HMO OPEN ACCESS
MEMBERSHIP AGREEMENT

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

WELCOME TO CONNECTICARE!

Here at ConnectiCare we're proud to say that we're one of the highest rated managed care companies for member satisfaction in the area. Here's more. We're also accredited by the National Committee for Quality Assurance (NCQA). NCQA is a private organization that inspects managed care companies all across the country with the intent on improving the quality of health care and service delivered to people. NCQA awarded us with an "excellent" rating for our commercial plans.

Now that you're a Member, we can start working closely with you and your doctors to make sure you and your family continue to make the right choices when it comes to maximizing the coverage available to you under this Plan.

IMPORTANT

Please be sure to read through the "Managed Care Rules And Guidelines" section of this Membership Agreement, so you can find out 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 Pre-Authorization before receiving care. In addition, you should also read through the "Exclusions And Limitations" section to find out what isn't covered under this Plan as well.

Form: CCI\HMO 01 (1\2010)

Approved for use beginning 2010

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Refer to the "Managed Care Rules And Guidelines" section to see if you have to use Participating Providers and to find out what services require Pre-Authorizations. Also refer to the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

INTRODUCTION

Besides being a formal contract, this Membership Agreement is your "owner's manual", so please read it and learn how your health benefit plan works before you even start to use it. That way, when you need to see a doctor or specialist, you'll know whether you need to obtain a Referral or Pre-Authorization first. If you don't understand something written in this Membership Agreement, please call us at the appropriate telephone number listed in the "Important Telephone Numbers And Addresses" subsection of the "Important Information" section of this Membership Agreement or visit us at our web site at www.connecticare.com and we'll be glad to help.

All of us here at ConnectiCare are committed to making this Plan work for you. And, if you speak a foreign language, translation and interpretation services are available to assist you with understanding this Plan. You may obtain interpreter services for verbal communications with us by calling (860) 674-5757 or 1-800-251-7722.

Hay servicios de traducción y de interpretación disponibles para ayudarlo a entender este Plan. Usted puede obtener el servicio de un intérprete para comunicaciones verbales con nosotros llamando al (860) 674-5757 o al 1-800-251-7722.

Des services de traduction et d'interprétation sont disponibles pour vous aider à comprendre ce Plan. Vous pouvez obtenir des services d'interprétation pour les communications verbales avec nous en composant le (860) 674-5757 ou le 1-800-251-7722.

I servizi di traduzione e interpretariato sono disponibili per assistervi nella comprensione di questo Piano. È possibile ottenere servizi di interpretariato per comunicazioni verbali con noi chiamando l'(860) 674-5757 o l'1-800-251-7722.

Serviços de tradução e interpretação estão disponíveis para auxilia-lo na compreensão deste Plano. Você pode obter serviços de interprete para comunicação conosco, telefonando para (860) 674-5757 ou 1-800-251-7722.

Παρέχονται υπηρεσίες μεταφράσεων και διερμηνείας για να σας βοηθήσουν να κατανοήσετε αυτό το Πρόγραμμα. Μπορείτε να ζητήσετε υπηρεσίες διερμηνείας για την προφορική επικοινωνία μαζί μας καλώντας το (860) 674-5757 ή το 1-800-251-7722.

我们提供翻译及传译服务，助你明白这计划。请致电(860)674-5757 或 1-800-251-7722 查询有关与我们沟通的传译服务详情。

إن خدمة الترجمة الكتابية والشفهية الفورية متوفرة لمساعدتكم في فهم هذه الخطة. يمكنكم الحصول على خدمة الترجمة الشفهية الفورية للتكلم معنا باتصالكم بالرقم ٥٧٥٧-٦٧٤(٨٦٠) أو ٧٢٢٢-٢٥١-٨٠٠-١.

អ្នកអាចទទួលកិច្ចការបកប្រែ ដើម្បីជួយអ្នកឲ្យចាយល់ពីគំរោងនេះ ។ អ្នកអាចទទួលកិច្ចការបកប្រែ សំរាប់ការប្រជុំរួយទាក់ទងគ្នាផ្ទាល់និងមាត់ ដោយទូរស័ព្ទមកយើងតាមលេខ (860) 674-5757 ឬក៏តាមលេខ 1-800-251-7722 ។

Ou kapab jwenn sèvis tradiksyon ak entèpretasyon pou ede w konprann Plan sa a. Si w bezwen yon entèprèt pou ede w nan kominikasyon pale, telefone nou nan nimewo (860) 674-5757 oswa 1-800-251-7722.

มีบริการแปลหนังสือและบริการนายพาสาไว้ เพื่อช่วยท่านเข้าใจแผนการนี้. ท่านอาจสามารถรับการบริการนายพาสาสำหลับการติดต่อสื่อสารโดยคำปากบำเรือได้ โดยโทรไปยังหมายเลข (860) 674-5757 หลื 1-800-251-7722.

Для лучшего понимания настоящего Плана, вы можете пользоваться нашими услугами по письменному и устному переводу. Для получения помощи в общении с нами вы можете воспользоваться услугами нашего переводчика если вы позвоните по телефону (860) 674-5757 или 1-800-251-7722.

זמינים לרשותך שירותי תרגום ופרשנות שיעזרו לך בהבנת התוכנית.
באפשרותך להשיג שירותי פרשנות לצורכי תקשורת מילולית איתנו ע"י
חיוג מס' טל' 674-5757 (860) או1-800-251-7722.

Aby ułatwić Państwu zrozumienie Planu, zapewniamy pomoc tłumacza. Pomoc naszego tłumacza ustnego uzyskać można, telefonując na numer (860) 674-5757 lub 1-800-251-7722.

Refer to the "Managed Care Rules And Guidelines" section to see if you have to use Participating Providers and to find out what services require Pre-Authorizations. Also refer to the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

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MEMBERSHIP AGREEMENT

This Membership Agreement (Agreement) describes the terms and conditions that must be followed in order for you and your covered dependents to obtain benefits for health care services. It is also the contract between the Employer and us if you are enrolled in this Plan through your Employer, or between you and us, if you are enrolled in this Plan and it is our non-group plan.

This Agreement includes this document and the following documents.

- Benefit Summary
- Enrollment Form
- Evidence Of Agreement (Employers only) and
- Riders and supplementary inserts, if any

When you see words like "we" or "us" that means ConnectiCare. When we refer to "you", we mean you, the Subscriber. And words in this Agreement that are in "Upper Case" have special meaning. You can find their meaning in the "Definitions" section of this Membership Agreement.

This Agreement replaces any agreement, contract, policy or program of the same coverage that we may have issued to you prior to the date we issued this Agreement. It is written according to the laws of the State of Connecticut. We have the right to make changes to this Agreement, but only with approval from the State of Connecticut Insurance Department. If we change this Agreement, we will tell you about the change when it becomes effective.

We have the discretionary authority to determine whether, and to what extent, you and your dependents are eligible for benefits under this Plan. We also have the discretionary authority to define and interpret the terms of this Agreement. All of our interpretations and decisions are final, conclusive and binding.

ACCEPTANCE OF AGREEMENT

This means that your Employer agrees to all the provisions of this Membership Agreement, including all the applicable Riders, when they either sign the Evidence Of Agreement, or when they pay Premium to us for coverage under this Plan.

And if you are enrolled in our non-group plan, acceptance of agreement pertains to you. It means that you agree to all the provisions of this Membership Agreement, including all applicable Riders, when you receive Plan benefits, or when you pay Premium to us for coverage under this Plan.

IMPORTANT INFORMATION

IMPORTANT RULES

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

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

- Read the "Managed Care Rules And Guidelines" section to see if you have to use Participating Providers and to find out what services require Pre-Authorizations.
- Read to the "Exclusions And Limitations" section to find out what's not covered under this Plan.
- Select a Primary Care Provider (PCP) to act as your "health care manager" and be your first resource for medical information.
- Except in an Emergency, **always** use physicians and facilities that are Participating Providers for *every* service or supply you receive in order to get the highest level of benefits. **None of our *HMO Plans* pay any benefits for Non-Participating Providers.**
- If you think you are in an Emergency situation or in need of Urgent Care, try to call your PCP first, if you have time, to find out what to do. If you do not have time to call, go to an emergency room or an Urgent Care Center, as appropriate. If it's possible, go to an emergency room or Urgent Care Center that is a Participating Provider.
- Always present your ID Card whenever obtaining health care services, durable medical equipment or supplies, including prescription drugs, if applicable.

IMPORTANT TELEPHONE NUMBERS AND ADDRESSES

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

Member Services

ConnectiCare

(860) 674-5757 or 1-800-251-7722

Behavioral Health Program

1-888-946-4658

Pre-Authorization or Pre-Certification

ConnectiCare

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

Behavioral Health Program

1-888-946-4658

Radiological Services Program (Outpatient diagnostic x-rays and therapeutic procedures)

1-877-607-2363

Submitting Claims to Us from Non-Participating Providers

ConnectiCare (all claims except Behavioral Health Program)

ConnectiCare Claims
PO Box 546

Refer to the "Managed Care Rules And Guidelines" section to see if you have to use Participating Providers and to find out what services require Pre-Authorizations. Also refer to the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

Farmington, Connecticut 06034-0546

Behavioral Health Program

ConnectiCare Claims
OptumHealth Behavioral Solutions
PO Box 30757
Salt Lake City, Utah 84130-0757

Questions And Complaints

ConnectiCare (all questions and complaints except Behavioral Health Program)

ConnectiCare Member Services
175 Scott Swamp Road
Farmington, Connecticut 06032 or

www.connecticare.com

Behavioral Health Program

OptumHealth Behavioral Solutions
Attention: Complaint Department
1900 E. Golf Road. Suite 300
Schaumburg, Illinois 60173

Fax 1-800-322-9104

OTHER IMPORTANT INFORMATION

This subsection describes some of the ways a managed care plan works. We know it can be daunting to hear about controlling costs and rules you have to follow, but those things are important if managed care plans are going to do what they were created to do – provide coverage for quality care while controlling health care costs at the same time. All managed care plans have to do that, and ConnectiCare is no different.

1. **Some Care Is Not Covered**. Managed care companies decide what care is or isn't covered by the insurance plan. That's part of a managed care company's job in trying to control costs. But these decisions aren't made in a vacuum. Our decisions are made by doctors and nurses with input from Members, physicians and other health care providers. Sometimes, even services you think should be covered are not paid for by this Plan, for example, if this Plan excludes them or if we determine they are not Medically Necessary. This Plan's exclusions are listed in the "Exclusions And Limitations" section of this Membership Agreement. And, if we have determined that a service is not Medically Necessary and is therefore denied, you can use our Appeal process and, eventually, you can even Appeal to the State of Connecticut Insurance Department for an external review of our denial.
2. **The Cost Of Care Matters**. Because managed care companies are in the business of trying to control health care costs, the cost of a service is considered when making coverage decisions. For example, if there is a less expensive but equally effective or more reasonable treatment available than the treatment that is being proposed, then we will consider the cost in determining whether to cover the proposed treatment. Cost is never the **only** criterion that is used and, again, input from Members, physicians and other health care providers is obtained to make these decisions.
3. **Drug Costs Matter**. You no doubt are aware that prescription drug costs are skyrocketing. So, as with other health care services, the cost of a medication is a factor when we decide where medications will go in our "tiered system" of Cost-Shares. Our tiered system places medications in categories that tell you what your Cost-Share will be for that medication. At ConnectiCare, if a covered medication is in a higher tier, that doesn't mean it's not a good medication or that you shouldn't get it. It just means that you will have to pay a higher amount for it. Sometimes there might be an equally effective generic or alternative medication on a lower tier that you can use. Other times you and your doctor will decide that you need to have the medication on the higher tier. But in any case, you can get the medication – you may just have to pay a higher amount for it.
4. **You Have To Use Participating Providers In HMO Plans.** As you know, HMOs operate by using a network of Participating Providers. That means that you have to use a Participating Provider in the network in order to get your care covered, even if you feel that a Non-Participating Provider is a "better" doctor or you prefer to use a Non-Participating Provider.
5. **Participating Provider Networks Can Change.** HMOs maintain networks of Participating Providers that you must use to get your care covered. But those networks can change at any time. Sometimes, doctors can even leave in the middle of the year, after you have enrolled in a plan, so you might have to switch your doctor to get your care covered. In those cases, we always make sure there are enough alternative doctors available to provide your care, and we have transition of care programs to ensure that your transition to a new doctor is as smooth as possible.
6. **In POS Plans You Get Lower Benefits If You Use Non-Participating Providers**. In Point of Service (POS) Plans, you have the option of using Non-Participating Providers and still get your care covered. That's one reason people enroll in POS plans – so they will have the option of using a doctor that's not in the plan's Participating Provider network. But that care will always be paid at the lower level of benefits. This is true even if you feel that a Non-Participating Provider is a "better" doctor or you prefer to use a Non-Participating Provider. If you want the higher level of benefits, you always have to use a Participating Provider.
7. **Health Care Providers Are Motivated To Think About The Care They Give**. Many Participating Providers (including doctors and Hospitals) in HMOs accept "financial risk" for treating Members. This means the amount of money the provider group receives from the managed care company depends on how many services the group performs. If they perform more services than expected, their compensation may be less. And, if their group provides fewer services than they

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expected to, then they may get paid more. However, no individual doctor's pay is directly related to any particular care he or she does or does not give and each doctor is always expected to act in the best interest of each of his or her patients.

8. **Confidential Information Is Shared With Others To Administer The Plan**. We take our privacy obligations **very** seriously. We collect a lot of very sensitive medical and other personal information about our Members that needs to be kept strictly confidential. Therefore, we have very extensive policies about who can and cannot see your private information. But you should know that we have to share your private information with others in order to administer your Plan. So companies that perform services for us to administer your plan, and, sometimes even your Employer, depending on what function they serve in administering this Plan, will have access to your private medical information. But these companies **all** sign confidentiality agreements and they are strictly prohibited from using the private information for anything other than administering this Plan. We **never** sell your private information to anyone.
9. **Confidential Information Is Used In Educational Programs**. One of the main roles managed care companies play is to give members and doctors information they should know concerning appropriate care. To accomplish this, we have several health education programs for chronic diseases, like asthma, diabetes and heart failure. We also send reminders and specially directed educational information about medications and specific treatments to our Members and their doctors. In some of our programs, directed information is sent to you and/or your doctors to tell them about what care you and they might consider getting for your diagnosis. The programs we run are developed with input from practicing physicians and use well-documented, established facts about treatment and care. We use claim information about you that is in our system to figure out which members and doctors should be sent educational information from us.
10. **The Plan's Rules Must Be Followed**. Insurance is complicated. There are a lot of rules to follow. We are making efforts to simplify things, but you really can't get around the fact there are rules you have to follow if you are going to get your care covered by insurance. Some of the rules require you to notify us before getting care, some of them require you to get your care only from certain providers, some of the rules put limits on the care you can get and some require you to only get certain types of care. All of the rules are in this Membership Agreement. You should also feel free to call our Member Services Department at the appropriate telephone number listed in the "Important Telephone Numbers And Addresses" subsection of the "Important Information" section of this Membership Agreement or to contact us at www.connecticare.com to ask any questions you might have or if you are unsure about whether you have to follow any particular rule before getting your care.

THE CONNECTICARE ID CARD

Your ConnectiCare ID card gives medical and pharmacy providers the information they need to bill us directly for services. In addition to your name and other information, the card may include your ID number, your Employer's group number, unless you are enrolled in our non-group plan, and information about your coverage.

Be sure to always carry your ConnectiCare ID Card and present it whenever you receive services at the doctor's office, in an emergency room or Urgent Care Center, and at any other health care facility. If you receive pharmacy benefits through ConnectiCare, your ID card should also be used when you receive prescriptions at Participating Pharmacies. And if you call or write our Member Services Department, please give the representative your ID number that will help us serve you better.

If you lose your ConnectiCare ID card, contact our Member Services Department by calling the appropriate telephone number listed in the "Important Telephone Numbers And Addresses" subsection of the "Important Information" section of this Membership Agreement or visit us at our web site at www.connecticare.com to request a replacement. It generally will take about ten business days for you to receive the replacement ID Card. If your coverage terminates, please destroy the card and do not attempt to use it.

Any attempt to use the card when you are not a Member in this Plan is against the law. You will be responsible for any claims incurred when you are not eligible for coverage. If you use the card after your coverage terminates and we pay benefits, you will have to reimburse us for the cost of the benefits we paid.

ELIGIBILITY AND ENROLLMENT

The Enrollment Form and any other forms we request must be received by us before you are considered a Member under this Plan. **You are responsible for providing us with the correct information on all forms and must notify us immediately of all changes in your name, address and telephone number, changes in Primary Care Provider (PCP) and changes in enrollment (please refer to the "Changes Affecting Eligibility" subsection of this section).**

If your name, address and telephone number were originally sent to us electronically by your Employer when you enrolled, your Employer must send us any changes in this information on your behalf. So be sure to also let your benefit administrator at work know about these types of changes.

Make sure all of the information you provided to us when you enrolled in this Plan (and do provide to us in the future) is true, correct and complete to the best of your knowledge

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and belief. Because if it's not, your coverage may be cancelled.

ELIGIBILITY RULES

If you are enrolled in one of our *HMO Plans*, these eligibility rules apply:

- ♥ You must live or work in the Service Area and your spouse must live with you or in the Service Area in order for you and your family to be covered by this Plan.

  This requirement to work in the Service Area only applies to you if you are enrolled in one of our group plans.

- ♥ You and your Eligible Dependents are no longer eligible for coverage if you are absent from the Service Area for more than 180 days, even if you still live or work in the Service Area.

- ♥ Plan Benefits for care received outside of the Service Area are extremely limited (coverage is only for Emergencies and Urgent Care).

General Rules

Subject to your Employer's rules for participation in this Plan, you and your Eligible Dependents are eligible for coverage under this Plan as follows.

SPECIAL POINT OF SERVICE (POS) PLAN RULE

If you are enrolled in one of our *POS Plans*, you and your Eligible Dependents do not have to live or work in the Service Area to be eligible for coverage.

1. You, the Employee, if you live or work in the Service Area; are or were employed full-time by your Employer (your Employer may also cover part-time employees or a member of the Employer's board of directors, if specified on the Evidence Of Agreement); and are eligible to participate under your Employer's policies, including your satisfying any waiting period agreed to by your Employer and us.

   If you work for an Employer with 50 or fewer employees, the majority of whom work in Connecticut, you do not have to work in the Service Area to be eligible for coverage under this Plan.

   The "Evidence Of Agreement" is a contract we use with your Employer, if you are enrolled in one of our group plans. It establishes such provisions as: Premiums; the Plan effective date; the effective date of coverage for Employees and Eligible Dependents and any special conditions.

If you are enrolled in our non-group plan, you, the Subscriber, must live in the Service Area and pay us the Premium required under this Plan.

2. Your spouse under a legally valid existing marriage who resides with you or in the Service Area.
3. Your partner under a legally valid civil union recognized by the State of Connecticut who resides with you or in the Service Area.

   You must add your partner to this Plan within 31 days of the civil union to be effective as of the date of the union. If you don't you must wait until the next Annual Enrollment Period to add your partner to this Plan.

   When your civil union partner is eligible for coverage, your partner will be covered just as a spouse would be covered under a legally valid, existing marriage. When this Membership Agreement uses the term "spouse", that term also applies to your partner under a legally valid civil union.

   You must notify us immediately of the dissolution of the civil union. Your notification of this information must be made to us in writing on a form acceptable to us. When coverage for your partner ceases, he or she and his or her children are eligible for group continuation as permitted under Connecticut law.
4. Your children under age 26 may be eligible for coverage under this Plan until:

   - ♥ They become married, or
   - ♥ They become covered as an employee under a group health plan.

   Your children must meet one of the following rules to be eligible for coverage until this Plan:

   Natural Children. Your natural children may be covered.

   Adopted Children. Children legally adopted by you may be covered if they meet the requirements for natural children in this section once the adoption is final. Before the adoption becomes final, the children are eligible for coverage when you become legally responsible for at least partial support for the children.

   Step-Children. Your step-children who are the natural or adopted children of your spouse, or children for whom your spouse is appointed legal guardian may be covered.

   Guardianship. Children for whom you are appointed the legal guardian may be covered.

   Handicapped Children. To continue to be eligible for coverage beyond the allowable age limit for dependent children , children must:

   - ♥ Reside in the Service Area or with you; and
   - ♥ Be unable to support themselves by working because of a mental or physical handicap, as certified by the children's physician; and
   - ♥ Be chiefly dependent on you or your spouse for support and maintenance due to the mental or physical handicap; and
   - ♥ Have become and continuously remained handicapped while they would have been eligible for dependent children coverage if they were not disabled.

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Proof of the handicap and the children's financial dependence must be provided to us within 31 days of the date upon which the children's coverage would otherwise end, or upon your enrollment in the Plan if the handicap existed prior to your enrollment. You must provide us proof that the children's handicap and financial dependence continue if we request it. We will not request proof more often than once a year.

Please note that non-resident aliens are not eligible for coverage. What that means is if you are not a U.S. citizen and you live or work in the country where you are a citizen, then you are not eligible for benefits under this Plan.

Qualified Medical Child Support Orders (QMCSOs)

The following "QMCSO" provision DOES NOT APPLY TO YOU, if you are enrolled in our non-group plan.

Special rules apply when a court issues a QMCSO requiring you to provide health insurance for children. Your Employer will decide whether you may enroll the children because of a QMCSO, and we will follow this decision. We will not require such children to live with you or in the Service Area in order to be covered. However, if you are enrolled in one of our ***HMO Plans***, you should be aware that benefits for care received outside of the Service Area are limited to Emergency Services and Urgent Care.

Adding A New Spouse

If you get married, you must add your new spouse to this Plan within 31 days of the marriage for coverage to be effective as of the date of the marriage. If you don't, you must wait until the next Annual Enrollment Period or the "Special Enrollment Period" to add your spouse to this Plan.

If you are enrolled in our non-group plan, you only have 30 days from the beginning of the Contract Year or the "Special Enrollment Period" to add your spouse to this Plan.

Adding New Children

You and your covered spouse's newborn natural children receive coverage for the first 31 days after birth. Coverage for these children will end at the earlier of your termination of coverage or the end of this 31-day period, unless you have submitted a notice to us to add such child(ren) and paid the additional applicable Premium, if any. If your newborn natural children are not added to this Plan within the 31 day period, any services received after that 31 day period are not covered and you must wait until the next Annual Enrollment Period or the "Special Enrollment Period" to add them to this Plan, if additional Premium was required.

All the rules of this Plan apply to benefits payable for newborn children, even if they are only covered for the first 31 days after birth.

If you are enrolled in our non-group plan, you only have 30 days from the beginning of the Contract Year or the "Special Enrollment Period" to add your newborn natural children to this Plan.

If your female Eligible Dependent children are covered by this Plan, then their newborn children may receive coverage **ONLY** for the first 31 days after their birth, unless you or your covered spouse become the children's legal guardian and you are enrolled in the Plan.

Newly adopted children, children for whom you become the legal guardian, and step-children must be enrolled within 31 days of the date of the adoption (or the date on which you or your spouse become at least partially legally responsible for the adopted children's support and maintenance), or the date of your marriage to the step-children's parent, or the date you became the legal guardian. If you do not add these children within the 31-day period, you must wait until the next Annual Enrollment Period or the "Special Enrollment Period" to add them to this Plan. In addition, we may require health underwriting for children legally placed for adoption if any required Premium and completed Enrollment Forms are not received by us within 31 days of the placement for the adoption.

If you are enrolled in our non-group plan, you only have 30 days from the beginning of the Contract Year or the "Special Enrollment Period" to add these children to this Plan.

CHANGES AFFECTING ELIGIBILITY

You must notify us immediately of any change that may affect you or your dependents covered under this Plan. These changes include, but are not limited to:

1. Your marriage or the marriage of your covered dependent children;
2. Your divorce;
3. The birth of your child or of a child of your female covered dependents;
4. Your covered dependent children attaining coverage as an employee under a group health plan;
5. Your covered dependent children attaining the maximum age limit for coverage under this Plan;
6. You or your spouse move or your work location changes;
7. Your termination of employment or reduction in work hours, unless you are enrolled in our non-group plan; and
8. Loss of eligibility for other reasons specified in this section, or the "Termination And Amendment" section of this Membership Agreement.

You can make these changes on an Enrollment Form, which is available through your Employer or by visiting us at our web site at **www.connecticare.com**. If you use an Enrollment Form, you must submit it through your Employer for all additions and deletions, even if your employee contribution amount does not change.

Refer to the "Managed Care Rules And Guidelines" section to see if you have to use Participating Providers and to find out what services require Pre-Authorizations. Also refer to the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

If you are enrolled in our non-group plan, you must return the Enrollment Form to us directly.

SPECIAL ENROLLMENT PERIOD

In general, if you decide not to enroll yourself, your spouse or your children because of other health insurance coverage, you may be able to enroll yourself or them in the future, as long as you request enrollment within 31 days after the other insurance coverage ends. This is called a "Special Enrollment Period." To qualify for this special enrollment, the other group health coverage must have been lost because COBRA benefits have expired, non-COBRA coverage terminated due to loss of eligibility for coverage or employer contributions for the coverage ended.

Another Special Enrollment Period can also occur when you have a "Life Event" such as marriage, the birth of a baby, or the adoption of a child. When the Life Event is marriage, you can enroll alone, or you and your spouse can enroll, or you, your spouse and any eligible dependents acquired through the marriage can enroll. When the Life Event is the birth of a baby or the adoption of a child, you can enroll alone, you and your spouse can enroll, you and the new baby or newly adopted child can enroll, or you, your spouse, and your new baby or newly adopted child can enroll. The effective date of coverage depends on the Life Event that triggers this Special Enrollment Period. **However, you must enroll within 31 days of the Life Event for coverage to become effective under this rule.**

- ♥ If the Life Event is your marriage, coverage is effective no later than the first day of the first calendar month beginning after the date on which we receive the completed Enrollment Form.
- ♥ If the Life Event is the birth of a baby, coverage is effective the date of the baby's birth.
- ♥ If the Life Event is the adoption or the placement of adoption of a child, coverage is effective the date of the adoption or placement of adoption.

