

For informational purposes, the Exchange staff provides the Advisory Committees with the following benefit exclusions included in the Certificate of Coverage that are relevant for each of the potential Essential Health Benefit benchmark plans.

Small Group Plans

- **Anthem BlueCare Health Maintenance Organization (HMO)**
- **Oxford Preferred Provider Organization (PPO)**
- **Aetna HMO**

Largest Non-Medicaid HMO

- **ConnectiCare HMO**

State Employee Health Benefit Plan

- **Anthem State Preferred Plan**
applies to both its Point-of-Service (POS) and Point-of-Enrollment (POE) plans
- **Oxford HMO**

Federal Employee Health Benefit Plan

- **Blue Cross and Blue Shield Service Benefit Plan**
applies to both the Standard Option and Basic Option
- **Government Employee Health Association, Inc. Benefit Plan**

Anthem. 

370 Bassett Road
North Haven, CT 06473

BlueCare Benefit Program

CERTIFICATE

PLEASE READ YOUR CERTIFICATE CAREFULLY

ADAM EQUIPMENT INC.

Group # 012593003

HBP # 1



2012-02-22

EXCLUSIONS AND LIMITATIONS

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

Please remember, this plan does not cover any service or supply not specifically listed as a covered service in this certificate. The following list of exclusions is not a complete list of all services, supplies, conditions or situations that are not covered services. If a service is not covered, then all services performed in conjunction with that service are not covered. Anthem BCBS is the final authority for determining if services or supplies are Medically Necessary.

The listed exclusions below are in addition to those set forth elsewhere in the Certificate.

The following services are not Covered Services under this Benefit Program; except when approved by Anthem BCBS as part of Case Management.

1. Benefits for services which are not:
 - a. Described in the Certificate;
 - b. Rendered or ordered by a Physician;
 - c. Within the scope of the Physician's, Provider's or Hospital's licensure, and
 - d. Medically Necessary Care for the proper diagnosis and treatment of the Member
2. Benefits may be reduced; or denied if subject to the Managed Benefits Managed Care Guidelines. Any reduced or denied benefits paid by the Member do not count towards any applicable Cost Share Maximums shown in the Schedule of Benefits.
3. Any reduction in benefits; including but not limited to: Penalties, imposed by another Plan; which are like those stated on the Managed Benefits Managed Care Guidelines, are not paid as a Covered Service.
4. Benefits for services rendered before the Member's Effective Date under this Benefit Program.
5. Benefits for services rendered after the person's Benefit Program has been: rescinded; suspended; cancelled; interrupted; or terminated. Any person getting services after his or her Benefit Program is: rescinded; suspended; cancelled; interrupted; or terminated for any reason will be liable for payment of such services.
6. Care for conditions that are required by State or Local law to be treated in a public facility.
7. Services and care in a Veteran's Hospital; or any Federal Hospital; except as may be required by law.
8. Services covered in whole; or in part by public; or private grants.
9. Studies related to pregnancy; except for major medical reasons.
10. Simplified or self-administered tests; and multiphasic screening.

11. Prenatal medical conferences with a pediatrician regarding an unborn child; unless the visit is the result of a medical referral.
12. Charges for the Member's room and board when the Member has a leave of absence from: the Hospital; Substance Abuse Treatment Facility; or other Inpatient Facility.
13. Evaluation; treatment; procedures; and Prescription Drugs related to and performance of sex-change operations including: follow-up treatment; care; and counseling.
14. Vaccines (other than routine immunizations; or those needed for travel).
15. Services; medical supplies; or supplies not listed as Covered Services. These include; but are not limited to: educational therapy; marital counseling; sex therapy; weight control programs; nutritional programs; and exercise programs.
16. Experimental or Investigational treatment; procedure; facility; equipment; drugs; devices; or supplies. Any services associated with; or as follow-up to any of the above is not a Covered Service.
17. Any treatment; procedure; facility; equipment; drug; device; or supply which requires Federal or other governmental agency approval not granted at the time services are rendered. Any service associated with; or as follow-up to; any of the above is not a Covered Service.
18. Any services by a Physician or Provider to himself or herself; or for services rendered to his or her: parent; spouse; children; grandchildren; or any other close family Member or relation; even if a Participating Physician or Participating Provider.
19. Services which the Member or Anthem BCBS is not legally required to pay.
20. Wigs; and other cranial prosthesis; except as noted in the Covered Services Section.
21. Inpatient services which can be properly rendered as Outpatient services.
22. Disease contracted; or injuries resulting from war.
23. Charges after the Provider's or Hospital's regular discharge hour on the day indicated for the Member's discharge by his/her Physician.
24. Eyeglasses; contact lenses.
25. Travel; whether or not recommended by a Physician.
26. Certain pulmonary function tests which; in the opinion of Anthem BCBS; do not meet the definition of a covered diagnostic laboratory test.
27. Services or procedures rendered without regard for specific clinical indications; routinely for groups or persons; or which are performed solely for research purposes.
28. Services or procedures which have become obsolete; or are no longer medically justified as determined by

appropriate medical fields.

29. Radiation therapy as a treatment for acne vulgaris.
30. Services required by third parties for: employment; membership; enrollment; or insurance, such as: school or employment physicals; physicals for summer camp; enrollment in health, athletic, or similar clubs; premarital blood work or physicals; or physicals required by insurance companies or court ordered alcohol or drug abuse courses.
31. Durable Medical Equipment and other items for home or personal use; except as provided in the Benefit section.
32. Prosthetic Devices; except as provided in the Benefit section. Examples of non-covered items include; but are not limited to:
 - Bite plates/dental prosthetics; except for maxillo-facial Prosthetic Devices used to replace anatomic structures lost during treatment of tumors;
 - Optical; or visual aids; including: eyeglasses or contact lenses; except for the treatment of: congenital aphakia; or for aphakia following cataract surgery when an intraocular lens is not medically possible;
 - Penile implants;
 - Xomed audiant bone conductors;
 - Orthotics (except for Medically necessary: molded foot orthotics; abduction; and rotation bars. One set/pair per Member per Calendar Year); arch supports; and corrective shoes;
 - Experimental; or research prostheses.
33. Treatment of pattern baldness;
34. Items generally used for personal comfort and/or useful to the Member's household; including but not limited to:
 - Air conditioners; humidifiers; air cleaners; filtration units; and related apparatus;
 - Whirlpools; saunas; and related apparatus;
 - Vans; and van lifts;
 - Stair; and chair lifts;
 - Exercise bicycles; and other types of exercise equipment
35. Physical therapy; chiropractic care; occupational therapy; speech therapy; and cardiac rehabilitative therapy; except as provided in the Benefit section.
36. Testing for or treatment of a Learning Disability; except as provided in the Benefit section.
37. Testing; training; or rehabilitation for educational; or developmental purposes; except as provided in the Benefit section.
38. Cosmetic surgeries, procedures and services performed primarily to improve appearance and not otherwise determined by Anthem BCBS to meet the coverage criteria for reconstructive surgeries, procedures and services as set forth in this Certificate.
39. Dental diagnosis; care; treatment or diagnostic imaging studies; except as provided in the Benefit section. Examples of non-Covered Services include; but are not limited to: the extraction of impacted wisdom teeth; correction of malposition of the teeth and jaw; treatment of dental caries; periodontics; endodontics; orthodontics; replacement of teeth; bonding; gold foil restorations; application of sealants; bitewing x-rays; crown or tooth preparations; fillings; crowns; bridges; dentures; inlays and onlays; and services with respect to congenital malformations. Anesthesia;

x-ray; laboratory; or facility fees for dental non-Covered Services shall also not be covered. Prosthetic Devices are not a Covered Service; except as provided in the Benefit section.

