell disease.

To be covered, the modified food products (low protein) and amino acid preparations must be ordered for the therapeutic treatment of one of the inherited metabolic diseases noted above by a doctor and administered under their direction.

Other Specialized Formulas: Specialized formulas are covered at the Modified Food Products and Specialized Formulas Drug Cost-Share amount listed on their Schedule of Benefits.

Specialized formulas are covered when the formula does not have to be part of the general nutritional labeling requirements of the federal Food and Drug Administration, and its intended use is solely for the dietary management of specific diseases or conditions. The formula must be Medically Necessary, ordered by a doctor and administered under his/her direction. Except as noted above, no other nutritional supplements, food supplements, infant formulas, enteral nutritional therapies, or specialized formulas are covered.

Pain Management Services: ConnectiCare covers Medically Necessary pain management services provided by a licensed Provider (including evaluation and therapy) for short or long-term pain conditions covered after the applicable Cost Sharing amount. Pain management services include acupuncture, as long as the treatment is ordered by a pain management specialist who is credentialed by the American Academy of Pain Management or who is a board-certified anesthesiologist, physiatrist, neurologist, oncologist, or radiation oncologist with additional training in pain management. The Cost Sharing amount depends on where the services are provided.

Exclusions and Limitations

Certain services, equipment, and supplies are excluded from coverage under this Agreement. These exclusions apply regardless of whether the services are within the scope of a Provider's license, except where expressly stated otherwise in this Section, or where otherwise required

by State Law. This is not an exhaustive list of services that are excluded from coverage under this Plan. Please contact ConnectiCare Member Services for questions regarding exclusions. ConnectiCare does not cover any services that are not identified or not included in the Covered Services section of this Agreement. These exclusions and limitations supersede and override the Covered Services section.

Alternative Treatments: ConnectiCare does not cover complementary or alternative medicine that is not considered standard medical treatment by the traditional United States medical community and as defined by the National Center for Complementary and Integrative Health (NCCIH) of the National Institutes of Health.

Examples of non-standard treatments include, but are not limited to:

- Acupressure.
- Acupuncture, except when acupuncture is provided as part of pain management.
- Animal assisted therapies.
- Art therapy.
- Ayurveda.
- Biofeedback.
- Bioidentical hormones.
- Colonic irrigation.
- Craniosacral therapy.
- Dance therapy.
- Essential metabolics analysis.
- Live blood cell analysis.
- Massage therapy.
- Megavitamin therapy.
- Mind-Body therapies.
- Music therapy.
- Reiki.
- Reflexology.
- Rolfing.
- Therapeutic touch.
- Wilderness, adventure, camping, outdoors, or other similar programs.

Assistive Communication Devices: ConnectiCare does not cover assistive communication devices including cellphones.

Athletic Devices: ConnectiCare does not cover devices that are for athletic performance, including Artificial Limbs.

Attorney Fees: ConnectiCare does not cover Attorney Fees.

Blood Products: ConnectiCare does not cover blood, blood products and related expenses.

Camps: ConnectiCare does not cover overnight camps or day camps focused on treatment or disability

Cardiac Rehabilitation: ConnectiCare does not cover cardiac rehabilitation for Phase III, unless the Member:

- Is being actively case managed and
- The rehabilitation is approved by ConnectiCare.

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.

Chiropractic Care: ConnectiCare does not cover chiropractic therapy that is long term or maintenance in nature.

Clinical Trials: ConnectiCare does not cover Clinical trial services as follows:

- Cost of Experimental or Investigational medicines or devices that are not exempt from new medicine or device application by the Food and Drug Administration (FDA).
- Costs for non-Covered Services.
- Costs that would not be covered by this Plan for 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.
- Transportation, lodging, food or other travel expenses for the Member or any family Member or companion of the Member.

Concierge Services: ConnectiCare does not cover concierge services (which means the fees a provider charges as a condition of selecting or using their services).

Cosmetic Services: ConnectiCare does not cover 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) subsections of the Covered Services 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 as described in the Reconstructive Surgery or Durable Medical Equipment (DME) subsections of the Covered Services section or as otherwise required by the 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.
- Treatment of craniofacial disorders, except as described in the Craniofacial Disorders provision of the Covered Services section.
- 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 include infection, bleeding, and dependent on the location by interfering with ADLs.

Court Ordered Non-Medically Necessary Care: ConnectiCare does not cover services that are court ordered but are not Medically Necessary, unless required by State Law.

Custodial Care: ConnectiCare does not cover 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 or is provided in the absence of skilled service and care provided by non-licensed professionals.

Dental Services: ConnectiCare does not cover the following dental services:

- Any service, procedure, or treatment modality not specifically listed in the Dental Services subsection of the Covered Services section as a covered Dental Service.
- Dental treatments, medications, and supplies that are not Medically Necessary.
- Experimental Or Investigational procedures.
- Procedures to alter vertical dimension (bite height based on the resting jaw position) including but not limited to, occlusal (bite) guards and periodontal splinting appliances (appliances used to splint or adhere multiple teeth together), and restorations (fillings, crowns, bridges, etc.).
- Space maintainers for dependent children aged thirteen and over (once per quarter or arch per lifetime).
- Services or supplies rendered or furnished in connection with any duplicate prosthesis or any other duplicate appliance.

- Restorations which are not of any dental health benefit, but primarily Cosmetic Treatment in nature, including, but not limited to laminate veneers.
- Payment of the applicable Cost Sharing of this Plan's Maximum Allowable Amount for the alternate service, if any, will be made toward such treatment and the balance of the cost remains the responsibility of the Member.
- Personalized, elaborate, or precision attachment dentures or bridges, or specialized techniques, including the use of fixed bridgework, where a conventional clasp designed removable partial denture would restore the arch.
- Payment of the applicable Cost Sharing of this Plan's Maximum Allowable Amount for the alternate service, if any, will be made toward such treatment and the balance of the cost remains the responsibility of the Member.
- General anesthesia, except for the following reasons:
 - Removal of one or more impacted teeth.
 - Removal of four or more erupted teeth.
 - Treatment of a physically or mentally impaired person.
 - Treatment of a child under age 11.
 - Treatment of a Member who has a medical problem, when the attending physician requests in writing that the treating Dentist administers general anesthesia. This request must accompany the dental claim form.
- Duplicate charges.
- Services incurred prior to the effective date of coverage.
- Services incurred after cancellation of coverage, or losses of eligibility.
- Services incurred in excess of any Contract Year maximum.
- Services or supplies that are not Medically Necessary according to accepted standards of dental practice.
- Services are incomplete.
- Orthodontic services for Members aged twenty-six and over, orthodontics is a covered Dental Service.
- Sealants on teeth other than the first and second permanent molars, or applications applied more frequently than every thirty-six months or a service provided outside of ages five through fourteen.
- Services such as trauma which are customarily provided under medical-surgical coverage.
- More than two oral examinations of any type in any consecutive 12-month period.
- More than two prophylaxes in any consecutive 12-month period.
- More than one filling per tooth surface in any consecutive 24-month period.
- More than one full mouth x-ray series in any period of thirty-six consecutive months.
- Bitewing x-rays or vertical bitewing x-rays in excess of eight films in any consecutive 12-month period.
- Adjustments or repairs to dentures performed within six months of the installation of the denture.
- Services or supplies in connection with periodontal splinting (adhering multiple teeth together).

- Implants and implantology services, including implant bodies, abutments, attachments, and implant supported prosthesis (such as crowns, dentures, pontics, or bridgework).
- Expenses incurred for the replacement of an existing denture which is or can be made satisfactory.
- Additional expenses incurred for a temporary denture.
- Expenses incurred for the replacement of a denture, crown, or bridge for which benefits were previously paid, if such replacement occurs within five years from the date of the previous benefit.
- Training in plaque control or oral hygiene, or dietary instruction.
- Completion of reporting forms.
- Charges for missed appointments.
- Charges for services and supplies which are not necessary for treatment of the injury or disease or are not recommended and approved by the attending Dentist, or charges which are not reasonable.
- Scaling and root planing, which is not followed, where indicated, by definitive pocket elimination procedures. In the absence of continuing periodontal therapy, scaling and root planning will be considered a prophylaxis and subject to the limitations of that procedure.
- Periodontal surgery procedures more than once per quadrant in any period of thirty-six consecutive months.
- More than one periodontal scaling and root planning per quadrant in any consecutive 36-month period.
- More than two periodontal maintenance procedures in any consecutive 12-month period, as well as periodontal therapy, periodontal maintenance procedures in the absence of benefited comprehensive periodontal therapy.
- Services for any condition covered by workers' compensation law or by any other similar legislation.
- Services to correct or in conjunction with treatment of congenital malformations (e.g., congenitally missing teeth, supernumerary teeth, enamel, and dental dysplasia), developmental malformation of teeth, or the restoration of teeth missing prior to the effective date of coverage.
- Claims submitted more than 11 months (335 days) following the date of service.

Disposable Supplies: Disposable supplies for home use, such as bandages, gauze, tape, antiseptics, dressings, Ace- type bandages, diapers, underpads, and other incontinence supplies are not covered.

Educational Counseling: ConnectiCare does not cover educational counseling, testing and support services including tutoring, mentoring, tuition and school-based services for children and adolescents required to be provided by or paid for by the school under the Individual with Disabilities Act.

Education Services: ConnectiCare does not cover educational services, except for educational services in connection with the 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) sections:

- Screening and treatment are associated with learning disabilities.
- Special education and related services.
- Testing, training, rehabilitation for educational purposes

Experimental or Investigational Treatment: ConnectiCare does not cover Experimental or Investigational treatment, except as described in the Covered Services section.

Extracorporeal Shock Wave Therapy: ConnectiCare does not cover extracorporeal shock wave therapy for the treatment of musculoskeletal conditions.

Facelifts: ConnectiCare does not cover facelift surgery or rhytidectomy.

Family Planning and Infertility Services: ConnectiCare does not cover Family planning and Infertility services, including but not limited to:

- Contraceptive drugs and devices, except to the extent insurance law requires coverage for these items. When they are covered, they are covered under the Covered Services section.
- Home births (except that complications of home births are covered).
- Infertility services not specifically covered under the Covered Services section, including but not limited to:
 - 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 Covered Services section.
 - Medications for sexual dysfunction.
 - Recruitment, selection and screening of donors or gestational carriers.
 - Reversal of surgical sterilization.
 - Surrogacy and all charges associated with surrogacy arrangements such as prescription drugs, fertilization or implantation, except if provided to a Member.
- Labor doulas and labor coaches.

Gene Therapy, Cell Therapy, and Cell-based Gene Therapy: Gene therapy, cell therapy (including stem cell therapy), and cell-based gene therapy, including any prescription drugs, procedures, or health care services related to these therapies are not covered. Coverage for other health care services and treatment options relating to a condition – for which these excluded therapies have been developed – is in accordance with this Agreement and any limitations outlined in applicable medical policy. As such, certain services may be subject to Prior Authorization

Genetic Testing: ConnectiCare does not cover genetic testing and analysis, except as described in the Covered Services section including, but not limited to:

- Genetic testing kits are available either directly to the consumer or via a physician prescription.
- Genetic testing is only for the benefit of another family Member.

Gynecomastia Surgery: ConnectiCare does not cover gynecomastia surgery.

Hair Loss or Growth Treatment: ConnectiCare does not cover items and services for the promotion, prevention, or other cosmetic treatment of hair loss or hair growth are not covered.

Health Club Memberships and Exercise Equipment: ConnectiCare does not cover health club Memberships and exercise equipment.

Home Health Aide: ConnectiCare does not cover home health aide care that is not patient care of a medical or therapeutic nature.

Homeopathic and Holistic Care: ConnectiCare does not cover homeopathic and holistic treatments.

Hypnosis: ConnectiCare does not cover Hypnosis, biofeedback, and acupuncture, except when acupuncture is provided as part of pain management.

Incarceration: ConnectiCare will not cover services for Members when rendered while the Member is incarcerated unless a court order specifically requires coverage.

Injection of Collagen: ConnectiCare does not cover injections of collagen or other fillers or bulking agents to enhance appearance.

Intermediate Care: Care in a licensed intermediate care facility is not covered. This exclusion does not apply to the services covered under in the Covered Services section.

Insufficient Evidence of Therapeutic Value: ConnectiCare does not cover any treatment for which there is Insufficient Evidence of Therapeutic Value for the use for which it is being prescribed.

Lift Procedures: ConnectiCare does not cover thigh, leg, hip, or buttock lift procedures.

Male Condoms: ConnectiCare does not cover male condoms are not covered except as otherwise required by federal or State Law.