In addition, when you, your spouse or your children lose eligibility for coverage under a state Medicaid or Children's Health Insurance Program (CHIP), you may all enroll in this Plan, as long as you request enrollment within 60 days after the date such other coverage ends.

Further, when you, your spouse or your children become eligible for group health plan premium assistance under a state Medicaid or Children's Health Insurance Program (CHIP) plan, you may all enroll in this Plan, as long as you request enrollment within 60 days after the date you are determined to be eligible for such premium assistance.

Subject to our review and approval, some Employers may have policies that provide for additional eligibility during Special Enrollment Periods.

EFFECTIVE DATE OF COVERAGE

GENERAL RULE

This Plan is effective for your Employer as described in this Agreement and the Evidence Of Agreement. This Plan will take effect for you and your Eligible Dependents on the date as described by your Employer's standard eligibility requirements.

If you are enrolled in our non-group plan however, the Enrollment Form and any other forms or statements we need must be received and accepted by us before you will be considered for membership under this Plan.
Your right to coverage for you and your dependents' is subject to the condition that all of the information you provide is true, correct and complete to the best of your knowledge and belief. In addition, you are responsible for providing us with immediate notification of all name, address, and phone number changes. This Agreement will take effect on the date as established above and by our standard eligibility requirements that apply to enrollment in our non-group plan.

The following rules also apply.

WHEN A MEMBER IS AN INPATIENT AT THE TIME OF ELIGIBILITY

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

APPLICATION OF AGREEMENT TO HEALTH SERVICES

This Agreement replaces the prior agreement, if any, between your Employer and us or you and us, if you are enrolled in our non-group plan. This Agreement applies to health care services rendered on and after the effective date of this Agreement. Medically Necessary health services and supplies are not covered if the patient is not enrolled as a Member under this Plan at the time the service or supply is rendered or received.

If this Agreement specifically excludes a multi-staged health care procedure that was covered by a prior agreement between your Employer and us, then any Member who had completed the initial covered procedure of that multi-staged procedure prior to the effective date of this Agreement will continue to be covered for that procedure until it is completed. Coverage will be available as long as the Member continues to be covered by this Agreement and the procedure is rendered in accordance with the terms (including timing) of Pre-Authorization or Pre-Certification given by us, if any.

Refer to the "Managed Care Rules And Guidelines" section to see if you have to use Participating Providers and to find out what services require Pre-Authorizations. Also refer to the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

MANAGED CARE RULES AND GUIDELINES

Your ability to obtain the benefits provided under this Plan depends on your following the managed care rules and guidelines of this Plan.

This Plan includes managed care rules and guidelines for such things as:

- Selection Of A Primary Care Provider (PCP)
- When You Need Specialized Care
- Services Requiring Pre-Authorization And Pre-Certification
- Using Participating Providers And Non-Participating Providers
- Benefits While Traveling Or Temporarily Out Of The Service Area
- After Hours Care
- Cost-Shares You Are Required To Pay
- Medical Necessity And Appropriate Setting Of Care
- Utilization Management
- Quality Assurance
- New Treatments
- Experimental Or Investigational
- Insufficient Evidence Of Therapeutic Value
- Member's Rights And Responsibilities
- Delegated Programs

SELECTION OF A PRIMARY CARE PROVIDER (PCP)

You and your covered dependents MUST SELECT A PCP who should be used in providing and coordinating your medical care, including routine care and follow-up care after the receipt of Emergency Services. PCPs are like health care managers and are made up of: doctors who maintain a general practice, pediatricians, family practitioners, and practitioners of internal medicine, as well as nurse practitioners.

Note: you and your covered dependents do not all have to have the same doctor as a PCP. Each of you can have a different one.

If for some reason you or your covered dependents do not select a PCP at the time of enrollment, we will do that for you. You will be notified of that PCP assignment. You or your covered dependents can change PCPs at any time by calling or writing our Member Services Department at the appropriate telephone number or address listed in the "Important Telephone Numbers And Addresses" subsection of the "Important Information" section or by visiting us at our web site at www.connecticare.com. You should use the most current version of our Provider Directory (or check our web site at www.connecticare.com) and call our Member Services Department to verify that the provider still continues to participate as a PCP under this Plan. In addition, by logging on to our web site, you can also obtain the professional qualifications of a PCP, by clicking on the individual provider's name.

In the event that your PCP is no longer contracting with us or if he or she will no longer be treating patients at a certain office where you may have been receiving care, you will be notified 30 days before the effective date of that change, if possible, or as soon as possible after we become aware of the change. You will then have to select a new PCP as described above if he or she is no longer contracting with us. If this happens to you, please call us if you need assistance.

WHEN YOU NEED SPECIALIZED CARE

Under this Plan, Members **ARE NOT** required to obtain a Referral in order to obtain benefits for services rendered by specialists. Although the Referral is not required, it is still a good idea to use your respective PCPs to coordinate your specialty care. In the event that a Member is seeing a Specialist Physician regularly and that Specialist Physician is no longer participating with us, the Member will be notified 30 days before the effective date of that change, if possible, or as soon as possible after we become aware of the change. Please call your PCP or refer to our Provider Directory to help you select a new Specialist Physician. In addition, by logging on to our web site (at www.connecticare.com), you can also obtain the professional qualifications of a Specialist Physician, by clicking on the individual provider's name.

SERVICES REQUIRING PRE-AUTHORIZATION OR PRE-CERTIFICATION

The Pre-Authorization Or Pre-Certification Process

Under this Plan, Participating Providers have the responsibility to obtain the necessary Pre-Authorization or Pre-Certification when they are treating you or your covered dependents.

Here's a list of services, equipment and supplies that require Pre-Authorization or Pre-Certification.

You Need Pre-Authorization Or Pre-Certification For The Following:

Admissions:

- Hospital admissions that are elective or not the result of an Emergency, including Behavioral Health Program services (mental health and alcohol or substance abuse services)
- Rehabilitation Facility admissions
- Skilled Nursing Facility admissions
- Sub-acute care admissions

Ambulance/Medical Transportation:

- Land or air ambulance/medical transport that is not due to an Emergency

Behavioral Health Program Services (mental health and alcohol or substance abuse services):

- All Behavioral Health Program services, including

Refer to the "Managed Care Rules And Guidelines" section to see if you have to use Participating Providers and to find out what services require Pre-Authorizations. Also refer to the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

inpatient and outpatient services, Partial Hospitalization, Intensive Outpatient services, Residential Treatment Facility programs and psychological testing

Durable Medical Equipment (DME) And Prosthetics

Pre-Authorization will only be required for the following items: insulin pumps, wound vacs, real time continuous blood glucose monitors, customized wheelchairs and scooters, osteogenic stimulators (including spinal, non-spinal and ultrasound).

Elective Services & Procedures:

Cancer clinical trials
Cardiac monitoring with Mobile Cardiac Outpatient Telemetry or continuous computerized daily monitoring with auto-detection (no Pre-Authorization is required for standard Holter monitors or loop event recording devices)
Chondrocyte Implantation of the Knee
Corneal Pachymetry, repeat testing only
Craniofacial treatment
Dental anesthesia/procedures
Gastric bypass surgery, including laparoscopic (if a covered benefit)
Genetic testing, except for cystic fibrosis, routine chromosomal analysis (e.g., peripheral blood or tissue culture, chorionic villus sampling, amniocentesis), and FISH testing for lymphoma or leukemia
Mammoplasty (breast augmentation or reduction)
Oncotype DX breast cancer test
Oral surgery (if a covered benefit)
Reconstructive surgery
Septoplasty (surgery of the nose), except when requested by an Ear, Nose and Throat Specialist
Sleep apnea surgery
Solid organ transplants (except cornea) and bone marrow transplants (all transplant Pre-Authorizations must be done at least ten business days prior to services being rendered)
Stereotactic radiosurgery
TMJ surgery (if a covered benefit)
Varicose vein surgery

Home Health Care:

Home health services
Home infusion therapy
Hospice care

Infertility Services

Injectible Drugs & Nutritional Supplements:

Nutritional supplements and food products, including modified food products for inherited metabolic diseases and specialized formulas (if a covered benefit)

Neuropsychological Testing (behavioral health and medical purposes)

Outpatient Radiological Services (except when such radiological services are done in conjunction with a biopsy or other surgical procedure):

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

Outpatient Rehabilitative Services:

Occupational therapy
Physical therapy
Speech therapy (including specialty Hospitals, acute care Hospitals and providers of rehabilitation services)

Prescription medications (only applies to certain medications)

Here's a list of the medications and supplies that also require Pre-Authorization.

You Need Pre-Authorization For The Following Prescription Drugs:

Acthar Gel
*Actos (Use metformin first)
*Actoplus Met (Use metformin first)
Aciphex (Use Prilosec OTC first)
Acne-Brand Name Oral Agents; Doryx, Dynacin, Adoxa, Myrac, Soladyn, Minocin PAC
Actiq (fentanyl citrate lozenge)
*Actonel (Use generic Fosamax first)
Adcirca
Adoxa (Use generics first)
Affinitor
Agrylin
*Allegra / Allegra D (Use loratadine/cetirizine OTC first)
Alpha 1-Proteinase Inhibitors (All)
Aldurazyme
Alimta
Aloxi (PA not required if provided by MD office)
*Altoprev (Use simva-, prava- or lova-statin first)
*Ambien CR (Use generic Ambien first)
Amerge (Use generic Imitrex first)
Amevive
Amrix (Use generic cyclobenzaprine)
Androderm
Androgel
Anzemet (Use ondansetron first)
Aplenzin (Use generic bupropion hcl)
Apokyn
Aralast
Arcalyst
Aranesp
Aricept (PA < 50 years old only)
Arthrotec (Use generics first)
Ascensia Test Strips (Use Accuchek or Freestyle first)
Astepro (Use Astelin first)
Avandia (Use metformin first)
Avandamet (Use metformin first)
Avandaryl (Use metformin first)
Avastin
Avodart (PA < 55 years old only)
Avonex
Axert (Use generic Imitrex first)
*Beconase AQ (Use fluticasone, Nasonex or Veramyst

Refer to the "Managed Care Rules And Guidelines" section to see if you have to use Participating Providers and to find out what services require Pre-Authorizations. Also refer to the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

first)
Betaseron
Bexxar
Blood Clotting Factors (All)
Boniva Injection
*Boniva Tablets (Use generic Fosamax first)
Botox
Bravelle
Brovana
Buphenyl
*Byetta
Cabergoline (Dostinex) (Use bromocriptine first)
Campral
*Cardura XL (Use generic doxazosin first)
*Celebrex
Cerezyme
Cesamet
Cetrotide
Chantix (PA not required for initial 30 days supply)
*Cholesterol Lowering Drugs: Altoprev, Crestor, Lescol/XL, Lipitor, Vytorin
Cimzia
Cinryze
*Clarinex / D (Use loratadine/cetirizine OTC first)
Clindagel
Clobex (Use generic clobetasol first)
CNL Nail kit
Clolar
Clomid
Coartem
Contraceptives (if excluded by group)
Compounded Medications
Copaxone
Coreg CR (Use carvedilol first)
Crestor (Use simva-, prava- or lova-statin first)
Crinone
*Cymbalta (Use SSRI generics first)
Dacogen
*Detrol / LA (Use generic oxybutynin IR/XL first)
Doryx (Use generics first)
Dostinex
Duetact (Use metformin first)
Dynacin (Use generics first)
Edular
*Effexor XR (Use generics first)
Elaprase
Elidel (PA <2 years of age)
Enbrel
*Enablex (Use generic oxybutynin IR/XL first)
Endometrin
Eloxatin
Erbitux
Euflexxa
Evoclin
Exelon (PA < age 50 only)
Exjade
Extina
Fabrazyme
Fentanyl citrate oral
Fentora
*fexofenadine (Use loratadine/cetirizine OTC first)
Flector Patch
Fexmid
Flolan
Flu Mist (PA for age 18 and older only)
Fluoxetine 40mg capsules
Follistim AQ
Food Supplements
Fortamet
Forteo
Fosamax plus D
Frova
Fuzeon
Ganirelix
Gastrocrom
Gelnique
Genotropin
Gleevec
Glumetza
Gonal-F
Growth Hormones (All)
HCG (chorionic gonadotropin)
Herceptin
Humatrope
Humira
Hyalgan
Hycamptin
Ilaris
Implanon
Increlex
Infergen
Injectable Drugs (All): excluding insulin
Interferons (All)
Infertility Medications (All)
Intron-A
Iressa
IV Immune Globulin (IVIG)
Ixempra
Januvia
Janumet
Kapidex
Keppra XR
Kineret
Klonopin Wafers (Use clonazepam tablets first)
Kuvan
Kytril (Use ondansetron first)
Lamictal ODT
Lamictal XR
Lamisil Oral Granules
*Lescol/XL (Use simva-, prava- or lova-statin first)
Letairis
*Lexapro (Use generics first)
*Lipitor (Use simva-, prava- or lova-statin first)
Lotronex
*Lovaza (formerly Omacor)
Lucentis

Refer to the "Managed Care Rules And Guidelines" section to see if you have to use Participating Providers and to find out what services require Pre-Authorizations. Also refer to the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

Lumigan (PA <age 50 only)
*Lunesta (Use generic Ambien first)
Luveris
Luvox CR (Use generics first)
Luxiq (Use generics first)
*Lyrica
Macugen
Marinol
Maxalt/Maxalt MLT
Menopur
Mepron
Minocin Combo Pack (Use generics first)
Mirena
Mozobil
Myobloc
Myozyme
Myrac (Use generics first)
Naglazyme
Namenda (PA < 50 years old only)
*Nasacort AQ (Use fluticasone, Nasonex or Veramyst first)
*Nasarel (Use fluticasone, Nasonex or Veramyst first)
Neulasta (PA pharmacy claims only)
Nexavar
Nexium (Use Prilosec OTC first)
Nimotop
Niravam (use generic alprazolam first)
Norditropin
Novarel
NPlate
Novoseven
Nutropin/AQ
Nuvigil
Olux (Use generic clobetasol first)
Omeprazole (Use Prilosec OTC first)
*Omnaris (Use fluticasone, Nasonex or Veramyst first)
Omnitrope
One Touch Test Strips
Oracea
Orencia
Orfadin
Orthovisc
Ovidrel
Oxandrin
*Oxytrol (Use generic oxybutynin IR/XL first)
Patanase (Use Astelin first)
*Paxil CR and CR generic (Use other SSRI generics first)
Pegasys
Peg-Intron
*Pexeva (Use generics first)
Ponstel
Prevacid (Use Prilosec OTC first)
Prevacid Naprapac
Prialt
Prilosec (Use Prilosec OTC first)
*Pristiq
Prolastin
Proleukin
Prolia
Promacta
Proscar (PA < 55 years old only)
Protonix (Use Prilosec OTC first)
Protopic (< 2 years of age)
Provigil
*Prozac Weekly (Use generics first)
Qualaquin
Rapaflo
Razadyne (PA < 50 years old only)
Rebetol
Rebetron
Rebif
Reclast
Relistor
Relpax
Regranex
Remicade
Remodulin
Repronex
Retisert
Revatio
Revlimid
*Rhinocort AQ (Use fluticasone, Nasonex or Veramyst first)
RiaStap
Ribavirin
Rituxan
Ryzolt ER
Saizen
*Sanctura (Use generic oxybutinyn IR/XL first)
Sancuso (Use odansetron first)
*Sarafem (Use generics first)
Savella
Simponi
*Singulair (Use loratadine OTC first for allergic rhinitis)
Smoking Cessation Medications
Soladyn (Use generic first)
Soliris
Somavert
Sporanox
Sprycel
Steroids, Anabolic (i.e Nandrolone)
Stavzor
Striant
*Strattera
Sucraid
Supartz
Sutent
*Symlin
Synagis
Synarel
Synvisc
Tasigna
Tarceva
Temodar
Testim
Testosterone (All)

Refer to the "Managed Care Rules And Guidelines" section to see if you have to use Participating Providers and to find out what services require Pre-Authorizations. Also refer to the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

TevTropin
Thalomid
Thyrogen
Tracleer
Travel Medication: including Malarone, Larium and Aralen
Travatan/Travatan Z (PA <age 50 only)
Treanda
Tretin X
Treximet
Trilipix
Torisel
Toviaz
Tykerb
Tysabri
Uloric (Use allopurinol first)
Ultram ER (Use tramadol)
Vectibix
Velcade
Venlafaxine ER (Use Effexor XR)
Ventavis
Verdeso (Use generic desonide first)
*Vesicare (Use generic oxybutynin IR/XL first)
Vidaza
Vivaglobin
Vivitrol
Voltaren Gel
Vusion
*Vytorin (Use simva-, prava- or lova-statin first)
Weight Loss Medication (if covered by your plan); Meridia, Xenical, Ionamin, Tenuate, etc
Vyvanse (Use generic Adderall XR first)
*Welchol
Xalatan (PA < age 50 only)
Xanax XR (use generic alprazolam first)
Xeloda
Xenazine
Xolair
Xyntha
Xyrem
*Xyzal (Use loratadine OTC first)
Zanaflex Caps (Use tablets)
Zantac gel dose (Use tablets)
Zavesca
Zegrid (PA for age > 15 years old) (Use Prilosec OTC first)
Zemaira
Zevelin
Zolinza
Zyban
Zolpimist (Use generic zolpidem first)
Zyflo CR (Use Singulair first)

(*) Pre-Authorization for these prescription drugs is not required within the first 90 days of membership with ConnectiCare.

In addition, any drug that is newly available to the market will also require Pre-Authorization until such time that we re-publish our list of drugs that require Pre-Authorization.

Changes To The Pre-Authorization Or Pre-Certification List

The Pre-Authorization or Pre-Certification lists may change at any time. When the lists change, you will be notified in our member newsletter. You can also contact our Member Services Department at the appropriate telephone number listed in the "Important Telephone Numbers And Addresses" subsection of the "Important Information" section or by visiting our web site at www.connecticare.com to find out if a service or prescription drug requires Pre-Authorization or Pre-Certification.

When Pre-Authorization Or Pre-Certification Is Denied

No benefits will be provided under this Plan if you or your covered dependents receive services or supplies after Pre-Authorization or Pre-Certification for them has been denied. Failure to comply with the requirements of this Plan will result in denial of benefits, except in those instances we mentioned where it is the responsibility of Participating Providers to request the applicable Pre-Authorization or Pre-Certification. In those instances, benefits available under this Plan will not be reduced or denied if the Participating Provider who rendered the treatment fails to request Pre-Authorization or Pre-Certification.

If you receive an explanation of benefits stating the claim was denied where it was the responsibility of the Participating Provider to request the applicable Pre-Authorization or Pre-Certification, contact our Member Services Department at the appropriate telephone number listed in the "Important Telephone Numbers And Addresses" subsection of the "Important Information" section, so we can help you resolve this issue.

Expedited Review For Pre-Authorization Or Pre-Certification

When this Plan requires your doctor to obtain Pre-Authorization or Pre-Certification for a Hospital stay or for a health care treatment while you are in the Hospital, he or she may request an "Expedited Review" of his or her request in the following circumstances.

1. You must already be admitted to a Participating Hospital and your physician must have determined your life will be endangered or that other serious injury or illness could occur if you are discharged from the Hospital or if the treatment in question is delayed.
2. Your attending physician must make a request for an Expedited Review by telephoning the appropriate number designated for Expedited Reviews. If your doctor is unable to make contact by calling that number, he or she may leave a voice-mail message at the designated alternative number(s).
3. If no additional information is required than what your doctor provided with his or her request for the Expedited Review, a decision will be made within three hours from the time the initial request was made. If this three-hour

Refer to the "Managed Care Rules And Guidelines" section to see if you have to use Participating Providers and to find out what services require Pre-Authorizations. Also refer to the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

deadline is not met, the Expedited Review request will be deemed approved.

4. If additional information is requested to make a decision, that decision will be made within three hours from the time all the necessary additional information was sent to complete the review. If this three-hour deadline is not met, the Expedited Review request will be deemed approved.
5. If the Expedited Review request is approved on the initial telephone call, an authorization number will be given.
6. If the Expedited Review request is not approved, you and your physician will have the Appeal process available to you, as described in the "Appeal Process" subsection of the "Claims Filing, Questions And Complaints, And Appeal Process" section.
7. Your attending physician must provide at least two methods of communication for responding to his or her request.
8. Reviewing staff will be available from 8:00 a.m. to 9:00 p.m. to process Expedited Review requests.
9. The three-hour time period will not apply to Expedited Review requests initiated between 6:00 p.m. and 8:00 a.m.

USING PARTICIPATING PROVIDERS AND NON-PARTICIPATING PROVIDERS

Always Use Participating Providers

Participating Providers are doctors, Hospitals, laboratories and other skilled health care professionals and licensed facilities that have agreed to provide Members with professional services and supplies. You may refer to the Provider Directory, visit us at our web site at www.connecticare.com, or call us for a list of Participating Providers in your area. A provider's listing in the Provider Directory or on the web site is not a guarantee the provider is still a Participating Provider at the time health care services are rendered. You should verify a provider is currently participating with us by calling the appropriate telephone number listed in the "Important Telephone Numbers And Addresses" subsection of the "Important Information" section before obtaining care.

The rate we pay Participating Providers for covered Health Services, before any deduction of any applicable risk withholds, may include:

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

You should also know that Participating Providers are not prohibited from disclosing, to a Member who inquires, the method that we use to compensate them.

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

It's always a good idea for you to take an active roll in the care you are receiving, so ask your Participating Provider questions about the care you are receiving. In addition, make sure to ask him or her to Refer you to Participating Providers and that any laboratory or radiology analysis done on your behalf be sent to laboratories or facilities that are Participating Providers as well.

Except in a few VERY LIMITED CIRCUMSTANCES, all health care services and supplies must be ordered, rendered and supplied by a Participating Provider or the service or supply will not be covered, even if you believe that a Non-Participating Provider is a "better" doctor or you prefer to use a Non-Participating Provider.

Here are the "very limited circumstances":

- Conditions requiring Emergency Services.
- For Urgent Care.

  "Urgent Care" means care for the treatment of a sudden and unexpected onset of illness or injury requiring care within 24 hours that can be treated in a physician's office or in an Urgent Care Center.
- Obtaining covered disposable medical supplies (supplies still need to be ordered by a Participating Provider, but they may be obtained from a Non-Participating Provider).
- If we or, as appropriate, our Delegated Program issue you written Pre-Authorization to use a Non-Participating Provider before you obtain the service or supply (see below).

  A Delegated Program is an outside company we use to manage and administer certain categories of benefits or services provided under this Plan. Please refer to the "Delegated Program" subsection of this section for more information about Delegated Programs.

To find out how to file Non-Participating Provider claims in these limited instances, please refer to the "Claims Filing" subsection of the "Claims Filing, Questions And Complaints, And Appeal Process" section.

Refer to the "Managed Care Rules And Guidelines" section to see if you have to use Participating Providers and to find out what services require Pre-Authorizations. Also refer to the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

Except as noted above, even if you or your covered dependents reside or travel outside of the Service Area for an extended length of time (e.g., you have a seasonal residence or are a student in another state), services or supplies will not be covered if they are received from Non-Participating Providers.

Non-Participating Providers (Out-Of-Plan Services)

You and your covered dependents must obtain written Pre-Authorization from us or, the applicable Delegated Program before treatment is rendered by a Non-Participating Provider (Out-Of-Plan Services) in order for the treatment to be covered under this Plan, unless the service or supply was due to one of the **EXCEPTIONS** just mentioned and that are listed in the "Always Use Participating Providers" subsection of this section.

The rate we pay for Non-Participating Provider covered Health Services may vary according to the provider utilized or the services received. Some Non-Participating Providers have agreed to give 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 amount we would pay a Participating Provider.

A Delegated Program is an outside company we use to manage and administer certain categories of benefits or services provided under this Plan. Please refer to the "Delegated Program" subsection of this section for more information about Delegated Programs.

Unless the service or supply was due to one of the **EXCEPTIONS** in the "Always Use Participating Providers" subsection of this section:

- If you or your covered dependents visit a Non-Participating Provider and receive health care services without Pre-Authorization, even if your doctor recommended the services or referred you there, you will be responsible for the payment for those services. Similarly, you will also be responsible for the payment for services if you were admitted into a Participating Hospital or referred to a Participating Provider by a Non-Participating Physician without Pre-Authorization from us.
- Pre-Authorization for Out-Of-Plan Services will only be given if both of the following conditions are met:

  The requesting Participating Provider is in the same specialty as the Non-Participating Provider whose services are requested, **AND**

  We or, as appropriate, our Delegated Program have determined, at our discretion, that Medically Necessary services are not reasonably available from a Participating Provider.
- Other care, such as routine care, prenatal care, preventive care, chemotherapy, home health care services, a medical condition that requires ongoing treatment, routine laboratory tests or follow-up visits, are not covered when you or your covered dependents are out of the Service Area.

You, or the Participating Provider, must request Pre-Authorization for Out-Of-Plan Services by calling or writing our Clinical Review Department at:

(860) 674-5860 or 1-800-562-6833

or

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

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

IT IS YOUR RESPONSIBILITY to ensure that written Pre-Authorization is received prior to treatment by a Non-Participating Provider.

We reserve the right to deny authorization for services or supplies rendered by a Non-Participating Provider. In the limited circumstance that authorization of services or supplies by a Non-Participating Provider is granted, that authorization may impose limits and determine which Non-Participating Provider may be used for the Health Services authorized.

Benefits While Traveling Or Temporarily Out Of Service Area

While you or your covered dependents are traveling or otherwise temporarily out of the Service Area, coverage is available for:

- Conditions requiring Emergency Services.
- Urgent Care.

  "Urgent Care" means care for the treatment of a sudden and unexpected onset of illness or injury requiring care within 24 hours that can be treated in a physician's office or in an Urgent Care Center.

Any continuing treatment of an illness or injury that is provided by Non-Participating Providers and can be delayed for 24 hours or greater will not be covered unless written Pre-Authorization is obtained first, as described above in the "Non-Participating Providers (Out-Of-Plan Services)" subsection of this section.