40. Oral surgery; except as provided in the Benefit section. An example of a non-Covered Service is; but is not limited to: the correction of malposition of the teeth or jaw; or the teeth and jaw.
41. Surgical exam; diagnosis; including: invasive (internal) and non-invasive (external) procedures and tests; and all services related to diagnosis and treatment; both medical and surgical; of temporomandibular joint dysfunction or syndrome also called myofascial pain dysfunction or craniomandibular pain syndrome. Examples of non-Covered Services include; but are not limited to: physiotherapy, such as therapeutic muscle exercises; galvanic or transcutaneous nerve stimulation; vapocoolant sprays, ultrasound or diathermy; behavior modification such as: biofeedback psychotherapy; Appliance therapy such as: occlusal Appliances (splints); or other oral Prosthetic Devices; and their adjustments; orthodontic therapy such as: braces; prosthodontic therapy such as: crowns; bridgework; and occlusal adjustments.
42. Routine foot care rendered:
 - a. In the exam, treatment or removal of all or part of: corns; callosities; hypertrophy; or hyperplasia of the skin; or subcutaneous tissues of the foot; or
 - b. In the cutting; trimming; or other non-operative partial removal of toenails; except when Medically Necessary in the treatment of neuro-circulatory conditions.
43. Emergency room services that are not related to a Medical Emergency.
44. Custodial Care when:
 - a. Primarily to provide room and board (with or without nursing care); and
 - b. Needed to help to support the essentials of daily living; and
 - c. Supervisory care by a Physician for a Member who is mentally or physically disabled; and who is not under active and specific medical; surgical; and/or psychiatric treatment which would be expected to reduce the disability to the extent needed for the Member to function outside a: protected; monitored; and/or controlled environment; or when despite such treatment there is no reasonable likelihood that the disability shall be so reduced.

Care shall be considered custodial even if:

- a. The Member is under the care of the Primary Care Physician; or a Participating Physician;
 - b. The Primary Care Physician or the Participating Physician prescribes services to: support; and maintain the Member's condition; or
 - c. The services and supplies are being provided by a registered nurse; or licensed practical nurse.
45. Ambulance services, including but not limited to:
 - a. Transport for elective Hospital Admissions; and

- b. Transport solely for the convenience of: the Member; family; or physician or Provider; except when Medically necessary; or in the case of a Medical Emergency.
- 46. Private room accommodations; except as noted in the Benefit section.
- 47. Drugs or medications; legend and over-the-counter; prescribed for use as an Outpatient; except as otherwise stated herein.
- 48. Whole blood; blood plasma; and other blood derivatives; and donor services that are provided by the American Red Cross.
- 49. Contraceptive devices.
- 50. Reversal of voluntary sterilization.
- 51. Sperm collection and preservation; all services related to surrogate parenting arrangements; and preparatory treatment.
- 52. Marriage counseling other than for the treatment of: a diagnosed mental illness; stress management; parent-child management; and pain control.
- 53. Psychiatric and other treatment for sexual dysfunction; including: sex therapy; unless documented to be caused by a medical condition and Prior Authorized by Anthem BCBS.
- 54. Care; treatment; procedures; services; or supplies that are primarily for dietary control including; but not limited to: any exercise or weight reduction programs; whether formal or informal; and whether or not recommended by a physician or Provider.
- 55. Special nutritional formulas for the treatment of Crohn's disease.
- 56. Human organ and tissue transplants; or associated donor costs; except as stated in the Benefit section.
- 57. Care; treatment; service; or supplies to the extent that the Member has obtained benefits under any applicable law; government program; or public or private grant; except for: Medicare; Medicaid; or any similar state program.
- 58. Any illness or injury for which benefits are paid; payable; or eligible for coverage under any Worker's Compensation Law; Automobile; or no-fault law to the extent permissible by law, or other similar law.
- 59. Anthem BCBS does not have to pay for expenses of services; which the Member or Anthem BCBS is not legally required to pay.
- 60. Routine eye exams; or refractions; except as provided in the Benefit Description.
- 61. Radial keratotomy.
- 62. Eye exercises and visual therapy.
- 63. Human growth hormone therapy; except when Medically Necessary for cases of hypopituitarism; and with Prior

Authorization from Anthem BCBS.

64. Hospital Outpatient clinic services.
65. Penalties imposed on a Member by the primary payer.
66. Inpatient private duty nursing.
67. Any medication or drug; which has a biotechnical application; is a genetically engineered biological product; or is listed in the formulary as such.
68. Hypodermic needles or syringes prescribed by a physician; except for the purpose of administering medicine for medical conditions; provided such medicines are Covered Services.
69. No benefits will be available for Maintenance Care which is:
 - a. Treatment provided for the Member's continued well-being by preventing deterioration of a chronic clinical condition; and
 - b. Maintenance of an achieved stationary status; which is a point where little; or no improvement in musculo-skeletal function can be made despite therapy.

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

70. All other services and items of care not listed in this Subscriber agreement; except as provided by Riders to this Benefit Program and agreed upon by both parties.
71. Benefits for services caused by or resulting from the Member's participation in a: riot or civil disorder; act of or attempt to commit an assault or felony.
72. Services for Chronic Care.
73. The following is a list of procedures which are not covered:
 1. Allogeneic; or Syngeneic Bone Marrow Transplant; or other forms of stem cell rescue; and stem cell infusion (with or without high dose chemotherapy and/or radiation) are those with a donor other than the patient. They are not covered; except in the following cases:
 - a. When at least five out of six histocompatibility complex antigens match between the patient; and the donor.
 - b. The mixed leukocyte culture is non-reactive.
 - c. One of the following conditions is being treated:
 - *Severe aplastic anemia;
 - *Acute nonlymphocytic leukemia in first or subsequent remission or early first relapse;

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

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

2. Autologous Bone Marrow Transplantation; or other forms of stem cell rescue; and stem cell infusion (in which the patient is the donor) with high dose chemotherapy or radiation are not covered except for the following:
 - a. Non-Hodgkin's lymphoma; high grade; first or subsequent remission. No morphological evidence of bone marrow involvement should be evident.
 - b. Hodgkin's disease as defined above with an absence of bone marrow involvement.
 - c. Acute nonlymphocytic leukemia in second remission; in which no HLA matched donor exists; or an allogeneic transplant is inappropriate.
 - d. Acute lymphocytic leukemia in second remission; in which no HLA matched donor exists; or an allogeneic transplant is inappropriate.
 - e. Retinoblastoma; adjuvant setting after successful induction (consolidation).
 - f. Neuroblastoma; adjuvant setting after successful induction (consolidation).

Autologous Bone Marrow Transplants; or other forms of stem cell rescue; and stem cell infusion (with high dose chemotherapy and/or radiation); for all other cases are not covered.

74. Any exclusion above will not apply to the extent that:

Coverage is specifically provided by name in this Plan; or

Coverage of the charges is required under any law that applies to the coverage.

75. No Benefits are available for any service, care, procedure or program for weight or appetite control, weight loss, weight management or for control of obesity even if the weight or obesity aggravates another condition.



When you receive Covered Services for an Urgent Care situation (as described above) from a non-Network Provider, outside of the Service Area, We will limit reimbursement to Our Fee Schedule.

Exclusions and Limitations

- Routine care is not Covered in an Urgent Care Center. Follow-up care is not Covered in an Urgent Care Center.
- All other applicable exclusions and limitations as listed in the “Exclusions and Limitations” Section applies.

8. Ambulance Services

Ambulance services for life-threatening Medical Emergencies will be Covered. Ambulance services for all other Medical Emergencies will be Covered when Medically Necessary. The Medical Management Coordinator will make this determination at the time of your call.

Inter-facility ambulance transfers will also be Covered if they receive Precertification.

9. Reimbursement and Copayments

When you receive Covered Services for a Medical Emergency or Urgent Care (as described above) from a Network Provider your Covered Services are Covered in full, less any required Copayment or Coinsurance listed in the Summary of Benefits.

When you receive Covered Services for a Medical Emergency or Urgent Care situation (as described above) from a non-Network Provider, We will limit reimbursement to the Usual, Customary and Reasonable Charges for those expenses. UCR is the amount charged or the amount We determine to be the reasonable charge, whichever is less, for a particular Covered Service in the geographical area it is performed. Additionally, reimbursement is subject to the applicable Copayment, Deductible and Coinsurance.

You are responsible for the applicable Copayment or Deductible and Coinsurance listed in the Summary of Benefits for each office visit, emergency room visit or emergency admission.

Copayments, Deductible and Coinsurance

Please see your Summary of Benefits for the applicable Copayment, Deductible and Coinsurance information.

Exclusions and Limitations

- Improper use of an emergency room or emergency admissions are not Covered. Routine care and treatment for conditions that We determine were not Medical Emergencies, when received in an emergency room, are not Covered. If you are not certain whether the services you received are Covered, please submit them to Us for review.
- All other applicable exclusions and limitations as listed in the “Exclusions and Limitations” Section applies.

Section III.

Exclusions and Limitations

Unless coverage is specifically provided under this Certificate or provided under a rider or attachment to this Certificate, the following services and benefits are not Covered.