Massage Therapy: ConnectiCare does not cover massage therapy is not covered.

Medical Supplies: ConnectiCare does not cover medical supplies, equipment or prosthetics that are not durable or that are not on ConnectiCare's list of covered equipment. Examples of excluded equipment including, but not limited to:

- Any item not primarily medical in nature
- Any item or service which is not covered by the Medicare or Medicaid programs.
- Assistive technology and adaptive equipment, including but not limited to:
- Communication boards, computers, equipment, and devices.
- Gait trainers.
- Prone standers.
- Supine boards.
- Other equipment not intended for use in the home.
- Beds, bedding and bed-related items.
- Bone growth (osteogenic) stimulators (spinal, non-spinal and ultrasonic).
- Clothing or bodywear, except as otherwise covered in the Covered Services section.
- Comfort or convenience items, including but not limited to:

- Furniture or modifications to furniture.
- Home climate control devices.
- Tubs, spas, or saunas.
- Compression and cold therapy devices.
- Compression or anti-embolism stockings, except when a Member has lymphedema, lymphedema related to cancer or a cancer related procedure.
- Cryotherapy; polar packs.
- Exercise equipment.
- Foot orthotics, except if the Member is diabetic.
- Hearing aids, except as described in the Covered Services section.
- Home or automobile equipment or modifications.
- Items used to perform or assist with personal hygiene.
- Lifts of any type.
- Mechanical stretch devices for treatment of joint stiffness (pre- or post-surgery) or joint contractures.
- Pneumatic compression devices for the treatment of lymphedema or the prevention of deep vein thrombosis.
- TENS units or other neuromuscular stimulators and related supplies, either internal or external, for the treatment of pain or other medical conditions.
- Wigs, hair prosthetics, scalp hair prosthetics or cranial prosthetics, except as described in the Covered Services section.

Medical Tourism: ConnectiCare will not cover any expenses related to medical tourism. Medical tourism refers to traveling outside the United States to receive medical care. This includes, but is not limited to, elective procedures, surgeries, treatments, and any follow-up care related to services received outside the country. Members who choose to seek medical care outside the United States will be fully responsible for all costs incurred.

Melasma: ConnectiCare does not cover treatment of Melasma.

New Treatments: ConnectiCare does not cover new treatments for which ConnectiCare has not yet made a coverage policy, except for drugs with FDA approval for the use for which they are prescribed.

Non-Emergency Medical Transportation: ConnectiCare does not cover transportation services that are non-Emergency medical transport services or chair car to and from a provider's office for routine care or if the transport services are for a Member's convenience. ConnectiCare reserves the right to initiate and facilitate inter-facility non-emergency medical transportation for Members when Medically Necessary and approved by ConnectiCare.

Non-Emergent Services Obtained in an Emergency Room: ConnectiCare does not cover services provided within an Emergency room by a Participating or Non-Participating Provider, which do not meet the definition of Emergency Services, are not covered.

Non-Licensed Individuals: ConnectiCare does not cover services rendered by non-licensed individuals.

Non-Medically Necessary Services: ConnectiCare does not cover non-medically necessary services or supplies, except as required by applicable federal or state law. This includes services that do not meet ConnectiCare's medical policy, clinical policy, or benefit policy guidelines.

Non-Member Services: ConnectiCare does not cover 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 the law.

Non-Surgical Treatment of TMJ: ConnectiCare does not cover non-surgical treatment of temporomandibular joint (TMJ) dysfunction or temporomandibular disease (TMD) syndrome, including but not limited to:

- Appliances.
- Behavior modification.
- Physiotherapy.
- Prosthodontic therapy.

Oral Nutrition: ConnectiCare does not cover outpatient oral nutrition, such as dietary or nutritional supplements, supplements, herbal supplements, weight loss aids, and food unless otherwise outlined in the Covered Services section.

Otoplasty: ConnectiCare does not cover Otoplasty or ear pinning.

Over-the-Counter Items: ConnectiCare does not cover 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 Covered Services section.

Pain Management: ConnectiCare does not cover pain management procedures and services, except as provided in the Covered Services section. Excluded services include:

- Automated percutaneous lumbar discectomy (APLD)/automated percutaneous nucleotomy.
- Coblation Nucleoplasty TM, disc nucleoplasty, decompression nucleoplasty plasma disc decompression.
- Endoscopic anterior spinal surgery/Yeung endoscopic spinal system (YESS)/percutaneous endoscopic discectomy (PELD)/arthroscopic microdiscectomy, selective endoscopic discectomy (SED).
- Endoscopic disc decompression, ablation or annular modulation using the DiscFX TM System.
- Endoscopic epidural adhesiolysis.
- Epiduroscopy, epidural myelography, epidural spinal endoscopy.
- Intradiscal and/or paravertebral oxygen/ozone injections.
- Intervertebral disc biacuplasty/cooled radiofrequency.
- Interdiscal electrothermal annuloplasty/Interdiscal electrothermal therapy (IDET).
- Intralesional Anesthesia or Postoperative Disposable Ambulatory Regional Anesthesia.
- Percutaneous laminotomy/laminectomy, percutaneous spinal decompression.

- Percutaneous laser discectomy/decompression, laser-assisted disc decompression (LADD).
- Percutaneous epidural adhesiolysis, percutaneous epidural lysis of adhesions, Racz procedure.
- Percutaneous intradiscal radiofrequency thermocoagulation (PIRFT), intradiscal radiofrequency thermomodulation or percutaneous radiofrequency thermomodulation.
- Prolotherapy.
- Spinal Distraction Systems.

Peak Flow: ConnectiCare generally does not cover peak flow meters; however, ConnectiCare will cover peak flow meters if all of conditions are met:

- The Member is enrolled in ConnectiCare’s asthma health management program.
- The Member is being actively case managed.
- The use of the peak flow meter is approved by ConnectiCare.

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.

Personal Convenience Items: ConnectiCare does not cover personal convenience or comfort items of any kind.

Plasma: ConnectiCare does not cover platelet-rich-plasma for bone, wound or tendon healing.

Piercings: ConnectiCare does not cover body piercings.

Prescription Drugs: ConnectiCare does not cover the following prescription drugs or supplies:

- 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 as otherwise required by applicable law.
- Certain prescription drugs and supplies are no longer covered when Clinically Equivalent Alternative Drugs or Supplies are available unless otherwise required by law or are otherwise determined by ConnectiCare 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 than the Clinically Equivalent Alternative Drug or Supply.
- 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.
- This exclusion does not apply if the drugs or medications are determined to be Medically Necessary.
- 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 will not be replaced.
- 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 Agreement.
- Infant formulas, dietary or food supplements, prescription medical foods and nutritional supplies, except as described in the Covered Services section.
- Medications for sexual dysfunction.
- Prescription drugs, medications, or supplies:
 - Covered by workers' compensation law or similar laws, or covered by workers' compensation coverage, even if the Member chooses not to claim those benefits, subject to applicable state law.
 - 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, subject to applicable state law.
 - 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 this Agreement, 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 ConnectiCare's Pharmacy and Therapeutic Committee unless they are Medically Necessary.

Private Duty Nursing: ConnectiCare does not cover private room accommodations or private duty nursing in a facility.

Provider Incurred Costs: ConnectiCare will not cover any expenses, fees, taxes, or surcharges imposed on the Member by any Provider or Facility that are the Provider or Facility's responsibility to pay.

Provider-to-Provider Consultation: ConnectiCare does not cover interprofessional consultations between providers without the Member present.

Rehabilitation Services (Long-Term): ConnectiCare does not cover rehabilitative 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.

Routine Foot Care: ConnectiCare does not cover Routine foot care (except when the Member is a diabetic), including, but not limited to the evaluation or treatment of subluxations (structural misalignments of the joints) of the feet, and the elevation or treatment of flattened arches and the prescription of supportive devices.

Routine Physical Exams in Urgent Care: ConnectiCare does not cover Routine physical exams or immunizations at an Urgent Care facility.

Screenings: ConnectiCare does not cover screening and/or testing required for public health surveillance, travel, education, employment, or returning to employment, obtaining medical coverage, life insurance coverage, licensing, or to comply with a court order or when required for parole or probation. except as required by law.

Sensory and Auditory Integration: ConnectiCare does not cover sensory and auditory integration therapy, unless covered under the Covered Services section.

Snoring: ConnectiCare does not cover treatment of snoring, including, but not limited to:

- Laser-assisted uvulopalatoplasty.
- Snoring guards.
- Somnoplasty, and any other snoring-related appliances.

Supplies: ConnectiCare does not cover services and supplies exceeding the benefit maximums. ConnectiCare also does not include services and supplies not specifically included in this document.

Services Covered by Another Party: 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 the law, are covered. Also covered are care, treatment or services that are otherwise Medically Necessary and provided in a Veteran's Hospital.

Services Provided Outside the Service Area: Except as otherwise provided in this Agreement, ConnectiCare does not cover any services and supplies provided to a Member outside the Service Area where the Member traveled to the location for the purposes of receiving medical services, supplies, or drugs are not covered. Also, routine care, preventive care, primary care, specialty care, and inpatient services are not covered when furnished outside the Service Area. When death occurs outside the United States, the medical evacuation and repatriation of remains is not covered. Please contact Member Services for more information.

Services Provided Outside the United States: Except as otherwise provided in this Agreement, ConnectiCare does not cover any services (both emergency and non-emergency), supplies, or prescription drugs received outside the United States are not covered.

Services Related to a Non-Covered Service: When a service is not covered, all services related to the non-Covered Service are not covered. This exclusion does not apply to the services ConnectiCare would otherwise cover to treat complications of the non-Covered Service. Any treatment or service related to the provision of a non-Covered Services, 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 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 us, and
- Related Services would be a Health Service if the non-covered benefit were covered by the Plan, or
- As required by applicable law.

Services Rendered by Immediate Family: ConnectiCare does not cover any service rendered by an immediate family Member of the Member's family.

Services with No Member Incurred Cost: ConnectiCare does not cover any service, supplies, or equipment that would be provided without cost to the Member in the absence of ConnectiCare covering the charge.

Smoking Cessation Products: ConnectiCare does not cover smoking cessation products.

Speech Therapy: ConnectiCare does not cover speech therapy for stuttering, lisp correction, or any speech impediment, except as described in the Covered Services section.

Sports Medicine Services: ConnectiCare does not cover sports medicine clinic services and treatments and the services of a personal trainer. In addition, there is also no coverage for any diagnostic services related to any of these programs, services, or procedures.

Surgical Procedures (Artificial Disc): ConnectiCare does not cover surgical procedures using an artificial disc.

Telehealth Services: ConnectiCare does not cover the following telehealth services:

- Costs for asking for Prior Authorization.
- 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, insurance 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 are not directly responsible for the Member's 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 electronic-mail, facsimile, or texting.

Third Party Coverage: ConnectiCare does not cover third party coverage, such as other primary insurance, workers' compensation and Medicare will not be duplicated.

Third Party Requested Services: ConnectiCare does not cover services required by third parties or pursuant to a court order, including:

- Blood tests.
- Medications, including prophylactic.
- Physical examinations.
- Supplies.
- Vaccinations/immunizations.

This exclusion does not apply to the covered substance use disorder that was provided to a Member pursuant to a court order.

Transplant Transportation Services: ConnectiCare does not cover Solid organ transplant and bone marrow transplant transportation costs, including, but not limited to:

- 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 Covered Services section.
- Expenses over those described in the Covered Services section.
- Local transportation costs while at the transplant facility.
- Car rental costs.

Transportation Services: ConnectiCare does not cover transportation, accommodation cost, and other non-medical expenses related to Covered Services (whether they are recommended by a physician or not), except as described in the Covered Services section.

Travel Services: ConnectiCare does not cover Services obtained for foreign or domestic travel, including:

- Camp.
- Employment.
- Insurance.
- Licensing.
- Pursuant to a court order.
- School.

Ventricular Assist Devices: ConnectiCare does not cover ventricular assist devices, except for bridge to heart transplantation.

Vision Services: ConnectiCare does not cover vision services except for as provided in the Covered Services section. Vision services that are not covered include, but not limited to:

- Adult eyeglasses and contact lenses.
- Eye surgeries and procedures primarily for the purpose of correcting refractive defects of the eyes, including, but not limited to:
 - Laser surgery.
 - Orthokeratology.
 - Radial keratotomy.
- Non-standard prescription lenses, frames, and prescription contact lenses, including tinted lenses.
- Vision and hearing examinations (except as described in the Covered Services section).
- Vision therapy and vision training

Vocational Counseling: ConnectiCare does not cover vocational counseling, testing and support services including job training, placement services, and work hardening programs (programs designed to return a person to work or prepare a person for specific work); Transitional Living services (including recovery residences).