To find out how to file Non-Participating Provider claims in these limited instances, please refer to the "Claims Filing" subsection of the "Claims Filing, Questions And Complaints, And Appeal Process" section.

Refer to the "Managed Care Rules And Guidelines" section to see if you have to use Participating Providers and to find out what services require Pre-Authorizations. Also refer to the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

Other care such as routine care, prenatal care, preventive care, chemotherapy, home health care services, a medical condition that requires ongoing treatment, routine laboratory tests and follow-up visits are not covered when you or your covered dependents are out of the Service Area.

AFTER HOURS CARE

You and your covered dependents are covered for Urgent Care and Emergencies during and after the normal business hours of Participating Providers. If possible, the Member should call his or her PCP in the event he or she is in need of medical care after hours. **PCPs (or covering PCPs) are available 24 hours a day, seven days a week**. You may also call the appropriate telephone number listed in the "Important Telephone Numbers And Addresses" subsection of the "Important Information" section to obtain the location of Urgent Care Centers that are Participating Providers and emergency rooms at Participating Hospitals.

If you and your covered dependents need mental health or alcohol or substance abuse care after hours, the Member should call the appropriate telephone number listed on the back of your ID card. **Representatives are available 24 hours a day, seven days a week** to coordinate this care.

Please consult the "Emergent/Urgent Care" subsection of the "Benefits" section for details about coverage for Emergencies and Urgent Care.

COST-SHARES YOU ARE REQUIRED TO PAY

This Membership Agreement **DOES NOT LIST THE AMOUNTS YOU ARE REQUIRED TO PAY** for covered Health Services.

The following paragraphs explain the Cost-Sharing arrangements this Plan may have.

Please refer to your Benefit Summary for the applicable Cost-Share amounts of this Plan, any maximums this Plan may have, and to see if the benefits of this Plan are administered per calendar year or per Contract Year.

Copayments

A Copayment is a Cost-Sharing arrangement in which each Member pays a specific charge directly to a provider for a covered Health Service every time the service is supplied.

Here are a few examples of some of the services that may require a Copayment:

You may have to pay a Copayment (even if you do not see a doctor) for: office based services (such as doctor office visits and consultations, diagnostic/therapeutic procedures, including biopsies, colonoscopies, endoscopies, etc., minor surgical procedures, immunizations, injections, and medical/surgical treatment of the eye); ambulatory surgical center services; rehabilitation therapy visits; Walk In/Urgent Care Center visits; emergency room visits; and inpatient Hospitalizations.

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

There are no Copayments for the following services, when no other services are provided:

- Allergy shots
- All pre-natal visits for routine care until the baby is born **after an initial visit**
- Chemotherapy administration (no matter where it is rendered
- Diagnostic Bone Mineral Density (BMD) DEXA screening for osteoporosis
- Immunizations
- Mammography

Some plans might require a Member to pay a higher Copayment for Specialist Physician office visits than for office visits to Primary Care Providers. In those plans, the Member may be required to pay the higher Copayment for visits to any Participating Provider including, but not limited to, specialist doctors (e.g., a cardiologist, dermatologist, obstetrician/gynecologist, etc., rehabilitation therapists, mental health professionals, etc.) not qualifying as his or her Primary Care Provider. (Primary Care Providers are Participating Physicians who maintain a general practice or have a specialty in family practice, internal medicine or pediatrics and are listed in our Provider Directory as Primary Care Providers.)

If this Plan applies a Hospital per admission Copayment for inpatient Hospitalization, the Member will not have to pay another Hospital per admission Copayment if the Member is readmitted for the same or a related condition within seven days after discharge.

In Plans where there is a Copayment for inpatient admissions, the Copayment amount may be:

- Per admission, or
- Per admission up to a maximum per year, or
- Per day up to a maximum per admission, or
- Per day up to a maximum per year, or
- Per day up to a maximum per admission up to a maximum per year

When your Plan has a Copayment maximum per admission or per year, the Copayment maximum is met by combining the total Copayment amounts the Member has paid for that admission or during the year for all inpatient admissions of any type. Please refer to your Benefit Summary to see the

Copayment amount you are required to pay for inpatient admission, if any, under your Plan.

Also, in plans with Copayments for inpatient admissions, the Copayment will not apply to Partial Hospitalizations or Intensive Outpatient services.

Emergency room Copayments will be waived if the Member is admitted directly to the Hospital from the emergency room.

Emergency room Copayments will also be waived if a Copayment was paid to an Urgent Care Center and the Member was directed by the treating physician at an Urgent Care Center to go immediately to an emergency room as the more appropriate medical setting for the required treatment.

Again, please refer to your Benefit Summary for the applicable Copayment amounts.

Deductibles

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

Benefit Deductibles

This Plan may have specific Benefit Deductibles that apply separately to certain services. Please refer to your Benefit Summary to see the Benefit Deductibles that may apply to your Plan. When your Plan does have specific Benefit Deductibles, they must be met by the Member each year before we will begin paying for those benefits, except if your Plan has a combined ambulatory services (outpatient) and inpatient Hospitalization services Benefit Deductible (see below).

The Member's Coinsurance, if any, related to these benefits with specific Benefit Deductibles **DOES NOT** count towards meeting any of those Benefit Deductibles.

Combined Ambulatory Services (Outpatient) And Inpatient Hospitalization Services Benefit Deductible Calculation

The individual Benefit Deductible amount (one Member) is met when one Member meets the individual Benefit Deductible amount specified on the Benefit Summary.

The family Benefit Deductible amount (two Members) is met for each Member when each Member separately meets the individual Benefit Deductible amount specified on the Benefit Summary.

The family Benefit Deductible amount (three or more Members) is met by combining the total expenses for Health Services incurred by each family member, whereby no one family member contributes more than the individual Member Benefit Deductible amount, up to the family Benefit Deductible amount as specified on the Benefit Summary.

This Benefit Deductible does not apply to Partial Hospitalizations or Intensive Outpatient services.

Amounts paid by Members as their Coinsurance responsibility or for services that are not covered by this Plan do not count towards meeting the Benefit Deductible.

This combined ambulatory services (outpatient) and inpatient Hospitalization services Benefit Deductible **DOES NOT** need to be met before we will begin paying for any other benefits that may have their own separate benefit Deductible.

Deductible and Coinsurance amounts paid for covered Health Services under this Plan are based on the lower of the provider's billed charges for the covered Health Services or our contracted rate.

90 Day Lookback Period

In certain circumstances, medical expenses the Member incurred under your Employer's prior plan will count towards meeting this Plan's Deductibles. This credit will be applied for expenses paid when benefit periods for the prior plan and this Plan are the same or overlapping and the expenses were actually incurred and applied against the deductibles of your Employer's prior plan during the 90 days before the effective date of this Plan. The following conditions must be met to obtain this credit:

- The expenses must have been incurred while the Member was covered by your Employer's prior plan;
- The expenses must have been credited towards the deductibles in your Employer's prior plan;
- The expenses must have been for benefits that this Plan would have covered if it had been in effect with your Employer on the date the Member incurred the expenses;
- The expenses must be such that they would have counted towards this Plan's Deductibles if this Plan had been in effect with your Employer when the Member incurred the expenses;
- The Member was not entitled to benefits under the prior plan's extension of benefits provision; and
- You must provide us with an explanation of benefits ("EOB") from the prior plan, or other proof acceptable to us, of the medical expenses incurred under the Employer's prior plan.

This 90 Day Lookback Period provision DOES NOT apply if your Plan's benefits are determined on a Contract Year.

Please refer to your Benefit Summary for the applicable Deductible amounts of this Plan.

Coinsurance

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

Except as otherwise required by law, the Coinsurance amount will be calculated based on the lesser of:

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

(See the full definition of Coinsurance in the "Definitions" section.)

Please refer to your Benefit Summary for the applicable Coinsurance amounts of this Plan.

Lifetime Maximum

This Plan may have a Lifetime Maximum. When this Plan has a Lifetime Maximum, it means there is a limit on the total amount of benefits any Member can obtain under this Plan throughout his or her lifetime. Here is an explanation of how the Lifetime Maximum option works.

If this Plan has a Lifetime Maximum, that maximum accrues as a combined, cumulative limit with respect to claims paid by us under this Plan (or an agreement with us that also had a Lifetime Maximum replaced by or replacing or amending this Plan with the same Employer) for services rendered by Participating Providers and also include payment made under our ***Prescription Drug Rider***, if specified on your Benefit Summary.

When a Member reaches this Lifetime Maximum, he or she is no longer eligible for any more benefits under this Plan.

Please refer to your Benefit Summary to see if this option applies to your Plan.

MEDICAL NECESSITY AND APPROPRIATE SETTING FOR CARE

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

1. In accordance with generally accepted standards of medical practice;
2. Clinically appropriate, in terms of type, frequency, extent, site and duration and considered effective for the patient's illness, injury or disease; 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.

"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.

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

If Health Services may be provided in more than one medically appropriate setting, it is within our discretion to choose the setting for the provision of those Health Services, and the Health Services must be provided in that setting in order for you and your covered dependents to be eligible for benefit coverage.

"Medically Necessary" health care services are those Health Services that are required diagnostic or therapeutic treatments for an illness or injury. The health care practitioner determines the medical care, but coverage of the care under this Plan is subject to Medical Necessity as determined by us. We use input from physicians, including specialists, to approve, and in some cases develop our Medical Necessity protocols.

As part of this Plan, we utilize Case Managers to aid in the arrangement and coordination of Medically Necessary care. At our discretion, development of alternative individual plans may include coverage of otherwise non-covered services or supplies.

Medically Necessary care includes care that may be appropriately provided in a medical office, a Hospital, a Skilled Nursing Facility or other medical facility, as well as in your home, and such care is provided or offered to be provided in such setting in accordance with this Plan.

UTILIZATION MANAGEMENT

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

QUALITY ASSURANCE

Our Quality Improvement (QI) Program is applicable to all of our Members under all of our Plans.

The goal of the QI Program is to establish processes, which will help facilitate the continuous improvement of the care and services provided to our Members. As a result, we will better serve the needs of Members, Employers and Participating Providers. Toward this end, the plan will focus on the following:

- ♥ 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, as perceived by Members, providers and Employers.

- ♥ 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 its interpretation to internal and peer review committees for analysis and action.
- ♥ Monitor whether the care and service provided meets or exceeds the established local, state, and national managed care standards.
- ♥ Develop innovative approaches to facilitating the delivery of care to diverse populations within.

The scope of activities within the QI Program focuses on facilitating the continuum of care, which includes: 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 Treatments are new supplies, services, devices, procedures or medications, or new uses of existing supplies, services, devices, procedures or medications, for which we have not yet made a coverage policy.

When we receive a request for coverage for a New Treatment, we review the New Treatment to determine whether it should be covered under this Plan.

During our review, New Treatment, other than drugs with FDA approval for the use for which they are prescribed, are not covered. However, during the review phase of a New Treatment, we may, in some limited circumstances and in our discretion, cover a New Treatment for Members in the same or similar circumstances before our determination is made. Once we complete our review, if we determine 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 we determine the New Treatment should not be covered by this Plan, then the New Treatment will continue to be excluded. If our decision not to cover the New Treatment requires an exclusion to be added to the Plan, the words describing the new exclusion will be added to this Membership Agreement at the next renewal date.

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 are specifically excluded as described in the "Exclusions And Limitations" section or in our ***Prescription Drug Rider***, if applicable. Such a New Treatment may also require Pre-Authorization. When the P&T Committee does its review, they will decide if the medication will remain at the highest tier cost share level or be switched to a lower tier cost share level, and also whether the medication will have Pre-Authorization requirements or dosage limits placed on it. When you receive a medication that is a New Treatment, the conditions under which you can receive the medication might change after the P&T Committee completes its review.

To obtain information about whether a procedure, medication, service, device or supply is a New Treatment, or if a New Treatment requires Pre-Authorization, or to obtain information about whether we have made our determination with respect to a New Treatment, you should contact our Member Services Department at the appropriate telephone number listed in the "Important Telephone Numbers and Addresses" subsection of the "Important Information" section.

EXPERIMENTAL OR INVESTIGATIONAL

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

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

If a Treatment has multiple features and one or more of its essential features is Experimental Or Investigational based on the above criteria, then the Treatment as a whole will be

considered to be Experimental Or Investigational and not covered.

We will monitor the status of an Experimental Or Investigational Treatment and may decide, using the criteria described in the definition of Experimental Or Investigational (see the "Definitions" section), 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, in our sole discretion, to be Experimental Or Investigational, will be considered as a covered Health Service under this Plan until such time as, in our sole discretion, the Treatment is deemed by us to be no longer Experimental Or Investigational and we have determined that it is Medically Necessary in treating or diagnosing a Member's illness or injury.

A Treatment will not be denied as Experimental Or Investigational if it 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.

INSUFFICIENT EVIDENCE OF THERAPEUTIC VALUE

Any 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 we determine, in our sole discretion, that either:

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

There may be Insufficient Evidence Of Therapeutic Value for a Treatment even when it has been approved by a regulatory body or recommended by a health care practitioner. In that case, the Treatment will still not be covered.

We will monitor the status of a Treatment for which there is Insufficient Evidence Of Therapeutic Value and may decide that a Treatment for which at one time there was Insufficient Evidence Of Therapeutic Value may later be a covered Health Service under this Plan. Coverage will not become effective until we have made a determination that there is sufficient evidence of therapeutic value for the Treatment and we have 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 a Member's illness or injury in order to be covered.

MEMBER'S RIGHTS AND RESPONSIBILITIES

Your Rights

You are encouraged to actively participate in decision-making with regard to managing your health care. As a Member of this Plan, you enjoy certain rights and benefits.

You have a right to:

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

Your Responsibilities

While enjoying specific rights of membership, you also have the following responsibilities.

You have a responsibility to:

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

All Rights And Obligations Under The Plan Are Limited To Our Ability To Make A Good Faith Effort With Regard To:

- Delays and failures to render Health Services due to a

major disaster or epidemic affecting our facilities or personnel or Participating Providers.

- ♥ Circumstances beyond our control such as complete or partial destruction of facilities, war, riot, disability of a significant number of Participating Providers, or similar events which result in a delay in providing services or the inability to provide services.
- ♥ Conditions where the Member has refused recommended treatment for personal reasons when Participating Providers believe no professionally acceptable alternative treatment exists.

DELEGATED PROGRAMS

We may use outside companies to manage and administer certain categories of benefits or services provided under this Plan. For example, Pre-Authorization or Pre-Certification as described in the "Managed Care Rules And Guidelines" section may have to be obtained from an outside company rather than from ConnectiCare. In addition, claims for Health Services might be processed by a company other than ConnectiCare, or when you disagree with a decision regarding covered Health Services, your Appeal may also be performed by an outside company. In these cases, when this Agreement refers to determinations, Pre-Authorizations, Referrals, and other decisions made under the terms of that Delegated Program, such determinations, Pre-Authorizations and other decisions are made by the outside company on our behalf.

Delegated Programs:

Behavioral Health Program - The Delegated Program under which we may provide management, administration and a network of providers for mental health, and alcohol and substance abuse services under this Agreement.

Radiological Services Program - The Delegated Program under which we may provide management, administration and a network of providers for outpatient diagnostic laboratory services, x-rays and therapeutic procedures under this Agreement.

Delegated Programs may be added or removed from this Plan at any time. When the list does change, you and your provider will be notified of the name, address and telephone number of the new company and any other necessary relevant information. We may communicate these changes in our member newsletter.

The telephone numbers and addresses of these Delegated Programs are listed in the "Important Telephone Numbers And Addresses" subsection of the "Important Information" section.

BENEFITS

This section describes all the benefits that are covered under this Plan. This Plan provides benefits for the Health Services listed on the following pages, as long as they are Medically Necessary.

Benefits for Health Services provided under this Plan are subject to all the terms and conditions of this Agreement, including the provisions in the "Managed Care Rules And Guidelines" and the "Exclusions And Limitations" sections of this Membership Agreement. Those two sections explain what you have to do to maximize the benefits you receive and also tell you what isn't covered under this Plan. A health care service may seem to be covered by the Plan because it is listed in this section, but it will not be covered if you do not follow the "Managed Care Rules And Guidelines" section of this Membership Agreement or if it is excluded or limited in the "Exclusions And Limitations" section of this Membership Agreement.

IMPORTANT

Refer to the "Managed Care Rules And Guidelines" section to see if you have to use Participating Providers and to find out what services require Pre-Authorizations. Also refer to the "Exclusions And Limitations" section to find out what's not covered under this Plan.

This Membership Agreement **DOES NOT LIST THE AMOUNTS THAT YOU ARE REQUIRED TO PAY** for covered Health Services. Please refer to your Benefit Summary for the applicable Copayment, Deductible, Coinsurance amounts, and benefit maximums of this Plan.

PREVENTIVE SERVICES

Services provided in the doctor's office for routine and preventive care are **covered** as follows.

Adult Preventive Care Services

Office visits for adult preventive care services (routine exams and preventive care) are **covered** in accordance with national guidelines.

The following is a suggested schedule for adult preventive care services:

Adult Preventive Care Services	
Ages 22 to 49:	**Every 1-3 Years, as appropriate**
Age 50 and Over:	**Annually, as appropriate**

The frequency of adult preventive care services is determined by the Member's physician.

Infant/Pediatric Preventive Care Services

Office visits for infant/pediatric preventive care services (routine exams and preventive care) are **covered** in accordance with national guidelines.

The following is a suggested schedule for infant/pediatric preventive care services:

Infant/Pediatric Preventive Care Services	
Under Age 2:	**At months 1, 2, 4, 6, 9, 12, 15, 18 and 24**
Ages 3 to 6:	**Every Year**
Ages 8 and 10:	**Every Year**
Ages 11 to 21:	**Every Year**

The frequency is determined by the Member's physician.

Refer to the "Managed Care Rules And Guidelines" section to see if you have to use Participating Providers and to find out what services require Pre-Authorizations. Also refer to the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

Blood Lead Screening And Risk Assessments

Blood lead screening and risk assessments ordered by the Member's Primary Care Provider are **covered** as follows, as required by State law.

Lead Screenings:

- At least annually for a child from nine to 35 months of age; and
- For a child three to six years of age who has not been previously screened or is at risk.

Risk Assessments:

- For lead poisoning at least annually for a child three to six years of age; and
- At any time in accordance with state guidelines for a child age 36 months or younger.

Gynecological Preventive Exam Office Services

Office visits for gynecological preventive exam office services (routine exams and preventive care) are **covered** in accordance with national guidelines.

The frequency of periodic health evaluations and checkups is determined by the Member's physician.

Cervical Cancer Screening

Cervical cancer screenings (pap tests) for female Members are **covered** in accordance with national guidelines.

The following is a suggested schedule for cervical cancer screening:

Cervical Cancer Screening
Annual screening should begin three years after the individual is sexually active, but no later than age 21. Women younger than 30, should undergo annual cervical cytology. Women age 30 and older who have had three consecutive negative cervical cytology screening test results may extend the interval to every two to three years based upon her physician's recommendation.

Mammogram Screenings

Mammogram screenings are **covered** in accordance with national guidelines and as prescribed by State law.

The following is a suggested schedule for mammogram screenings:

Mammogram Screenings	
Ages 35 to 39:	**One baseline screening**
Age 40 and over:	**One screening mammogram per year**

Mammogram screenings may be covered more often as determined by a physician.

In addition, comprehensive ultrasound screening of an entire breast or breasts are **covered,** if a mammogram demonstrates heterogeneous or dense breast tissue based on national guidelines or if a woman is believed to be at increased risk for breast cancer due to family history or prior personal history of breast cancer, positive genetic testing or other indications as determined by a woman's physician or advanced practice registered nurse.

Some types of breast cancer screenings (e.g., when a Member has or is suspected of having a clinical genetic disorder) require Pre-Authorization. Please refer to the "Genetic Testing" subsection of the "Benefits" section for more information regarding genetic testing.

If a Member requires an ultrasound screening that is not considered routine, that ultrasound screening is **covered**, but it may not be exempt from any Plan Deductible your Plan may have. Please refer to your Benefit Summary to see if your Plan has certain services that are exempt from your Plan's Deductible.

Routine Vision Exams

Routine eye care, including a refraction (a test to determine whether you are near-sighted or far-sighted), is not covered, unless:

- This Plan has our ***Vision Care Rider***.

  If this Plan does have our ***Vision Care Rider***, annual routine eye exams and glasses are **covered** in accordance with the terms of the Rider.

  If this Plan **DOES NOT** include our ***Vision Care Rider***, then screening exams for a Member who is under age 19 are **covered** unless he or she has been diagnosed with a refraction problem.

  In addition, Members with diabetes are **covered** for a routine eye exam each year. These screenings and eye exams are **covered** under the terms of the ***Vision Care Rider***, if there is one. Otherwise, they are **covered** under this Agreement as a medical service.

- You are a Member in the ***CSEHRP HMO Open Access Plan***, in which case coverage is available if you are under age 17 or you have diabetes.

OTHER PREVENTIVE SERVICES

Colorectal Cancer Screenings

Colorectal cancer screenings, such as annual fecal occult blood testing (FOBT), fecal immunochemical test (FIT), and flexible sigmoidoscopy, colonoscopy, or radiologic imaging are **covered** in accordance with national guidelines. Colorectal cancer screenings may be covered more often as determined by a physician based on the Member's medical history and/or risk factors.

There may be a Cost-Share that you will be required to pay for these screenings. The Cost-Share amount depends on where the procedure is rendered and your Plan. For example, if you have a procedure performed at a physician's office, you will be required to pay an office services Copayment, but if the service is performed on an outpatient basis, whether in a Hospital or ambulatory surgery facility, you will be required to pay an ambulatory services Cost-Share amount.

Refer to the "Managed Care Rules And Guidelines" section to see if you have to use Participating Providers and to find out what services require Pre-Authorizations. Also refer to the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

Please refer to your Benefit Summary to see the Cost-Share amount you are required to pay, if any, under your Plan.

Hearing Screenings

Hearing screenings are **covered** as follows:

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

Immunizations

Immunizations (vaccine and injection of vaccine) are **covered** in accordance with national guidelines. The guidelines are frequently provided to physicians and our Members. Coverage for vaccines such as Hepatitis is limited under these guidelines.

The following immunizations are **NOT** covered:

- Immunizations obtained solely because they are required by a third party (such as job, travel, school, or camp).
- Immunizations obtained for travel.
- Immunizations and vaccinations for cholera, plague and yellow fever.
- Routine immunizations obtained at an Urgent Care Center.
- Vaccinations an employer is legally required to provide due to an employment risk.

Newborn Care

Newborn children are **covered for the first 31 days following birth** as prescribed by State law.

Continued coverage for a newborn child requires the newborn to be enrolled in this Plan within 31 days of his or her birth for coverage to continue beyond this initial 31 days. There is no coverage beyond 31 days for a newborn who does not qualify as your dependent child.

Please refer to the "Adding New Children" subsection of the "Eligibility And Enrollment" section of this Membership Agreement for more information and rules regarding coverage for newborn children.

Prostate Screening

Laboratory and diagnostic tests to screen for prostate cancer are **covered** as prescribed by State law for a male Member who:

- Is 50 years of age or older; 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.

OUTPATIENT SERVICES

This Plan covers Medically Necessary services provided in the doctor's office, including consultations, or in the Member's home to treat an illness or injury. The following provisions describe what types of doctor's services are covered.

Please refer to the rules described in the "Using Participating Providers And Non-Participating Providers" subsection of the "Managed Care Rules And Guidelines" section to find out how to obtain covered Health Services.

Primary Care Provider Office Services

When you have an injury or illness that does not require specialized care and for which the care can be obtained in your Primary Care Provider's office, the services are **covered** subject to the Primary Care Provider Office Services Cost-Share amount.

Specialist Office Services

When you have an injury or illness that does require specialized care and for which the care can be obtained in a Specialty Physician's office, the services are **covered** subject to the Specialist Office Services Cost-Share amount.

Gynecological Office Services

When you require gynecological services that can be obtained in your physician's office, the services are **covered.**

Maternity Care Office Services

When you require maternity services (pre-natal and post-partum), which can be obtained in your physician's office, the services are **covered.** There may be a Cost-Share that you will be required to pay for care related to pregnancy for each visit, even after the initial pre-natal office visit. The Cost-Share amount depends on where the procedures are rendered.

Allergy Testing

Allergy testing with allergenic extract (or RAST allergen specific testing) is **covered up to $315 every two years.** Similarly, allergy testing for medication, biological or venom sensitivity is **covered up to $315 every two years**.

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

Laboratory Services

Outpatient laboratory services, including services performed in a Hospital or laboratory facility are **covered**.

Some laboratory services require a doctor's order and/or Pre-Authorization to be covered. Please refer to the "Services Requiring Pre-Authorization Or Pre-Certification" subsection of the "Managed Care Rules And Guidelines" section of this Membership Agreement.

Refer to the "Managed Care Rules And Guidelines" section to see if you have to use Participating Providers and to find out what services require Pre-Authorizations. Also refer to the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

Radiological Services

Outpatient diagnostic x-rays and therapeutic procedures under this Plan may be provided under our Radiology Services Program. We may use an outside company to manage and administer this program.

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

Some radiology services require a doctor's order and/or Pre-Authorization to be covered. Please refer to the "Services Requiring Pre-Authorization Or Pre-Certification" subsection of the "Managed Care Rules And Guidelines" section of this Membership Agreement.

Non-Advanced Radiology

Covered non-advanced radiology services may include Medically Necessary outpatient diagnostic x-rays (e.g., chest x-rays) when order by a physician.

Advanced Radiology

Covered advanced radiology services include the following outpatient services when Medically Necessary and when order by a physician.

- ♥ Computerized Axial Tomography (CAT)
- ♥ Magnetic Resonance Imaging (MRI)
- ♥ Positron Emission Tomography (PET)
- ♥ Nuclear cardiology

Note: Bone mineral densitometry is limited to one test per Member every 23 months. If more frequent bone mineral densitometry are needed to monitor your medical condition, Pre-Authorization is required.