1. Services which are not Medically Necessary. If there is a dispute between a Provider and Us about the Medical Necessity of a service or supply, you or your Physician may appeal Our decision. Any disputed service or supply will not be Covered during the appeal process (please refer to the “Utilization Review Appeal” provision of this Certificate).
2. Fifty percent or \$500, whichever is less of the benefits normally payable for Covered Services for which a required Precertification was not obtained.
3. Acupuncture therapy.
4. An adopted newly born infant's initial hospital stay if the natural parent has coverage available for the infant's care.
5. Blood, blood plasma and blood derivatives other than as described as Covered under Section II of this Certificate. Synthetic blood, apheresis or plasmapheresis, the collection and storage of blood or the cost of securing the services of blood donors are not Covered.
6. Birth control pills, implantable contraceptive drugs, condoms, foams or devices, IUDs, diaphragms, contraceptive jellies and ointments even if they are being prescribed or recommended for a medical condition other than birth control. Please check your Summary of Benefits to see if coverage of these items has been added through a Prescription Drug Rider.
7. Care for conditions that by federal, state or local law must be treated in a public facility including, but not limited to, commitments for mental illness. Additionally, to the extent allowed by law, we do not Cover care or treatment provided in a Hospital that is owned or operated by any federal, state or other governmental entity.
8. Comfort or convenience items including, but not limited to: barber services; guest meals and accommodations; telephone, television or radio charges; travel expenses; or take-home supplies. We also do not Cover the purchase or rental of household fixtures or equipment including, but not limited to: escalators; elevators; swimming pools; exercise cycles; air purifiers; air conditioners; water purifiers; allergenic pillows, mattresses or waterbeds.

9. Cosmetic surgery, plastic or reconstructive surgery which is performed primarily to improve the appearance of any portion of the body including but not limited to: surgery for sagging of extra skin; any augmentation or reduction procedure (e.g., mammoplasty); liposuction; keloids; rhinoplasty and associated surgery.

Complications of such surgeries are Covered only if they are Medically Necessary and are otherwise Covered. Remedial work is not Covered.

10. Court ordered services or services that have been ordered as a condition of probation or parole. However, these services may be Covered if We agree that the services are Medically Necessary, are otherwise Covered, the Member has not exhausted their benefit for the Calendar Year, and the treatment is provided in accordance with our policies and procedures.

11. Custodial care, domiciliary care, long-term care, maintenance care, adult day care or rest cures. We do not Cover room, board, nursing care or personal care which is rendered to assist a Member who, in Our opinion, has reached the maximum level of physical or mental function possible and will not make further significant clinical improvement.

12. Dental services related to the care, filling, removal or replacement of teeth and the treatment of injuries or diseases of the teeth, gums and temporomandibular joint, including, but not limited to: apicoectomy, orthodontics, root canals, soft tissue impaction, temporomandibular joint dysfunction therapy, alveolectomy, treatment of periodontal disease or orthognathic surgery. As described in Section II, 2, G, "Oral Surgery," only dental services required to treat accidental injury of sound, natural teeth are Covered.

13. Detoxification.

14. Diabetic services or supplies as follows. The following are not Covered as diabetic services or supplies: services or supplies that are not both Medically Necessary and prescribed by the Member's Physician or qualified health professional; membership in health clubs, diet clubs or plans for the purpose of losing weight even if recommended by the Member's Physician or qualified health professional; any counseling or courses in diabetes management other than as described as Covered under this Certificate; stays at special facilities or spas for the purpose of diabetes education or management; and special foods, diets aids and supplements related to dieting;

15. TENS units are Covered only when certain medical criteria are met.

16. Equipment, clothing, vitamins, supplements or other items and services that may be offered by a Naturopath.

17. Experimental, investigational or ineffective; surgical or medical treatments, procedures, drugs, or research studies including, but not limited to: transplants, stem cell retrieval, cancer chemotherapy protocols, AIDS clinical trials or I.V. therapies that are not recognized as acceptable medical practice and any such services where federal or other governmental agency approval is required

but has not been granted. We will make the determination as to whether the requested service is excluded in accordance with this provision. In certain instances, such procedures may be Covered if they are approved in advance by Our Medical Advisory Board and provided in accordance with the provisions of this Certificate.

We will Cover autologous bone marrow transplants combined with high dose chemotherapy when medically appropriate, for the treatment of: advanced neuroblastoma, second remission acute leukemia, relapsed Hodgkin's disease, relapsed non-Hodgkin's lymphoma, and metastatic breast cancer or any other diagnosis that Our Medical Advisory Board determines to be appropriate. Such treatment must be approved in advance by Our Medical Advisory Board and provided in accordance with the provisions of this Certificate.

18. Improper use of an emergency room or emergency admissions. Routine care and treatment for conditions that We determine were not Medical Emergencies, when received in an emergency room, are not Covered. If you are not certain whether the services you received are Covered, please submit them to Us for review.

19. Learning and behavioral disorders. Services for the evaluation or treatment (including remedial education) of: learning disabilities or minimal brain dysfunction; mental retardation; developmental and learning disorders or behavioral problems except as noted under the "Early Intervention Services/ Birth to Three Program" section. We also do not Cover behavioral training or cognitive rehabilitation.

20. When Medicare is the primary payor, We Cover the Services provided by this Certificate only to the extent they are not Covered under Medicare.

21. Military service related conditions. Conditions that are connected with a Member's service in the military and for which the Member is legally entitled to receive services at a government facility provided the facilities are reasonably available to the Member (maximum three hour drive time).

22. No-fault automobile insurance. Any Covered Services that are payable as personal injury benefits under mandatory no-fault automobile insurance. Where permitted by state law, any Covered Services which are eligible for payment under the provisions of an automobile insurance contract or pursuant to any federal or state law which mandates indemnification for such services to persons suffering bodily injury from motor vehicle accidents.

23. Non-eligible institutions. Any services or supplies furnished by a non-eligible institution, which is defined as other than a Hospital or Skilled Nursing Facility, and which is primarily a place of rest, a place for the aged, or any similar institution, regardless of how denominated.

24. Non-medical services and long-term rehabilitation services for physical therapy or the treatment of alcoholism or drug abuse, including rehabilitation services in a specialized inpatient or residential facility, except as specifically Covered under this Certificate.

25. No-show charges. If a Provider charges a fee for a missed appointment, you will be responsible for the payment of the fee.

26. Occupational conditions, ailments, or injuries arising out of and in the course of employment. Such conditions, ailments or injuries are not Covered if they are subject to coverage, in whole or in part, under any workers' compensation, occupational disease or similar law. This applies even if the Member's rights have been waived or qualified.

27. Outpatient prescription drugs. Please check your Summary of Benefits to see if coverage of these items has been added through a rider.

28. Private or special duty nursing.

29. Recreational, educational or sleep therapy and related diagnostic testing.

30. Rehabilitation services or physical therapy on a long-term basis. Speech or occupational therapy to correct a condition that is not the result of a disease, injury or a congenital defect for which surgery has been performed.

31. Routine foot care including nail trimming, corn and callous removal, cleaning, soaking or any other hygienic maintenance or care.

32. Sex, marital or religious counseling, including sex therapy and treatment of sexual dysfunction.

33. Sex Transformations. Any procedure or treatment designed to alter the physical characteristics of a Member from the Member's biological sex to those of the opposite sex regardless of any diagnosis of gender role or psychosexual orientation problems.

34. Special foods and diets, supplements, vitamins and enteral feedings except as noted under the "Medically Necessary Infant Formula and Specialized Formulas" section. Please check your Summary of Benefits to see if coverage of these items has been added through a Prescription Drug Rider.

35. Special medical reports not directly related to treatment. Appearances in court or at a hearing.

36. Temporomandibular joint syndrome. Dental procedures and appliances for the treatment of temporomandibular joint syndrome or craniomandibular pain syndrome. Surgical and nonsurgical medical procedures are Covered if Precertified and approved by Our Medical Director.

37. Third party requests for physical examinations, diagnostic services and immunizations in connection with: obtaining or continuing employment; obtaining or maintaining any license issued by a municipality, state or federal government; obtaining insurance coverage; foreign travel; school admissions or attendance including examinations required for participation in athletic activities.

38. Transplant services required by a Member when the Member serves as an organ donor are not Covered unless the recipient is a Member. The medical expenses of a non-Member acting as a donor for a Member are not Covered if the non-Member's expenses will be covered under another health plan or program. Donor fees in connection with organ transplant surgery are excluded. We do not Cover travel expenses, lodging, meals or other accommodations for, donors or guests.

39. Coverage Outside of the United States. No coverage is available outside of the United States **if the Member traveled out-of-the country to obtain medical treatment**, drugs or supplies (with the exception of Canada, Mexico and U.S. possessions). Additionally, We will not Cover any treatment, drugs or supplies that are unavailable or illegal in the United States.