War and Felonious Occupation: ConnectiCare does not cover war or felonious occupation related to treatment or supplies, whether the war is declared or undeclared.

Weight Loss: ConnectiCare does not cover weight loss/control services, equipment, and treatment, including, but not limited to:

- Bariatric surgery.
- Commercial diet plans and any clinics and services in connection with such plans or programs.
- Exercise equipment.
- Weight loss or weight control programs.

Wilderness Camp: ConnectiCare does not cover services required by or received at a Wilderness Camp or a boarding school, including:

- Medications, including prophylactic.
- Physical examinations, blood tests.
- Supplies.
- Vaccinations/immunizations

Coordination of Benefits

Coordination of Benefits (COB) refers to a process where multiple health insurance plans work together to determine which payer is responsible for the initial payment of healthcare claims, and how the remaining balance is distributed among other involved payers. The goal is to ensure that a person with dual coverage receives the maximum benefits without excessive payments or duplicate coverage.

Other Insurance

Insurance effective at any one time on the Member under a like policy or policies in this insurer is limited to the one such policy elected by the insured, their beneficiary, or their estate, as the case may be, and the insurer will return all premiums paid for all other such policies.

Insurance with other Insurers – Expense Incurred Benefits: If there be other valid coverage, not with ConnectiCare, providing benefits for the same loss on other than an expense incurred basis and of which this insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability for such benefits under this Agreement shall be for such proportion of the indemnities otherwise provided hereunder for such loss as the like indemnities of which ConnectiCare had notice (including the indemnities under this Agreement) bear to the total amount of all like indemnities for such loss, and for the return of such portion of the premium paid as shall exceed the pro-rata portion for the indemnities thus determined. For the purpose of applying this provision when other coverage is on a provision of service basis, the “like amount” of such other coverage shall be taken as the amount which the services rendered would have cost in the absence of such coverage.

Insurance with Other Insurers – Other Benefits: If there be other valid coverage, not with this insurer, providing benefits for the same loss on other than an expense incurred basis and of which this insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability for such benefits under this Agreement shall be for such proportion of the indemnities otherwise provided hereunder for such loss as the like

indemnities of which the insurer had notice (including the indemnities under this Agreement) bear to the total amount of all like indemnities for such loss, and for the return of such portion of the premium paid as shall exceed the pro-rata portion for the indemnities thus determined.

Other Valid Coverage: Other valid coverage refers to any other insurance policy, coverage, or plan as permitted by State Law that provides benefits for the same loss or expense for which this Agreement covers, and which is considered valid and legally binding.

Automobile Insurance Policies: To the extent permissible by law, benefits shall not be provided by this Plan for Covered Services paid, payable or required to be provided as basic reparations benefits under any no-fault or other automobile insurance policy.

ConnectiCare shall be entitled:

- To charge the Member for such a dollar value, to the extent that the Member has received payment from any and all sources, including but not limited to, first party payment.

A Member who fails to secure no-fault insurance required by law shall be deemed to be his or her own insurer and ConnectiCare shall reduce his or her benefits for Covered Services by the amount of basic reparations benefits or other benefits provided for injury if such a no-fault policy had been obtained.

If a Member is entitled to benefits under a no-fault or other automobile insurance policy, benefits for Covered Services will only be provided when a Member follows all of the guidelines stated in the Managed Care Rules And Guidelines section. It is necessary to follow all the guidelines in the Managed Care Rules and Guidelines section in order for ConnectiCare to continue to provide benefits for Covered Services when the no-fault or other automobile insurance policy benefits are exhausted.

Workers' Compensation: As required by law, ConnectiCare will not exclude coverage under this Plan for a sole proprietor who is eligible for, but who does not elect, workers' compensation. In addition, to the extent permissible by law, no benefits shall be provided for Covered Services paid, payable or eligible for coverage under any workers' compensation law, employer's liability or occupational disease law, denied under a managed workers' compensation program as Out-of-Network services or which, by law, were rendered without expense to the Member.

ConnectiCare shall be entitled to the following:

1. To charge the entity obligated under such law for the dollar value of those benefits to which the Member is entitled.
2. To charge the Member for such a dollar value, to the extent that the Member has been paid for the Covered Services.
3. To reduce any sum owing to the Member by the amount that the Member has received payment.
4. To place a lien on any sum owing to the Member for the amount ConnectiCare have paid for Covered Services rendered to the Member, in the event that there is a disputed

and/or controverted claim between the Member's employer and the designated workers' compensation insurer as to whether or not the Member is entitled to receive workers' compensation benefits payments.

5. To recover any such sum owing as described above, in the event that the disputed and/or controverted claim is resolved by monetary settlement to the full extent of such settlement.

6. If a Member is entitled to benefits under workers' compensation, employer's liability, or occupational disease law, it is necessary to follow all of the guidelines in the Managed Care Rules And Guidelines section in order for this Plan to continue to provide benefits for Covered Services when the workers' compensation benefits are exhausted.

Rights To Receive and Release Necessary Information: ConnectiCare routinely sends questionnaires to Members where the order of coverage and benefits among responsible plans is in question. ConnectiCare reserves the right to deny any or all claims until the complete questionnaire has been returned to ConnectiCare.

Any person claiming services or payments under this Plan must furnish ConnectiCare or ConnectiCare's agents, any information needed to implement the subrogation provisions. For the purposes of implementing these provisions or a similar provision of any other plan, ConnectiCare 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 Services that ConnectiCare are responsible for, ConnectiCare may pay to that plan any amounts ConnectiCare determined 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, ConnectiCare will be fully released from liability under this Plan.

Rights of Recovery: When payments or services have been made or arranged by ConnectiCare in excess of the maximum for allowable expenses, no matter to whom paid, ConnectiCare will have the right to recover the excess from any person (including the Member), insurance companies, or other organizations. ConnectiCare's right to do that will be limited to the amount that the Member has received from another plan.

Medicare Eligibility: If a Member becomes enrolled in Medicare after this Agreement became effective for the Member, the Member can still remain eligible for coverage under this Plan. If a Member has both Medicare Part A and Part B, Medicare is the primary Plan over this Plan.

Members who have coverage receive ConnectiCare Plan Benefits, but Medicare will be the primary Plan.

Claims

ConnectiCare has the right to review any claims and to interpret and apply the terms of this Plan to determine whether benefits are payable.

Filing a Claim: Members or Providers must promptly submit to ConnectiCare claims for Covered Services rendered to Members. All claims must be submitted in a form approved by

ConnectiCare and must include all medical records pertaining to the claim if requested by ConnectiCare or otherwise required by ConnectiCare's policies and procedures. Claims must be submitted by the Member or Provider to ConnectiCare within 180 after the following have occurred:

- Discharge for inpatient services or the date of service for outpatient services; and
- The provider has been furnished with the correct name and address for ConnectiCare.

If ConnectiCare is not the primary payer under coordination of benefits or third-party liability, the Provider must submit claims to ConnectiCare within 30 calendar days after final determination by the primary payer. Except as otherwise provided by State Law, any claims that are not submitted to ConnectiCare within these timelines are not eligible for payment and Provider waives any right to payment. Members are responsible for ConnectiCare's receipt of claims from Non-Participating Providers.

Claims From a Participating Provider: When a Member receives Covered Services from a Participating Provider, the Member is responsible for paying for any non-covered services and all the Cost Sharing amounts of this Plan, including the Plan Deductible, Copayment amounts, and any Coinsurance amounts. The Participating Provider who treated the Member is responsible for filing claims with ConnectiCare in accordance with their provider contract, and any payment from ConnectiCare will be made to the billing provider.

Special Rule: Members who are enrolled in a POS Deductible Open Access Plans or ConnectiCare's POS Open Access HDHP Plan

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

- The Participating Provider's charges.
- What charges in what amount ConnectiCare applied to the Plan Deductible.
- What charges in what amount ConnectiCare paid by ConnectiCare.
- The reasons for any adjustments to those billed charges.
- The amount the Member is required to pay to the Participating Providers, if any.

Any amount owed to the Participating Providers must be paid directly to the provider. Contact ConnectiCare if the Participating Provider bills the Member for more than the EOB says the Member must pay.

Members can find out the status of the Member's medical claims on ConnectiCare's website at MyConnectiCarePortal.com.

Members can find out the status of their behavioral health claims (those for mental health and alcohol or substance use) on the OptumHealth Behavioral Solutions website at www.liveandworkwell.com.

Any questions about claims, the Member should call ConnectiCare's Members Services Department.

Claims From a Non-Participating Provider

If a Member receives care from a Non-Participating Provider, a claim must be submitted to ConnectiCare at the appropriate address listed in this document.

The claim should include the following information:

- The Subscriber's name.
- The patient's name and ConnectiCare ID number (including suffix).
- A complete, itemized bill for services, which includes both a description of the service and the diagnosis.

Charge card receipts and balance due statements are not acceptable.

Generally, ConnectiCare's payment for Covered Services provided by a Non-Participating Provider is made directly to a Member, and the Member is responsible for paying the rendering provider, unless the Member writes on the claim form that they want ConnectiCare to pay the provider, with the following exceptions:

- ConnectiCare will pay an emergency medical transportation company provider within the United States directly when there is a law that permits ConnectiCare to do so.
- ConnectiCare 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.

ConnectiCare may also pay the Member directly if the Non-Participating Provider does not provide ConnectiCare with information that ConnectiCare requests for claim payment. Claims must be received by ConnectiCare 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.

Members can find out the status of the Member's medical claims on ConnectiCare's website at [MyConnectiCarePortal.com](https://myconnecticareportal.com).

Members can find out the status of the Member's behavioral health claims (those for mental health and alcohol or substance use) on the OptumHealth Behavioral Solutions website at www.liveandworkwell.com.

Payment to Custodial Parent: In situations where ConnectiCare has not paid the Member's Eligible Dependent children's claims directly to the provider, the law may require that ConnectiCare send the payment directly to the custodial parent if ConnectiCare are notified in writing, even if that parent is not a participant under this Plan.

Claims for Emergency Services: Members should review a claim for payment for Emergency Services provided by Non-Participating providers to make sure it is complete before they send the claim to ConnectiCare. In some cases, emergency room claims sent to ConnectiCare by a Hospital may be denied, if they have missing, incomplete or improperly coded information.

Members Covered by Another Insurance Plan: If a Member is covered under another plan and ConnectiCare is the secondary carrier, the Member has 180 days from the date the primary plan processed the claim to submit the claim to ConnectiCare. Please refer to the Coordination of Benefits section for a description of how to determine whether this Plan is the primary or secondary insurance company and any requirements that apply to the Member.

Members should remind their provider when the Member is covered under another plan, so the Member's services can be billed and paid for correctly.

Refund of Overpayments: Whenever ConnectiCare has made payments for Covered Services, including prescription drugs, either in error or in excess of the maximum amount allowed under this Plan, ConnectiCare have the right to recover these payments from:

- Any person to or for whom the payments were made.
- Any insurance companies.
- Any other person or organization.

Members have no right to expect future coverage for non-Covered Services, supplies, or medicines, because of payments made by ConnectiCare in error. ConnectiCare's right to recover ConnectiCare's incorrect payment may include subtracting amounts from future benefit payments. Members must complete and send ConnectiCare any documents ConnectiCare asks for and do whatever is necessary to protect ConnectiCare's right to recover any erroneous or excess payments.

Assignment of Benefits: Except for benefits to a dentist or oral surgeon, the benefits of this Plan are not transferable to any third party. When a Member sees a Participating Provider, they will usually bill ConnectiCare directly. When a Member sees a Non-Participating Provider for Covered Services, other than covered Dental Services, ConnectiCare may choose to pay the Member or to pay the provider directly. To the extent allowed by law, ConnectiCare will not accept an assignment to a Non-Participating Provider.

Claim Processing: Claims payment will be made to Participating Providers in accordance with the timeliness provisions set forth in the Provider's contract, federal and State Law. Unless the Provider and ConnectiCare have agreed in writing to an alternate payment schedule, federal and State Law. ConnectiCare will pay the Provider of service within 30 calendar days after receipt of a claim submitted with all relevant medical documentation and that complies with ConnectiCare billing guidelines and requirements. The receipt date of a claim is the date ConnectiCare receives either written or electronic notice of the claim.

Member Reimbursement: With the exception of any required Cost Sharing amounts, if a Member has paid for a Covered Service or prescription that was Prior Authorized or does not require Prior Authorization, ConnectiCare will repay the Member. The Member must submit the claim for reimbursement within 180 days from the date they made the payment.