Outpatient Rehabilitative Therapy

Medically Necessary short-term outpatient rehabilitative therapy (including those services rendered at a day program facility and in an office) are **covered up to the maximum benefit as shown on the Benefit Summary** if they are expected to return function to pre-illness or pre-injury levels.

Wound care supplies related to a Member's treatment when the care is being provided by a licensed physical or occupational therapist or licensed Home Health Agencies are also covered. Coverage for these supplies will not apply to the disposable medical supplies benefit maximum, if there is one, as long as they are provided by an outpatient therapy facility. All physical, occupational and speech therapy, no matter where it is rendered, must be ordered by a physician and Pre-Authorized.

- ♥ 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.

  Occupational therapy for fine motor developmental delays and other non-injury or non-illness related speech impediments are not covered, except as provided in the "Autism Services" or "Birth To Three Program (Early Intervention Services)" provisions of "Other Outpatient Services" subsection.

- ♥ In the case of speech therapy, services are limited to therapy when speech has been attained and then lost as a result of illness or injury.

  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 "Autism Services" or "Birth To Three Program (Early Intervention Services)" provisions of "Other Outpatient Services" subsection.

- ♥ 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 Pre-Authorized by us as part of the surgical procedure.

Chiropractic Services

Medically Necessary short-term chiropractic services include, but are not limited to office visits and manipulation. These services are **covered after the applicable Cost-Share up to the maximum benefit as shown on the Benefit Summary** if they are expected to return function to pre-illness or pre-injury levels.

There is no coverage for physical therapy, occupational therapy, speech therapy or chiropractic therapy that is long term or maintenance in nature.

EMERGENT/URGENT CARE

When you or one of your covered dependents need treatment due to a sudden or unexpected illness or injury, or because of a Medical Emergency, this Plan provides coverage as follows.

Walk-In/Urgent Care Centers

Urgent Care is defined as: "services for the treatment of a sudden and unexpected onset of illness or injury requiring care within 24 hours that can be treated in a physician's office or in an Urgent Care Center."

Urgent Care is **covered** when provided in an Urgent Care Center. These centers are not emergency rooms for the treatment of life or disability threatening illness or injury. It is recommended that the Member contact his or her Primary Care Provider (PCP) prior to the use of an Urgent Care Center so the PCP can be involved in the management of health care by either treating the Member or directing him or her to an appropriate provider.

Treatment received at an Urgent Care Center is **covered**. The following limitations and conditions apply to the use of an Urgent Care Center:

- Use of Urgent Care Centers is appropriate only in those situations where a physician is unable to provide or arrange for the treatment of an illness or injury.
- All follow-up or continued care must be provided by a Participating Provider unless Pre-Authorized, in writing, by us to be covered at the highest level of benefit that this Plan offers.

  Continuing care and follow-up care in Urgent Care Centers is not covered, even if the "Center" is a Participating Provider, except for the removal of stitches, if the same Urgent Care Center used to obtain the stitches is used for their removal.
- Claims for visits to Urgent Care Centers that are Non-Participating Providers must be submitted to us within 180 days of the receipt of care.

  To find out how to file Non-Participating Provider claims in this limited instance, please refer to the "Claims Filing" subsection of the "Claims Filing, Questions And Complaints, And Appeal Process" section of this Membership Agreement.

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

Emergency Room

An Emergency is defined as: "the sudden and unexpected onset of an illness or injury with severe symptoms whereby a Prudent Layperson, acting reasonably, would believe that emergency medical treatment is needed."

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

Determination of whether a condition is an Emergency rests exclusively within our discretionary authority.

Emergency Services rendered both within and outside of the Service Area are **covered at the In-Network Level Of Benefits** as prescribed by State law, whether rendered in a Participating Hospital or Non-Participating Hospital emergency room. In the event of an Emergency, medical assistance should be obtained as soon as possible. It is strongly urged that you seek care:

- From the closest emergency room; or
- From a Participating Hospital emergency room (and if possible you or your representative should contact your Primary Care Provider (PCP) or, for mental health care or alcohol and substance abuse Emergencies, your practitioner or our Behavioral Health Program, at the appropriate telephone number listed in the "Important Telephone Numbers And Addresses" subsection of the "Important Information" section of this Membership Agreement, prior to obtaining care so the PCP, your practitioner or our Behavioral Health Program can be involved in the management of your health care);
- By telephoning 911, if necessary and where this medical response system is available.

Ambulance/Medical Transport Services

Emergency Services

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

Non-Emergency Services

Non-Emergency land ambulance/medical transport services for non-routine care visits will be **covered** as a medical service only when Medically Necessary and with Pre-Authorization if the Member's medical condition is such that any other method of transport would result in injury or would be detrimental to the Member's health as determined by us.

Non-Emergency air ambulance/medical transport will be **covered** as a medical service only when Medically Necessary and with Pre-Authorization if the Member is in-patient at an acute care facility and needs air transportation to another acute care facility because Medically Necessary services are not available in the facility where the patient is confined.

There is no coverage for non-Emergency land or air ambulance/medical transport services if it is for Member convenience.

HOSPITAL SERVICES

This Plan covers the following Medically Necessary services or supplies rendered at Hospitals and other facilities.

Inpatient admissions, except those required due to an Emergency, must be Pre-Certified at least five business days before you or your covered dependents are admitted. When the admission relates to a solid organ transplant or bone marrow transplant, Pre-Certification must be obtained ten business days before any evaluative services are performed.

Semi Private Room And Board

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

Inpatient Hospital Services include:

- Administration of whole blood, blood plasma and derivatives.
- Anesthesia and oxygen services.
- Autologous blood transfusions (self-donated blood) limited to the following procedures: coronary artery bypass graft, heart valve replacement, total hip replacement, bilateral knee replacement, prostatectomy, laminectomy/spinal fusion,

hysterectomy and facial reconstruction.

- ♥ Drugs and biologicals.
- ♥ Intensive care unit and related services.
- ♥ Laboratory, x-ray and other diagnostic tests.
- ♥ Nursing care.
- ♥ Operating room and related facilities.
- ♥ Physician services in the Hospital not billed by physicians.
- ♥ Room and board in a semi-private room.
- ♥ Therapy: cardiac rehabilitation, inhalation, occupational, physical, pulmonary, radiation and speech.

Dental Anesthesia

Medically Necessary anesthesia, nursing and related Hospital services for the treatment of dental conditions are **covered** as prescribed by State law when:

- ♥ The services, supplies or medications are Medically Necessary as determined by the Member's treating dentist or oral surgeon and his or her Primary Care Provider (PCP), and
- ♥ The treatment is Pre-Certified or Pre-Authorized, and
- ♥ The Member has a dental condition of significant dental complexity that requires the dental procedure be performed in a Hospital as determined by a licensed dentist in conjunction with a licensed physician specializing in primary care;

or when:

The Member has a developmental disability that places him or her at serious risk as determined by a licensed physician specializing in primary care.

Medically Necessary anesthesia for the treatment of dental conditions as described in this provision may also be covered in an outpatient setting as long as all these same conditions are met.

Outpatient facility and anesthesia charges (but not practitioner charges) of a provider are covered for a Member who needs to have dental services performed in an outpatient facility because of a serious medical condition that requires close monitoring or treatment during the procedure, when Pre-Authorized by us.

Mastectomy Services

Health Services for a mastectomy or lymph node dissection are **covered**. If the Member is admitted to a Hospital, a minimum of a 48-hour length of stay following the mastectomy or lymph node dissection is covered. A longer stay is covered if recommended by the Member's physician.

If medically appropriate, and with the Member's consent and the attending physician's approval, the Member may select a shorter Hospital length of stay or have services performed in an outpatient facility.

Maternity Services

Inpatient Services

Any female Member who is admitted to a Hospital for delivery 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 as prescribed by State law.

Post Discharge Benefits

If the female Member and her newborn child stay in the Hospital for the 48 or 96-hour length of stay, the following post-discharge home health services will be available:

- ♥ Vaginal Delivery (48-Hour Length of Stay):

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

  One lactation consultant visit at home up to two months after the delivery.

- ♥ Caesarean Delivery (96-Hour Length of Stay):

  One lactation consultant visit at home up to two months after the delivery.

Optional Early Discharge Programs

If medically appropriate, and with the Member's physician's approval, a female Member may select a shorter Hospital length of stay. In these situations, the following home health services will be provided:

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

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

  One lactation consultant visit at home up to two months after the delivery.

Solid Organ Transplants And Bone Marrow Transplants

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

The following organ transplants and bone marrow transplants are covered: cornea, heart, heart-lung, kidney, liver, lung, pancreas, pancreas-kidney, intestinal, and bone marrow transplants.

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 the provisions of this subsection. Except for cornea transplants, all requests for transplants and related services require Pre-Authorization at the time of diagnosis not less than ten business days prior to any evaluative services to determine eligibility for the transplant.

Refer to the "Managed Care Rules And Guidelines" section to see if you have to use Participating Providers and to find out what services require Pre-Authorizations. Also refer to the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

If Pre-Authorization has not been obtained, payment for the transplant and related services, as well as for medical diagnosis and evaluation, will be denied. **Requests for benefits for transplants will be Pre-Authorized only for Participating Providers, or other providers that we have existing contracts with** (or through a subcontractor of ours), or other medical facilities with which we (or a subcontractor of ours) have contracted prior to the request for Pre-Authorization, for a predetermined negotiated rate applicable to us.

There are no benefits available under this Plan when transplants and related services are rendered by a Non-Participating Provider or by a Participating Provider without the required Pre-Authorization.

Medically Necessary expenses of the transplant donor, including Medically Necessary services and tests related to determining compatibility, are **covered after the applicable Cost-Share amount**. The Cost-Share amount depends on where the procedures are rendered. Coverage is only available if the transplant recipient is our Member and the Pre-Authorization for evaluation (described in the above paragraphs) has been obtained. This is true whether or not the donor is our Member.

Transportation, Lodging, And Meal Expenses For Transplants

Expenses for transportation, lodging, and meals for the transplant recipient and his or her companion are **reimbursable up to a maximum of $10,000 per transplant episode.**

A "transplant episode" is the time from the initial evaluation for the transplant until 90 days after the recipient is discharged from the transplant facility or until the recipient is cleared to return home, whichever is sooner.

A transplant facility is a facility as described in the preceding "Solid Organ Transplants And Bone Marrow Transplants" provisions.

If additional transplants occur during the transplant episode, the additional transplants are considered a single transplant episode subject to $10,000 overall benefit limit.

If readmission to the transplant facility is necessary for the transplant recipient within 90 days of the date of discharge, the readmission will be considered part of the same transplant episode and any remainder of the $10,000 benefit not previously used will be available.

The transplant facility must be more than 300 miles from the transplant recipient's home for this reimbursement to apply.

- Transportation costs incurred for travel to and from transplant facility for the transplant recipient and one other individual accompanying the recipient are **covered**.

  If air transportation is chosen, coverage includes round trip transportation for the transplant recipient and one other individual accompanying the recipient **up to two round trips per person**

  If travel occurs via automobile, mileage will be reimbursed based on the federal Internal Revenue Code mileage reimbursement rate at the time the travel was undertaken for **a maximum of one round trip from the transplant recipient's home to the transplant facility**.

- Lodging and meal expenses are **covered up to $150 total per day** for the transplant recipient and the individual accompanying the transplant recipient.

Transportation, lodging, and meal receipts must be submitted to us at the appropriate address listed in the information you receive from us when authorizing this reimbursement.

There is no coverage for the following expenses:

- 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 this provision.
- Expenses over the total per day limits for lodging and meals and the overall $10,000 transplant episode benefit limit.
- Local transportation costs while at the transplant facility.
- Rental car costs.

Ambulatory Services (Outpatient)

Medically Necessary ambulatory services (outpatient), including surgery, radiological diagnostic procedures, podiatric procedures, and diagnostic procedures are **covered**. There may be a Cost-Share that you will be required to pay for Medically Necessary ambulatory surgery or certain radiological diagnostic procedures. Please refer to your Benefit Summary to see the Cost-Share amount you are required to pay, if any, under your Plan.

Some of these services require Pre-Authorization from us. Ambulatory services include procedures performed by a physician on an outpatient basis, whether in a Hospital, at an ambulatory surgery facility, or at a birthing center.

Skilled Nursing And Rehabilitation Facilities

Medically Necessary skilled nursing care provided in: a Skilled Nursing Facility; an acute Rehabilitation Facility; or on a specialized inpatient rehabilitation floor in an acute care Hospital, is **covered as prescribed by State law up to the maximum benefit as shown on the Benefit Summary**.

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 physician. The doctor's order must specify the skills of qualified health

professionals such as registered nurses, physical therapists, occupational therapists, or speech pathologists, etc., required for the Member's care in the facility.

Admissions and continued stay requests will be reviewed utilizing nationally recognized criteria 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.
- Admissions must be Pre-Certified by us.

The benefit maximum does not apply to Hospice care.

MENTAL HEALTH SERVICES

We provide benefits for mental health treatment based on a short-term model, according to accepted psychiatric diagnostic criteria. Mental health services under this Plan are administered under our Behavioral Health Program. Decisions regarding mental health coverage are made by licensed mental health professionals. We may use an outside company to manage and administer that program.

Inpatient Mental Health Services

Medically Necessary inpatient mental Health Services, as defined in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders", rendered in an acute care general Hospital or a Residential Treatment Facility, are **covered** just as they would be for any other illness or injury as described in the "Hospital Services" section of this Membership Agreement as prescribed by State law.

Inpatient Alcohol And Substance Abuse Services

Medically Necessary inpatient services, supplies and medications in connection with medical complications of alcoholism, such as cirrhosis of the liver, gastrointestinal bleeding, pneumonia and delirium tremens, as defined in the most recent edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, are **covered** just as they would be for any other illness or injury as described in the "Hospital Services" section of this Membership Agreement as prescribed by State law.

Outpatient Mental Health And Alcohol And Substance Abuse Treatment

Medically Necessary outpatient services for the diagnosis and treatment of mental illnesses, as defined in the most recent edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders are **covered** just as they would be for any other illness or injury as described in the "Outpatient Services" section of this Membership Agreement as prescribed by State law. The services must be provided by a licensed mental health provider. Benefits also include treatment for alcohol and substance abuse.

Any outpatient treatment for mental health and alcohol and substance abuse services, including office visits, subsequent to an evaluation must be Pre-Authorized.

Please refer to the "Inpatient Mental Health Services" and "Inpatient Alcohol And Substance Abuse" subsections of this section for a description of coverage of inpatient mental health and alcohol and substance abuse services.

There is no coverage for conditions with the following diagnoses:

- Caffeine-related disorders,
- Communication disorders,
- Learning disorders,
- Mental retardation,
- Motor skills disorders,
- Relational disorders,
- Sexual deviation, and
- Other conditions that may be a focus of clinical attention not defined as mental disorders in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders."

OTHER SERVICES

The Plan provides benefits for other Health Services as follows.

Disposable Medical Supplies

Certain disposable medical supplies, which are used in conjunction with covered durable medical equipment or covered medical treatment received in the home, are **covered after the Disposable Supplies Cost-Share is met, and then, at the specified Coinsurance, up to the benefit maximum, if any, as shown on the Benefit Summary**.

Examples of covered disposable medical supplies are BiPAP and CPAP masks. **Not all disposable medical supplies are covered by this Plan**. To find out if an item is covered, the Member should call our Member Services Department at the appropriate telephone number listed in the "Important Telephone Numbers And Addresses" subsection of the "Important Information" section of this Membership Agreement. **Tip: Before calling, ask your doctor for the applicable code for the supply he or she is prescribing. This will help us to determine if the supply is covered.** We have the right to change the list of covered disposable medical supplies from time to time, at our discretion.

The following limitations and conditions apply to the disposable supply benefit:

- To be covered, disposable medical supplies must be

prescribed or ordered by a physician.

Having a prescription or doctor's order from a physician is not a guarantee the disposable medical supplies are covered.

- Disposable medical supplies prescribed or ordered by a physician may be obtained from either a Participating Provider or a Non-Participating Provider. To obtain the disposable supply, the Member must present the prescription or doctor's order from the physician to the provider who is selling the supplies.
- Disposable medical supplies will also be covered if they are dispensed in: (a) a physician's office as part of the physician services; or (b) an emergency room as part of Emergency Services; or (c) an Urgent Care Center as part of Urgent Care. In these cases, the disposable medical supplies will be **covered as part of the Disposable Medical Supplies, Emergency Room or Walk-In/Urgent Care Centers benefit, as applicable**.
- All Medically Necessary disposable medical supplies, when ordered by a physician for the treatment of insulin dependent diabetes, insulin using diabetes, gestational diabetes and non-insulin using diabetes, are **covered** as prescribed by State law.

Benefit Maximum

If this Plan has a disposable medical supply benefit maximum (as shown on the Benefit Summary), that maximum does not apply to disposable medical supplies for the treatment of insulin dependent diabetes, insulin using diabetes, gestational diabetes and non-insulin using diabetes. However, if the Member obtains supplies for the treatment of diabetes as described, they will count towards meeting the benefit maximum.

For example, if this Plan has a $300 benefit maximum for disposable medical supplies and the Member receives $250 worth of covered supplies for the treatment of diabetes, this amount is accumulated toward the $300 benefit maximum and the Member will only be able to obtain benefits for another $50 for any non diabetes related disposable medical supplies in that year. If the $300 benefit maximum is ultimately reached in that year, the Member will still be covered for additional disposable medical supplies for the treatment of diabetes.

This benefit maximum applies to the total disposable medical supplies benefits payable, whether at the In-Network Level Of Benefits or the Out-Of-Network Level Of Benefits.

The benefit maximum does not apply to Hospice care.

Oxygen prescribed by a physician and equipment or supplies for the use of oxygen are not subject to either the durable medical equipment (DME) or disposable medical supplies Cost-Share or maximum benefit provisions.

Durable Medical Equipment (DME) Including Prosthetics

DME, including prosthetics, consists of non-disposable equipment which is primarily used to serve a medical purpose that is generally not useful to a person in the absence of illness or injury and is appropriate for use in the home, including breast prosthetics following a mastectomy.

DME benefits also include DME for the treatment of insulin dependent diabetes, insulin using diabetes, gestational diabetes and non-insulin using diabetes and craniofacial disorders, hearing aids for a Member age 12 and under and wigs for a Member suffering hair loss as a result of chemotherapy or radiation therapy when the wig as prescribed by an oncologist.

Certain DME is **covered after the Durable Medical Equipment (Including Prosthetics) Cost-Share, up to the benefit maximum, if any, as shown on the Benefit Summary**.

Not all DME is covered. To find out if an item is covered, call our Member Services Department at the appropriate telephone number listed in the "Important Telephone Numbers And Addresses" subsection of the "Important Information" section of this Membership Agreement. **Tip: Before calling, ask your doctor for the applicable code for the equipment he or she is prescribing. This will help us to determine if the equipment is covered.** We have the right to change the list of covered DME from time to time, at our discretion.

The following limitations and conditions apply to the DME Benefit:

- Some DME requires Pre-Authorization before it will be covered. The DME that requires Pre-Authorization is listed in the "Services Requiring Pre-Authorization Or Pre-Certification" subsection of the "Managed Care Rules And Guidelines" section of this Membership Agreement.
- To be covered, DME must be: (a) prescribed by a physician; and (b) Pre-Authorized by us (as required); and (c) provided by a DME supplier that is a Participating Provider in order for the DME to be covered at the highest level of benefits under this Plan. However, if the Participating Provider does not carry the covered DME, it may be purchased at a store that is a Non-Participating Provider as long as both (a) and (b), above, are met.

  Having a prescription for DME from a physician is not a guarantee the DME is covered.
- DME will also be covered without Pre-Authorization if it is dispensed in: (a) a physician's office as part of

physician services; (b) an emergency room as part of Emergency Services; or (c) an Urgent Care Center as part of Urgent Care. In these cases, DME will be **covered as part of the DME, Emergency Room or Walk-In/Urgent Care Centers benefit, as applicable**.

- ♥ 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. We 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.
- ♥ To be covered, DME must not duplicate the function of any previously obtained equipment.
- ♥ DME for the treatment of craniofacial disorders is **covered.**
- ♥ DME for the treatment of insulin dependent diabetes, insulin using diabetes, gestational diabetes and non-insulin using diabetes is **covered**.
- ♥ Hearing aids for a Member age 12 and under are covered up to a yearly maximum of $1,000 every 24 months.
- ♥ Wigs prescribed by an oncologist for a Member suffering hair loss as a result of chemotherapy or radiation therapy are **covered without Pre-Authorization up to a yearly maximum of $350**.

There is no coverage for:

- ♥ Hearing aids, except as noted.
- ♥ Medical supplies or equipment that are not considered to be durable medical equipment or disposable medical supplies or that are not on our covered list of such equipment or supplies.
- ♥ Non-durable equipment such as orthopedic or prosthetic shoes, foot orthotics, and prophylactic anti-embolism stockings (jobst stockings) without a history deep vein thrombosis and varicose veins.
- ♥ Wigs, hair prosthetics, scalp hair prosthetics and cranial prosthetics, except as noted.

Benefit Maximum

If this Plan has a DME benefit maximum (as shown on your Benefit Summary), that maximum is separate from the benefit maximum for hearing aids for a Member age 12 and under. This means that if that Member receives coverage for other DME, he or she is still eligible for $1,000 of hearing aid coverage every 24 months. And if the Member receives coverage for a hearing aid, he or she is still eligible for the maximum amount of DME coverage specified on your Benefit Summary for other covered DME.

If this Plan has a DME benefit maximum (as shown on the Benefit Summary), that maximum does not apply to DME for a wig when the wig is required in connection with hair loss suffered as a result of chemotherapy or radiation therapy as well as DME for the treatment of insulin dependent diabetes, insulin using diabetes, gestational diabetes and non-insulin using diabetes and the treatment of craniofacial disorders. However, if the Member obtains a wig when the wig is required in connection with hair loss suffered as a result of chemotherapy or radiation therapy as described, the wig does count towards meeting that benefit maximum, just as DME for the treatment of diabetes or appliances for the treatment of craniofacial disorders as described, count towards meeting that benefit maximum.

For example, if this Plan has a $1,500 benefit maximum for DME and the Member receives $500 worth of covered equipment for the treatment of diabetes, $250 worth of appliances for the treatment of craniofacial disorders, and $250 for a wig when the wig is required in connection with hair loss suffered as a result of chemotherapy or radiation therapy these amounts are accumulated toward the $1,500 benefit maximum and the Member will only be able to obtain benefits for another $500 for any non diabetes, non craniofacial disorders or non wig related DME in that year. If the $1,500 benefit maximum is ultimately reached in that year, the Member will still be covered for additional DME for the treatment of diabetes, craniofacial disorders, and a wig when the wig is required in connection with hair loss suffered as a result of chemotherapy or radiation therapy.

This benefit maximum applies to the total DME benefits payable, whether at the In-Network Level Of Benefits or the Out-Of-Network Level Of Benefits.

The benefit maximum does not apply to Hospice care.

Oxygen prescribed by a physician and equipment or supplies for the use of oxygen are not subject to either the durable medical equipment (DME) or disposable medical supplies Cost-Share or maximum benefit provisions.

Ostomy Supplies And Equipment

Medically Necessary disposable medical supplies and durable medical equipment for ostomy care following surgery are **covered up to $1,000 per year** as prescribed by State law. Examples of covered ostomy supplies and equipment include collection devices, irrigation equipment and supplies, skin barriers and skin protectors.

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

- ♥ In order to be covered, ostomy supplies and equipment must be prescribed or ordered by a physician as a result of surgery.
- ♥ Ostomy supplies or equipment prescribed or ordered by a physician may be obtained from either a Participating Provider or a Non-Participating Provider. To obtain the supply or equipment, the Member must present the prescription or doctor's order from the physician to the provider who is

selling the supply or equipment.

- Ostomy supplies or equipment will also be covered if they are dispensed in: (a) a physician's office as part of the physician services; or (b) an emergency room as part of Emergency Services; or (c) an Urgent Care Center as part of Urgent Care. In these cases, the ostomy supplies and equipment will be **covered as part of the Outpatient Services, Emergency Room or Walk-In/Urgent Care Centers benefit, as an applicable benefit**.

Benefit Maximum

If this Plan has a disposable medical supply or durable medical equipment (DME) benefit maximum (as shown on the Benefit Summary), that maximum does not apply to supplies or equipment related to ostomy surgery. In addition, if the Member obtains supplies or equipment related to ostomy surgery, they **DO NOT** count towards meeting that benefit maximum.

For example, if this Plan has a $300 benefit maximum for disposable medical supplies and the Member receives $250 worth of covered supplies related to ostomy surgery, that amount **DOES NOT** accumulate toward the $300 benefit maximum and the Member will still be able to obtain benefits for $300 for other covered disposable medical supplies in that year. And if the $300 benefit maximum is ultimately reached in that year, the Member will still be covered for disposable medical supplies related to ostomy surgery, up to $1,000 in that year.

The benefit maximum applies to the total disposable medical supplies related to ostomy surgery benefits, whether at the In-Network Level Of Benefits or the Out-Of-Network Level Of Benefits.

The benefit maximum does not apply to Hospice care.

Home Health Services

Medically Necessary home health services, as described below, must be provided by a Home Health Agency and Pre-Authorized. Home health services are **covered as prescribed by State law up to the maximum benefit as shown on the Benefit Summary**, if:

- We determine that Hospitalization or admission to a Skilled Nursing Facility would otherwise be required; or,
- The Member is diagnosed as terminally ill and his or her life expectancy is six months or less; or
- A plan of home health care is ordered by a physician and approved by us.

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

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

Custodial Care, convalescent care, domiciliary care and rest home care are not home health services benefits under this Plan.

The benefit maximum does not apply to Hospice care.

ADDITIONAL SERVICES

Cancer Clinical Trials

Certain routine care for a Member who is a patient in certain cancer clinical trials is **covered** as prescribed by State law just as routine care would be covered under this Plan if the Member was not involved in a cancer clinical trial. All of the terms and conditions of your Membership Agreement apply to these benefits in addition to the following.