When a Member is traveling for other purposes, only Medical Emergencies and Urgent Care will be Covered outside of the United States (with the exception of Canada, Mexico and U.S. possessions).

40. Usual, Customary and Reasonable Charges (UCR). Any charges by a Non-Network Provider that are in excess of the UCR Charges, as determined by Us, for Covered Services are excluded from coverage and are the Member's responsibility.

41. Eye glasses, hearing aids (except for children age 12 and under as outlined in the Certificate) and examinations for the prescription or fitting thereof.

42. Weight Control. All services, supplies, programs and surgical procedures for the purpose of weight control; unless Medically Necessary for the treatment of morbid obesity.

43. Wigs, or any other appliance or procedure related to hair loss regardless of the disease or injury causing the Member's hair loss.

44. Any service, supply or treatment not specifically listed in this Certificate as a Covered Service, supply or treatment. Any supply or treatment for which the Member has no legal obligation to reimburse the provider. Any supply or treatment provided by a member of the Member's immediate family (e.g. spouse, mother, step-mother, father, step-father, sister, step-sister, brother, step-brother or any "in-law").

Section IV.

Grievance and Appeal Procedure

How Will the Plan Handle Any Questions or Problems?

Our Grievance Procedure provides for a meaningful, dignified and confidential procedure to hear and resolve Grievances between

TEXT TAG CMPPECT0521

**AETNA HEALTH INC.
(CONNECTICUT)**

CERTIFICATE OF COVERAGE

This Certificate of Coverage ("**Certificate**") is part of the Group Agreement ("**Group Agreement**") between Aetna Health Inc., hereinafter referred to as **HMO**, and the **Contract Holder**. The **Group Agreement** determines the terms and conditions of coverage. The **Certificate** describes covered health care benefits. Provisions of this **Certificate** include the Schedule of Benefits, any riders, and any amendments, endorsements, inserts, or attachments. Riders, amendments, endorsements, inserts, or attachments may be delivered with the **Certificate** or added thereafter.

HMO agrees with the **Contract Holder** to provide coverage for benefits, in accordance with the conditions, rights, and privileges as set forth in this **Certificate**. **Members** covered under this **Certificate** are subject to all the conditions and provisions of the **Group Agreement**.

Coverage is not provided for any services received before coverage starts or after coverage ends, except as shown in the Continuation and Conversion section of this **Certificate**.

Certain words have specific meanings when used in this **Certificate**. The defined terms appear in bold type with initial capital letters. The definitions of those terms are found in the Definitions section of this **Certificate**.

This Certificate is not in lieu of insurance for Workers' Compensation. This Certificate is governed by applicable federal law and the laws of Connecticut.

READ THIS ENTIRE CERTIFICATE CAREFULLY. IT DESCRIBES THE RIGHTS AND OBLIGATIONS OF MEMBERS AND HMO. IT IS THE CONTRACT HOLDER'S AND THE MEMBER'S RESPONSIBILITY TO UNDERSTAND THE TERMS AND CONDITIONS IN THIS CERTIFICATE.

IN SOME CIRCUMSTANCES, CERTAIN MEDICAL SERVICES ARE NOT COVERED OR MAY REQUIRE PRE-AUTHORIZATION BY HMO.

NO SERVICES ARE COVERED UNDER THIS CERTIFICATE IN THE ABSENCE OF PAYMENT OF CURRENT PREMIUMS SUBJECT TO THE GRACE PERIOD AND THE PREMIUMS SECTION OF THE GROUP AGREEMENT.

THIS CERTIFICATE APPLIES TO COVERAGE ONLY AND DOES NOT RESTRICT A MEMBER'S ABILITY TO RECEIVE HEALTH CARE SERVICES THAT ARE NOT, OR MIGHT NOT BE, COVERED BENEFITS UNDER THIS CERTIFICATE.

PARTICIPATING PROVIDERS, NON-PARTICIPATING PROVIDERS, INSTITUTIONS, FACILITIES OR AGENCIES ARE NEITHER AGENTS NOR EMPLOYEES OF HMO.

Important

Unless otherwise specifically provided, no Member has the right to receive the benefits of this plan for health care services or supplies furnished following termination of coverage. Benefits of this plan are available only for services or supplies furnished during the term the coverage is in effect and while the individual claiming the benefits is actually covered by the Group Agreement. Benefits may be modified during the term of this plan as specifically provided under the terms of the Group Agreement or upon renewal. If benefits are modified, the revised benefits (including any reduction in benefits or elimination of benefits) apply for services or supplies furnished on or after the effective date of the modification. There is no vested right to receive the benefits of the Group Agreement.

DD. **Additional Benefits.**

- **Durable Medical Equipment Benefits.**

Durable Medical Equipment will be provided when pre-authorized by **HMO**. The wide variety of **Durable Medical Equipment** and continuing development of patient care equipment makes it impractical to provide a complete listing, therefore, the **HMO** Medical Director has the authority to approve requests on a case-by-case basis. Covered **Durable Medical Equipment** includes those items covered by Medicare unless excluded in the Exclusions and Limitations section of this **Certificate**. **HMO** reserves the right to provide the most cost efficient and least restrictive level of service or item which can be safely and effectively provided. The decision to rent or purchase is at the discretion of **HMO**.

Instruction and appropriate services required for the **Member** to properly use the item, such as attachment or insertion, is also covered upon pre-authorization by **HMO**. Replacement, repairs and maintenance are covered only if it is demonstrated to the **HMO** that:

1. it is needed due to a change in the **Member's** physical condition; or
2. it is likely to cost less to buy a replacement than to repair the existing equipment or to rent like equipment.

All maintenance and repairs that result from a misuse or abuse are a **Member's** responsibility.

A **Copayment**, an annual maximum out-of-pocket limit, and a annual maximum benefit may apply to this service. Refer to the Schedule of Benefits attached to this **Certificate**.

For information on Pediatric Hearing Aid benefit maximums, refer to the Pediatric Hearing Aid Benefits provision above.

EXCLUSIONS AND LIMITATIONS

A. **Exclusions.**

The following are not **Covered Benefits** except as described in the Covered Benefits section of this **Certificate** or by rider(s) and/or amendment(s) attached to this **Certificate**:

- Ambulance services, for routine transportation to receive outpatient or inpatient services.
- Biofeedback, except as pre-authorized by **HMO**.
- Blood and blood plasma, including but not limited to, provision of blood, blood plasma, blood derivatives, synthetic blood or blood products other than blood derived clotting factors, the collection or storage of blood plasma, the cost of receiving the services of professional blood donors, apheresis or plasmapheresis. Only administration, processing of blood, processing fees, and fees related to autologous blood donations are covered.
- Care for conditions that state or local laws require to be treated in a public facility, including but not limited to, mental illness commitments.
- Care furnished to provide a safe surrounding, including the charges for providing a surrounding free from exposure that can worsen the disease or injury.

- **Cosmetic Surgery**, or treatment relating to the consequences of, or as a result of, **Cosmetic Surgery**, other than **Medically Necessary Services**. This exclusion includes, but is not limited to, surgery to correct gynecomastia and breast augmentation procedures, and otoplasties. Reduction mammoplasty, except when determined to be **Medically Necessary** by an **HMO** Medical Director, is not covered. This exclusion does not apply to surgery to correct the results of injuries causing the impairment, or as a continuation of a staged reconstruction procedure, or congenital defects necessary to restore normal bodily functions, including but not limited to, cleft lip and cleft palate. This exclusion does not apply to mastectomy and breast reconstruction after mastectomy pursuant to Connecticut Public Act 97-198.
- Costs for services resulting from the commission of, or attempt to commit a felony by the **Member**.
- Court ordered services, or those required by court order as a condition of parole or probation.
- **Custodial Care**.
- Dental services, including but not limited to, services related to the care, filling, removal or replacement of teeth and treatment of injuries to or diseases of the teeth, dental services related to the gums, apicoectomy (dental root resection), orthodontics, root canal treatment, soft tissue impactions, alveolectomy, augmentation and vestibuloplasty treatment of periodontal disease, false teeth, prosthetic restoration of dental implants, and dental implants. This exclusion does not apply to orthodontic processes and appliances for the treatment of craniofacial disorders for **Member's** 18 years of age or younger as outlined in the Covered Benefits section of this **Certificate**.
- Educational services and treatment of behavioral disorders, together with services for remedial education including evaluation or treatment of learning disabilities, minimal brain dysfunction, developmental and learning disorders, behavioral training, and cognitive rehabilitation. This includes services, treatment or educational testing and training related to behavioral (conduct) problems, learning disabilities, or developmental delays. Special education, including lessons in sign language to instruct a **Member**, whose ability to speak has been lost or impaired, to function without that ability, are not covered.
- **Experimental** or **Investigational Procedures**, or ineffective surgical, medical, psychiatric, or dental treatments or procedures, research studies, or other experimental or investigational health care procedures or pharmacological regimes as determined by **HMO**, unless pre-authorized by **HMO**.