For covered medical services, Members must mail this information to ConnectiCare Member Services at the address on the inside cover of this Agreement. The Member will need to mail ConnectiCare a copy of the bill for the Covered Services from the Provider or facility and a copy of the receipt. The Member should also include the name of the Member for whom they are submitting the claim and their policy number. Submission of the form does not guarantee payment.

Paying Bills: Members should refer to their Schedule of Benefits for their Cost Sharing responsibilities for Covered Services. Members may be liable to pay full price for services when:

- The Member asks for and gets medical services, prescription drugs, or equipment that are not covered.
- Except in the case of Emergency Services, the Member asks for and gets healthcare services from a Provider or facility that is a Non-Participating Provider without getting a Prior Authorization when required from ConnectiCare.

If ConnectiCare fails to pay a Participating Provider for providing Covered Services, the Member will not be responsible for paying the Participating Provider for any amounts owed by ConnectiCare. This does not apply to Non-Participating Providers.

Cost Sharing Calculation: To the extent required by State Law, ConnectiCare will calculate the Member's Deductible or Coinsurance payment based on the lesser of the provider's or vendor's charges for the Covered Services or the amount payable by the ConnectiCare or a ConnectiCare subcontractor for such goods or services, except as otherwise required by the laws of a foreign state when applicable to providers, vendors or patients in such foreign state.

Appeals, Complaints, and Grievances: A Member or their authorized representative can ask questions or send ConnectiCare complaints or Appeals about benefits and other issues concerning this Plan. Since most questions or complaints can be resolved informally, ConnectiCare suggests that the Member contact ConnectiCare's Member Services Department first. In addition, Member may also submit a complaint by using ConnectiCare's website at ConnectiCare.com.

Representatives are available Monday through Friday, during regular business hours, to explain policies and procedures and answer the Member's questions. If a Member is calling after normal business hours, they should leave a detailed voice mail message, including the Member's ConnectiCare ID number and return telephone number.

ConnectiCare will return the Member's telephone calls during regular business hours. In the event a problem or complaint cannot be informally resolved, a formal Appeal process is available, as outlined below.

Appeal Process: If the Member is not satisfied with a decision, ConnectiCare or a ConnectiCare Delegated Program has been made regarding Covered Services, benefits, Prior Authorization, or claims, then the Member may request an Appeal on the Member's behalf.

Before pursuing the Appeal process, the Member should consider seeking immediate assistance from ConnectiCare Member Services Department. Many questions and complaints can be resolved quickly and informally by speaking with one of ConnectiCare representatives. However, if the Member chooses to make use of the Appeal process, ConnectiCare will not subject the Member to any sanctions or impose any penalties on the Member. The Member 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 the Member's benefit request.

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 Prior Authorization of an inpatient admission or the Prior Authorization of a certain surgical 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.

In either case, the Appeal request may be initiated orally, electronically or by mail by calling, faxing, or writing ConnectiCare. ConnectiCare has designated the ConnectiCare Member Services Department to coordinate Appeals. The ConnectiCare Member Services Department can be contacted as follows:

Telephone: 1-800-251-7722
Fax: 1-855-276-7538 ConnectiCare
Member Services Appeals
PO Box 36120
Louisville, Kentucky 40233-6120

For all behavioral health Appeals, ConnectiCare behavioral health Delegated Program can be contacted as follows:

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

When contacting ConnectiCare or ConnectiCare's behavioral health Delegated Program, the Member should explain why the Member feels the original decision should be overturned. The Member is entitled and encouraged to submit additional written comments, documents, records and letters and treatment notes from the Member's health care professional and any other material relating to the Member's benefit request for consideration. The Member has the right to ask the Member's health care professional for such letters or treatment notes.

The Appeal must be filed with ConnectiCare as soon as possible after the Member receive the original decision, but no later than 180 calendar days after the Prior Authorization request was denied or 180 calendar days after the claim for benefits was denied, whichever comes first. If the Member fails to submit the Member's request within the 180 calendar days, the Member loses the Member's right to an Appeal.

The Member may contact the Commissioner of the State of Connecticut Insurance Department, the Division of Consumer Affairs within the Insurance Department or the office of the Healthcare Advocate at any time for assistance, complaints or upon the completion of ConnectiCare's internal Appeal process. Their contact information is as follows:

State of Connecticut Insurance Department
Insurance Commissioner
PO Box 816
Hartford, Connecticut 06142-0816
860-297-3900
or

The Consumer Affairs Unit
1-800-203-3447
Office of the Healthcare Advocate
P.O. Box 1543

Hartford, CT. 06144
or

(Toll Free) 1-866-466-4446
or
www.ct.gov/oha
or

Email: healthcare.advocate@ct.gov

Medical Necessity Appeal

Internal Appeal Process: If the Member disagrees with a decision regarding the Medical Necessity of a particular Covered Service, such as a denial of a request for Prior Authorization of an inpatient admission or the Prior Authorization of a certain surgical procedure, the Member may Appeal that decision. ConnectiCare's internal Appeal process is designed to resolve Appeals quickly

1. ConnectiCare will investigate the Member's Appeal request. If during this investigation, ConnectiCare acquires new or additional evidence, or new or ~~an~~ additional scientific or clinical rationale, it will be reviewed as part of the Member's Appeal. ConnectiCare will provide such new or additional information to the Member or the Member's representative for review. The Member will have five business days to respond to the new or additional information.
2. ConnectiCare will arrange to have the Appeal reviewed by a Clinical Peer who was not involved in the original decision. If Clinical Peer agrees with ConnectiCare's decision to deny coverage but uses new or additional information for their decision, then the Member or the Member's authorized representative will be provided with the new or additional information and will have five business days to respond to the new or additional information before the decision is issued.
3. The Member or the Member's authorized representative and the Member's practitioner will be sent a written decision no later than thirty calendar days for pre-service and concurrent Appeals or sixty calendar days for post service Appeals.
4. If the Member is not satisfied with the decision, the Member or the Member's authorized representative or any provider with the Member's consent may be able to have the decision reviewed by a Clinical Peer who has no association with ConnectiCare by submitting a request for an external review through the State of Connecticut Insurance Department when the Adverse Determination or final Adverse Determination involves an issue of rescission, eligibility, Medical Necessity, appropriateness, health care setting, level of care or effectiveness. Please refer to the "External Review and Expedited External Review" provision in this subsection.

Urgent Care Appeals: The Member may file an Appeal on an urgent basis with ConnectiCare if:

- ConnectiCare has issued an Adverse Determination for coverage, and:
 - The time period for making a non-urgent care request determination could seriously jeopardize the Member's or the Member's covered dependent's life, health, or ability to regain maximum function, or
 - In the opinion of a health care professional with knowledge of the medical condition, the Member or the Member's covered dependent would be subject to severe

pain that could not be adequately managed without the Health Services or treatment related to the Appeal.

- The Member's request concerns a substance use disorder or a co-occurring mental disorder, or
- The Member's request concerns a mental disorder requiring inpatient services, Partial Hospitalization, residential treatment, or Intensive Outpatient services necessary to keep the Member from requiring an inpatient setting.

Behavioral Health Urgent Requests: A decision on an urgent Appeal concerning a substance use disorder, a co-occurring mental disorder or a mental disorder requiring inpatient services, Partial Hospitalization, residential treatment or Intensive Outpatient services necessary to keep the Member from requiring an inpatient setting will be made as soon as possible, taking into account the Member's condition, but not LATER than 24 hours after receipt of the request, provided that ConnectiCare has the information necessary to make a determination and provided if the Urgent Care request is a concurrent review request to extend a course of treatment beyond the initial period of time or the number of treatments, such request is made NOT LESS THAN 24 hours prior to the expiration date of the prescribed period of time or number of treatments. For reviews of an Appeal involving a concurrent review request, the Member's treatment shall be continued without liability to the Member until the Member has been notified of the review decision.

Other Urgent Requests: A decision on an urgent Appeal will be made as soon as possible, taking into account the Member's condition. If ConnectiCare receives all of the necessary information with the Member's Appeal, the Member will receive a decision within two business days of receipt of all necessary information but no later than 48 hours after ConnectiCare has received the Member's Appeal or within 72 hours after receiving the Member's request if any portion of the 48-hour period falls on a weekend, except as noted below. If ConnectiCare needs additional information in order to make the decision, then ConnectiCare will contact the Member within 24 hours of ConnectiCare's receipt of the Member's Appeal to tell the Member specifically what information ConnectiCare needs, ConnectiCare will make the decision no later than 48 hours after receipt of the missing information.

If the urgent Appeal involves an Adverse Determination of a concurrent review Urgent Care request, the treatment shall be continued without liability to the Member until the Member has been notified of the review decision.

If the Member is not satisfied with the urgent Appeal decision made by ConnectiCare, then the Member, the Member's authorized representative or any provider with the Member's consent may request an external review through the State of Connecticut Insurance Department when the Adverse Determination or final Adverse Determination involves an issue of Medical Necessity, appropriateness, health care setting, level of care or effectiveness. Please refer to the "External Review and Expedited External Review" provision in this subsection.

Bypassing the Internal Appeal Process: If any of the following circumstances apply, the Member may be able to bypass ConnectiCare's internal Appeal process and file a request for an expedited external review:

- The Member has a medical condition for which the time period for completion of an expedited internal Appeal would seriously jeopardize the Member's life or health or would jeopardize the Member's ability to regain maximum function.

- The Adverse Determination involves a denial of coverage based on a determination that the recommended or the requested Health Service or treatment is Experimental or Investigational and the Member's treating health care professional certifies in writing that such recommended or requested Health Service or treatment would be significantly less effective if not promptly initiated.

The Member, or the Member's provider acting on the Member's behalf with the Member's consent, may simultaneously file a request for an internal Appeal and an expedited external review. The independent review organization will determine whether the Member will be required to complete the internal Appeal process prior to conducting the expedited external review.

Please refer to the "External Review and Expedited External Review" provision in this subsection for details on filing for an expedited external review

External Review and Expedited External Review: The Member or the Member's authorized representative may file a request for an expedited external review if:

- The Member has a medical condition for which the time period for completion of an external review would seriously jeopardize the Member's life or health or would jeopardize the Member's ability to regain maximum function, or
- The final Adverse Determination concerns an admission, availability of care, continued stay or Covered Service for which the Member received Emergency Services, but the Member have not been discharged from a facility, or
- The denial of coverage was based on a determination that the recommended or requested Covered Service or treatment is Experimental or Investigational and the Member's treating health care professional certifies in writing that such recommended or requested Covered Service or treatment would be significantly less effective if not promptly initiated.

Note: An expedited external review is not available when the requested services have already been provided.

1. The external review or expedited external review request must be submitted to the State of Connecticut Insurance Department in writing. The address and telephone number are as follows:

State of Connecticut Insurance Department
Insurance Commissioner
PO Box 816
Hartford, Connecticut 06142-0816
1-860-297-3910

2. The external review request must be made within 120 calendar days of the Member's receipt of the final denial letter. However, an expedited external review may be filed without receipt of ConnectiCare's final denial letter. The Member does not need a final denial letter in order to file for an external review if ConnectiCare fails to strictly adhere to the requirements under the law with respect to making utilization review and benefit determinations.

3. When filing a request for an external review the Member will be required to authorize the release of any medical records that may be required to be reviewed for the purpose of making a decision on such request.

4. If the Member requests an external review or an expedited external review, the Member will receive additional information including instructions on how to supply additional comments or materials related to the Member's benefit request.

5. The Member or the Member's authorized representative will be provided with a written decision from the independent review organization (within 45 calendar days for a standard external review, 20 calendar days for an external review involving a health care service or treatment that is Experimental or Investigational, 48 hours for an expedited external review (except when any portion of the 48 hours falls in a weekend) or five calendar days for an expedited external review involving a health care service or treatment that is Experimental or Investigational, from the independent review organization's receipt of the request. A decision on an expedited review concerning a substance use disorder, a co-occurring mental disorder or a mental disorder requiring inpatient services, Partial Hospitalization, residential treatment or Intensive Outpatient services necessary to keep the Member from requiring an inpatient setting will be made as soon as possible, taking into account the Member's condition, but not later than 24 hours from the independent review organization's receipt of the request.