In order for the Member to be eligible for coverage, the trial must be conducted under an independent peer-reviewed protocol approved by one of the National Institutes of Health, a National Cancer Institute affiliated cooperative group, the federal Food and Drug Administration (FDA) as part of an investigational new medication or device exemption, or the federal Department of Defense or Veterans Affairs.

The Connecticut Insurance Department has issued a standardized form for use when asking us to cover routine care costs in a clinical trial. When we receive this form we will approve or deny coverage within five business days of receipt of the materials reasonably needed to review the request, except that we may take ten business days when we use an independent expert to review the request. Requests for Phase III preventive trials will be approved or denied within 14 business days. Denials are subject to the State of Connecticut utilization review external Appeal program as described in the "Appeal Process" subsection of the "Claims Filing, Questions And Complaints, And Appeal Process" section of this Membership Agreement.

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

- Evidence that the Member meets all of the selection criteria for the trial, including clinical or pre-clinical data that shows that the trial is likely to benefit the Member commensurate with the trial's risks;
- Evidence that the Member has given appropriate informed consent to the trial;
- Copies of any medical records, protocols, test results or other clinical information used to enroll the Member in the trial;
- A summary of how the anticipated 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 someone else, including the entity sponsoring the trial; and

- ♥ Any other information we may reasonably need to review the request.

If we need any additional information to determine coverage, we will request it within five business days of receiving a request for clinical trial coverage. We will not cover routine costs that are eligible for reimbursement by another entity.

There is no coverage for the following:

- ♥ The cost of Experimental Or Investigational medications or devices not approved for sale by the FDA;
- ♥ Costs for non-Health Services;
- ♥ Facility, ancillary, professional services and medication costs paid for by grants or funding for the trial;
- ♥ Costs that are inconsistent with widely accepted and established regional or national standards of care for a particular diagnosis, or costs for services that are performed specifically to meet the requirements of the trial;
- ♥ Costs that would not be covered by your Plan for a non-Experimental Or Investigational treatment; and
- ♥ Transportation, lodging, food or other travel expenses for the Member or any family member or companion of the Member.

Coverage includes Hospitalization at a Non-Participating Hospital, if the treatment is not available at a Participating Hospital and is not paid for by the clinical trial sponsor. Payments made to a Non-Participating Hospital for cancer clinical trials will be available at no greater cost to the Member than if the treatment was provided at a Participating Hospital.

Cardiac Rehabilitation

Phase I cardiac rehabilitation is **covered** as part of the "Semi Private Room And Board", provisions of the "Hospital Services" subsection.

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

Phase III cardiac rehabilitation is only available for Members who meet the criteria for enrollment into our HeartCare health management program and when the rehabilitation program is approved by us. Cardiac rehabilitation is not covered for Phase IV.

Corneal Pachymetry

Corneal pachymetry (measurement of the thickness of the cornea) is **covered after the applicable Cost-Share amount**. The Cost-Share amount depends on where the test is rendered. Coverage is available for **one complete test per lifetime without Pre-Authorization**. Repeat corneal pachymetry tests require Pre-Authorization.

Genetic Testing

Certain genetic testing is **covered after the applicable Cost-Share amount** when a Member has or is suspected of having a clinical genetic disorder and when Pre-Authorized. The Cost-Share amount depends on where the test is rendered. Coverage will be available in the following circumstances **AND** when the result of the genetic testing will impact the Member's treatment:

1. When the Member has obtained genetic counseling and an appropriate evaluation consisting of a complete history, physical examination, conventional diagnostic studies and pedigree analysis and there remains the possibility of a genetic diagnosis.
2. For a Member who is at risk of inheriting or transmitting a genetic disorder, including but not limited to the following disorders:
   - ♥ Hereditary non-polyposis colorectal cancer (HNPCC)
   - ♥ Familial adenosis polyposis (FAP)
   - ♥ Cystic fibrosis (CF) - Pre-Authorization is NOT required
   - ♥ Hereditary Breast and Ovarian Cancer Syndrome (BRCA)
   - ♥ Medullary thyroid cancer and multiple endocrine neoplasia type 2, MEN2 (RET)
3. To guide medication therapy for the treatment of lymphoma, leukemia, and inflammatory bowel disease.
4. For prenatal genetic testing associated with chorionic villus sampling and/or amniocentesis - **Pre-Authorization is required ONLY for prenatal genetic testing for DNA diagnosis.**
5. Some pre-implantation genetic testing in the setting of a in-vitro fertilization (IVF), gamete intra-fallopian transfer (GIFT), zygote intra-fallopian transfer (ZIFT) and low tubal ovum transfer procedures that are covered by this Plan. Please see the "Infertility Services" subsection for more information.

Health Management Programs

Health management programs are designed to help the Member stay in control of his or her chronic health conditions, so that the Member can maintain his or her functional status and quality of life.

Members in this Plan may be eligible to enroll in one or more of our health management programs. In addition, Members may be contacted and managed by our High Risk Member Outreach Program.

Depending on the programs that are available at that time, a Member may receive items or services (e.g., educational mailings or visits; nicotine replacement therapy (NRT); pillboxes; special medical equipment such as a blood pressure monitor/cuff, a peak flow meter, a glucose monitor or a scale to assist during convalescence or to monitor a special medical condition) as value added services or covered

benefits in our discretion. When these items are covered benefits, they will not be subject to standard claim processing and Cost-Sharing rules. If you are enrolled in one of our high deductible health Plans, the health management program items or services that are covered benefits are subject to the Plan Deductible. However, those items or services may not to be subject to the other Cost Share amounts that do apply after the Plan Deductible is satisfied. Please refer to your Benefit Summary to see if your Plan is one of our high deductible health Plans and to find out which Cost-Shares apply to your Plan after the Plan Deductible is met.

Please call our Member Services Department at the appropriate telephone number listed in the "Important Telephone Numbers And Addresses" subsection of the "Important Information" section of this Membership Agreement to find out more about our current health management programs.

Hospice Care

Hospice care is **covered** if the Member has a life expectancy of six months or less and if the care is Pre-Authorized or Pre-Certified by us. The Member's physician must contact us to arrange Hospice care.

Hospice care does not apply to any specific benefit maximums your Plan may have.

Other Outpatient Services

Autism Services

Medically Necessary diagnosis and treatment of Autism Spectrum Disorders (ASDs), identified and ordered in accordance with a treatment plan developed by a licensed physician, psychologist or clinical social worker pursuant to a comprehensive evaluation are **covered** as prescribed by State law as follows.

- Behavioral Therapy for children up until their 15th birthday, when provided or supervised by a behavioral analyst who is certified by the Behavioral Analyst Certification Board, or a licensed physician, or a licensed psychologist.
  - **The annual benefit limit for Behavioral Therapy for a child who is less than nine years old is $50,000.**
  - **The annual benefit limit for Behavioral Therapy for a child who is at least nine but less than 13 years old is $35,000**.
  - **The annual benefit limit for Behavioral Therapy for a child who is at least 13 but less than 15 years old is $25,000**.
- Direct psychiatric or psychological services and consultations provided by a licensed psychiatrist or 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 in your Benefit Summary.

- Prescription drugs when prescribed by a physician, physician's assistant or advanced practice registered nurse for the treatment of symptoms and comorbidities of ASD, as covered. under our *Prescription Drug Rider*.

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

Birth To Three Program (Early Intervention Services)

Early intervention services consist of care as part of an Individualized Family Service Plan as prescribed by State law and are available for a Member from birth until the child's third birthday. These services are **covered as provided by the Connecticut Early Intervention Services program up to the amount as required by Connecticut State law after the applicable Cost Share amount**. The Cost-Share amount depends on where the procedures are rendered. This benefit amount does not apply to the application of any maximum lifetime or annual limits described in this Membership Agreement.

Casts And Dressing Application

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

Craniofacial Disorders

Medically Necessary orthodontic treatment and appliances for the treatment of craniofacial disorders are **covered** for Members age 18 and younger as prescribed by State law, if the treatment and appliances are prescribed by a craniofacial team recognized by the American Cleft Palate-Craniofacial Association and if Pre-Authorized by us. The Cost-Share amount depends on where the procedures are rendered.

Orthodontic appliances will be **covered** as described in the "Durable Medical Equipment (DME) Including Prosthetics" subsection of the "Benefits" section.

Diabetes Services

All Medically Necessary laboratory and diagnostic tests for diabetes and all Medically Necessary services, supplies, equipment and prescription drugs when ordered by a physician for the treatment of insulin dependent diabetes, insulin using diabetes, gestational diabetes and non-insulin using diabetes (including treatment for routine foot care) are **covered** as prescribed by State law. The Cost-Share amount depends on where the procedures are rendered.

Education

Outpatient self-management training for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and non-insulin using diabetes if the training is prescribed by a licensed health care professional is **covered**. The training must be provided by a certified, registered or

licensed health care professional trained in the care and management of diabetes. The Cost-Share amount depends on where the training is rendered.

Benefits will cover:

- Up to ten hours of initial training for a Member who is initially diagnosed with diabetes for the care and management of diabetes, including, but not limited to, counseling in nutrition and proper use of equipment and supplies for the treatment of diabetes; and
- Up to four hours for Medically Necessary training and education as a result of a subsequent diagnosis by a physician of a significant change in the Member's symptoms or condition that requires modification of his or her program of self-management of diabetes; and
- Up to four hours for Medically Necessary training and education as a result of the development of new techniques and treatment for diabetes.

Prescription Drugs And Supplies

If this Plan includes our ***Prescription Drug Rider*** and a Member obtains prescription drugs and supplies for the treatment of diabetes, including insulin, syringes, needles, testing agents and lancets from a Participating Pharmacy, the rules of the Rider, including its Cost-Share provisions apply. If a Member obtains these same supplies for the treatment of diabetes from some other supplier that is not a Participating Pharmacy, the supplies are covered as described in the "Disposable Medical Supplies" and "Durable Medical Equipment (Including Prosthetics)" subsections of the "Benefits" section of this Membership Agreement.

If this Plan **DOES NOT** include our ***Prescription Drug Rider***, then those diabetes medications and supplies:

- Must be obtained from a Participating Pharmacy.
- Require the following Copayments for a 30-day supply:

  $10 for Tier 1 drugs

  $20 for Tier 2 drugs

  $35 for Tier 3 drugs

  $40 for Tier 4 drugs
- May be obtained from our designated mail order program. In this case, if a 90-day supply is covered, **only two times the Copayments listed above is charged**.

Participating Pharmacies have information about Brand Name Drugs and Supplies with Generic Equivalents that are required to be substituted. We have the right to change the medications or supplies that are required to be substituted in our discretion.

A Member will only be dispensed a Generic Equivalent drug or supply when a Generic Equivalent drug or supply is required, unless the prescribing physician has indicated on the prescription drug order that there should be no substitution, or unless a Member requires that there be no substitution.

If a Member obtains a Brand Name Drug Or Supply when a Generic Equivalent is available, he or she will be responsible to pay the applicable Copayment for the corresponding Generic Brand Name Drug Or Supply in addition to the difference between the Generic Equivalent drug or supply price and the Brand Name Drug Or Supply that you obtained.

We may require the Member's treating physician to furnish us 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.

Upon approval of any newly approved federal Food and Drug Administration (FDA) medications, we have the right to implement Pre-Authorization criteria and to set quantity limits to promote appropriate use and to avoid abuse.

Prescription drugs administered by injection, which are not obtained from a physician or from a Home Health Agency, are not covered Health Services, unless this Plan includes our ***Prescription Drug Rider***. In that case, these prescription drugs are subject to rules of the Rider.

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.

GENERIC DRUG OR SUPPLY (GENERICS)
A drug or supply manufactured and approved by federal FDA standards that has the same active ingredients as the original Brand Name Drug Or Supply and is classified as a generic by a nationally recognized source and recognized by us 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 we require be substituted for a Brand Name Drug Or Supply. Not all Brand Name Drugs with Generic Equivalents are required to be substituted.

Drug Ingestion Treatment (Accidental)

Services needed to treat the accidental ingestion or consumption of a controlled drug are **covered** as prescribed by State law. The Cost-Share amount depends on where the procedures are rendered.

Eye Care

Diseases And Abnormal Conditions Of The Eye

Medically Necessary medical and surgical diagnosis and treatment of diseases or other abnormal conditions of the eye and adjacent structures are **covered after the applicable Cost-Share amount**. The Cost-Share amount depends on where the services or care are rendered. This includes annual

retinal eye exams for Members with an existing condition of the eye, such as glaucoma or diabetic retinopathy.

Hospital Care

Visits a physician makes to examine or treat a Member who is hospitalized are **covered**. Please refer to the "Hospital Services" subsection of this section to learn more about coverage for other Hospital Services.

Infertility Services

Benefits

The following Medically Necessary diagnostic and testing procedures and therapy needed to treat diagnosed Infertility are **covered at the applicable Cost-Share amounts as shown on the Benefit Summary, up to the policy limits described below** if Pre-Authorized by us for a Member up to his or her 40th birthday.

- ♥ Ovulation induction (to a maximum of four cycles without regard to the reasons for the ovulation induction).
- ♥ Intrauterine insemination (to a maximum of three cycles per recipient, regardless of source, where one cycle is defined as one intrauterine insemination (IUI) within a 30 day period).
- ♥ 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 not more than two embryo implantations per cycle). These cycles are only covered when the Member has been unable to conceive or produce conception or sustain a successful pregnancy through the less expensive and medically appropriate treatments covered by this Plan.

  A particular Infertility treatment or procedure 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 Pre-Authorized, as part of a Pre-Authorized 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 also require Pre-Authorization.

  These drugs or medications are only available for the gender indicated by the federal Food and Drug Administration (FDA) and must be covered under our ***Prescription Drug Rider***.

  If the Member's Plan **DOES NOT** include our ***Prescription Drug Rider***, then those drugs prescribed for Infertility will be **covered at 50% Coinsurance based on what we would pay for the drug when they are obtained at a Participating Pharmacy.**

Guidelines

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

1. For certain Infertility services a Member must be treated by a Board Eligible or Board Certified Reproductive Endocrinologist at a facility that conforms to the standards and guidelines of the American Society of Reproductive Medicine or the Society of Reproductive Endocrinology and Infertility after he or she has obtained an evaluation from the OB-GYN or PCP.

   If you are enrolled in either our ***HMO Personal Care Plan*** or our ***POS Personal Care Plan*** (a plan that requires Referrals), then services will not be covered, unless you obtain a Referral from your OB-GYN or PCP to the Board Eligible or Board Certified Reproductive Endocrinologist as noted above.
2. All services must be provided by the providers noted above in order to be covered. If you are enrolled in one of our ***HMO Plans*** (a plan that requires you use Participating Providers), then you must use Participating Providers.

   In addition, oral medications needed to treat Infertility may be prescribed by your OB-GYN.

There is no coverage for:

- ♥ Cryopreservation (freezing) or banking of eggs, embryos, or sperm.
- ♥ Genetic analysis and testing, except as described above or in the "Genetic Testing" subsection of the "Benefits" section.
- ♥ Medications for sexual dysfunction, unless your Plan includes our ***Supplemental Sexual Dysfunction Prescription Drug Rider***.
- ♥ Recruitment, selection and screening and any other expenses of donors (donors of eggs, embryos and sperm).
- ♥ Reversal of surgical sterilization.
- ♥ Surrogacy and all charges associated with surrogacy.

There may be instances where Infertility benefits will not be covered where the Employer is a "religious employer" as defined in 26 USC 3121 or a church-affiliated organization. When this occurs there will be a statement on your Benefit Summary.

Lyme Disease Services

Treatment of lyme disease is **covered** as prescribed by State law as follows:

- ♥ Up to a maximum of 30 days of intravenous antibiotic therapy or 60 days of oral antibiotic therapy (or both); and

- ♥ Further antibiotic treatment if it is recommended by a board certified rheumatologist, infectious disease specialist, or neurologist.

These antibiotic drugs will be covered under the Membership Agreement, subject to the Cost-Shares listed in the "Prescription Drugs" section of the Benefit Summary.

If the Member's Benefit Summary **DOES NOT** include Cost-Shares for prescription drugs, then those antibiotic drugs prescribed for lyme disease will be covered as described in the "Prescription Drugs And Supplies" provision of the "Diabetes Services" subsection.

Neuropsychological Testing

Psychological, neuropsychological, and neurobehavioral testing are **covered** as prescribed by State law. Pre-Authorization is required, **EXCEPT** for neuropsychological testing ordered by a physician to assess the extent of any cognitive or developmental delays due to chemotherapy or radiation treatment in a child diagnosed with cancer.

Nutritional Counseling

Nutritional counseling services are limited to **two visits per Member per calendar year** and 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 in a physician's office or outpatient facility.

Nutritional Supplements And Food Products

Enteral Or Intravenous Nutritional Therapy

Enteral (tube feeding) or intravenous nutritional products are **covered** when ordered by a physician, if they are needed due to a medical illness or injury, are to be used for the total caloric needs of the Member, and with Pre-Authorization from us.

Oral nutritional products (except for Modified Food Products For Inherited Metabolic Diseases and Other Specialized Formulas) that are specially modified to permit absorption of nutrients through an abnormal gastrointestinal tract are **covered** when:

- ♥ Ordered by a physician;
- ♥ They are needed due to a gastrointestinal illness or injury preventing the normal absorption of nutrients;
- ♥ They are to be used for the total caloric needs of a Member; and
- ♥ With Pre-Authorization from us.

Modified Food Products For Inherited Metabolic Diseases

Modified food products (low protein) and amino acid modified preparations are **covered** as prescribed by State law for the treatment of the following inherited metabolic diseases: cystic fibrosis, phenylketonuria (for which newborn screening is required), hypothyroidism, galactosemia, sickle cell disease, maple syrup urine disease, homocystinuria, congenital adrenal hyperplasia, biotinidase deficiency, and other such tests for inborn errors of metabolism as shall be described by the Department of Public Health. The modified food products (low protein) and amino acid preparations must be ordered for the therapeutic treatment of those inherited metabolic diseases by a physician and administered under his or her direction.

Benefits will be paid at 100% for these modified food products, even if your Plan requires you to meet a Deductible before benefits will be paid and you have not yet met that Deductible amount. If you are enrolled in one of our *HMO or POS High Deductible Health Plans (HDHP)*, this benefit is subject to your Deductible before benefits will be covered at 100%.

Other Specialized Formulas

Specialized formulas are **covered** as prescribed by State law if Pre-Authorized by us, for a Member up to their twelfth birthday when the formula is exempt from 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 physician and administered under his or her direction. For a specialized formula to be Medically Necessary, among other requirements, other feeding options must have been tried and failed.

Benefits will be paid at 100% for these other specialized formulas, even if your Plan requires you to meet a Deductible before benefits will be paid and you have not yet met that Deductible amount. If you are enrolled in one of our *HMO or POS High Deductible Health Plans (HDHP)*, this benefit is subject to your Deductible before benefits will be covered at 100%.

No other nutritional supplement, food supplement, infant formula, enteral nutritional therapy, or specialized formula are covered.

Pain Management Services

Medically Necessary pain management services provided by a physician (including evaluation and therapy) for acute or chronic pain conditions are **covered after the applicable Cost-Share amount**. The Cost-Share amount depends on where the procedures are rendered.

Prescription Drugs

Depending on the option chosen, prescription drug benefits may be available under this Plan. There is no coverage under this Plan for prescription drug benefits unless the Member also has our ***Prescription Drug Rider*** as part of this Plan. Please refer to the rules of the Rider, if any, and your Benefit Summary for specific coverage details.

Refer to the "Managed Care Rules And Guidelines" section to see if you have to use Participating Providers and to find out what services require Pre-Authorizations. Also refer to the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

There are exceptions where we will provide coverage for certain medications (insulin and some other injectables), even without the Rider. These exceptions are described in other sections of this Agreement. For example, prescription drugs for diabetes are covered as prescribed by State law even if you do not have our *Prescription Drug Rider*. See the "Diabetes Services" provisions under the "Other Outpatient Services" subsection of this section of this Membership Agreement.

Generally, when prescription drugs and supplies are covered under this Plan, they are placed in a tiered system of categories that tell the Member what his or her Cost-Share amount will be for that medication or supply. We want the Member to know that the medications or supplies in those categories can change, even in the middle of the year. The Member should call our Member Services Department at the appropriate telephone number listed in the "Important Telephone Numbers And Addresses" subsection of the "Important Information" section of this Membership Agreement to find out which tier (if any) a prescription drug or supply is in.

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

Specialty Drugs:

Certain specialty prescription drugs require Pre-Authorization and must be filled through specialty pharmacies. These drugs consist of biotechnology drugs that require special handling, a higher level of pharmacy expertise, increased patient knowledge to administer and are not needed immediately for acute conditions, and traditionally are not stocked by retail pharmacies. When your physician contacts us for Pre-Authorization of the drug, he or she will be notified of the number to call to contact the specialty pharmacy if Pre-Authorization is granted. Specialty prescription drugs, when Pre-Authorized by us, will be dispensed for a maximum of 30-days supply per fill. You may also obtain the contact information for the specialty pharmacy by calling Member Services directly at the appropriate telephone number listed in the "Important Telephone Numbers And Addresses" subsection of the "Important Information" section. The drugs will be shipped to your doctor's office, your home, or other location based on the type of drug or treatment. Specialized counseling and education is available to you from the specialty pharmacies regarding proper administration, storage, dosage, drug interactions, and side effects of these specialty drugs.

The specialty drugs affected are as follows:

Growth Hormone including:
- Accretropin
- Genotropin
- Humatrope
- Increlex
- Norditropin
- Nutropin
- Nutropin AQ
- Saizen
- Serostim
- TevTropin

Blood Clotting Factors including:
- Benefix
- Humate P
- Kogenate FS
- Monarc M
- NovoSeven
- Recombinate
- Xyntha

Hepatitis C Treatments including:
- Copegus
- Infergen
- Peg Intron
- Pegasys
- Rebetol
- Rebetron
- Ribavirin

LHRH Agonists including;
- Eligard
- Lupron
- Trelstar
- Viadur
- Vantas
- Zoladex

Multiple Sclerosis Treatments including:
- Avonex
- Betaseron
- Copaxone
- Rebif
- Tysabri

Other Drugs including:
- Acthar
- Actimmune
- Apokyn
- Aralast
- Botox (botulinium toxin type A)
- Cerezyme
- Fabrazyme
- IVIG (Immuneglobulin)
- Prolastin
- Soliris
- Synagis
- Thyrogen
- Xolair
- Zemaira

Oral Oncology Agents Including:
- Gleevec
- Nexavar
- Revlimid
- Sprycel
- Sutent
- Tarceva

Refer to the "Managed Care Rules And Guidelines" section to see if you have to use Participating Providers and to find out what services require Pre-Authorizations. Also refer to the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

Tasigna
Temodar
Thalomid
Torisel
Tykerb
Xeloda
Zolinza

Psoriasis/Rheumatoid Arthritis/Crohn's Disease Treatments including:

Amivive
Cimzia
Enbrel
Humira
Orencia
Remicade
Rituxan RA
Simponi

Pulmonary Hypertension Drugs including:

Flolan
Letairis
Remodulin
Tracleer
Ventavis

Infertility Drugs including:

Bravelle
Chorionic Gonadotropin (HCG)
Follistim AQ
Ganirelix
Gonal-F
Menopur
Novarel
Ovidrel
Repronex

Viscosupplements including:

Euflexxa
Hyalgan
Orthovisc
Supartz
Synvisc

This list may change at any time. When the list does change, you will be notified in our member newsletter. You should call our Member Services Department at the appropriate telephone number listed in the "Important Telephone Numbers And Addresses" subsection of the "Important Information" section (or visit us at our web site at www.connecticare.com) to find out if a prescription drug must be filled through a specific vendor and where you can have the prescription filled. We have the right to change the drugs on the list in our discretion.

Renal Dialysis

Renal dialysis for the treatment of kidney disease is **covered**.

In addition, if you are enrolled in one of our ***HMO Plans***, renal dialysis for the treatment of kidney disease will also be **covered up to six renal dialysis treatments per year** if Pre-Authorized by us and if the treatment is rendered to a Member by a Non-Participating Provider while he or she is out of the Service Area for one week or more.

To find out how to file Non-Participating Provider claims in this limited instance, please refer to the "Claims Filing" subsection of the "Claims Filing, Questions And Complaints, And Appeal Process" section of this Membership Agreement.

If you are enrolled in one of our ***POS Plans***, renal dialysis is always **covered** at the Out-Of-Network Level Of Benefits.

Sleep Studies

Sleep studies are **covered after the applicable Cost-Share amount**. The Cost-Share amount depends on where the procedures are rendered. Coverage is available for **one complete study per lifetime** when provided by a practitioner at a sleep facility that is accredited by the American Academy of Sleep Medicine (AASM). A complete sleep study may include more than one session at a sleep study center.

Wound Care Supplies

Medically Necessary wound care supplies administered under the direction of a physician for the treatment of epidermolysis bullosa are **covered** as required by State law with Pre-Authorization from us.

Benefits will be **covered after the applicable Cost-Share amount**. The Cost-Share amount depends on where the supplies are obtained.

Surgery And Other Care Related To Surgery

Medically Necessary surgery provided by a physician is **covered after the applicable Cost-Share amount**. The Cost-Share amount depends on where the procedures are rendered. Some surgical procedures require Pre-Authorization from us first. The surgical procedures that require Pre-Authorization are listed in the "Services Requiring Pre-Authorization Or Pre-Certification" subsection of the "Managed Care Rules And Guidelines" section of this Membership Agreement.

Anesthesia Services

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

Breast Implants

The surgical removal of any breast implant which was implanted on or before July 1, 1994, without regard to the purpose of the implantation, is **covered** as prescribed by State law. The services must be provided by a physician. The surgical implantation of a prosthetic device required in connection with the surgical removal of a breast due to a tumor is also **covered**.

Refer to the "Managed Care Rules And Guidelines" section to see if you have to use Participating Providers and to find out what services require Pre-Authorizations. Also refer to the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

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 physician are **covered**. Oral surgery requires Pre-Authorization.