This exclusion will not apply with respect to drugs:

1. that have been granted treatment investigational new drug (IND) or Group c/treatment IND status;
2. that are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute or Federal Drug Administration; or
3. **HMO** has determined that available scientific evidence demonstrates that the drug is effective or the drug shows promise of being effective for the disease.

A **Member** who has been diagnosed with a condition that creates a life expectancy of less than two years and has been denied an otherwise covered procedure, treatment or drug on the grounds that it is **Experimental**, may request an expedited **Appeal** and may **Appeal** a denial thereof to the Insurance Commissioner.

- Hair analysis.
- Hearing aids; except as provided in the **Covered Benefits** section.
- Home births; except **Covered Benefits** related to complications of home births.
- Home uterine activity monitoring.
- Household equipment, including but not limited to, the purchase or rental of exercise cycles, water purifiers, hypo-allergenic pillows, mattresses or waterbeds, whirlpool or swimming pools, exercise and massage equipment, central or unit air conditioners, air purifiers, humidifiers, dehumidifiers, escalators, elevators, ramps, stair glides, emergency alert equipment, handrails, heat appliances, improvements made to a **Member's** house or place of business, and adjustments made to vehicles.
- Hypnotherapy, except when pre-authorized by **HMO**.
- Implantable drugs, except contraceptive implantable drugs.
- Military service related diseases, disabilities or injuries for which the **Member** is legally entitled to receive treatment at government facilities and which facilities are reasonably available to the **Member**.
- Missed appointment charges.
- Non-medically necessary services, including but not limited to, those services and supplies:
 1. which are not **Medically Necessary**, as determined by **HMO**, for the diagnosis and treatment of illness, injury, restoration of physiological functions, or covered preventive services;
 2. that do not require the technical skills of a medical, mental health or a dental professional;
 3. furnished mainly for the personal comfort or convenience of the **Member**, or any person who cares for the **Member**, or any person who is part of the **Member's** family, or any **Provider**;
 4. furnished solely because the **Member** is an inpatient on any day in which the **Member's** disease or injury could safely and adequately be diagnosed or treated while not confined;
 5. furnished solely because of the setting if the service or supply could safely and adequately be furnished in a **Physician's** or a dentist's office or other less costly setting.
- Nursing and home health aide services provided outside of the home (such as in conjunction with school, vacation, work or recreational activities).
- Orthotics.
- Outpatient supplies, including but not limited to, medical consumable or disposable supplies such as syringes, incontinence pads, elastic stockings, and reagent strips. This exclusion does not apply to Diabetic or Ostomy Supplies, as listed in the Covered Benefits section of this **Certificate**.
- Payment for that portion of the benefit for which Medicare or another party is the primary payer.

- Personal comfort or convenience items, including those services and supplies not directly related to medical care, such as guest meals and accommodations, barber services, telephone charges, radio and television rentals, homemaker services, travel expenses, take-home supplies, and other like items and services.
- Prescription or non-prescription drugs and medicines, except for insulin and those provided on an inpatient basis.
- Private Duty Nursing (See the Home Health Benefits section regarding coverage of nursing services).
- Recreational, educational, and sleep therapy, including any related diagnostic testing.
- Religious, marital and sex counseling, including services and treatment related to religious counseling, marital/relationship counseling, and sex therapy.
- Reversal of voluntary sterilizations, including related follow-up care and treatment of complications of such procedures.
- Routine foot/hand care, including routine reduction of nails, calluses and corns.
- Services for which a **Member** is not legally obligated to pay in the absence of this coverage.
- Services for the treatment of sexual dysfunctions or inadequacies, including therapy, supplies, or counseling for sexual dysfunctions or inadequacies that do not have a physiological or organic basis.
- Services, including those related to pregnancy, rendered before the effective date or after the termination of the **Member's** coverage, unless coverage is continued under the Continuation and Conversion section of this **Certificate**.
- Services performed by a relative of a **Member** for which, in the absence of any health benefits coverage, no charge would be made.
- Services required by third parties, including but not limited to, physical examinations, diagnostic services and immunizations in connection with obtaining or continuing employment, obtaining or maintaining any license issued by a municipality, state, or federal government, securing insurance coverage, travel, school admissions or attendance, including examinations required to participate in athletics, except when such examinations are considered to be part of an appropriate schedule of wellness services.
- Services which are not a **Covered Benefit** under this **Certificate**, even when a prior **Referral** has been issued by a **PCP**.
- Specific non-standard allergy services and supplies, including but not limited to, skin titration (wrinkle method), cytotoxicity testing (Bryan's Test), treatment of non-specific candida sensitivity, and urine autoinjections.
- Specific injectable drugs, including:
 1. experimental drugs or medications, or drugs or medications that have not been proven safe and effective for a specific disease or approved for a mode of treatment by the Food and Drug Administration (FDA) and the National Institutes of Health (NIH);
 2. drugs related to the treatment of non-covered services; and

3. drugs related to the treatment of infertility, contraception, and performance enhancing steroids.
- Special medical reports, including those not directly related to treatment of the **Member**, e.g., employment or insurance physicals, and reports prepared in connection with litigation.
 - Surgical operations, procedures or treatment of obesity, except when pre-authorized by **HMO**.
 - Therapy or rehabilitation, including but not limited to, primal therapy, chelation therapy, rolfing, psychodrama, megavitamin therapy, purging, bioenergetic therapy, vision perception training, and carbon dioxide.
 - Thermograms and thermography.
 - Transsexual surgery, sex change or transformation, including any procedure or treatment or related service designed to alter a **Member's** physical characteristics from the **Member's** biologically determined sex to those of another sex, regardless of any diagnosis of gender role or psychosexual orientation problems.
 - Treatment in a federal, state, or governmental entity, including care and treatment provided in a non-participating **Hospital** owned or operated by any federal, state or other governmental entity, except to the extent required by applicable laws.
 - Treatment of mental retardation, defects, and deficiencies. This exclusion does not apply to mental health services or to medical treatment of mentally retarded **Members** in accordance with the benefits provided in the Covered Benefits section of this **Certificate**.
 - Treatment of occupational injuries and occupational diseases, including those injuries that arise out of (or in the course of) any work for pay or profit, or in any way results from a disease or injury which does. If a **Member** is covered under a Workers' Compensation law or similar law, and submits proof that the **Member** is not covered for a particular disease or injury under such law, that disease or injury will be considered "non-occupational" regardless of cause. This exclusion does not apply to sole proprietors, partners and corporate officers in accordance with Connecticut law.
 - Unauthorized services, including any service obtained by or on behalf of a **Member** without a **Referral** issued by the **Member's PCP** or pre-authorized by **HMO**. This exclusion does not apply in a **Medical Emergency**, in an **Urgent Care** situation, or when it is a direct access benefit. The **Participating Provider** is responsible for obtaining pre-authorization and the issuance of necessary **Referrals**. The **Member** is held harmless for any covered services a **Participating Provider** performs without the appropriate pre-authorization or **Referrals**.
 - Vision care services and supplies, including orthoptics (a technique of eye exercises designed to correct the visual axes of eyes not properly coordinated for binocular vision) and radial keratotomy, including related procedures designed to surgically correct refractive errors.
 - Weight reduction programs, or dietary supplements.
 - Acupuncture and acupuncture therapy, except when performed by a **Participating Physician** as a form of anesthesia in connection with covered surgery.
 - Non-surgical treatment of temporomandibular joint disorder (TMJ), including but not limited to, treatment performed by prosthesis placed directly on the teeth, surgical and non-surgical medical and dental services, and diagnostic or therapeutics services related to TMJ.

B. Limitations.

- In the event there are 2 or more alternative **Medical Services** which in the sole judgment of **HMO** are equivalent in quality of care, **HMO** reserves the right to provide coverage only for the least costly **Medical Service**, as determined by **HMO**, provided that **HMO** pre-authorizes the **Medical Service** or treatment.
- Determinations regarding eligibility for benefits, coverage for services, benefit denials and all other terms of this **Certificate** are at the sole discretion of **HMO**, subject to the terms of this **Certificate**.