Administrative (Non-Medical Necessity) Appeal: If the Member disagrees 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, the Member may Appeal that decision:

1. If the Member files an Appeal, ConnectiCare will notify the Member not later than three business days after we receive the Member's Appeal that the Member or the Member's authorized representative are/is entitled to submit written materials to ConnectiCare to be considered when conducting a review of the Member's Appeal.
2. When the Appeal is received, it will be forwarded for review.
3. A staff Member who was not involved in the original decision will review the Appeal.
4. The Member or the Member's authorized representative will be provided with a written decision no later than twenty business days after ConnectiCare receive the Member's Appeal request. If ConnectiCare is unable to comply with this time period due to circumstances beyond ConnectiCare's control, the time period may be extended by ConnectiCare for up to ten business days, provided that on or before the 20th business day ConnectiCare provides the Member or the Member's authorized representative written notice of the extension and reason for the delay.

Legal Notices & General Provisions:

Member Cooperation: The Member agrees to cooperate with ConnectiCare and to follow ConnectiCare's rules and instructions in all administrative matters required for the administration of this Plan.

Member Eligibility Changes: The Member must meet the eligibility requirements of ConnectiCare. It is the Members' responsibility to notify ConnectiCare within 31 days if the Member changes their residence.

If the Member moves within the Service Area of this Plan, Premium rates will be adjusted, if necessary, to adjust to the Member's new address and the current ages of the Member's Eligible Dependents, effective at the beginning of the Premium Period following the change of residence.

Balance Billing: ConnectiCare contract with Participating Providers to make sure that the Member will not be billed for any Covered Services that are covered by this Plan. The Member is responsible for services billed that are subject to coordination of benefits and all of the Copayments, Deductibles and Coinsurance the Member is required to pay if the Member or the Member's Eligible Dependents are covered by another plan and that other plan is determined to be the primary plan. In this case, a Participating Provider may bill the Member for Copayments, deductibles, and Coinsurance due under that other plan (the primary plan). Check the Coordination of Benefits section to find out the Member's responsibilities.

Terms of Agreement: By being covered under this Plan, the Member and the Member's Eligible Dependents accept all of the rules of this Plan.

Agreement Binding on Members: By electing coverage or accepting benefits under this Agreement, all Members legally capable of contracting, and the legal representatives for all Members incapable of contracting, agree to all provisions of this Agreement.

Assignment: Except for dental benefits, a Member may not assign this Agreement or any of the rights, interests, claims for money due, benefits, claims, or obligations hereunder without ConnectiCare's prior written consent. Consent may be refused at ConnectiCare's discretion.

Proofs of Loss: Written proof of loss must be furnished to ConnectiCare at its said office in case of claim for loss for which this Agreement provides any periodic payment contingent upon continuing loss within 90 days after the termination of the period for which ConnectiCare is liable and in case of claim for any other loss within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than 1 year from the time proof is otherwise required.

Proof of Loss Claim Form: ConnectiCare, upon receipt of a notice of claim, will provide such forms as are usually provided by it for filing proofs of loss. If such forms are not furnished within 15 days after the giving of such notice the Member shall be deemed to have complied with the requirements of this Agreement as to proof of loss upon submitting, within the time fixed in the Agreement for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

Proof of Loss Time of Payment of Claims: Indemnities payable under this Agreement for any loss other than loss for which this Agreement provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this Agreement provides periodic payment will be monthly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

Legal Action: No action at law or in equity shall be brought to recover on this Agreement prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this Agreement. No such action shall be brought after the expiration of 3 years after the time written proof of loss is required to be furnished.

Liability of Benefits: ConnectiCare will have no liability for benefits other than as provided by this Plan.

Policy, Procedures, Rules, and Interpretations: ConnectiCare may establish reasonable policies, procedures, rules, and interpretations to promote the orderly and efficient administration of this Plan.

Agreement Reinstatement: If it ended for any reason, other than termination for non-payment of Premium, this Agreement may be reinstated if ConnectiCare received the Member's request for reinstatement within 10 days of the termination date and all outstanding Premiums are paid in full.

Incorporation by Reference: This document, including the Enrollment Form, Schedule of Benefits, Riders, and supplemental inserts is the entire contract and understanding between the Member and ConnectiCare. It replaces all prior agreements and understandings relating to the subject matter. Except as described in this document, this document may be waived, discharged, or ended only when done in writing and signed by the party against which enforcement of the waiver, discharge or termination is sought.

Invalidity: If any provision of this Agreement is held illegal, invalid, or unenforceable in a judicial proceeding, such provision shall be severed and shall be inoperative, and the remainder of this Agreement shall remain operative and in full force and effect.

Governing Law: Except as preempted by Federal Law, this Agreement will be governed in accordance with State Law and the rules, regulations or other standards set forth by the State of Connecticut Insurance Department. Any provision that is required to be in this Agreement by State or Federal Law shall bind ConnectiCare and Members whether or not set forth in this Agreement.

Participating Provider Agency: Participating Providers are not ConnectiCare's employees or agents. They are independent contractors with the responsibility for determining and providing health care for their patients.

Refusal of Service: A Participating Provider may refuse to provide services or treatment to the Member or the Member's Eligible Dependents if the Member does not pay the required Cost Share amounts required under this Plan.

Services Received Indemnification: ConnectiCare is not responsible for the Member's decision to receive treatment, services or supplies provided by Participating Providers, nor is ConnectiCare responsible or liable for the treatment, services or supplies provided by Participating Providers.

Pre-Existing Conditions: ConnectiCare does not discriminate in the provision of Covered Services on the basis of pre-existing health condition.

Incontestability: This Agreement shall be incontestable, except for nonpayment of premium, after it has been in force for two years from its date of issue.

Plan Year Benefits: This Plan calculates benefits on a Contract Year basis. This means that the benefit changes to the Member's benefit plan become effective upon the Renewal Date (when a new Agreement or amendatory Rider may be issued to the Member).

Surprise Bill: If the Member receives a Surprise Bill, ConnectiCare 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 Participating Provider.

Changes in Premiums and Cost Sharing: Any change to this Agreement, including, but not limited to, changes in Premiums, or Covered Services, Deductible, Copayment, Coinsurance and Annual Out-of-Pocket Maximum amounts, is effective after 60 days' notice to the Subscriber's address of record with ConnectiCare.

Acts Beyond ConnectiCare's Control: If circumstances beyond the reasonable control of ConnectiCare, including any major disaster, epidemic, complete or partial destruction of facility, war, riot, or civil insurrection, result in the unavailability of any facilities, personnel, or Participating Providers, then ConnectiCare and the Participating Provider shall provide or attempt to provide Covered Services in so far as practical, according to their best judgment, within the limitation of such facilities and personnel and Participating Providers. Neither ConnectiCare nor any Participating Provider shall have any liability or obligation for the delay or failure to provide Covered Services if such delay or failure is the result of any of the circumstances described above.

Waiver: ConnectiCare's failure to enforce any provision of this Agreement shall not be construed as a waiver of that provision or any other provision of this Agreement or impair ConnectiCare's right to require a Member's performance of any provision of this Agreement.

Genetic Information: ConnectiCare will not collect genetic information from the Member for the purpose of underwriting or otherwise. ConnectiCare will not request or require the Member to take any genetic tests. ConnectiCare will not adjust premiums or otherwise limit coverage based on genetic information.

Notices: Any notices required by ConnectiCare under this Agreement will be sent to the most current address or record for the Subscriber. The Subscriber is responsible for reporting any change in address to ConnectiCare.

Time Limit on Certain Defenses: After 2 years from the date of issue of this Agreement, no misstatements, except fraudulent misstatements, made by the applicant in the application for such Agreement shall be used to void the Agreement or to deny a claim for loss incurred or disability (as defined in the Agreement) commencing after the expiration of such 2-year period. No claim for loss incurred or disability (as defined in the Agreement) commencing after 2 years from the date of issue of this Agreement shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this Agreement.

Physical Examinations: ConnectiCare, at its own expense, shall have the right and opportunity to examine the person of the Member when and as often as it may reasonably

require during the pendency of a claim hereunder where it is not forbidden by State and Federal Law.

Automobile Accident-Related Injuries: ConnectiCare does not exclude coverage for automobile accident-related injuries, except as permitted by State Law.

Felonious Occupation or Criminal Activity: ConnectiCare is not liable for any loss to which a contributing cause was the Member's commission of or attempt to commit a felony or to which a contributing cause was the Member's being engaged in an felonious occupation or other willful felonious criminal activity.

Wellness and Other Program Benefits: This Agreement may include access to a wellness program offered to encourage Members to complete health activities that support their overall health. Any program is voluntary and available to all Subscribers at no cost. The program would additionally be available to Dependents 18 years and older at no cost. ConnectiCare may offer the Member rewards or other benefits for participating in certain health activities and programs provided by Participating Providers. The rewards and program benefit available to the eligible Member may include benefits such as gift cards.

Members should consult with their PCP before participating. The wellness program is optional, and the benefits are made available at no additional cost to eligible Members. Rewards and program benefits are available for redemption only while the Subscriber or eligible Dependent is currently enrolled with a ConnectiCare Plan. For more information, please contact Member Services. ConnectiCare may offer incentives from time to time, at ConnectiCare's discretion, in order to introduce the Member to covered programs and services available under this Plan, incent the Member to access certain medical services, and use online tools that enhance the Member's coverage and services.

Health Incentive: The purpose of these incentives includes, but are not limited to, making Members aware of cost-effective benefit options or services, helping them achieve their best health, and encouraging the Member 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,
- Retailer coupons, or
- Any combination of these.

Acceptance of these incentives is voluntary as long as ConnectiCare offers the incentives program. ConnectiCare may discontinue an incentive for a particular covered program or service at any time. If a Member has any questions about whether receipt of an incentive or retailer coupon results in taxable income to them, ConnectiCare recommends consultation with a 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.

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 ConnectiCare's health management programs. In addition, Members may be contacted and managed by ConnectiCare or ConnectiCare's Delegated Program.

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 monitors 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 a Member is enrolled in one of ConnectiCare's 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 Sharing amounts that do apply after the Plan Deductible is satisfied.

Members can call the ConnectiCare Member Services Department to find out more about ConnectiCare's current health management programs.

Underwriting Prohibition: ConnectiCare will not rescind or cancel coverage on the basis of written information submitted on, with or omitted from an insurance application by the Member if the ConnectiCare failed to complete medical underwriting and resolve all reasonable medical questions related to the written information submitted on, with or omitted from the insurance application before issuing the Agreement.

Blood Oxygen Level: ConnectiCare does not deny coverage based exclusively on the Member's blood oxygen level as measured by a pulse oximeter.

No Reduction in Coverage: ConnectiCare does not reduce coverage because the Member is only eligible for Medicare due to age but not enrolled, disability, or end-stage renal disease.

Health Status: ConnectiCare does not deny benefits based on health status.

Naturopathic and Healing Arts Notice: ConnectiCare will not deny reimbursement for any services which may be legally performed by any practitioner of the healing arts licensed to practice in Connecticut, and reimbursement under such the Agreement will not be denied because of race, color or creed nor shall ConnectiCare make or permit any unfair discrimination against particular individuals or persons so licensed.

Explanation of Benefits (EOBs) Disclosure Addendum

ConnectiCare will issue Explanations of Benefits (EOBs) to Members covered under this Plan when there is any balance owed by the Member. The Subscriber or a Member, if he or she is legally capable of consenting to the provision of Covered Services, may make a written request that ConnectiCare not issue EOBs or that ConnectiCare 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 Addendum:

ConnectiCare complies with applicable Federal civil rights laws and does not discriminate on the basis of age, color, disability, national origin, race, or sex.

To help you effectively communicate with us, ConnectiCare provides services free of charge and in a timely manner:

- ConnectiCare provides reasonable modifications and appropriate aids and services to people with disabilities. This includes: (1) Qualified interpreters. (2) Written Information in other formats, such as large print, audio, accessible electronic formats, and Braille.
- ConnectiCare provides language services to people who speak another language or have limited English skills. This includes: (1) Qualified oral interpreters. (2) Information translated in your language.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact ConnectiCare Member Services at 1-800-251-7722 or TTY/TDD: 711, Monday to Friday, 8 a.m. to 6 p.m., local time.