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 physician and when Pre-Authorized is **covered** as prescribed by State law.

- ♥ Procedures to correct a serious disfigurement or deformity resulting from: (a) illness or injury, or (b) surgical removal of tumor, or (c) treatment of leukemia.
- ♥ Medically Necessary reconstructive surgery for the correction of a congenital anomaly restoring physical or mechanical function to that part of the Member's body.

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

Sterilization

Sterilization services provided by a physician are **covered after the applicable Cost-Share amount**. The Cost-Share amount depends on where the procedures are rendered.

EXCLUSIONS AND LIMITATIONS

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

1. Abdominoplasty, lipectomy and panniculectomy.
2. All assistive communication devices.
3. Any treatment for which there is Insufficient Evidence Of Therapeutic Value for the use for which it is being prescribed is not covered.
4. Any treatment or services related to the provision of a non-covered benefit, including educational and administrative services related to the use or administration of a non-covered benefit, as well as evaluations and medical complications resulting from receiving services that are not covered ("Related Services"), unless **both** of these 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
   - ♥ The Related Services would be a Health Service if non-covered benefit were covered by the Plan.
5. Attorney fees.
6. Benefits for services rendered before the Member's effective date under this Plan and after the Plan has been rescinded, suspended, canceled, or interrupted or terminated, except as otherwise required by applicable law.
7. Blood donation expenses incurred by the Member's relatives or friends for their blood donated for use by the Member. Also, whole blood, blood plasma, and other blood derivatives and donor services, which are provided by the Red Cross and cord blood retrieval or storage.
8. Cancer clinical trial services as follows:
   - ♥ The cost of Experimental Or Investigational medications or devices not approved for sale by the FDA;
   - ♥ Costs for non-Health Services;
   - ♥ Facility, ancillary, professional services and medication costs paid for by grants or funding for the trial;
   - ♥ Costs that are inconsistent with widely accepted and established regional or national standards of care for a particular diagnosis, or costs for services that are performed specifically to meet the requirements of the trial;
   - ♥ Costs that would not be covered by your Plan for a non-Experimental Or Investigational treatment; and
   - ♥ Transportation, lodging, food or other travel expenses for the Member or any family member or companion of the Member.
9. Cardiac rehabilitation for Phase III, unless the Member meets the criteria for enrollment into our HeartCare health management program, is being actively case managed and the rehabilitation is approved by us. Phase III Cardiac Rehabilitation may be covered as part of a health management program value-added service or benefit. Phase IV cardiac rehabilitation is always excluded.
10. Care, treatment, services or supplies to the extent the Member has obtained benefits under any applicable law, government program, public or private grant, or for

which there would be no charge to the Member in the absence of this Plan, except where benefits are obtained in a Veteran's Home or Hospital for a non service connected disability or as required by applicable law. However, care treatment or services that are otherwise Medically Necessary and provided in a Veteran's Hospital are covered.

11. Conditions with the following diagnoses:
    - ♥ Caffeine-related disorders,
    - ♥ Communication disorders,
    - ♥ Learning disorders,
    - ♥ Mental retardation,
    - ♥ Motor skills disorders,
    - ♥ Relational disorders,
    - ♥ Sexual deviation, and
    - ♥ Other conditions that may be a focus of clinical attention not defined as mental disorders in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders".
12. Cosmetic Treatments and procedures, including, but not limited to:
    - ♥ Any medical or Hospital services related to Cosmetic Treatments or procedures,
    - ♥ Benign nevus or any benign skin lesion removal (except when the nevus or skin lesion causes significant impairment of physical or mechanical function,
    - ♥ Benign seborrhic keratosis,
    - ♥ 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" and "Durable Medical Equipment (DME) Including Prosthetics" subsections of the "Benefits" section or as otherwise required by applicable law),
    - ♥ Dermabrasion,
    - ♥ Excision of loose or redundant skin and/or fat after the Member has had a substantial weight loss,
    - ♥ Liposuction,
    - ♥ Otoplasty,
    - ♥ Reduction mammoplasty for Members under age 18 (except or as described in the "Reconstructive Surgery" and "Durable Medical Equipment (DME) Including Prosthetics" subsections of the "Benefits" section or as otherwise required by applicable law);
    - ♥ Scar revision following surgery or injury (except when the scar causes significant impairment of physical or mechanical function),
    - ♥ Septoplasty, septorhinoplasty, and rhinoplasty, unless necessary to alleviate a significant nasal obstruction,
    - ♥ Skin tag removal,
    - ♥ Spider vein removal (including sclerotherapy),
    - ♥ Tattoo removal,
    - ♥ Treatment of craniofacial disorders, except as otherwise described in the "Craniofacial Disorders" subsection of the "Benefits" section, and
    - ♥ Vascular birthmark removal (except when the vascular birthmark causes significant impairment of physical or mechanical function).
13. Custodial Care, convalescent care, domiciliary care, and rest home care. Also care provided by home health aides that is not patient care of a medical or therapeutic nature or care provided by non-licensed professionals.
14. Dental services, including but not limited to:
    - ♥ Anesthesia, except as otherwise required by State law,
    - ♥ Bite appliances or night guards,
    - ♥ Bone grafts,
    - ♥ Correction of congenital malformation, including genial, mandibular or maxillary osteotomies; and vestibuloplasty,
    - ♥ Correction of oral malocclusion,
    - ♥ Crowns,
    - ♥ Dental implants,
    - ♥ Prosthetic devices, except as otherwise provided herein,
    - ♥ Repair, restoration or re-implantation of teeth following an injury, and
    - ♥ Tooth extractions, including impacted teeth
15. Education services, including testing, training, rehabilitative for educational purposes and screening and treatment associated with learning disabilities and special education and related services, unless covered under the "Autism Services" or "Birth To Three Program (Early Intervention Services)" subsections of the "Benefits" section.
16. Experimental Or Investigational treatment.
17. Family planning services, including but not limited to:
    - ♥ Contraceptive drugs and devices, except to the extent applicable insurance law requires coverage for these items. When they are covered, they are covered under our ***Prescription Drug Rider***. If you do not have our ***Prescription Drug Rider*** as part of this Plan, there is no coverage for contraceptive drugs and devices,
    - ♥ Home births (except that complications of home births shall be covered),
    - ♥ Infertility services not specifically covered under the

Refer to the "Managed Care Rules And Guidelines" section to see if you have to use Participating Providers and to find out what services require Pre-Authorizations. Also refer to the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

"Infertility Services" subsection of the "Benefits" section or our ***Prescription Drug Rider, if applicable,*** and/or our ***Amendatory Rider for Massachusetts Mandated Benefits, if you are a resident of the state of Massachusetts,*** are excluded, including but not limited to the following:

- ♦ Cryopreservation (freezing) or banking of eggs, embryos, or sperm.
- ♦ Genetic analysis and testing, except as described in the "Infertility Services" or "Genetic Testing" subsections of the "Benefits" section.
- ♦ Medications for sexual dysfunction, unless your Plan includes our ***Supplemental Sexual Dysfunction Prescription Drug Rider***.
- ♦ Recruitment, selection and screening and any other expenses of donors (donors of eggs, embryos and sperm).
- ♦ Reversal of surgical sterilization.
- ♦ Surrogacy and all charges associated with surrogacy.

♥ Labor doulas and labor coaches are excluded.

18. Foot orthotics, except if the member is diabetic.
19. Health club membership and exercise equipment.
20. Hearing aids, except as otherwise described in the "Durable Medical Equipment (DME), Including Prosthetics" subsection of the "Benefits" section.
21. Hypnosis (except as an integral part of psychotherapy), biofeedback (except when ordered by a physician to treat urinary incontinence) and acupuncture.
22. Infant formulas, food supplements, nutritional supplements and enteral nutritional therapy, except as provided in the "Nutritional Supplements And Food Products" subsection of the "Benefits" section or our ***Prescription Drug Rider***, if applicable.
23. Massage, except when part of a prescribed physical or occupational therapy program if that program is a covered benefit.
24. Medical supplies or equipment that are not considered to be durable medical equipment or disposable medical supplies or that are not on our covered list of such equipment or supplies.
25. Neuropsychological and neurobehavioral testing, except when it is performed by an appropriately licensed neurologist, psychologist, or psychiatrist and when it is performed to assess the extent of any cognitive or developmental delays due to chemotherapy or radiation treatment in a child diagnosed with cancer.
26. New Treatments for which we have not yet made a coverage policy.
27. Non-durable equipment such as orthopedic or prosthetic shoes, foot orthotics, and prophylactic anti-embolism stockings (jobst stockings) without a history deep vein thrombosis and varicose veins.
28. Non-Emergency land or air ambulance/medical transport services to and from a physician's office for routine care or if it is for Member convenience.
29. Non-Medically Necessary services or supplies.
30. Non-medical supportive counseling services (individual or group) for alcohol or substance abuse (e.g., Alcoholics Anonymous).
31. Non-Participating Provider treatments or supplies, except in the case of Emergencies or Urgent Care, disposable medical supplies or when Out-Of-Plan services are Pre-Authorized, in writing, in advance, or when you are enrolled in one of our ***POS Plans***.
32. 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.
33. Overnight or day camps focused on illness or disability.
34. Over-the-counter (OTC) items of any kind, including but not limited to home testing or other kits and products, except as provided throughout the "Benefits" section.
35. Peak flow meters are excluded.

    However, peak flow meters may be covered if:

    ♥ The Member is enrolled in our asthma health management program,

    ♥ Is being actively case managed, and

    ♥ The use of the peak flow meter is approved by us.

    When those conditions are met, peak flow meters may be provided as part of an asthma health management program value-added service or as a benefit.
36. Personal convenience or comfort items of any kind.
37. Physical therapy, occupational therapy, speech therapy or chiropractic therapy that is long term or maintenance in nature.
38. Private room accommodations and private duty nursing in a facility.
39. Routine foot care and treatment, unless Medically Necessary for neuro-circulatory conditions.
40. Routine physical exams and immunizations at an Urgent Care Center.
41. Sensory and auditory integration therapy, unless covered under the "Autism Services" or "Birth To Three Program (Early Intervention Services)" subsections of the "Benefits" section.
42. Services and supplies exceeding the applicable benefit maximums.
43. Services and supplies not specifically included in this Membership Agreement.
44. Services or supplies rendered by a physician or provider

Refer to the "Managed Care Rules And Guidelines" section to see if you have to use Participating Providers and to find out what services require Pre-Authorizations. Also refer to the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

to himself or herself, or rendered to his or her family members, such as parents, grandparents, spouse, children, step-children, grandchildren or siblings.

45. Services rendered at Hospital-based clinics are excluded unless the Hospital clinics are contracted with us for specific services.
46. Services (e.g., physical examinations, blood tests), supplies, vaccinations/immunizations and medications, including prophylactic, required by or received at a wilderness camp or a boarding school.
47. Services (e.g., physical examinations, blood tests), supplies, vaccinations/immunizations and medications, including prophylactic, required by third parties or obtained for foreign or domestic travel (e.g., employment, school, camp, licensing, insurance, travel and pursuant to a court order).
48. Sex change services.
49. Smoking cessation products are excluded, except as otherwise required by applicable law. When that occurs, the product must be obtained with a prescription and Pre-Authorized.

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

    - ♥ The Member is enrolled in one of our health management programs,
    - ♥ Is being actively case managed, and
    - ♥ The use of the smoking cessation product is approved by us.

    When those conditions are met, smoking cessation products may be provided as part of a health management program value-added service or as a benefit.
50. Solid organ transplant and bone marrow transplant transportation costs, including:

    - ♥ Any expenses for anyone other than the transplant recipient and the designated traveling companion.
    - ♥ Any expenses other than the transportation, lodging and meals described in this provision.
    - ♥ Expenses over the total per day limits for lodging and meals and the overall $10,000 transplant episode benefit limit.
    - ♥ Local transportation costs while at the transplant facility.
    - ♥ Rental car costs.
51. Speech therapy for stuttering, lisp correction, or any speech impediment not related to illness or injury, except as required by applicable law.
52. Third party coverage, such as other primary insurance, workers' compensation and Medicare will not be duplicated.
53. Transportation, accommodation costs, and other non-medical expenses related to Health Services (whether they are recommended by a physician or not), except as otherwise described in the "Benefits" section.
54. Treatment of snoring in the absence of sleep apnea.
55. Vision services including:

    - ♥ Eyeglasses and contact lenses, unless the contact lenses are the only mechanism available to restore visual function for a Member who has no visual function, or unless this Plan includes our ***Vision Care Rider*** (and the Rider includes these items),
    - ♥ Eye surgeries and procedures primarily for the purpose of correcting refractive defects of the eyes,
    - ♥ Vision and hearing examinations (except as described in the "Eye Care" and "Hearing Screenings" subsections of the "Benefits' section), and
    - ♥ Vision therapy and vision training.
56. War related treatment or supplies, whether the war is declared or undeclared.
57 Web visits, e-visits, and other on-line consultations, health evaluations using internet resources, as well as telephone consultations.
58. Weight loss/control treatment, programs, clinics, medications, and surgical treatment for morbid obesity.
59. Wigs, hair prosthetics, scalp hair prosthetics and cranial prosthetics, except for a wig as, as described in the "Durable Medical Supplies (DME) Including Prosthetics" subsection of the "Benefits" section.

COORDINATION OF BENEFITS (COB) AND SUBROGATION AND REIMBURSEMENT

You or one of your covered dependents might be covered under another insurance plan for the same Health Services covered under this Plan. This section is here to explain to you which insurance plan pays first.

The following "Coordination Of Benefits" subsection DOES NOT APPLY TO YOU, if you are enrolled in our non-group plan.

Benefits provided under this Plan are subject to the Coordination of Benefits (COB) and Subrogation provisions as described in this section.

COORDINATION OF BENEFITS

Definitions

There are some special terms that we use in this section and only in this section. Here are their definitions.

1. **PLAN**: In this section Plan means any group health insurance policy or other GROUP arrangement by which health care benefits, including prescription drug benefits, are provided or paid for or the basic reparation benefits of any automobile no-fault insurance policy or Medicare.

   The term Plan will be interpreted separately for each policy or other arrangement for benefits as well as that

portion of any plan which reserves the right to consider the benefits of other plans in determining its benefits and that portion which does not.

2. **ALLOWABLE EXPENSE**: In this section Allowable Expense means any expense at least a part of which is covered by at least one of the Plans covering a Member. When a Plan provides benefits, the reasonable cash value of each service that would be rendered will be considered a benefit for the purpose of this section; any service actually provided will be considered an Allowable Expense and a benefit paid.
3. **COORDINATION**: In this section Coordination means that, regarding a specific claim, the Plans determine among themselves:

   ♥ Which Plans are responsible for payment;

   ♥ Which Plan pays first, second, third, and so on; and

   ♥ How much of the claim each Plan is responsible for paying.

General

If Members are eligible to receive health benefits under another Plan, the benefits provided under this Plan will be coordinated with the benefits under the other Plan(s), so that neither the Member nor the provider receives the value of more than 100% of his or her medical and health care costs.

In addition, in no event will we be liable for more than we would have paid if we were the primary insurer paying for the claim.

Health benefits will be coordinated with:

♥ Any services that are the legal obligation of a third party or that are covered by insurance or a governmental program, such as Medicare, or that are provided as basic compensation of benefits under any no-fault or other automobile insurance policy, or that are any other recovery mechanism permitted by State or Federal statutes.

♥ Services covered under Title XVIII and amendments (Medicare Parts A and B).

Workers' Compensation

If you or your covered dependents are injured at work, you will be covered under worker's compensation. If that ever happens workers' compensation is always the primary and the only payor on the claims to which it pertains. Health Services are not covered by this Plan, if they are for a work related injury.

In other words, Health Services are not covered by this Plan if they:

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

Medicaid

Medicaid is a State program with Federal matching funds that is provided under certain conditions to people, regardless of their age when their income and resources are insufficient to pay for health care and they meet program guidelines. If the Member is also covered under Medicaid, we are always the primary payor for Health Services and we do not coordinate benefits with Medicaid.

Medicare Part D

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

Automobile Insurance Policies

Anybody who owns a car must have automobile insurance. Automobile insurance is always the primary payor in relation to group health insurance, unless otherwise prohibited by law. Whenever Members are required to purchase basic reparations or medical pay coverage under any automobile policy by any State law, or otherwise have that kind of coverage under any automobile insurance policy, we will be entitled to charge:

♥ The insurer for the dollar value of those benefits to which the Member is entitled, or

♥ The Member for that value to the extent he or she has received payment, or would have received payment under the basic compensation of benefits coverage under the automobile insurance policy.

Student Accident Or Sickness Insurance Policies

We do not coordinate benefits with student accident or sickness insurance polices where the student or parent pay the entire premium, if you are enrolled in one of our group Plans.

Primary vs. Secondary Coverage

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

1. The Plan that covers the individual as a policyholder or subscriber pays before the Plan that covers the individual as a dependent.
2. **Birthday Rule:** When two or more Plans cover the same child as a dependent of different persons who are called "parents" and are not separated or divorced:

   ♥ The benefits of the Plan of the parent whose birthday falls earlier in a calendar year are paid before those of the Plan of the parent whose birthday falls later in the year.

   So, if your birthday occurs on May 1st and your spouse's birthday is on April 16th, then your spouse's Plan would pay first.

Refer to the "Managed Care Rules And Guidelines" section to see if you have to use Participating Providers and to find out what services require Pre-Authorizations. Also refer to the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

- If both you and your spouse have the same birthday, the benefits of the Plan that covered the parent longer are paid before those of the Plan that covered the other parent for a shorter period of time.

However, if the other Plan does not have the "Birthday Rule" described above, but instead has a rule based upon the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule based upon the gender of the parent will determine the order of benefits.

3. When two or more Plans cover a person as a dependent child of divorced or separated parents, the order of priority for the Plans will be determined in the following manner.
   - First, the Plan of the parent with custody of the child;
   - Then, the Plan of the spouse of the parent with custody of the child; and
   - Finally, the Plan of the parent not having custody of the child.

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

When This Plan Is Not Primary

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

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

Rights To Receive And Release Necessary Information

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

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

Facility Of Payment

If another Plan makes payments for covered Health Services that we are responsible for, we may, at our sole discretion, pay to that Plan any amounts we determine 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, we will be fully released from liability under this Plan.

Rights Of Recovery

When payments or services have been made or arranged by us in excess of the maximum for Allowable Expenses, no matter to whom paid, we will have the right to recover the excess from any persons (including you), insurance companies, or other organizations. Our right to do that will be limited to the amount that you have received from another Plan.

SUBROGATION AND REIMBURSEMENT

You or your covered dependents may receive or be eligible to receive Plan Benefits for an injury or an illness for which some third person, organization, or governmental entity is liable to pay damages. In these cases, in accordance with applicable law, the third person, organization or governmental entity may have primary payment responsibility and not by way of limitation, may include the following sources: a third party tortfeasor or his insurer, payments under an uninsured or underinsured motorist

policy, a Worker's Compensation award or settlement, a recovery made pursuant to a no-fault insurance policy, and any medical payment coverage in any automobile or homeowner's insurance policy. For claims we paid in relation to that injury or illness, we or our agent will have a lien upon the proceeds of any recovery from that third person, organization or governmental entity. You and your covered dependents agree to reimburse us, in full, without any offset or reduction under any theory of attorney or common fund, made-whole, or comparative negligence, provided, however, that if health benefits were specifically subtracted from the proceeds of a judicial award, no reimbursement of that amount of health benefits shall be required. That lien will be equal to the value of any services provided or paid for under this Plan in relation to that injury or illness. The lien may, but need not, be filed with such third person, organization, or governmental entity or in any court of competent jurisdiction.

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

MEDICARE ELIGIBILITY

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

If Medicare is the primary Plan over this Plan, then you or your covered dependents who have Medicare may be eligible for a reduced Medicare rate. Not all Members or Employers are eligible for the reduced rates, even if Medicare is primary for the Member.

If you are enrolled in our non-group plan and became eligible for Medicare after this Membership Agreement became effective for you, you can still remain eligible for coverage under this Plan. If you or your covered dependents have both Medicare Part A and Part B, Medicare is the primary Plan over this Plan and you or your covered dependents may be eligible for a reduced Medicare rate. Not all Members are eligible for the reduced rates, even if Medicare is primary for the Member.
You or your covered dependents who have Medicare receive our same Plan Benefits, but Medicare will be the primary Plan.
The following "Medicare" rules DO NOT APPLY TO YOU IF YOU ARE ENROLLED IN OUR NON-GROUP PLAN.

Age 65 Or Older

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

End Stage Renal Disease (ESRD)

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

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

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

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

Other Medicare Eligibility

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

Age 65 And Older And Disabled

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

CLAIMS FILING, QUESTIONS AND COMPLAINTS, AND APPEAL PROCESS

This section tells you the procedures for filing claims, registering complaints, and appealing our decisions regarding your benefits. We have the right to review any claims and the discretion to interpret and apply the terms of this Plan to determine whether benefits are payable.

Refer to the "Managed Care Rules And Guidelines" section to see if you have to use Participating Providers and to find out what services require Pre-Authorizations. Also refer to the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

CLAIMS FILING

Claims for payment for Health Services must be received by us 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. You can check the status of your medical claims at any time by checking our web site at www. connecticare.com and logging in as described.

Bills From A Participating Provider

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

Special Rules If You Are Enrolled In Our *HMO or POS Deductible Open Access Plans Or Our HMO Open Access HDHP Plan*

If you are enrolled in our ***HMO or POS Deductible Open Access Plans or HMO Open Access HDHP Plan***, an explanation of benefits ("EOB") will be sent to you.

This explanation will indicate:

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

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

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

Bills From A Non-Participating Provider

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

The claim should include the following information.

- 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.

  NOTE: Charge card receipts and "balance due" statements are not acceptable.
- A copy of the written Pre-Authorization letter issued by us or, as appropriate, our Delegated Program, authorizing you or your covered dependents to see the Non-Participating Provider under this Plan. If care by the Non-Participating Provider did not need written Pre-Authorization (for example, because it was an Emergency or for Urgent Care), then you must submit an explanation along with the claim.

  This requirement does not apply to you if you are enrolled in any of our ***POS Plans***.
- If the claim was a result of an Emergency or Urgent Care you or your covered dependents needed while outside of the United States, please be sure the itemized bill is written or translated in English and that it shows the amount you paid in U.S. dollars. In this case, it may be helpful for you to also include your charge receipt with the itemized bill.

Our payment for covered Health Services provided by a Non-Participating Provider is made directly to you and you are responsible for making payment to the provider of service, unless you indicate on the claim form that you want the payment to go to the provider or when an ambulance company provider is entitled to be paid directly by us pursuant to applicable law. In addition, we may also pay you directly, if the Non-Participating Provider does not provide us with information that we request for claim payment.

Special Rules If You Are Enrolled In Our *HMO Deductible Open Access Plan Or Our HMO Open Access HDHP Plan*

If you are enrolled in our ***HMO Deductible Open Access Plan or our HMO Open Access HDHP Plan***, when coverage for treatment provided by a Non-Participating Provider is allowed (e.g., Pre-Authorized or for Urgent Care or is an Emergency Service), you will be required to pay the associated Cost-Share amounts that you would pay if the services were rendered by a Participating Provider. Payment will be based on the Non-Participating Provider's billed charges. Please refer to the "Cost-Shares You Are Required To Pay" subsection of the "Managed Care Rules And Guidelines" section and your Benefit Summary to find out the Cost-Share amounts you are required to pay under your Plan. If you receive treatment from a Non-Participating Provider that is not covered by your Plan, you will be solely responsible for paying the Non-Participating Provider, and the amount you pay will not count toward your Plan Deductible or your Coinsurance amount.

Payment To Custodial Parent

In accordance with the law, in situations where we have not paid your covered dependent children's claims directly to the provider, we will send the payment directly to the custodial

Refer to the "Managed Care Rules And Guidelines" section to see if you have to use Participating Providers and to find out what services require Pre-Authorizations. Also refer to the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

parent if we are notified in writing, even if that parent is not a participant under this Plan.

Claims For Emergency Services

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

If You Are Covered By Another Insurance Plan

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

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

Refund To Us Of Overpayments

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

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

Questions And Complaints

You or your legal representative can always ask questions or submit complaints or Appeals about benefits and other issues concerning this Plan. Since most questions or complaints can be resolved informally, we suggest that you contact our Member Services Department first. The appropriate telephone numbers and addresses for Member Services are listed in the "Important Telephone Numbers And Addresses" subsection of the "Important Information" section of this Membership Agreement. In addition, you may also submit a complaint by using our web site at www.connecticare.com.

Representatives are available Monday through Friday, during regular business hours, to explain policies and procedures and answer your questions. When you call, a representative will either answer your question or forward it to the appropriate department or individual for a response. If you are calling after normal business hours, you may leave a detailed voice mail message, including your ConnectiCare ID number and your telephone number. An associate will return your telephone call 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 you are not satisfied with a decision we or our Delegated Programs have made regarding Health Services, benefits, Pre-Authorization, Pre-Certification or claims, then you or your legal representative may request an Appeal on your behalf.

Of course, before pursuing the Appeal process, you should always consider seeking immediate assistance from our Member Services Department, as described in the "Questions And Complaints" subsection of this section. Often, questions and complaints can be resolved quickly and informally by speaking with one of our representatives. However, if you choose to make use of the Appeal process, we will not subject you to any sanctions or impose any penalties on you.

The Appeal process is divided into two categories.

1. One category deals with the **Medical Necessity Appeal** of a particular Health Service, such as a denial of a request for Pre-Certification of an inpatient admission or the Pre-Authorization of a certain 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 us as follows:

Telephone: 1-800-251-7722

Facsimile: 1-800-319-0089

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

For urgent or expedited behavioral health reviews, contact our behavioral health Delegated Program. The appropriate telephone number and address are listed in the "Important Telephone Numbers And Addresses" subsection of the "Important Information" section of this Membership Agreement.

Refer to the "Managed Care Rules And Guidelines" section to see if you have to use Participating Providers and to find out what services require Pre-Authorizations. Also refer to the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

When filing an Appeal, you should explain why you feel the original decision should be overturned and submit any other information you think is relevant.
The Appeal must be made as soon as possible after you receive the original decision, but no later than six months after the Pre-Authorization request was denied or six months after the claim for benefits was denied, whichever comes first.