DETERMINATIONS REGARDING DENIAL OF BENEFITS DUE TO INAPPROPRIATE USE OF THE HMO NETWORK ARE AT THE SOLE DISCRETION OF THE HMO.

TERMINATION OF COVERAGE

A **Member's** coverage under this **Certificate** will terminate upon the earliest of any of the conditions listed below and termination will be effective on the date indicated on the Schedule of Benefits.

Upon cancellation or discontinuation of coverage under the **Group Agreement**, the **Contract Holder** shall furnish each **Subscriber** notice of such cancellation or discontinuation not less than 15 days preceding the effective date of cancellation or discontinuance.

A. Termination of Subscriber Coverage.

A **Subscriber's** coverage will terminate for any of the following reasons:

1. employment terminates;
2. the **Group Agreement** terminates;
3. the **Subscriber** is no longer eligible as outlined in this **Certificate** and/or on the Schedule of Benefits; or
4. the **Subscriber** becomes covered under an alternative health benefit plan or under any other plan which is offered by, through, or in connection with, the **Contract Holder** in lieu of coverage under this **Certificate**.

B. Termination of Dependent Coverage.

A **Covered Dependent's** coverage will terminate for any of the following reasons:

1. a **Covered Dependent** is no longer eligible, as outlined in this **Certificate** and/or on the Schedule of Benefits;
2. the **Group Agreement** terminates; or
3. the **Subscriber's** coverage terminates.

C. Termination For Cause.

HMO may terminate coverage for cause:

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.

Humira
Orencia
Remicade
Rituxan RA
Simponi
Stelara

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
Synvisc One

Except for these changes, all of the remaining provisions in the “Benefits” section of your member document remain unchanged.

EXCLUSIONS AND LIMITATIONS

NOTE: There are some exclusions that have been revised in your member document since you received it and some others that have been deleted. As a result, please read through this section carefully.

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 your member document, 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.

Effective for Plan renewals or new Plans on or after January 1, 2011, the following exclusions in the “Exclusions And Limitations” section are added or revised.

Any Treatment for which there is Insufficient Evidence Of Therapeutic Value for the use for which it is being prescribed is not covered.

Smoking cessation products are excluded, except to treat nicotine addiction. 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 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.

The following exclusion is deleted from the “Exclusions And Limitations” section effective for Plan renewals or new Plans on or after January 1, 2011.

Services rendered at Hospital-based clinics are excluded unless the Hospital clinics are contracted with us for specific services.

Except for these changes, all of the remaining exclusions and limitations in the “Exclusions And Limitations” section remain unchanged.

CLAIMS FILING, QUESTIONS AND COMPLAINTS, AND APPEAL PROCESS

Effective for Plan renewals or new Plans on or after January 1, 2011, the first paragraph of the “Claims Filing” subsection of the “Claims Filing, Questions, And Complaints, And Appeal Process” section of your member document is revised and a second paragraph has been added.

CLAIMS FILING

Non-behavioral health 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.

Behavioral health claims for payment for Health Services must be received by us within 90 days from the date the services were received. Claims submitted more than 90 days after the date the services were received will not be reimbursed. You can check the status of your behavioral health claims at any time by checking the **OptumHealth Behavioral Solutions/UBH** web site at www.liveandworkwell.com and logging in as described.

Except for these changes, all of the remaining provisions in the “Claims Filing, Questions, And Complaints, And Appeal Process” section remain unchanged.

TERMINATION AND AMENDMENT

Except as noted, **effective for Plan renewals or new Plans on or after June 1, 2010,** paragraphs 2 and 10 of the “Termination Of Your Coverage” provisions of the “Group Termination” subsection of the “Termination And Amendment” section of your member document are deleted and replaced with the following.

GROUP TERMINATION

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.

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

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.

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

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.

STATE PREFERRED SUMMARY BOOKLET

PLEASE READ YOUR SUMMARY BOOKLET CAREFULLY

State of CT

State Preferred -\$15

Important: This is not an insured Benefit Plan. The benefits described in this Summary Booklet or any rider or amendments hereto are funded by the Employer who is responsible for their payment. Anthem BCBS provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

EXCLUSIONS AND LIMITATIONS

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

Please remember, this plan does not cover any service or supply not specifically listed as a Covered Service in this Summary Booklet. The following list of exclusions is not a complete list of all services, supplies, conditions or situations that are not Covered Services. If a service is not covered, then all services performed in conjunction with that service are not covered. Anthem BCBS is the final authority for determining if services or supplies are Medically Necessary.

The listed exclusions below are in addition to those set forth elsewhere in the Summary Booklet.

The following services are not Covered Services under this Benefit Program, except when approved by Anthem BCBS as part of Case Management.

1. Benefits for services which are not:
 - a. specifically described in the Summary Booklet
 - b. rendered or ordered by a Physician
 - c. within the scope of the Physician's, Provider's or Hospital's licensure; and
 - d. Medically Necessary Care for the proper diagnosis and treatment of the Covered Person.
2. Benefits may be reduced or denied subject to the Managed Benefits – Managed Care Guidelines. Any reduced or denied benefits paid by the Covered Person do not apply toward the Cost Share Maximums shown in the Schedule of Benefits.
3. Any reduction in benefits, including but not limited to Penalties, imposed by another Plan, which are similar to those stated in the Managed Benefits – Managed Care Guidelines, are not reimbursable as a Covered Service.
4. Benefits for services rendered before the Covered Person's Effective Date under this Benefit Program.
5. Benefits for services rendered after the person's Benefit Program has been rescinded, suspended, cancelled, interrupted or terminated. Any person obtaining services after his or her Benefit Program is rescinded, suspended, cancelled, interrupted or terminated for any reason will be solely responsible for payment of such services.
6. Care for conditions which are required by State or Local law to be treated in a public facility.
7. Services and care in a Veteran's Hospital or any Federal Hospital, except as may be otherwise required by law.
8. Services covered in whole or in part by public or private grants.
9. Services required by third parties, including but not limited to: school, employment, summer camp and premarital physicals and related tests.
10. Studies related to pregnancy except for significant medical reasons.
11. Simplified or self-administered tests and multiphasic screening.
12. Cosmetic surgeries, procedures and services performed primarily to improve appearance and not otherwise determined by Anthem BCBS to meet the coverage criteria for reconstructive surgeries, procedures and services set forth in this Summary Booklet.
13. Dental diagnosis, care, treatment and diagnostic imaging studies are not Covered Services. Oral surgery diagnosis, care, treatment and diagnostic imaging studies are not Covered Services, except as provided in this

Benefit Program. Examples of non-Covered Services include, but are not limited to: the treatment of dental caries; endodontics; orthodontics; replacement of teeth; bonding; gold foil restorations; application of sealants; bitewing x-rays; crown or tooth preparations; fillings; crowns; bridges; dentures; inlays and onlays; the corrections of malpositions of the teeth and jaw; and services with respect to congenital malformations. X-ray, laboratory or facility fees for dental services will not be covered. Dental prosthetics are not a covered benefit except as provided for in this Benefit Program.

14. Sperm collection and preservation, all services related to surrogate parenting arrangements and preparatory treatment.
15. Except for the initial office visit, all services related to the non-surgical treatment of temporomandibular joint dysfunction or syndrome also called myofascial pain dysfunction or craniomandibular pain syndrome. This exclusion includes but is not limited to the following: invasive (internal) and non-invasive (external) procedures and tests, contrast and non-contrast imaging, physical therapy, and appliance therapy such as occlusal Appliances (splints) or adjustments. Anthem BCBS will not provide benefits unless otherwise provided for by an Amendatory Rider to this Benefit Program.
16. Routine foot care in the absence of systemic or vascular disease affecting the foot, including hygienic care, treatment of corns or calluses, services performed in conjunction with fitting of supportive or comfort devices for the foot or other foot care, including orthopedic and corrective shoes (except for Medically Necessary foot orthotics, abduction and rotation bars. One set/pair per Covered Person per Calendar Year).
17. Services for Custodial Care, Chronic Care and/or Maintenance Care. Including without limitation, Methadone and Suboxone maintenance or any other similar maintenance therapy program and its related testing, supplies, visits and treatment.
18. Prenatal medical conferences with a pediatrician regarding an unborn child unless the visit is the result of a medical referral.
19. Charges for the Covered Person's room and board when the Covered Person has a leave of absence from the Hospital, Substance Abuse Treatment Facility or other Inpatient Facility.
20. Evaluation, treatment, procedures and Prescription Drugs related to and performance of sex-change operations including follow-up treatment, care and counseling.
21. Vaccines other than routine immunizations or those needed for travel.
22. Services, medical supplies or supplies not specifically listed as Covered Services. These include but are not limited to educational therapy, marital counseling, sex therapy, weight control programs, nutritional programs and exercise programs.
23. Penile Implants.
24. Experimental or Investigational treatment, procedure, facility, equipment, drugs, devices or supplies. Any services associated with or as follow-up to any of the above is not a Covered Service.
25. Any treatment, procedure, facility, equipment, drug, device or supply which requires Federal or other governmental agency approval not granted at the time services are rendered. Any service associated with, or as follow-up to, any of the above is not a Covered Service.
26. Any services by a Physician or Provider to himself or herself or for services rendered to his or her parent, spouse, children, grandchildren or any other immediate family member or relation, even if a Participating Physician or Participating Provider.
27. Services which the Covered Person or Anthem BCBS is not legally required to pay.
28. Wigs, except as noted in the Covered Services section.
29. Inpatient services which can be properly rendered as Outpatient services.
30. Disease contracted or injuries resulting from war.
31. Charges after the Provider's or Hospital's regular discharge hour on the day indicated for the Covered Person's discharge by his/her Physician.