If you believe we have discriminated on the basis of age, color, disability, national origin, race, or sex, you can file a grievance. You can file a grievance by phone, fax, mail, or through your secure member portal. If you need help writing your grievance, we will help you. You may obtain our grievance procedure by visiting our website at [Connecticare.com/legal/nondiscrimination](https://connecticare.com/legal/nondiscrimination). Call our Civil Rights Coordinator at 1-800-251-7722, TTY/TDD: 711 or submit your grievance to:

ConnectiCare Grievance and Appeals Department
P.O. Box 4061
Farmington, CT 06034-4061
Fax: 1-800-319-0089
Website: MyConnectiCarePortal.com

You can also file a civil rights complaint (grievance) with the U.S. Department of Health and Human Services, Office for Civil Rights, online through the Office for Civil Rights Complaint Portal 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, D.C. 20201
Phone: 1-800-368-1019
TTY: 1-800-537-7697

Complaint forms are available here: <https://www.hhs.gov/sites/default/files/ocr-cr-complaint-form-package.pdf>

Patient Protection and Affordable Care Act Addendum:

Primary Care Provider (PCP): A PCP handles routine and basic healthcare needs. PCPs offer services like physical exams, immunizations, and treatment for non-urgent health issues or injuries. ConnectiCare encourages Members to select a PCP from the Provider Directory. For information on how to select a PCP, and for a list of the PCP Participating Providers, visit ConnectiCare's website at [Connecticare.com/CTFindCare](https://connecticare.com/CTFindCare) or call. If a PCP is not selected, one will be assigned by ConnectiCare.

Members can request to change their PCP at any time through [MyConnectiCarePortal.com](https://myconnecticareportal.com) or by contacting Member Services.

Each family Member can select a different PCP. A doctor who specializes in pediatrics may be selected as a child's PCP. A doctor who is an OB/GYN may be selected as a Member's PCP, with direct access no referrals required. For children, a Member may designate a pediatrician as the PCP.

Sometimes a Member may not be able to select the PCP from the Provider Directory they want. This may happen because:

- The PCP is no longer a Participating Provider with ConnectiCare, or
- The PCP already has all the patients they can take care of right now.

Members do not need Prior 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 ConnectiCare'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 Providers who specialize in obstetrics or gynecology, visit ConnectiCare's website at, [Connecticare.com/CTFindCare](https://connecticare.com/CTFindCare) or call ConnectiCare.

Plan Description Addendum

This addendum, in conjunction with this document, any Rider and the Provider Directory constitutes compliance with the disclosure requirements of Connecticut law, "AN ACT CONCERNING MANAGED CARE," regarding Plan Descriptions.

ConnectiCare is a for-profit health care center, organized under the Connecticut Business Corporations Act. If ConnectiCare's status should change, the Member will be notified in ConnectiCare's Member electronic newsletter.

ConnectiCare is also accredited by the National Committee for Quality Assurance (NCQA).

The following information is a summary of ConnectiCare's 2024 utilization review data with respect to the number of certifications requested; the number of admissions, services, procedures, or extension of stays not certified; and the number of denials upheld or reversed on Appeals within ConnectiCare's utilization review process. This information includes review data for benefits managed or administered by an outside company under its own Connecticut utilization review license.

Utilization Review Data

	ConnectiCare, Inc.
Requests for Certification	2,128
Certification Denials	386 (18.13%)
Number of Appeals of Denials	46 (11.91%)
Number of Denials Reversed Upon Appeal	40 (10.36%)

Below are the medical loss ratios for 2024.

Medical Loss Ratios

State Medical Loss Ratio

	ConnectiCare, Inc.
	100.9%

Federal Medical Loss Ratio

	ConnectiCare, Inc.
	87.9%

Quality Improvement Program

1. Based on the **HEDIS (Healthcare Effectiveness Data and Information Set) CAHPS (Consumer Assessment of Healthcare Providers and Systems) Member Satisfaction** study for 2024, 86.65% of ConnectiCare's Members gave ConnectiCare an 8 or above when they were asked to rate ConnectiCare's health plan on a scale ranging from worst health plan ("0") to the best health plan ("10").
2. ConnectiCare makes information about its Quality Improvement Program available to all Members, including information about the quality information program, including goals, processes, and outcomes as they relate to Member health and service. The Member may access this information at [Connecticare.com](https://connecticare.com). If the Member would like a written copy, the Member should call ConnectiCare's Member Services Department.
3. Connecticut law requires the State of Connecticut Insurance Department to develop and distribute a consumer report card, which compares:
 - All licensed managed care organizations, and
 - The fifteen largest licensed health insurers that use provider networks not included above.

Member Rights and Responsibilities

Member Rights

The Member has a right to:

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

Member Responsibilities

The Member has a responsibility to:

- Select a Primary Care Provider (PCP).
- Provide, to the extent possible, information providers need to render care and ConnectiCare need to provide coverage.
- Follow the plans and instructions for care that the Member has agreed to with practitioners.
- Keep scheduled appointments or give sufficient advance notice of cancellation.
- Pay the Copayments, Deductibles or Coinsurance.
- Follow the rules of this Plan and assume fiscal responsibility for not following the rules.
- Understand the Member's 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 ConnectiCare's employees by treating them with respect and dignity.
- Read this document describing this Plan's benefits and rules.

Federal Patient Protection and Affordable Care Act Notices

IMPORTANT NOTICE: Your Rights and Protections Against Surprise Medical Bills

As a ConnectiCare Member, we want to ensure you understand your rights under the federal No Surprises Act. This law provides important protection for you against unexpected medical bills, also known as "surprise bills."

What are Surprise Bills?

Surprise bills can happen when you receive care from an out-of-network provider or facility, and you did not have the chance to choose an in-network option. Surprise bills are bills for health care services, other than emergency services or urgent crisis center services, received by a Member for services rendered by an out-of-network health care provider, where such services were rendered by

- Such out-of-network provider at an in-network facility, during a service or procedure performed by an in-network provider or during a service or procedure previously approved or authorized by the health carrier and the Member did not knowingly elect to obtain such services from such out-of-network provider, or
- A clinical laboratory, as defined by State Law, which is an out-of-network provider, upon the referral of an in-network provider.

A Surprise Bill does not include a bill for health care services received by a Member when an in-network health care provider was available to render such services, and the Member knowingly elected to obtain such services from another health care provider who was out-of-network.

This can occur in situations like:

- **Scheduled procedures at in-network facilities:** Even if you choose an in-network hospital or surgery center, some of the doctors or other providers involved in your care (like anesthesiologists or radiologists) may be out-of-network.

Your Protections Under the No Surprises Act:

The No Surprises Act protects you from these unexpected out-of-network charges in the following ways:

- **Emergency Services:** If you receive emergency care, your Cost Sharing (like Copayments, Coinsurance, and deductibles) will be the same as if you received the care from an in-network provider. This applies even if the emergency facility or the emergency physicians are out-of-network. Once you are stable, your plan may require you to use an in-network provider for ongoing care.
- **Certain Non-Emergency Services at In-Network Facilities:** When you receive covered non-emergency services at an in-network hospital, Ambulatory Surgery Center, or other in-network facility, you are also protected from surprise bills from out-of-network providers who work there. This includes services like anesthesia, radiology, pathology, assistant surgeons, hospitalists, and intensivists.

- **Cost Limitations:** In these situations, out-of-network providers cannot bill you more than the in-network Cost Sharing amount for these services.
- **Notice and Consent:** In certain non-emergency situations at in-network facilities, you may be asked to provide written consent to receive care from an out-of-network provider and agree to pay more. However, you are not required to sign this consent, and if you do not, your plan will still pay the in-network Cost Sharing amount. This consent cannot be requested for Emergency Services.

What You Need to Do:

- **Understand Your ConnectiCare Plan:** Familiarize yourself with your in-network providers and facilities. This can help you make informed choices about your care whenever possible.
- **Ask Questions:** Before a scheduled procedure, do not hesitate to ask if all the providers involved in your care are in the ConnectiCare network.
- **Review Your Bills:** Carefully review your medical bills when you receive them. If you believe you have been wrongly billed by an out-of-network provider for services protected by the No Surprises Act, you have the right to dispute the bill.

How to Dispute a Bill:

If you believe you have received a surprise bill that violates the No Surprises Act, here is what you can do:

1. **Contact ConnectiCare:** First, contact ConnectiCare's Member Services at the number on your insurance card to discuss the bill. We can help determine if the charges were processed correctly.
2. **Federal Independent Dispute Resolution (IDR) Process:** If you disagree with ConnectiCare's decision, you have the right to request an independent review through the federal IDR process. You generally have sixty business days from the date on the initial payment or denial of payment to initiate this process. More information about the IDR process, including how to submit a request, can be found at <https://www.cms.gov/nosurprises>.

We are Here to Help:

ConnectiCare is committed to ensuring you receive the care you need at an affordable cost. If you have any questions about the No Surprises Act or your ConnectiCare coverage, please do not hesitate to contact ConnectiCare's Member Services team at the number listed on your Member ID card or visit ConnectiCare's website [ConnectiCare.com](https://www.connecticare.com).

This notice is a summary of your rights under the No Surprises Act. For more detailed information, please visit <https://www.cms.gov/nosurprises>.

Reimbursement Information:

Emergency Services: If emergency services were rendered to a Member by a Non-Participating Provider, such health care provider may bill ConnectiCare directly and the ConnectiCare shall reimburse such health care provider the greatest of the following amounts:

- The amount the Member's health care plan would pay for such services if rendered by an in-network health care provider.
- The usual, customary, and reasonable rate for such services; or
- The amount Medicare would reimburse for such services.

As used in this subparagraph, "usual, customary and reasonable rate" means the eightieth percentile of all charges for the particular health care service performed by a health care provider in the same or similar specialty and provided in the same geographical area, as reported in a benchmarking database maintained by a nonprofit organization specified by the Connecticut Insurance Commissioner. Such an organization shall not be affiliated with any health carrier.

Urgent Crisis Center: If urgent crisis center services were rendered to a Member at a Non-Participating urgent crisis center, such urgent crisis center may bill ConnectiCare directly for such urgent crisis center services. The health carrier shall reimburse such out-of-network urgent crisis center or Member, as applicable, for such urgent crisis center services at the in-network rate under the Member's health care plan as payment in full, unless such ConnectiCare and urgent crisis center agree otherwise.

Notice: If health care services were rendered to an Member by an Non-Participating Provider and the ConnectiCare failed to inform such Member, if such Member was required to be informed, of the network status of such health care provider pursuant to State Law, the health carrier shall not impose a Coinsurance, Copayment, Deductible or other out-of-pocket expense that is greater than the Coinsurance, Copayment, Deductible or other out-of-pocket expense that would be imposed if such services were rendered by Participating health care provider.

English	For free language assistance services, and auxiliary aids and services, call 1-800-251-7722 (TTY: 711).
Spanish Español	Para obtener servicios gratuitos de asistencia lingüística, así como ayudas y servicios auxiliares, llame al 1-800-251-7722 (TTY: 711).
Portuguese Português	Para obter serviços de assistência linguística e materiais e serviços auxiliares gratuitos ligue para 1-800-251-7722 (telefone de texto [TTY]: 711).
Polish Polski	Aby uzyskać bezpłatną pomoc językową oraz dodatkowe wsparcie i usługi, należy zadzwonić pod numer 1-800-251-7722 (TTY: 711).
Chinese (Traditional) 中文 (台灣繁體)	如需免費的語言協助服務以及輔助裝置和服務，請致電1-800-251-7722 (聽障專線：711)。
Italian Italiano	Per i servizi di assistenza gratuiti in italiano nonché per supporti e servizi ausiliari, chiamare 1-800-251-7722 (TTY: 711).
French Français	Pour bénéficier de services d'assistance linguistique gratuits, ainsi que de services et aides complémentaires, appelez le 1-800-251-7722 (ATS : 711).
French Creole Kreyòl Ayisyen	Pou asistans lang gratis, epi èd ak sèvis oksilyè, rele 1-800-251-7722 (TTY: 711).
Russian Русский	Для получения бесплатных услуг языковой помощи, а также вспомогательных средств и услуг, позвоните: 1-800-251-7722 (телетайп: 711).
Vietnamese Tiếng Việt	Để sử dụng dịch vụ hỗ trợ ngôn ngữ miễn phí cũng như các dịch vụ và tính năng hỗ trợ thêm, hãy gọi 1-800-251-7722 (TTY: 711).
Arabic العربية	اتصل على الرقم 1-800-251-7722 (الهاتف النصي 711) لتلقي خدمات المساعدة اللغوية المجانية والخدمات والمساعدات الإضافية.
Korean 한국인	무료 언어 지원 서비스와 보조 지원 및 서비스를 원하시면 1-800-251-7722 (TTY: 711)로 연락 주시기 바랍니다.
Albanian shqip	Për shërbime falas të asistencës gjuhësore në shqip, mbështetje dhe shërbime shtesë, telefononi numrin 1-800-251-7722 (TTY: 711).
Hindi हिंदी	निःशुल्क भाषा सहायता सेवाओं और सहायक ऐड एवं सेवाओं के लिए 1-800-251-7722 (TTY: 711) पर कॉल करें।
Tagalog	Para sa libreng serbisyo sa tulong sa wika, at mga auxiliary aid at serbisyo, tumawag sa 1-800-251-7722 (TTY: 711).
Greek Ελληνικά	Για δωρεάν υπηρεσίες γλωσσικής υποστήριξης, καθώς και βοηθητικά μέσα και υπηρεσίες, καλέστε στο 1-800-251-7722 (TTY: 711).