Medical Necessity Appeal

Independent Review Organization

If you disagree with a decision regarding the **Medical Necessity** of a particular Health Service, such as a denial of a request for Pre-Certification of an inpatient admission or the Pre-Authorization of a certain surgical procedure, you may Appeal that decision. Our Appeal process is designed to resolve Appeals quickly and impartially through the use of an independent review organization of medical practitioners (except for behavioral health expedited and urgent reviews, which are reviewed by an appropriately licensed specialist through our behavioral health Delegated Program).

1. The independent review organization will arrange to have the Appeal reviewed by a board-certified physician specialist in the field related to the condition that is the subject of the Appeal who was not involved in the original decision.
2. You or your legal representative and provider of record will be sent a written decision no later than 30 calendar days after receipt of the request for the Appeal.
3. If you are not satisfied with the decision made by the independent review organization, then you or your legal representative or any provider with your consent, may request a utilization review external appeal through the State of Connecticut Insurance Department. Please refer to the "Utilization Review External Appeal" provision explained later in this subsection.

Urgent Review of Certain Denials

You may file an Appeal on an urgent basis with us if you or your covered dependent have an Emergency or life-threatening situation, if a delay in treatment could seriously jeopardize your or your covered dependent's life or health or ability to regain maximum function, or you or your covered dependent would be subject to severe pain that could not be adequately managed. A decision on an urgent Appeal will be made by us within two business days of receipt of all necessary information, but in no event later than 72 hours after receipt of the urgent Appeal request.

If the time frame for completing the urgent Appeal described above may cause or exacerbate an Emergency or life-threatening situation for you or your covered dependent, then you or your legal representative or your provider with your consent may request an expedited external appeal through the State of Connecticut Insurance Department. Please refer to the "Utilization Review External Appeal" provision explained later in this subsection.

If you are not satisfied with the urgent Appeal decision **made by us**, then you, your legal representative or any provider with your consent may request a utilization review external appeal through the State of Connecticut Insurance Department. Please refer to the "Utilization Review External Appeal" provision explained later in this subsection. **Please note that a behavioral health urgent review is reviewed by an appropriately licensed specialist who was not involved in the original decision through our behavioral health Delegated Program, and not an independent review organization.**

Expedited Review Of Certain Denials

If you have been diagnosed with a condition that creates a life expectancy of less than two years and coverage has been denied because the service, supply or medication requested is Experimental Or Investigational, an expedited review of that denial may be requested. **Please note that an expedited behavioral health review is reviewed by an appropriately licensed specialist who was not involved in the original decision through our behavioral health Delegated Program, and not an independent review organization.**

1. A written decision will be made to you or your legal representative or provider of record within two business days of receipt of all necessary information, but in no event later than 72 hours after receipt of the expedited review request.
2. If you are not satisfied with the Appeal decision, then you, your legal representative or any provider with your consent, may request a utilization review external appeal through the State of Connecticut Insurance Department. Please refer to the "Utilization Review External Appeal" provision explained later in this subsection.

Utilization Review External Appeal

1. The utilization review external appeal must be submitted to the State of Connecticut Insurance Department in writing. The address and telephone number are:

   State of Connecticut Insurance Department
   Insurance Commissioner
   PO Box 816
   Hartford, Connecticut 06142-0816

   860-297-3910

2. The appeal must be made within 60 calendar days of your receipt of the final denial letter. However, an expedited external utilization review appeal may be filed without receipt of our final denial letter if you decide to appeal because you feel the timeframe for completing our urgent Appeal may cause or exacerbate an Emergency or life-threatening situation.
3. The appeal will require a fee of $25 payable to the State of Connecticut Insurance Department. This fee will be waived if you are poor or unable to pay.

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

Refer to the "Managed Care Rules And Guidelines" section to see if you have to use Participating Providers and to find out what services require Pre-Authorizations. Also refer to the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

Administrative (Non-Medical Necessity) Appeal

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

1. When the Appeal is submitted, it will be forwarded for review.
2. A staff member who was not involved in the original decision will review the Appeal.
3. You or your legal representative will be provided with a written decision within 30 calendar days after receipt of the request.

TERMINATION AND AMENDMENT

GROUP TERMINATION

The rules in the following "Termination Of Your Employer's Coverage" and "Termination Of Your Coverage" subsections APPLY TO YOU IF YOU ARE ENROLLED IN ONE OF OUR GROUP PLANS. There are different termination rules that apply to a non-group Subscriber. They appear in the "Non-Group Termination" subsection later in this "Termination And Amendment" section.

Termination Of Your Employer's Coverage

This Agreement and your Employer's coverage under this Plan will terminate on the earliest day that any of the following events occurs.

1. At the end of the grace period (specified in the "Premium Payment" section of this Membership Agreement) your Employer fails to make the Premium payments due; or

   At another date after the grace period that we specify in writing to your Employer. This date will not be earlier than midnight of the third business day following the date you or your Employer receives our written notice to terminate its coverage due to its failure to pay the required Premium due.
2. In the event your Employer has committed fraud (as determined by a court of competent jurisdiction), or in the event your Employer has willfully concealed or misrepresented any material fact or circumstance in applying for coverage under this Plan.
3. In the event your Employer fails to comply with the following conditions that we may require, in order for coverage to be available under this Agreement:

   - ♥ Service Area requirements, as described in the "Eligibility And Enrollment" section of this Membership Agreement;
   - ♥ Employer contribution requirements; or
   - ♥ Group participation rules, which may be either those pertaining to:

     The Health Insurance Portability and Accountability Act of 1996 (HIPAA), if your Employer has at least two Employees, but not more than 50; or

     State law, if your Employer has more than 50 Employees.
4. In the event that we terminate coverage for all Employers.
5. In the event your Employer's membership in a bona fide association through which this coverage is provided (as defined by Federal law) ceases. This can only occur if coverage is terminated uniformly without regard to the health status of any Member covered through the Employer under this Plan.
6. At the end of the month the termination occurs if your Employer provides us with written notice at least **30 days in advance** of the requested termination date. Notification must be submitted to us on your Employer's letterhead and include the date of the requested termination.
7. On the date your Employer is liquidated, ceases to operate, no longer employs any active employees or no longer covers any active employees with us.
8. On the date agreed upon by your Employer and us.

Termination Of Your Coverage

This Agreement will terminate and coverage under this Plan will terminate on the earliest day that any of the following events occurs.

1. On the date this Agreement and your Employer's coverage terminates as described above in the "Termination Of Your Employer's Coverage" subsection of this section.
2. On the last day of the month during which you cease to be either an Employee; or on the date established by your Employer's termination standards.

   Your Eligible Dependents' coverage will terminate on the last day of the month after the month which he or she ceases to be an Eligible Dependent; or on the date established by your Employer's termination standards if coverage continues under COBRA or Connecticut rules.
3. In the event a Member has committed fraud (as determined by a court of competent jurisdiction), or has willfully concealed or misrepresented any material fact or circumstance in applying for enrollment or in obtaining Plan Benefits. However, we may not contest the Member's coverage under this subsection "3" beyond two years from the Member's effective date of coverage under this Agreement.
4. On the anniversary of the effective date of this Plan following a Member's voluntary disenrollment during an Annual Enrollment Period, or according to any other schedule agreed to by your Employer and us.
5. 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
- ♥ Our employees, our affiliates or our subcontractors.

6. For a Member's persistent refusal to comply with treatment that is prescribed and Medically Necessary.
7. For a Member's failure to take such reasonable actions as may be necessary to secure our rights under this Plan.
8. In the event the Member has repeatedly failed to make the required Cost-Sharing payments to providers (if we decide to terminate your coverage under this provision, termination will take effect 30 days following our written notice stating our intent to terminate).
9. In the event you fail to remit your contribution toward Premium, as may be required by your Employer.
10. The date you no longer reside or work in the Service Area or your covered dependents no longer reside with you or in the Service Area as described in the "Eligibility And Enrollment" section of this Membership Agreement.
11. The date you and your Eligible Dependents are absent from the Service Area for more than 180 days, even if you still live or work in the Service Area.

NON-GROUP TERMINATION

The rules in the following "Termination Of A Subscriber's Coverage" and "Termination Of A Non-Group Member's Coverage" subsections APPLY TO YOU IF YOU ARE ENROLLED IN OUR NON-GROUP PLAN.
There are different termination rules that apply to a group Subscriber. They appear in the "Group Termination" subsection that appears earlier in this "Termination And Amendment" section.

Termination Of The Subscriber's Coverage

1. At the end of the grace period (specified in the "Premium Payment" section) if you fail to make the Premium payments due; or

   At another date after the grace period that we specify in writing. This date will not be earlier than midnight of the third business day following the date you receive our written notice to terminate your coverage due to your failure to pay the required Premium due.
2. In the event that we cease to offer coverage in the individual market in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
3. The date of termination specified by you in a written notice sent to us at least 30 days in advance.
4. The date the Member moves outside of the Service Area.
5. On the date agreed upon by you and us.
6. In the event that we stop offering this Plan to any Members.

Termination Of A Non-Group Member's Coverage

This Agreement will terminate and coverage under this Plan will terminate on the earliest day that any of the following events occurs.

1. On the date this Agreement and your coverage terminates as described in the "Termination Of The Subscriber's Coverage" subsection of this section.
2. On the last day of the month during which you cease to be a Subscriber.

   Your Eligible Dependent spouse's coverage will terminate on the last day of the month after the month which he or she ceases to be an Eligible Dependent.

   Your Eligible Dependent child's coverage will terminate on the day this Plan renews on or after the date he or she ceases to be an Eligible Dependent.
3. In the event a Member has committed fraud (as determined by a court of competent jurisdiction), or has willfully concealed or misrepresented any material fact or circumstance in applying for enrollment or in obtaining Plan Benefits. However, we may not contest the Member's coverage under this subsection "3" beyond two years from the Member's effective date of coverage under this Agreement.
4. 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
   - ♥ Our employees, our affiliates or our subcontractors.
5. For a Member's persistent refusal to comply with treatment that is prescribed and Medically Necessary.
6. For a Member's failure to take such reasonable actions as may be necessary to secure our rights under this Plan.
7. In the event the Member has repeatedly failed to make the required Cost-Sharing payments to providers. (If we decide to terminate your coverage under this provision, termination will take effect 30 days following our written notice stating our intent to terminate.)
8. The date you no longer reside in the Service Area or your covered dependents no longer reside with you or in the Service Area as described in the "Eligibility And Enrollment" section of this Membership Agreement.
9. The date you and your Eligible Dependents are absent from the Service Area for more than 180 days, even if you still live or work in the Service Area.

EXTENSION OF BENEFITS

The following "Extension Of Benefits" provisions DO NOT APPLY TO YOU IF YOU ARE ENROLLED IN OUR NON-GROUP PLAN.

When This Plan Is The Prior Plan

1. If a Member is an inpatient at a Hospital, Hospice, Skilled Nursing Facility, Rehabilitation Facility or Residential Treatment Facility on the date that this Agreement is terminated with the Employer for any of the reasons stated in the "Termination of Your Employer's Coverage" paragraphs of the "Group Termination" subsection of the "Termination And Amendment" section of this Membership Agreement and the Employer does not obtain replacement coverage in another plan offered or insured by us immediately after coverage under this Plan terminates, this Plan will cover the costs of the Hospitalization or inpatient stay as well as the medical care relating to that Hospitalization or inpatient stay until the Member is no longer an inpatient.

   Coverage will be for either the actual length of the inpatient stay or for up to 12 months, whichever is shorter. Coverage is still subject to all of the terms, conditions and rules of this Plan, including Medical Necessity, Pre-Authorization, Pre-Certification, cost-sharing, benefit maximums, etc. To be eligible for payment, all claims for coverage must be submitted in accordance with the terms of this Plan.

2. If a Member is Totally Disabled (and not confined) on the date this Agreement is terminated with your Employer for any of the reasons stated in the "Termination of Your Employer's Coverage" paragraphs of the "Group Termination" subsection of the "Termination And Amendment" section of this Membership Agreement and your Employer does not obtain any replacement coverage or obtains self-funded replacement coverage immediately after coverage under this Plan terminates, coverage will be continued under this Agreement for the services related to the disabling condition for that Member without Premium.

   This coverage will continue for that Member's disability until the first of the following occurs:

   - For a period of 12 months following the calendar month in which this Agreement was terminated; or
   - Until he or she is no longer Totally Disabled.

   Proof of the disability must be sent to us within one year of the termination of this Agreement.

   To be eligible for payment, all claims for coverage must be submitted in accordance with the terms of this Plan.

3. If a Member is Totally Disabled (and not confined) on the date this Agreement is terminated with your Employer for any of the reasons stated in the "Termination of Your Employer's Coverage" paragraphs of the "Group Termination" subsection of the "Termination And Amendment" section of this Membership Agreement and your Employer obtains insured replacement coverage in another plan immediately after coverage under this Plan terminates, coverage under the Agreement will end on the date this Agreement is terminated, and the new plan will be responsible for all claims incurred as of the effective date of the replacement coverage, including claims for the disabling condition.

When This Plan Is the Succeeding (Replacement) Plan

1. When your Employer terminated its prior group health plan and replaced it with this Plan, and a Member was inpatient at a Hospital, Skilled Nursing Facility, Rehabilitation Facility, or Residential Treatment Facility on the effective date of this Plan, the coverage under this Plan will be effective, but this Plan will not cover the costs of that Hospitalization or inpatient stay or any medical care relating to that Hospitalization or inpatient stay if these costs are the responsibility of a previous carrier. You should notify us when an inpatient stay under these circumstances occurs. When this Plan is a replacement plan and becomes responsible for covering a Member who is inpatient on the effective date of this group Plan, reasonable transition of care benefits will be available to allow the Member to use their current Non-Participating Providers to treat the condition related to the confinement for a period of time during which it is clinically appropriate to require use of those current Non-Participating Providers. During the transition period, benefits for the condition related to the confinement will not be reduced because the current providers do not participate in our network, or because services were pre-certified by the Member's prior carrier but not by us.

2. When your Employer terminated its prior group health plan and replaced it with this Plan, this Plan will pay benefits for a Member who is Totally Disabled (but not confined in a health care facility as described above), on the date this Plan became effective, but this plan will not cover the disabling condition if coverage for the disabling condition is the responsibility of a previous carrier. Reasonable transition of care benefits will be available for treatment of the disabling condition, allowing the new Member to use his or her current Non-Participating Providers for a period of time during which it is clinically appropriate to require use of those current providers. During the transition period, benefits for treatment of the disabling condition will not be reduced because the current providers do not participate in our network, or because services were pre-certified by the Member's prior carrier but not by us.

Your Employer must continue group coverage for you and your covered dependents during your absence due to illness or injury, not to exceed 12 months from the beginning of the absence. Your Employer may charge you for this continuation, but no more than what would be charged if you had continued to be an active covered employee. This continuation will end earlier if you and your covered dependents no longer meet the eligibility requirements of this Plan. In that event, the Member may be eligible for continued coverage under COBRA.

NOTICE OF GROUP PLAN TERMINATION

In the event this Agreement is terminated with your Employer (including substitution of coverage), your Employer must provide you with 15 days notice before the termination.

AMENDMENT

We may amend this Agreement by providing 60 days written notice to your Employer if you are covered in a group plan, or to you if you are covered under our non-group plan.

COBRA AND CONTINUATION OF COVERAGE

The following "COBRA And Continuation Of Coverage" provisions DO NOT APPLY TO YOU IF YOU ARE ENROLLED IN OUR NON-GROUP PLAN.

As the result of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and Connecticut State law, a "Qualified Beneficiary" is offered the ability to continue coverage under this group Plan when a "Qualifying Event" occurs.

THE FOLLOWING IS A SUMMARY ONLY of the circumstances under which a Member may be eligible for continued group coverage under the COBRA and Connecticut rules. The Employer is responsible for notifying the Member of these rights and for administering the COBRA and Connecticut rules. (However, certain Employers may have hired us to perform certain billing services for the Employer for continuation premiums.)

In addition, Trade Adjustment Assistance (TAA)-eligible individuals and their dependents, as well as those who receive benefits from the Pension Benefit Guaranty Corporation (PBGC) and their dependents, may be eligible for extended COBRA coverage. Have your Employer contact us if you are eligible for TAA or PBGA benefits.

Your Right To Continue Benefits

As described in COBRA and Connecticut law, if coverage under this Agreement were to terminate due to a "Qualifying Event," a "Qualified Beneficiary" (you or your covered dependents) may elect to continue coverage for up to 18, 29, 36 months or longer, based on the Qualifying Event(s) which occurred:

1. You and your covered dependents may continue coverage **up to 18 months** when coverage terminates due to a reduction in your hours or termination of your employment for reasons other than gross misconduct.
2. You and your covered dependents may continue coverage **until you experience an event listed in the "Special Termination Of Continuation Coverage Conditions" provision of the "Termination Of Continuation Coverage" subsection**, if you experience a reduction, leave of absence or termination of employment as a result of your eligibility to receive Social Security income.
3. An individual who is disabled may have continuation coverage extended (subject to an extra fee) **from 18 months up to 29 months** provided the individual was disabled for Social Security purposes on the date of the Qualifying Event or within the first 60 days of continuation coverage. In this case, the disabled individual must notify the Employer within 60 days of the Social Security Administration's determination of disability and within the initial 18-month continuation period.
4. Coverage may continue **for up to 36 months** for the following persons:

   - ♥ A covered child who ceases to be an Eligible Dependent.
   - ♥ A covered spouse and dependents if you die.
   - ♥ A covered spouse and dependents whose coverage ceases due to divorce or legal separation from you.
   - ♥ A covered spouse and dependents if coverage ceases due to your entitlement for Medicare.

   A child who is born to or adopted by you during the continuation period is also a Qualified Beneficiary entitled to continuation. There is a special continuation period for you if you are retired and your Employer declares bankruptcy under Title 11 of the United States Code and you and your covered dependents lose substantial coverage within one year before or after the date the bankruptcy proceedings commenced.

   If continuation is elected, coverage will continue as though a Qualifying Event had not occurred. Any accumulation of Deductibles, Coinsurance or benefits paid prior to the Qualifying Event, which had been credited toward any Deductible, Coinsurance or maximum benefits of this Plan, will be retained as they would have been had the Qualifying Event not occurred.

   During Annual Enrollment Periods, an individual with continuation of coverage has the same rights as active Employees to change his or her coverage or to add or eliminate coverage for covered dependents covered by this Plan.

   If, after the first Qualifying Event, another Qualifying Event occurs, coverage can be continued for an additional period, up to a total of 36 months from the date coverage under this Plan would have first stopped. If the Subscriber retires and becomes entitled to Medicare within 18 months after retirement, the Subscriber's

dependent Qualified Beneficiaries are entitled to continuation for up to 36 months beginning with the date of retirement. If the Subscriber becomes entitled to Medicare and then later retires (or otherwise stops working or has reduced hours resulting in loss of coverage), the Subscriber's dependent Qualified Beneficiaries are entitled to continuation for the greater of:

- Up to 36 months from the date of Medicare entitlement; or
- Up to 18 months from the date of the retirement or reduction in hours or employment termination.

The Subscriber is entitled to continuation for up to 18 months from the date of retirement or reduction in hours or employment termination, or until you experience an event listed in the "Special Termination Of Continuation Coverage Conditions" provision of the "Termination Of Continuation Coverage" subsection if the retirement, or reduction in hours results from eligibility to receive Social Security income.

These group continuation provisions do not apply to newborn children who are covered only for 31 days after birth, as described in the "Eligibility And Enrollment" section of this Membership Agreement, unless the newborn children are properly enrolled in this Plan as covered dependents within 31 days of their birth.

Notification Requirements

In order to be eligible for continuation, you must provide notice to your Employer within 60 days of the date of the following Qualifying Events.

- Your marriage is dissolved.
- You become legally separated from your spouse.
- Your dependent child no longer qualifies as your Eligible Dependent.

Complete instructions on how to elect continuation will be provided by your Employer.

Election Period

The length of time during which a Qualified Beneficiary may decide whether or not to continue coverage extends until the later of 60 days after the date coverage would have stopped due to the Qualifying Event or 60 days after the date notice of the right to continue coverage is sent.

A special COBRA election period may be available if you become eligible for trade adjustment assistance (TAA) under the Trade Act of 2002. If you did not elect COBRA previously for loss of coverage related to TAA, the special COBRA election period begins on the first day of the month in which you become eligible for TAA and lasts for 60 days, EXCEPT that you may not elect COBRA more than six months after your TAA-related loss of coverage. If you elect COBRA during this special election period, the COBRA coverage will begin on the first day of the special election period. However, the COBRA coverage will end on the same date it would have terminated if you had elected COBRA when you first became eligible for it.

Payments

The Qualified Beneficiary has 45 days from the date of the election to make the first payment of premium. The first payment will include any payment for the coverage before the date of the election. For example, if the election to continue coverage is made 60 days following the Qualifying Event and payment is made 45 days following the election, a total of three months premium must be paid on that date. The premium to continue coverage will be determined by your Employer in accordance with the law.

Termination Of Continuation Coverage

Continuation of coverage shall not continue beyond the day any of the following events happen:

- The date the person reaches the maximum period of continuation of benefits (18, 29 or 36 months from the date of the Qualifying Event).
- The date this Agreement stops being in force for any of the reasons listed in the "Termination Of Your Employer's Coverage" or the "Termination Of Your Coverage" subsections of this section, except paragraph "2" of the "Termination Of Your Coverage" subsection. (If your Employer offers another group health plan, coverage may continue under that plan.)
- 30 days after the required payment for the coverage is due and not made.
- For Qualified Beneficiaries who had extended continuation coverage from 18 to 29 months due to disability, the extra 11 months ends the first day of the month that begins more than 30 days following the month in which the disabled individual is determined not to be disabled.
- The date the person becomes, after electing continuation, covered under any other group health plan or becomes entitled to Medicare. This does not apply if the other group health plan excludes or limits coverage on a person's pre-existing condition. If you or your Eligible Dependents are already covered under any other group health plan or Medicare before electing continuation coverage, you may still elect continuation coverage under this Plan.

Special Termination Of Continuation Coverage Conditions

If your retirement, reduction in hours or employment termination results from your eligibility to receive Social Security income, then continuation of coverage for you and your dependents ends on the earliest of the following to occur:

- This Plan is no longer in force with your Employer;

  (NOTE: If your Employer offers another health

plan, coverage may continue under that plan.)

- ♥ 30 days after the required payment for coverage has not been made;
- ♥ The date you become eligible for Medicare; or
- ♥ The date you become eligible for other group coverage.

Subject to our review and approval, some Employers may have continuation policies that provide for additional terms of continuation coverage.

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

The following "Your Right To Continue Benefits When Called Up To Active Military Services" provisions DO NOT APPLY TO YOU IF YOU ARE ENROLLED IN OUR NON-GROUP PLAN.

If coverage under this Agreement stops because you have to leave work because you were called up to active military service, you and your covered dependents may elect to continue coverage under terms similar to COBRA for **up to 24 months** after your absence from work begins or for your period of active duty service, whichever is shorter. The Premium to continue coverage will be determined by your Employer in accordance with the law. The COBRA rules for payment of Premium and termination of coverage procedures will apply to this continuation coverage.

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

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

CONVERSION PRIVILEGE

The following "Conversion Privilege" provisions DO NOT APPLY TO YOU IF YOU ARE ENROLLED IN OUR NON-GROUP PLAN.

Connecticut State Health Reinsurance Association (HRA) Conversion

If a Member ceases to be covered by this Plan (whether or not the Plan has terminated with the Employer), he or she may apply for conversion through the Connecticut Health Reinsurance Association (HRA). The former Member must apply for the conversion within 31 days of his or her loss of coverage under this Plan. The terms of coverage under the HRA plan are subject to the rules and regulations of the HRA in force at the time of conversion. They are approved by the State of Connecticut Insurance Department.

PREMIUM PAYMENT

We determine the amount, time and manner of the payment of Premium, which will be subject to approval by the State of Connecticut Insurance Department.

1. All Premiums must be sent to us in accordance with our payment instructions, and according to the rates in force on behalf of the number of Members covered under this Plan.
2. All Premiums are due and payable on the first of the month for which coverage is applicable and the first day of a calendar month thereafter. A grace period of one calendar month is allowed. This means that if payment is not made on or before the date it is due, it may be paid during the grace period. If payment is not made during the grace period, this Plan will terminate on the last day of the grace period. When the Plan is cancelled for non payment of Premium, the payment of Premium is still due, including the amount of Premium accumulated during the grace period.

   Payment must reach us in time for us to complete our posting process in order for it to be considered paid by the end of the grace period.

   If Premium is not paid as described above, coverage under this Plan will cease as described in the "Termination And Amendment" section of this Membership Agreement.
3. We may add a late payment charge of one percent per month for any Premium paid after the grace period.
4. Our bills reflect the membership changes of which we have been notified and which we have processed. Premium payment must be sent as billed, unless another payment method has been mutually agreed upon between your Employer and us as applicable. Membership changes received and processed afterward will be reflected on the next bill.
5. Premiums may be increased by us on the beginning date of any Contract Year or when otherwise mutually agreed upon by you (for non-group Members) or the Employer and us. We will provide 30 days notice when this occurs. We may also increase Premium if benefits under this Plan are changed due to State or Federal law requirements. Such change will be made effective as of the effective date of the change in benefits. You (if you are a non-group Member) or the Employer will be notified of the increase as soon as practical.
6. You (if you are a non-group Member) or the Employer must notify us prior to the date on which a Member's coverage is to terminate under this Plan in order for termination to be effective on that date. This notification must be sent to us in writing and can be done electronically, if the Employer typically transfers eligibility information electronically to us.

   In the event the Employer fails to provide us with this notice and continues to make Premium payments for that Member, we will refund only up to two months of

Premium payment from the first of the month in which notification to us was received. However, if Plan Benefits were provided to that Member during the period for which Premium would be refunded, we may elect not to refund the Premium for that period.