32. Charges in excess of the Maximum Allowed Amount.
33. Eyeglasses and contact lenses.
34. Supervisory care by a Physician for a Covered Person who is mentally or physically disabled and who is not under specific medical, surgical or psychiatric treatment to reduce the disability to the extent necessary to enable the patient to live outside an institution providing medical care; or when despite such treatment, there is no reasonable likelihood that the disability will be so reduced.
35. Travel, whether or not recommended by a Physician.
36. Certain pulmonary function tests which in the opinion of Anthem BCBS do not meet the definition of a covered diagnostic laboratory test.
37. Services or procedures rendered without regard for specific clinical indications, routinely for groups or individuals or which are performed solely for research purposes.
38. Services or procedures which have become obsolete or are no longer medically justified as determined by appropriate medical specialties.
39. Radiation therapy as a treatment for acne vulgaris.
40. Services rendered by a Physician in the employ of a Home (e.g. Skilled Nursing Facility) do not qualify as Home & Office Care.
41. The following is a list of procedures which are not covered:
 1. Allogeneic or Syngeneic Bone Marrow Transplant or other forms of stem cell rescue and stem cell infusion (with or without high dose chemotherapy and/or radiation) are those with a donor other than the patient. They are not covered except in the following cases:
 - a. When at least five out of six histocompatibility complex antigens match between the patient and the donor.
 - b. The mixed leukocyte culture is non-reactive.
 - c. One of the following conditions is being treated:
 - * Severe aplastic anemia
 - * Acute nonlymphocytic leukemia in first or subsequent remission or early first relapse
 - * Myelodysplastic syndrome
 - * Secondary acute nonlymphocytic leukemia as initial therapy
 - * Acute lymphocytic leukemia in second or subsequent remission
 - * Acute lymphocytic leukemia in first remission
 - * Chronic myelogenous leukemia in chronic and accelerate phase
 - * Non-Hodgkin's lymphoma, high grade, in first or subsequent remission
 - * Hodgkin's lymphoma low grade, which has undergone conversion to high grade
 - * Neuroblastoma, stage 3 or relapsed stage 4
 - * Ewing's sarcoma
 - * Severe combined immunodeficiency syndrome
 - * Wiskott-Aldrich syndrome
 - * Osteopetrosis, infantile malignant
 - * Chediak-Higashi syndrome
 - * Congenital life-threatening neutrophil disorders to include Kostmann's syndrome, chronic granulomatous disease, and cartilage hair hypoplasia
 - * Diamond Blackfan syndrome
 - * Thalassemia
 - * Sickle cell anemia
 - * Primary thrombocytopathy including Glanzmann's syndrome
 - * Gaucher disease
 - * Mucopolysaccharidoses and lipidoses to include Hurler's syndrome, Sanfilippo's syndrome, Maroteaux-Lamy syndrome, Morquio's syndrome, Hunter's syndrome, and metachromatic leukodystrophy

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

2. Autologous Bone Marrow Transplantation or other forms of stem cell rescue and stem cell infusion (in which the patient is the donor) with high dose chemotherapy or radiation are not covered except for the following:
 - a. Non-Hodgkin's lymphoma, high grade, first or subsequent remission. No morphological evidence of bone marrow involvement should be evident.
 - b. Hodgkin's disease as defined above with an absence of bone marrow involvement.
 - c. Acute nonlymphocytic leukemia in second remission, in which no HLA matched donor exists or an allogeneic transplant is inappropriate.
 - d. Acute lymphocytic leukemia in second remission, in which no HLA matched donor exists or an allogeneic transplant is inappropriate.
 - e. Retinoblastoma, adjuvant setting after successful induction (consolidation).
 - f. Neuroblastoma, adjuvant setting after successful induction (consolidation).

Autologous Bone Marrow Transplants or other forms of stem cell rescue and stem cell infusion (with high dose chemotherapy and/or radiation), for all other cases are not covered.

42. Drugs or medications, legend and over-the-counter, prescribed for use as an Outpatient except as otherwise stated herein.
43. Reversal of voluntary sterilization.

SPD Outline:
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Freedom Network

Summary Plan Description

******* Nutritional Counseling needs to be added to the Program 3* per calendar year. ** Prosthetics, orthordic coverage one pair medically necessary,*Skilled Nursing Facility, chemotherapy co-pays***Infertility treatments need to be addressed, birth control (non pills) Check benefit by benefit*** Oxford could compare to Anthem Straighten out Co-Pay discrepancy.**

****** Connecticut COBRA Continuation up to 30 months**

PLEASE READ YOUR SUMMARY BOOKLET CAREFULLY

Important: This is not an insured benefit plan. The benefits described in this booklet or rider and amended are funded by the employer who is responsible for payment Oxford Health Plans is solely the plan administrator and does not assume any financial risk with regards to claims.

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- b. Reasonable and necessary lodging and meal expenses, not to exceed \$150 total per day (\$200 total if two companions are accompanying a minor child), are payable for the individual accompanying the patient;
 - c. Lodging for the transplant recipient, which receiving Medically Necessary post-operative outpatient care at the Hospital.

***Pre-certification Required: All transplants must be Pre-certified by the Claims Administrator's Medical Director. Additionally, all transplants must be performed at Network Hospitals that the Claims Administrator has specifically approved and designated to perform these procedures.**

Copayments, Deductibles and Coinsurance

Please refer to your Schedule of Benefits for applicable Copayment, Deductible, and Coinsurance information.

Exclusions and Limitations

1. All transplants must be prescribed by your PCP or your Network Specialist(s) and must be Pre-certified by the Claims Administrator's Medical Director.
2. All transplants must be performed at Network Facilities that the Claims Administrator has specifically approved and designated to perform these procedures.
3. The Plan does not cover travel expenses, lodging, meals or other accommodations for donors or guests.
4. The Plan does not cover the cost of bone marrow storage for a Participant with current disease in anticipation of a transplant.
5. The medical expenses of a non-Participant acting as a donor for a Participant are not Covered if the non-Participant's expenses will be covered under another health plan or program.
6. Donor fees in connection with organ transplant surgery are not Covered (only donor search fees are Covered).
7. Routine harvesting and storage of Stem Cells from newborn cord blood is not covered.
8. **Experimental/Investigational Treatments.** In general the Plan will not cover experimental or investigational treatments except as Covered under the Experimental Treatment benefit.
9. All other applicable exclusions and limitations as listed in the "Exclusions and Limitations" section.

Exclusions and Limitations

Well-Baby and Well-Child Care

Adult Periodic Physical Examinations

Adult Immunizations

Meningitis Vaccinations

Well-Woman Examinations

- Well-woman examinations are limited to two per Calendar Year. Benefits for non-therapeutic and elective abortions are limited as shown in your Schedule of Benefits.

Family Planning services

The Plan does not Cover: birth control pills, implantable contraceptive drugs, condoms, foams or devices, diaphragms, contraceptive jellies and ointments even if they are being prescribed or recommended for a medical condition other than birth control.

1. Implantable contraceptive drugs, FDA Approved Devices and Appliances including but not limited to Diaphragms, contraceptive jellies and ointments even if they are being prescribed or recommended for a medical condition other than birth control.

Birth Control Pills and Implantable Contraceptive Drugs.