Prior Authorization Addendum

ConnectiCare's Prior Authorization lists may change at any time. Read the Member electronic newsletter to learn about the changes. Members can also contact the ConnectiCare Member Services Department or visit ConnectiCare's web site at ConnectiCare.com.

Members Need Prior Authorization for the Following:

Admissions:

Hospital admissions that are elective or not the result of an Emergency, including: Acute Hospitals admissions* Partial Hospitalizations Programs (PHP)/High Intensity Outpatient* 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 or is not medically necessary to a hospital

Biomarker Testing

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)

Arthroplasty

Arthroscopy

Cardiac monitoring with Mobile Cardiac Outpatient Telemetry or continuous computerized daily monitoring with auto-detection (no Prior 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)

Coverage at an in-network benefit level for out-of-network provider or facility unless services are due to an Emergency.

Craniofacial treatment

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 Prior 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

Home Health Care:

Home health services including home health aides, skilled nursing visits, PT, OT, Speech, IV infusion

Hospice care

Infertility Services

Intensive Outpatient 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)* Please note, this does not include neuropsychological testing for children diagnosed with cancer. Transcranial Magnetic Stimulation*

Site of Service Programs:

Prior 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

***Prior Authorization is conducted by OptumHealth Behavioral Solutions - 1-888-946-4658**

****Prior Authorization is conducted by NIA Magellan – 1-877-607-2363**

*****Prior Authorization is conducted by eviCore - 1-888-835-2042**

Members Need Prior Authorization for the Following Prescription Drugs:

Abiraterone Acetate	Anzemet	Brilinta
Acitretin	Apomorphine HCl	Brimonidine
Actemra	Aprepitant	Budesonide
Actemra Actpen	Aranesp	Buprenorphine
Actimmune	Arcalyst	Buprenorphine
Acyclovir Ointment	Aripiprazole	Hydrochloride
Adempas	Armodafinil	Butorphanol
Ajovy	ASA/Dipyrida	Cabometyx
Ajovy Autoinjector	Atomoxetine	Calcip/Betam
Akynzeo	Atovaquone	Calcipotrien Oin Betameth
Alecensa	Avonex Administration	Calcitriol
Alinia	Pack	Capecitabine
Aliskiren	Avonex Pen	Caprelsa
Alocril	Azasite	Carisoprodol ASA/COD
Alomide	Baraclude	Cayston
Alosetron	Baxdela	Cerdelga
Alphanine	Belsomra	Cevimeline
Altabax	Bepotastine	Chemet
Alyq	Berinert	Cimzia
Ambrisentan	Besivance	Cinacalcet HCL
Ameluz	Betaine	Cipro HC
Aminocapr	Bexarotene	Cipro/Dexa
Amnesteem	Beyfortus	Claravis
Amphetami	Bosentan	Clindamy/Ben Gel

Clindamycin Gel Tretinoin	Egoloid	Gammaked
Clindamycin Phos-Benzoyl	Ergot//Caffen	Gammaplex
Perox Gel	Erivedge	Gamunex-C
Clonidine	Erlotinib Hcl	Gatifloxacin
Cometriq	Ertaczo Cream	Gilotrif
Cordran	Ery/Benzoyl Gel	Glatiramer Acetate
Corlanor Sol	Eskata Solution	Glatopa
Cosentyx	Esomeprazole	Gleostine
Cresemba	Etoposide	Hadlima
Cuvitru	Eucrisa	Halcinonide
Cyclosporine	Euflexxa	Halog Oin
Cystagon	Eurax	Hemofilm
Cystaran	Everolimus	Heparin
Dalfampridine Er	Extavia Inj	Hizentra
Daptomycin	Ezetim/Simva	Hyalgan
Dasatinib	Farydak	Hydrocod/IBU
Deferasirox	Fasenra	Hydrocone ER
Deferiprone	Fasenra Pen	Hydromorphone Er
Deferiprone (3 Times A	Febuxostat	Hydroxy Capr
Day)	Fenoprofen	Hyqvia
Desmopressin	Fentanyl	Ibrance
Dexcom G6	Fentanyl Citrate	Icatibant
Dexcom G7	Fesoterodine	Iclusig
Dexmethylph	Fingolimod	Imatinib Mesylate
Dextroamphet	Firmagon	Imbruvica
Diacomit	Flebogamma Dif	Imiquimod
Dificid	Flucytosine	Increlex
Difluprednate Emul	Fondaparinux	Inlyta
Dihydroergot Inj	Foscavir	Isotretinoin
Dimethyl Fumarate	Fragmin	Ivabradine
Doptelet	Freestyle Libr Kit 2 Sensor	Ivermectin
Doxepin	Freestyle Libr Mis 2 Reader	Ixinity
Doxercalcif	Freestyle Kit Sensor	Jakafi
Dronabinol	Freestyle Libre 3 Reader	Kalydeco
Droxidopa	Devi	Kanjinti
Dutast/Tamsu	Freestyle Libre 3 Sensor	Kepivance
EconazoleCream	Misc	Ketoprofen
Elmiron	Freestyle Libre2 Kit	Kevzara
Emcyt	Plus/Sen	Kineret
Emgality	Freestyle Libre3 Kit	Klarity-A
Emgality Syringe	Plus/Sen	Koate
Emsam	Freestyle Mis Reader	Kogenate FS
Enbrel	Fuzeon Inj	Kovaltry
Entresto	Gamastan	Kyprolis
Epogen	Gammagard Liquid	Lacrisert

Lapatinib	Nexletol	Primaquine
Lastacaft Sol	Nexlizet	Privigen Inj
Lenalidomide	Nilutamide	Procrit
Lenvima	Nisoldipine	Progesterone
Leukeran	Nitazoxanide	Pulmozyme
Leukine	Nitisinone	Quzyttir Inj
Lidocaine	Novoeight	Ramelteon
Linezolid	Novoseven	Rebif
Linzess	Nplate	Rebif Rebidose
Lisdexamfetamine	Nucala	Rebyota Susp
Lotemax Oin	Nucynta ER	Recombinate Inj
Loteprednol	Nulojix	Regranex Gel
Lubiprostone	Octagam Inj	Relistor
Luliconazole Cream	Octreotide Acetate	Repatha
Lurasidone	Odomzo	Retacrit
Lynparza	Ofev	Rexulti
Lysodren	Ogivri	Ridaura
Marplan	Omnaris	Riluzole
Matulane	Omnitrope	Rinvoq
Meclofen	Opsumit	Rivastigmine
Mefenam	Oravig	Rixubis
Mekinist	Orencia	Roflumilast
Melphalan	Orenitram	Rubraca
Memantine	Osmoprep	Rylora Symp
Metaxalone	Osphena	Santyl Oin
Methamphetamine	Otezla	Sapropterin Dihydrochloride
Methitest	Oxandrolone	Savella
Methylphenidate ER	Oxaprozin	Signifor
Methyltestos	Oxiconazole Cream	Sildenafil Citrate
Micafungin Inj	Oxistat	Silodosin
Miglustat	Oxycodone ER	Simponi
Mirabegron	Oxycontin	Simponi Aria
Mitoxantron	Oxymorphone Hcl Er	Skyrizi
Modafinil	Paliperidone	Skyrizi (2 Syringes) Kit
Monoclate-P	Panretin	Skyrizi Pen
Motofen	Paricalcitol	Skyrizi On-Body
Movantik	Pazopanib	Sodium Oxybate
Multaq	Pegasys Inj	Sodium Phenylbutyrate
Myorisan	Penciclovir Cream	Somavert
Naftifine Cream and Gel	Perphen/Amit	Sorafenib
Naftin Gel	Pirfenidone	Spravato
Natacyn Sus	Piroxicam	Stimate sol
Neuac Gel	Plegridy	Stivarga
Neupro	Pomalyst	Sulconazole
Nevanac	Praziquantel	Sunitinib Malate

Supartz FX	Tobramycin Sulfate	Verzenio
Symlinpen 120	Tolcapone	Vilazodone
Symlinpen 60	Tolvaptan	Visco-3 SOSY
Symproic	Toposar Inj	Voriconazole
Synarel	Toremifene	Vraylar
Synribo	Tracleer	Xalkori
Tabloid	Tramadol HCl Er	Xeljanz
Tacrolimus Oin	Tremfya	Xeljanz Xr
Tadalafil	Treprostinil	Xerava Inj
Tafinlar	Tretinoin Cap	Xgeva
Tagrisso	Triluron Inj	Xifaxan
Tanex Acid	Trintellix	Xolair
Tasigna	Truxima sol	Xtandi
Tasimelteon	Tymlos	Zaltrap
Tavaborole Sol	Tysabri	Zejula
Tavalisse	Ubrelyv	Zenatane
Tazarotene	Uptravi	Zileuton ER
Temozolomide	Vabomere Inj	Zilretta
Temsirolimus Sol	Valganciclov	Zinplava Sol
Teriflunomide	Veklury Inj	Zirgan
Teriparatide	Velphoro	Zoledronic Inj
Tetrabenazine	Vemlidy	Zolinza
Thalomid	Venclexta	Zontivity
Thyrogen	Venclexta Starting Pack	Zydelig
Tigecycline Inj	Ventavis	Zykadia
Tiopronin	Veregen	

Specialty Drugs:

Specialty drugs that require Prior Authorization should only be filled through specialty pharmacies that are Participating Pharmacies. The list of specialty drugs that have this requirement is, as follows.

Acromegaly:

Lanreotide Acetate
Mycapssa
Octreotide Acetate
Sandostatin
Signifor Lar
Somatuline Depot
Somavert

Alpha-1 Antitrypsin

Deficiency:

Aralast Np
Glassia

Prolastin-C

Zemaira

Amyloidosis:

Amvuttra
Attruby
Onpattro
Vyndamax
Vyndaqel
Wainua

Asthma:

Cinqair
Dupixent

Fasenra

Fasenra Pen

Nucala

Tezspire

Xolair

Atopic Dermatitis:

Adbry

Cibinqo

Dupixent

Ebglyss

Cardiac Disorders:

Camzyos

Dofetilide
Tikosyn
Coagulation Disorders:

Ceprothin
Veopoz

**Cryopyrin-Associated
Periodic Syndromes:**

Arcalyst
Ilaris

Cystic Fibrosis:

Alyftrek
Bethkis
Bronchitol
Cayston
Kalydeco
Kitabis Pak
Orkambi
Pulmozyme
Symdeko
Tobi
Tobramycin
Trikafta

Endocrine Disorders -

Other

Cortrophin
Crenessity
Tzield

**Gastrointestinal
Disorders-Other:**

Bylvay
Chenodal
Cholbam
Ctexli
Gattex
Iqirvo
Livdelzi
Livmarli
Ocaliva
Solesta

Gout:

Krystexxa

**Growth Hormone and
Related Disorders:**

Egrifta Sv
Genotropin

Humatrope
Increlex
Ngenla
Norditropin Flexpro
Nutropin Aq Nuspin

Omnitrope
Serostim
Skytrofa
Sogroya
Zomacton

Hemophilia:

Advate
Adynovate
Afstyla
Alhemo
Alphanate
Alphanine Sd
Alprolix
Altuviiiio
Benefix
Coagadex
Corifact
Desmopressin Acetate

Eloctate
Esperoct

Feiba
Fibryga
Hemlibra
Hemofil M

Humate-P
Hympavzi

Idelvion
Ixinity

Jivi
Koate

Koate-Dvi
Kogenate Fs

Kovaltry
Novoeight
Novoseven Rt

Nuwiq

Obizur
Profilnine

Rebinyn
Recombinate

Riastap
Rixubis
Roctavian
Sevenfact
Tretten
Vonvendi
Wilate
Xyntha
Xyntha Solofuse

Hepatitis C:

Epclusa
Harvoni
Ledipasvir/Sofosbuvir
Mavyret
Pegasys
Ribavirin
Sofosbuvir/Velpatasvir
Sovaldi
Vosevi
Zepatier

Hereditary Angioedema:

Berinert
Cinryze
Firazyr
Haegarda
Icatibant Acetate
Kalbitor
Orladeyo
Ruconest
Sajazir
Takhzyro

Hormonal Therapies:

Aveed
Camcevi
Eligard
Fensolvi
Firmagon
Leuprolide Acetate
Lupron Depot
Lupron Depot-Ped
Supprelin La
Trelstar Mixject
Triptodur
Yorvipath
Zoladex

Immune Deficiencies and Related Disorders:

Alyglo
Asceniv
Bivigam
Cutaquig
Cuvitru
Cytogam
Flebogamma Dif
Gamastan
Gammagard Liquid
Gammagard S/D Iga Less
Th
Gammaked
Gammaplex
Gamunex-C
Hepagam B
Hizentra
Hyperhep B
Hyperrho S/D
Hyperrho S/D Mini-Dose
Hyqvia
Joenja
Nabi-Hb
Octagam
Panzyga
Privigen
Revcovi
Rhogam Ultra-Filtered Plu
Rhopylac
Varizig
Winrho Sdf
Xembify
Xolremdi
Infectious Disease – Other:
Actimmune
Arikayce
Livtencity
Rebyota
Vowst
Inflammatory Bowel Disease:
Adalimumab-Adbm
Avsola

Cimzia
Cimzia
Cyltezo Starter Package F
Entyvio
Humira
Hyrimoz
Infectra
Infliximab
OmvoH
Otulfi
Pyzchiva
Remicade
Renflexis
Rinvoq
Skyrizi
Stelara
Steqeyma
Tremfya
Velsipity
Wezlana
Yesintek
Yuflyma
Zymfentra
Iron Overload:
Deferasirox
Deferiprone
Deferoxamine Mesylate
Desferal
Exjade
Ferriprox
Ferriprox Twice-A-Day
Jadenu
Jadenu Sprinkle
Lysosomal Storage Disorder:
Aldurazyme
Aqneursa
Brineura
Cerdelga
Cerezyme
Cystadrops
Cystagon
Cystaran
Elaprase
Elelyso

Elfabrio
Fabrazyme
Galafold
Kanuma
Lamzede
Lumizyme
Mepsevii
Miglustat
Miplyffa
Naglazyme
Nexviazyme
Opfolda
Pombiliti
Procysbi
Vimizim
Vpriv
Xenpozyme
Yargesa
Zavesca
Movement Disorders:
Apokyn
Apomorphine Hydrochloride
Austedo
Droxidopa
Duopa
Edaravone
Inbrija
Ingrezza
Northera
Nuplazid
Onapgo
Qalsody
Radicava
Skyclarys
Tetrabenazine
Vyalev
Xenazine
Multiple Sclerosis:
Ampyra
Aubagio
Avonex
Avonex Pen
Bafiertam
Betaseron
Briumvi

Copaxone
Dalfampridine Er
Dimethyl Fumarate
Fingolimod Hydrochloride
Gilenya
Glatiramer Acetate
Glatopa
Kesimpta
Lemtrada
Mavenclad
Mayzent
Mitoxantrone Hcl
Ocrevus
Ocrevus Zunovo
Plegridy
Ponvory
Rebif
Rebif Rebidose
Tascenso Odt
Tecfidera
Teriflunomide
Tysabri
Vumerity
Zeposia

Muscular Dystrophy:

Agamree
Amondys 45
Deflazacort
Duvyzat
Emflaza
Exondys 51
Viltepso
Vyondys 53

Neuromuscular:

Evrysdi
Rystiggo
Spinraza
Vyvgart
Vyvgart Hytrulo
Zilbrysq

Oncology:

Abecma
Abiraterone Acetate
Abitrtega
Abraxane

Adcetris
Adriamycin
Adstiladrin
Afinitor
Afinitor Disperz
Akeega
Alecensa
Alimta
Alunbrig
Alymsys
Amtagvi
Anktiva
Aphexda
Arranon
Arsenic Trioxide
Arzerra
Asparlas
Augtyro
Avastin
Axtle
Ayvakit
Azacitidine
Balversa
Bavencio
Beleodaq
Belrapzo
Bendamustine
Bendeka
Besponsa
Besremi
Bexarotene
Bizengri
Bleomycin Sulfate
Blincyto
Bortezomib
Boruzu
Bosulif
Braftovi
Brukinsa
Busulfan
Busulfex
Cabometyx
Calquence
Camptosar
Capecitabine

Caprelsa
Carboplatin
Carmustine
Carvykti
Cisplatin
Cladribine
Clofarabine
Columvi
Cometriq
Copiktra
Cosela
Cotellic
Cyclophosphamide
Cyclophosphamide
Cyramza
Cytarabine
Dacarbazine
Dactinomycin
Danyelza
Danziten
Darzalex
Darzalex Faspro
Dasatinib
Datroway
Daunorubicin
Daurismo
Decitabine
Demser
Dexrazoxane
Docetaxel
Docivvyx
Doxil
Doxorubicin Hcl
Doxorubicin Hydrochloride
Elahere
Elitek
Ellence
Elrexfio
Elzonris
Empliciti
Enhertu
Epinly
Erbitux
Eribulin Mesylate
Erivedge

Erleada	Imkeldi	Mercaptopurine
Erlotinib Hydrochloride	Inlyta	Mesna
Etopophos	Inqovi	Mesnex
Etoposide	Inrebic	Methotrexate
Everolimus	Iressa	Methotrexate Sodium
Evomela	Irinotecan	Metyrosine
Faslodex	Istodax	Mitomycin
Floxuridine	Itovebi	Monjuvi
Fludarabine Phosphate	Iwilfin	Mugard
Fluorouracil	Ixempra Kit	Mutamycin
Folotyng	Jakafi	Mvasi
Fotivda	Jaypirca	Mylotarg
Frindovyx	Jelmyto	Nelarabine
Fruzaqla	Jemperli	Nerlynx
Fulvestrant	Jevtana	Nexavar
Fyarro	Kadcyla	Niktimvo
Gavreto	Kanjinti	Ninlaro
Gazyva	Kepivance	Nipent
Gefitinib	Keytruda	Nubeqa
Gemcitabine Hcl	Khapzory	Odomzo
Gilotrif	Kimmtrak	Ogivri
Gleevec	Kisqali	Ogsiveo
Gleostine	Koselugo	Ojemda
Gliadel Wafer	Krazati	Ojjaara
Gomekli	Kyprolis	Omisirge
Grafapex	Lapatinib Ditosylate	Oncaspar
Halaven	Lazcluze	Onivyde
Hepzato	Lenalidomide	Ontruzant
Herceptin	Lenvima	Onureg
Herceptin Hylecta	Leucovorin Calcium	Opdivo
Hercessi	Levoleucovorin	Opdivo Qvantig
Herzuma	Libtayo	Opdualag
Hycamtin	Lonsurf	Orgovyx
Ibrance	Loqtorzi	Orserdu
Iclusig	Lorbrena	Oxaliplatin
Idamycin Pfs	Lumakras	Paclitaxel
Idarubicin Hcl	Lunsumio	Paclitaxel Protein-Bound
Idhifa	Lutathera	Padcev
Ifex	Lynparza	Pamidronate Disodium
Ifosfamide	Lysodren	Paraplatin
Imatinib Mesylate	Lytgobi	Pazopanib Hydrochloride
Imbruvica	Margenza	Pedmark
Imdelltra	Matulane	Pemazyre
Imfinzi	Mekinist	Pemetrexed
Imjudo	Mektovi	Pemetrexed Disodium

Pemfexy	Talvey	Vidaza
Pemrydi Rtu	Talzenna	Vinblastine Sulfate
Perjeta	Tarceva	Vincristine Sulfate
Phesgo	Targretin	Vinorelbine Tartrate
Photofrin	Tasigna	Vistogard
Piqray	Tazverik	Vitrakvi
Pluvicto	Tecartus	Vivimusta
Polivy	Tecentriq	Vizimpro
Pomalyst	Tecentriq Hybreza	Vonjo
Portrazza	Tecvayli	Voranigo
Poteligeo	Temodar	Voraxaze
Proleukin	Temozolomide	Votrient
Provenge	Temsirolimus	Vyloy
Purixan	Tepadina	Vyxeos
Qinlock	Tepmetko	Welireg
Retevmo	Tevimbra	Xalkori
Revlimid	Thalomid	Xeloda
Revuforj	Thiotepa	Xermelo
Rezlidhia	Thyrogen	Xgeva
Rezurock	Tibsovo	Xofigo
Riabni	Tice Bcg	Xospata
Rituxan	Tivdak	Xpovio
Rituxan Hycela	Topotecan Hcl	Xtandi
Romidepsin	Torisel	Yervoy
Romvimza	Torpenz	Yondelis
Rozlytrek	Trazimera	Yonsa
Rubraca	Treanda	Zaltrap
Ruxience	Trisenox	Zejula
Rybrevant	Trodelvy	Zelboraf
Rydapt	Truqap	Zepzelca
Rylaze	Truxima	Zevalin Y-90
Rytelo	Tukysa	Ziihera
Sarclisa	Turalio	Zirabev
Scemblix	Tykerb	Zoledronic Acid
Sorafenib	Unituxin	Zolinza
Sorafenib Tosylate	Uvadex	Zydelig
Sprycel	Valchlor	Zykadia
Stivarga	Valrubicin	Zynlonta
Strontium Chloride Sr-89	Valstar	Zynyz
Sunitinib Malate	Vanflyta	Zytiga
Sutent	Vectibix	Osteoporosis:
Sylvant	Vegzelma	Evenity
Tabrecta	Velcade	Forteo
Tafinlar	Venclexta	Prolia
Tagrisso	Verzenio	Reclast

Teriparatide
Tymlos
Zoledronic Acid
Paroxysmal Nocturnal Hemoglobinuria:
Bkemv
Empaveli
Fabhalta
Piasky
Soliris
Ultomiris
Voydeya
Phenylketonuria
Javygtor
Kuvan
Palynziq
Sapropterin Dihydrochloride
Psoriasis:
Adalimumab-Adbm
Bimzelx
Cosentyx
Cyltezo Starter Package F
Humira
Hyrimoz
llumya
Otezla
Otulfi
Pyzchiva
Selarsdi
Siliq
Skyrizi
Sotyktu
Spevigo
Stelara
Steqeyma
Taltz
Tremfya
Wezlana
Yesintek
Pulmonary Arterial Hypertension:
Adcirca
Adempas
Alyq
Ambrisentan

Bosentan
Epoprostenol Sodium
Flolan
Liqrev
Opsumit
Opsynvi
Orenitram
Remodulin
Revatio
Sildenafil
Sildenafil Citrate
Tadalafil
Tadliq
Tracleer
Treprostinil
Tyvaso
Uptravi
Veletri
Ventavis
Winrevair
Pulmonary Disorders – Other:
Esbriet
Ofev
Pirfenidone
Rare Disorders – Other:
Crysvita
Dojolvi
Enspryng
Firdapse
Gamifant
Givlaari
Rethymic
Scenesse
Tavneos
Uplizna
Vijoice
Zokinvy
Renal Disease:
Cinacalcet Hydrochloride
Filspari
Jynarque
Oxlumo
Parsabiv
Rivfloza

Sensipar
Tarpeyo
Thiola
Thiola Ec
Tiopronin
Tiopronin Dr
Venxxiva
Rheumatoid Arthritis:
Abrilada
Actemra
Adalimumab-Aacf
Adalimumab-Aaty
Adalimumab-Adaz
Adalimumab-Adbm
Adalimumab-Fkjp
Adalimumab-Ryvk
Amjevita
Cyltezo
Enbrel
Hadlima
Hulio
Humira
Hyrimoz
Kevzara
Kineret
Olumiant
Orencia
Otrexup
Rasuvo
Rinvoq
Rinvoq Lq
Simlandi
Simponi
Simponi Aria
Tofidence
Tyenne
Xeljanz
Xeljanz Xr
Yuflyma
Yusimry
Seizure Disorders:
Acthar
Acthar Gel
Diacomit
Epidiolex

Fintepla
Sabril
Vigabatrin
Vigadrone
Vigafyde
Vigpoder
Ztalmy
Sleep Disorder:
Hetlioz
Hetlioz Lq
Lumryz
Lumryz Starter Pack
Sodium Oxybate

Tasimelteon
Wakix
Xyrem
Xywav
**Systemic Lupus
Erythematosus:**
Benlysta
Lupkynis
Saphnelo
Thrombocytopenia:
Adzynma
Alvaiz
Cabliivi

Doptelet
Mulpleta
Promacta
Tavalisse
Urea Cycle Disorders:
Buphenyl
Carbaglu
Carglumic Acid
Olpruva
Pheburane
Sodium Phenylbutyrate

In addition, any drug that is newly available to the market will also require Prior Authorization until such time as ConnectiCare re-publish ConnectiCare's list of drugs requiring Prior Authorization.