7. If coverage begins at any time up through the 15th day of a month, a whole month's Premium is due. If coverage begins after the 15th day of a month, no Premium is due for that month. If coverage terminates at any time up through the 15th day of a month, no Premium is due for that month. If coverage terminates on or after the 16th day of a month, a whole month's Premium is due.

GENERAL PROVISIONS

1. The Employer hereby agrees that, during every Contract Year, there will be an Annual Enrollment Period of at least two weeks in which an Employee and/or his or her dependents may enroll in this Plan. This is the only time that an Employee and/or his or her dependents are permitted to enroll for coverage under this Plan, except as provided in the "Eligibility And Enrollment" section of this Membership Agreement. It is the responsibility of the Employer to provide advance notification of the Annual Enrollment Period to its Employees and COBRA beneficiaries.
2. You and the Employer hereby agree to cooperate with us and to follow our policies, procedures, and instructions in all administrative matters required for the orderly administration of this Agreement.
3. We contract with Participating Providers to ensure that you will not be billed for any Health Services that are covered by this Plan. This does not include services billed that are subject to subrogation and coordination of benefits and applicable copayments, deductibles and coinsurance you are required to pay if you or your covered dependents are covered by another plan and that other plan is determined to be his or her primary plan according to the rules described in the "Coordination Of Benefits (COB) And Subrogation" section of this Membership Agreement. In this case a Participating Provider may bill you for copayments, deductibles and coinsurance due under that other plan (the primary plan). Please refer to the "When This Plan Is Not Primary" provision of the "Coordination Of Benefits" subsection of the "Coordination Of Benefits (COB) And Subrogation" section of this Membership Agreement to find out your responsibilities when this occurs.
4. Upon our request, the Employer hereby agrees to supply us with copies of all summary plan descriptions prepared and distributed by the Employer which describe our Plan Benefits.
5. By being covered under this Plan, you and your covered dependents accept all of the terms, conditions and provisions of this Agreement.
6. No legal action can be brought against us under this Agreement, unless it is initiated within 12 months from the date the complained of services were rendered.
7. We will have no liability for benefits other than as provided by this Agreement.
8. The benefits of this Agreement are not transferable and may not be assigned to any third party, except when the Member indicates on the claim form that payment should be sent directly to the provider of the covered Health Service or when an ambulance company provider is entitled to be paid directly by us pursuant to applicable law.
9. We may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of this Plan.
10. If terminated for any reason, this Agreement may be reinstated only at our discretion. Such reinstatement may be subject to an additional fee as determined by us.
11. This Agreement embodies the entire Agreement and understanding between us and the Employer and us and the Members. It replaces all prior agreements and understandings relating to the subject matter. Except as otherwise described in this Agreement, this Agreement may be changed, waived, discharged or terminated only by an instrument in writing signed by the party against which enforcement of the change, waiver, discharge or termination is sought.
12. If any portion of this Agreement is or becomes, for any reason, invalid or unenforceable, that portion will be ineffective only to the extent of the invalidity or unenforceability and the remaining portion or portions will nevertheless be valid, enforceable and of full force and effect.
13. This Agreement will be governed by and construed in accordance with the laws of the State of Connecticut, but only to the extent those laws are not preempted by the Employee Retirement Income Security Act (ERISA).
14. In the event the Employer transfers eligibility information electronically to us regarding you or your Eligible Dependents, the Employer agrees to the following:

    - ♥ To require its Employees to enroll in this Plan on behalf of himself or herself and any Eligible Dependents by:
        - ♦ Completing and signing an Enrollment Form; or
        - ♦ Telephonic or computer enrollment using a script (the content of the script must include information we provide to the Employer in writing), along with a written acknowledgment concerning the terms of this Plan, particularly authorizing the transfer of confidential information ("Acknowledgment"), signed by Employees (the content of the Acknowledgment must include information we provide to the Employer in writing); or

Refer to the "Managed Care Rules And Guidelines" section to see if you have to use Participating Providers and to find out what services require Pre-Authorizations. Also refer to the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

- ♦ Telephonic or computer enrollment, with a written acknowledgment concerning the terms of this Plan, particularly authorizing the transfer of confidential information ("Acknowledgment"), signed by Employees (the content of the Acknowledgment must include information we provide to the Employer in writing).

- ♥ If Enrollment Forms or Acknowledgments are used as described above, the Employer agrees to maintain these completed Enrollment Forms and Acknowledgments for not less than ten years following the date the Employee who is the subject of the form or Acknowledgment has terminated participation in this Plan.
- ♥ To provide the original or a copy of any individual Enrollment Form or Acknowledgment to us, upon our request, for our use in administering this Plan. We will return the Enrollment Form or Acknowledgment, if it was an original, when we are finished using it.
- ♥ To provide us with timely, accurate enrollment information on an "Enrollment File" (weekly/twice per week/monthly/twice per month/or at such other times as agreed to by us and the Employer), in a format and layout that we agreed to.
- ♥ To pay us an additional charge, as we specify, for programming work we require for changes the Employer wishes to make to the standard format or layout of the Enrollment File we agreed to. We will bill the Employer for any additional charge in the month following the completion of the programming. The bill will be due upon receipt and payable within 15 calendar days following receipt by the Employer.

15. Participating Providers are not our employees or agents. They are independent contractors with the responsibility for determining and providing health care for their patients.
16. A Participating Provider may refuse to provide services or treatment to you or your covered dependents if you do not pay the required Cost-Share amounts required under this Plan.
17. We are not responsible for your decision to receive treatment, services, or supplies provided by Participating Providers, nor are we responsible or liable for the treatment, services or supplies provided by Participating Providers.
18. As the result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), effective June 1, 1997, if your or your covered dependent's coverage terminates under the Plan, we will automatically provide you with a Certificate of Creditable Coverage which can be presented to a subsequent insurance plan to reduce or eliminate pre-existing condition limitations. You may request additional Certificates for a period of up to 24 months from the date your or your covered dependent's coverage terminates. In some instances, your Employer performs these duties for us.
19. This Plan does not limit coverage for conditions just because you had the condition before you became covered under the Plan.
20. When this Plan calculates benefits on a calendar year, the Plan calculates benefits on a calendar year basis, even if the Plan year is different from the calendar year. This means that changes to your benefit plan become effective upon renewal (when a new Membership Agreement or amendatory Rider may be issued to you), but when renewal is in the middle of the calendar year, the benefits already used during the calendar year will continue to count toward the total benefits available to you for that calendar year. Please refer to your Benefit Summary to see if benefits for your Plan are covered per calendar year or per Contract Year.

DEFINITIONS

The following defined terms have special meaning and may be found throughout this Agreement. They are referenced using capital letters like this (Upper Case).

ANNUAL ENROLLMENT PERIOD

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

APPEAL

The request for review when the Member disagrees with a decision regarding covered Health Services, benefits, Pre-Authorization, Pre-Certification or claims processing.

AUTISM SPECTRUM DISORDERS (ASD)

The pervasive developmental disorders set forth in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders", including but not limited to autistic disorder, Rett's disorder, childhood disintegrative disorder, Asperger's disorder, and pervasive developmental disorder not otherwise specified.

BEHAVIORAL HEALTH PROGRAM

A Delegated Program under which we may provide for management, administration and a network of providers for mental health, and alcohol and substance abuse services under this Agreement. 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 Agreement refers to determinations, Pre-Authorizations, Pre-Certifications, Referrals and other decisions made under the terms of the Behavioral Health Program, such determinations, Pre-Authorizations, Pre-Certifications, Referrals and other decisions are made by the Delegated Program on behalf of us and we have the ultimate authority to make these discretionary decisions. ***Referrals only apply to you if you are enrolled in either our HMO Personal Care Plan or our POS Personal Care Plan***.

BEHAVIORAL THERAPY
Any interactive Behavioral Therapy derived from evidence-based research, 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 autism 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 the Pre-Authorization or Pre-Certification for certain Medically Necessary health care services that require Pre-Authorization or Pre-Certification prior to the receipt of these services from or arranged by a Non-Participating Provider if your are enrolled in any of our *POS Plans*.

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

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

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

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

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

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

If your are enrolled in one of our *POS Plans*, Coinsurance means the percentage of the Maximum Allowable Amount that you are legally responsible to pay after any applicable Deductible is met.

When Coinsurance applies as a result of the In-Network Level Of Benefit, 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 Health Service at the time it is provided; or
- The contracted rate with the physician or provider for the Health Service.

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

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

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

CONNECTICARE, WE, US OR OUR
ConnectiCare, Inc., the health maintenance organization insuring this Plan.

CONTRACT YEAR
For group plans, a period of 12 months beginning on the effective date of this Agreement, and each 12-month period following the first one. A shorter or longer period of time may be agreed upon in writing by us and the Employer.

If you are enrolled in our non-group plan, the initial Contract Year begins on the effective date of this Agreement and ends on December 31st of that same year and then each calendar year thereafter.

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

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

COSMETIC TREATMENTS
Any medical or surgical treatment for which the primary purpose is to change appearance as we determine in our sole discretion.

Refer to the "Managed Care Rules And Guidelines" section to see if you have to use Participating Providers and to find out what services require Pre-Authorizations. Also refer to the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

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

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

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

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

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

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

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

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

In these cases, when this Agreement refers to determinations, Pre-Authorizations and other decisions made under the terms of that Delegated Program, such determinations, Pre-Authorizations, Referrals and other decisions are made by the outside company on our behalf. ***Referrals only apply to you if you are enrolled in either our HMO Personal Care Plan or our POS Personal Care Plan***

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

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

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

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

EMERGENCY SERVICES
Health Services required for an Emergency.

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

EMPLOYER
A business entity that meets our underwriting requirements, that is accepted by us, and that has entered into an Evidence Of Agreement with us.

ENROLLMENT FORM
The application form provided or approved by us, used to enroll or disenroll you and/or your covered dependents.

EVIDENCE OF AGREEMENT
The agreement between us and the Employer, which includes this Agreement and establishes such provisions as: Premiums; the Plan effective date; the effective date of coverage for Employees and Eligible Dependents and any special conditions.

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

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

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

HEALTH SERVICES
Those diagnostic and therapeutic, medical, surgical, and mental health services and supplies that are Medically Necessary and available to you and your covered dependents under this Plan. Health Services must be provided or rendered by a licensed health care provider within the scope of his, her or its license or authorization in accordance with the laws and regulations of the governmental authority having jurisdiction.

HOME HEALTH AGENCY
A duly licensed agency where:

1. Nursing care is provided by a registered nurse or licensed practical nurse;
2. Home health aide services consisting of patient care of a medical or therapeutic nature are provided by someone other than a registered or licensed practical nurse;
3. Physical, occupational or speech therapy is provided;
4. Certain medical supplies, drugs and medicines prescribed by a physician and laboratory services to the extent such services would be covered if Medically Necessary, as we determine, are provided; and
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 applicable laws;
2. Provide 24-hour-a-day, seven days-a-week service;
3. Be under the direction of a duly qualified physician;
4. Have a nurse coordinator who is a registered graduate nurse with clinical experience, including experience in caring for terminally ill patients;
5. Have as its main purpose the provision of hospice services;
6. Have a full-time administrator;
7. Maintain written records of services given to the patient, and
8. Maintain malpractice insurance coverage.

For purposes of this Plan, a Home Health Agency that provides hospice care in the home or a hospice, which is part of a Hospital, will be considered a Hospice.

HOSPITAL
An institution duly licensed as a hospital by the governmental authority having jurisdiction.

HOSPITALIZATION
Health Services rendered by a Hospital as either:

Inpatient Hospitalization: Those services rendered to a patient while that patient is assigned to a specific bed and location, and registered as an "inpatient" at a Hospital; or

Partial Hospitalization/Day Treatment Program: Those covered behavioral health services which are rendered in a facility or Hospital-based program that provides services for at least 20 hours per week.

INDIVIDUAL PRACTICE ASSOCIATION OR IPA
An individual practice association or other organization of providers, including but not limited to a physician-hospital organization (PHO) and a group practice, that has entered into a services arrangement with us or an affiliate or subcontractor of ours to provide Health Services to Members under this Plan.

Refer to the "Managed Care Rules And Guidelines" section to see if you have to use Participating Providers and to find out what services require Pre-Authorizations. Also refer to the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

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

IN-NETWORK LEVEL OF BENEFITS
Generally, the maximum level of benefits under this Plan available for Health Services provided to a Member directly by his or her Primary Care Provider (PCP) or upon Referral *(POS Personal Care Plan only)* from his or her PCP or, for mental health and alcohol and substance abuse care, from our Behavioral Health Program, to a Participating Provider if you are enrolled in one of our ***POS Plans***. The In-Network Level Of Benefits under this Plan is described in the Benefit Summary.

INSUFFICIENT EVIDENCE OF THERAPEUTIC VALUE
Insufficient Evidence Of Therapeutic Value occurs when we determine in our sole discretion that either:

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

There may be Insufficient Evidence Of Therapeutic Value for a Treatment even when it has been approved by a regulatory body or recommended by a health care practitioner, and the Treatment will not be covered.

INTENSIVE OUTPATIENT (IOP)
The level of behavioral health care which is less intensive than Partial Hospitalization, but more intensive than outpatient services. Typically, IOP services are customized to meet the individual patient's needs, but have the capacity for a maximum of three to five encounters per week of less than four hours each in duration. The range of services offered is designed to address a mental health or substance abuse disorder in a coordinated, interdisciplinary treatment modality.

LIFETIME MAXIMUM
The maximum total dollar amount allowable per Member for Health Services eligible for payment under this Plan. The Lifetime Maximum is listed in the Benefit Summary and applies as a combined, cumulative limit with respect to every condition, disease, or ailment of the Member for which benefits have been paid under this Plan (or an agreement with us that also had a Lifetime Maximum replaced by or replacing or amending this Plan with the same Employer). Please refer to the "Managed Care Rules And Guidelines" section for more information about how the Lifetime Maximum applies to your Plan.

MAXIMUM ALLOWABLE AMOUNT
The amount of a Non-Participating Provider's billed charge for a Health Service, which we use to determine what we reimburse under this Plan is the Maximum Allowable Amount if you are enrolled in any of our ***POS Plans***. Only charges that you are legally required to pay for a Health Service will count towards the Maximum Allowable Amount. So, if the physician or provider is not charging you for part or all of the Health Service and you are therefore not legally obligated to pay for that waived amount, we will not count that waived amount towards the Maximum Allowable Amount.

We have the sole authority to determine what we use for the Maximum Allowable Amount. The Maximum Allowable Amount can change from time to time, as well as the criteria we will use to determine the Maximum Allowable Amount. The Maximum Allowable Amount is determined using the following guidelines:

1. Generally, the Maximum Allowable Amount is based on a specified percentile of prevailing billed charges as determined by the Prevailing Healthcare Charge System (PHCS), or the amount specified by the fee for service Medicare Resource Based Relative Value System (RBRVS) multiplied by a conversion factor assigned by us.

   When the Employer chooses and pays the appropriate Premium for a higher percentile of PHCS than our standard, the percentile amount used to determine the Maximum Allowable Amount under this Plan will be specified in the Evidence Of Agreement.
2. For Health Services for which PHCS does not have prevailing billed charges or for which there is no amount specified by RBRVS, we will use a percentage of billed charges to determine the Maximum Allowable Amount.
3. The Maximum Allowable Amount may be a provider negotiated or discounted amount.
4. For a prescription drug administered in a physician's office, a facility, or at home, the Maximum Allowable Amount will be no less than the average wholesale price (AWP) as determined by us.
5. For a prescription drug or supply obtained at a pharmacy, the Maximum Allowable Amount will be the lesser of the actual charge for the medication or supply or the negotiated contracted rate for that medication or supply that we would have paid, if the medication or supply had been obtained at a Participating Pharmacy.

The Maximum Allowable Amount will never be more than the billed charges.

It is the Member's responsibility to pay Cost-Shares, Benefit Reductions and amounts charged by the provider in excess of the Maximum Allowable Amount. Where the Maximum Allowable Amount is a provider negotiated or discounted amount, the Member is not responsible for the provider's charge in excess of that amount.

You can contact us at the appropriate telephone number in the "Important Telephone Numbers And Addresses"

subsection of the "Important Information" section of this Membership Agreement if you need to determine the Maximum Allowable Amount for a claim.

MEDICALLY NECESSARY OR MEDICAL NECESSITY

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

1. In accordance with generally accepted standards of medical practice;
2. Clinically appropriate, in terms of type, frequency, extent, site and duration and considered effective for the patient's illness, injury or disease; 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, YOU, AND YOUR ELIGIBLE DEPENDENTS

A person enrolled in this Plan, including you and your Eligible Dependents.

MEMBERSHIP AGREEMENT OR AGREEMENT

This document (which includes the rights, benefits, terms, conditions and limitations of this Plan available to you and your covered dependents), and including the applicable Benefit Summary, Evidence Of Agreement, Riders, insert pages and Enrollment Forms.

NEW TREATMENTS

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

NON-PARTICIPATING HOSPITAL

A Hospital that is not a Participating Hospital.

NON-PARTICIPATING PHYSICIAN OR NON-PARTICIPATING PROVIDER

A duly licensed physician or health care provider that is not a Participating Physician or a Participating Provider.

OUT-OF-NETWORK LEVEL OF BENEFITS

Generally, a lesser level of benefits than the In-Network Level Of Benefits under this Plan available for Health Services provided to a Member when the Health Services are not eligible for benefit coverage at the In-Network Level Of Benefits if your are enrolled in one of our ***POS Plans***. Except in cases of Emergencies or as otherwise provided in this Agreement, Health Services obtained from or arranged by Non-Participating Providers or from Participating Providers without a Referral (where a Referral is necessary) from the Member's Primary Care Provider (PCP) or for mental health and alcohol and substance abuse care, a Referral (where a Referral is necessary) from our Behavioral Health Program, are payable at the Out-Of-Network Level Of Benefits. The Out-Of-Network Level Of Benefits for benefits under this Plan is the Coinsurance percentage described in the Benefit Summary multiplied by the Maximum Allowable Amount charges after any Copayments or Deductible is applied. If the Out-Of-Pocket Maximum is met for a Member in a year, then the Out-Of-Network Level Of Benefits is modified as described in the definition of Out-Of-Pocket Maximum, below, for the remainder of that year.

OUT-OF-PLAN SERVICES

Health care services rendered by a Non-Participating Provider, when you are enrolled in one of our ***HMO Plans***, where Participating Providers must be used.

OUT-OF-POCKET MAXIMUM

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

PARTICIPATING HOSPITAL

A Hospital that has entered into an agreement with us, an IPA or an affiliate or subcontractor of ours to provide certain Health Services to you and your covered dependents.

PARTICIPATING PHARMACY

A pharmacy that has entered into an agreement with us, an IPA or an affiliate or subcontractor of ours to provide covered prescription drugs and supplies to you and your covered dependents. A Participating Pharmacy does not include a Hospital pharmacy, even if the Hospital is a Participating Hospital.

PARTICIPATING PHYSICIAN

A health care professional duly licensed to practice as a physician who has entered into an agreement with us, an IPA, or an affiliate or a subcontractor of ours to provide certain Health Services to you and your covered dependents.

PARTICIPATING PROVIDER

A health care practitioner or facility including a Participating Physician, Participating Pharmacy, Participating Hospital or other similar practitioner or facility as prescribed by State law, that is duly licensed to provide health care services and

that has entered into an agreement with us, an IPA or an affiliate or a subcontractor of ours to provide certain Health Services to you and your covered dependents.

Participating Providers do not include Hospital-based clinics, even if the Hospital is a Participating Hospital, unless the Hospital clinic is specifically contracted with us.

PLAN
For group plans the program operated by us providing coverage for Health Services for Members upon which we and your Employer have agreed. For non-group plans, the non-group program issued to you, which is operated by us providing coverage for Health Services to Members.

PLAN BENEFITS
Health Services as specified in this Agreement.

PRE-AUTHORIZATION OR PRE-AUTHORIZED
The authorization, based on Medical Necessity, needed from us, or the applicable Delegated Program in advance of the Member's receipt of certain specified Health Services.

Pre-Authorization also includes the written authorization from us or the applicable Delegated Program, needed in advance of the Member's receipt of Health Services from a Non-Participating Provider in order to have those services or supplies covered at highest level of benefits under the Plan.

PRE-CERTIFICATION OR PRE-CERTIFIED
The registration and approval process, based on Medical Necessity, needed in advance of the Member's Partial Hospitalization or inpatient admission to a Hospital, Hospice, Residential Treatment Facility, Rehabilitation Facility or Skilled Nursing Facility that is obtained from us, or the applicable Delegated Program.

PREMIUM
The regular payments required to be made to us by you or the Employer as applicable under this Agreement to ensure that coverage remains in effect.

PRIMARY CARE PROVIDER OR PCP
A physician or a nurse practitioner who is a Participating Provider selected by or assigned to the Member, who is normally engaged in one of the following primary care specialties:

- ♥ Family medicine;
- ♥ Internal medicine; or
- ♥ Pediatrics; and

who is eligible to be listed as a PCP in the Provider Directory, as updated from time to time.

PROVIDER DIRECTORY
The listing of Participating Providers compiled and prepared for our benefit plans as updated from time to time.

PRUDENT LAYPERSON
A person who is without medical training and who draws on his or her practical experience when making a decision regarding whether Emergency medical treatment is needed. A Prudent Layperson will be considered to have acted "reasonably" if other similarly situated laypersons would have believed, on the basis of observation of the medical symptoms at hand, that Emergency medical treatment was necessary.

RADIOLOGY SERVICES PROGRAM
A Delegated Program under which we may provide for management, administration and a network of providers for outpatient diagnostic x-rays and therapeutic procedures under this Agreement. 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 Agreement refers to determinations, Pre-Authorizations, Referrals and other decisions made under the terms of the Radiology Services Program, such determinations, Pre-Authorizations, Referrals and other decisions are made by the Delegated Program on behalf of us and we have the ultimate authority to make these discretionary decisions. ***Referrals only apply to you if you are enrolled in either our HMO Personal Care Plan or our POS Personal Care Plan***.

REFERRAL
An approval communicated to us by the Member's Primary Care Provider (PCP) (or the covering physician designated by the Member's PCP), an OB/GYN that is a Participating Physician, or for mental health and alcohol and substance abuse care, from our Behavioral Health Program, which the Member must obtain prior to his or 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. ***Referrals only apply to you if you are enrolled in either our HMO Personal Care Plan or our POS Personal Care Plan***.

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 governmental or other authority having jurisdiction.

RESIDENTIAL TREATMENT FACILITY
A treatment center for children and adolescents that provides residential care and treatment for emotionally disturbed individuals and is licensed and accredited by the governmental authority having jurisdiction.

RIDER
A written amendment that modifies the terms and conditions of this Agreement. It may increase or decrease benefits, waive a condition of coverage, or alter this Agreement in another way.

SERVICE AREA
The State of Connecticut, including all cities and towns in the State of Connecticut existing now or at any time in the future.

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.

Refer to the "Managed Care Rules And Guidelines" section to see if you have to use Participating Providers and to find out what services require Pre-Authorizations. Also refer to the "Exclusions And Limitations" section to find out what services are not covered under this Plan.

SPECIALIST PHYSICIAN
A Participating Physician, other than the Member's PCP.

SUBSCRIBER OR YOU
You, when you are enrolled in this Plan and eligible to receive Plan Benefits.

TOTALLY DISABLED
With respect to an Employee, the inability of the Employee because of an injury or disease to perform the duties of any occupation for which he is suited by reason of education, training or experience, and, with respect to an Eligible Dependent, the inability of the Eligible Dependent because of an injury or disease to engage in substantially all of the normal activities of persons of like age and sex in good health.

URGENT CARE
Health Services for the treatment of a sudden and unexpected onset of illness or injury requiring care within 24 hours that can be treated in a physician's office or in an Urgent Care Center.

URGENT CARE CENTER OR WALK-IN-CENTER
A facility duly licensed to provide Urgent Care.

UTILIZATION MANAGEMENT
The process of evaluating and determining the coverage for and the appropriateness of medical care services, as well as providing any needed assistance to the clinician or the patient in cooperation with other parties, to ensure appropriate use of resources. Utilization Management includes Pre-Authorization, Pre-Certification, concurrent review, retrospective review, discharge planning and Case Management.

PLAN DESCRIPTION ADDENDUM

This addendum, in conjunction with this Agreement, any applicable Rider and the Provider Directory constitutes compliance with the disclosure requirements of Connecticut law, "AN ACT CONCERNING MANAGED CARE," regarding Plan Descriptions.

We are a for-profit health care center, organized under the Connecticut Business Corporations Act. If our status should change, you will be notified in our member newsletter.

We are also accredited by the National Committee for Quality Assurance (NCQA).

The following information is a summary of our 2008 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 our utilization review process. This information does not include review data for benefits managed or administered by an outside company under its own Connecticut utilization review license.

Utilization Review Data

Requests for Certification

46,487

Certification Denials

7,307, or approximately 15.7%

Number of Appeals of Denials

462, or 6.3%

Number of Denials Reversed Upon Appeal

159, or approximately 34.4%

Below are the ratios of medical and administrative costs to gross premium revenue for 2008.

Medical Loss Ratio

85.06%

Administrative Loss Ratio

15.02%

Quality Improvement Program

1. ConnectiCare makes information about its Quality Improvement Program available to all Members. This includes information about the quality information program, including goals, processes and outcomes as they relate to Member health and service. You may access this information at www.connecticare .com. If you would like a written copy, you should feel free to call our Member Services Department at the appropriate telephone number listed in the "Important Telephone Numbers And Addresses" subsection of the "Important Information" section of this Membership Agreement.
2. Connecticut law requires the State of Connecticut Insurance Department to develop and distribute a consumer report card, which compares:
   - ♥ All applicable licensed managed care organizations, and
   - ♥ The 15 largest licensed health insurers that use provider networks not included above.

Refer to the "Managed Care Rules And Guidelines" section to see if you have to use Participating Providers and to find out what services require Pre-Authorizations. Also refer to the "Exclusions And Limitations" section to find out what services are not covered under this Plan.