Over-the-counter items including but not limited to: condoms, jellies, creams, devices (i.e. sponges) and suppositories are not covered.

The following Infertility Services are not covered: injectable infertility drugs such as Pergonal, Metrodin, etc., cost for an ovum donor or donor sperm, sperm storage costs, cryopreservation and storage of embryos, ovulation predictor kits, In vitro services for woman who have undergone tubal ligation, reversal of tubal ligations, any infertility services if the male has undergone a vasectomy, or all costs for and relating to surrogate motherhood (maternity services are Covered for Participants acting as surrogate mothers). Services to reverse voluntary sterilizations are not Covered. Treatment of an underlying medical condition will not be denied (if the treatment is otherwise Covered under the SPD) solely because the medical condition results in infertility.

Screening for Colorectal Cancer

Diabetic Equipment, Supplies and Education

Diabetes Self Management and Education

The Services and Items are covered only as follows:

The items must be Medically Necessary, as determined by the Claims Administrator and provided in amounts that follow a reasonable treatment plan developed by a Physician for the Participant.

The following are not covered:

- (1) Membership in health clubs; diet plans; or other organizations, even if: recommended by a Physician or a Qualified Health Provider for the purpose of losing weight;
- (2) Any counseling or courses in diabetes management other than as described above;
- (3) Stays at special facilities or spas for the purpose of diabetes education/management;
- (4) Special foods, diet aids and supplements related to dieting; and
- (5) Any item that is not both Medically Necessary and prescribed by the Participant's Physician or qualified health provider.

Diabetic services or supplies as follows. The following are not Covered as diabetic services or supplies: services or supplies that are not both Medically Necessary and prescribed by the Participant's Physician or qualified health professional; membership in health clubs, diet clubs or plans for the purpose of losing weight even if recommended by the Participant's Physician or qualified health professional; any counseling or courses in diabetes management other than as described as Covered under this SPD; stays at special facilities or spas for the purpose of diabetes education or management; and special foods, diets aids and supplements related to dieting;

Health Education

Naturopathic Care

Specialty Care

Surgical and Obstetrical Services

- This Plan does not cover dental services covered under the UnitedHealth care dental plan. As described in "Oral Surgery," only dental services required to treat accidental injury of sound, natural teeth, treatment for temporomandibular joint and removal of bony impacted wisdom teeth are covered.
- This Plan does not Cover cosmetic surgery, reconstructive or plastic surgery that is done for a condition that does not meet the specific criteria stated in "Reconstructive and Corrective Surgery," including but not limited to: cosmetic surgery, plastic or reconstructive surgery which is performed primarily to improve the appearance of any portion of the body including, but not limited to: surgery for sagging skin or extra skin; any augmentation or reduction procedure (e.g., mammoplasty); liposuction; rhinoplasty and rhinoplasty done in conjunction with Covered nasal or Covered sinus surgery. Complications of such surgeries are covered

only if they are Medically Necessary and are otherwise covered. Remedial work is not covered. **Please see**

- **“Reconstructive and Corrective Surgery” for a description of when plastic or reconstructive surgery is Covered.**

Maternity and Newborn Care

Newborn Care

- An adopted newly born infant's initial hospital stay if the natural parent has coverage available for the infant's care.
- Special foods and diets, supplements, vitamins and enteral feedings are not covered except as noted under the “Medically Necessary Infant Formula and Specialized Formulas” section.
 - An adopted newly born infant's initial Hospital stay if the natural parent has coverage available for the infant's care.
 - Special Foods, formulas and enteral feedings unless otherwise Covered under the Medically Necessary Infant Formula and Specialized Formula Benefit.

Allergy Testing and Treatment

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

Rehabilitation Services

- Covered Services must begin within six months of the later to occur:
 1. the date of the injury or illness that caused the need for the therapy;
 2. the date the Participant is discharged from a Hospital where the surgical treatment was rendered; or and in no event will the therapy continue beyond 365 days after such an event.
 3. the date outpatient surgical care is rendered.

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- Rehabilitation services or physical therapy on a long-term basis is not covered.
 - Speech, physical or occupational therapy to correct a condition that is not the result of a disease, injury or congenital defect for which surgery has been performed is not covered.
 - The Plan does not cover speech, physical or occupational therapy if a Participant has reached maximum level of physical or mental function possible and will not make further significant clinical improvement.
 - The Plan does not cover speech, physical or occupational therapy for acquired conditions which result in mental retardation which, in the Claims Administrator's determination, lack the probability for improvement.
 2. Rehabilitation services or physical therapy on a long-term basis. Speech or occupational therapy to correct a condition that is not the result of a disease, injury or a congenital defect for which surgery has been performed.

Reconstructive and Corrective Surgery

- **The following are not Covered:** Cosmetic, reconstructive or plastic surgery that is done for a condition that does not meet the specific criteria stated above, including but not limited to: cosmetic surgery, plastic or reconstructive surgery which is performed primarily to improve the appearance of any portion of the body including, but not limited to: surgery for sagging skin or extra skin; any augmentation or reduction procedure (e.g., mammoplasty); liposuction; rhinoplasty and rhinoplasty done in conjunction with a Covered nasal or Covered sinus surgery.
- Complications of such surgeries are covered only if they are Medically Necessary and are otherwise covered. Remedial work is not covered. Remedial work is any medical procedure to correct either undesired results or an unsuccessful procedure connected to a prior non-Covered Cosmetic surgery/procedure.
- The reconstructive or corrective surgery must be performed within two years of the surgery that was necessitated by the trauma, infection or disease.

Cosmetic, reconstructive or plastic surgery that is done for a condition that does not meet the specific criteria stated in "Reconstructive and Corrective Surgery," including but not limited to: cosmetic surgery, plastic or reconstructive surgery which is performed primarily to improve the appearance of any portion of the body including but not limited to: surgery for sagging skin or extra skin; any augmentation or reduction procedure (e.g., mammoplasty); liposuction; rhinoplasty and rhinoplasty done in conjunction with Covered nasal or Covered sinus surgery. Complications of such surgeries are Covered only if they are Medically Necessary and are otherwise Covered. Remedial work is not Covered.

Oral Surgery

Exclusions and Limitations

- General dental services, including but not limited to the following, are not Covered: Dental services related to the care, filling, removal or replacement of teeth; the treatment of injuries (except as described above); or diseases of the teeth, gums; including, but not limited to: apicoectomy, orthodontics, root canals, soft tissue impaction, alveolectomy, treatment of periodontal disease or orthognathic surgery.
- All other applicable exclusions and limitations as listed in the “Exclusions and Limitations” Section apply.

Laboratory Procedures and X-ray Examinations

1. All tests and procedures must be performed by a Network Provider. **Please remember, unless you are receiving preadmission testing, Network Hospitals are not Network Providers for laboratory procedures and tests.**
2. The Plan does not Cover laboratory procedures, or any other procedure if the Participant has not obtained the required Referral.
3. All other applicable exclusions and limitations as listed in the “Exclusions and Limitations” section.

Internal and External Prosthetic Devices

External Breast Prosthesis

- **For all external prostheses, coverage is for standard equipment only. The Plan does not cover customization of any prosthetic device.**
- Replacement prosthesis will be covered when Medically Necessary as a result of normal growth, or a significant change in the member's physical condition that renders the prosthesis unusable. The Plan does not otherwise cover the cost of repairs or replacement.
- Additional breast prostheses and post mastectomy bra/sleeves that are required due to the surgical removal of breasts due to tumors will be Covered subject to Medical Necessity and require Pre-certification. The Plan does not otherwise cover the cost of repairs or replacement.
- Wigs are not covered for male pattern baldness, female pattern baldness, natural aging or premature aging.
- Coverage does not include artificial organs.

Wigs are Covered only if prescribed by a licensed oncologist for a patient who suffers hair loss as a result of chemotherapy for the treatment of leukemia and outpatient chemotherapy following

surgical procedures in connection with the treatment of tumors and may be subject to a dollar amount limitation as shown in your Schedule of Benefits.

Repair and Replacement of Prosthetic Devices

1. Only functionally necessary replacements are covered.
2. Only repairs and maintenance that are not covered under the manufacture's warranty or purchase agreement are covered.
3. All other applicable exclusions and limitations as listed in the "Exclusions and Limitations" section.

Durable Medical Equipment and Braces

1. The Plan does not Cover blood pressure monitoring devices; car seats; arch supports; cervical collars; corrective shoes; corsets; elastic hose; false teeth; tilt tables; electronic communication devices; in-flight oxygen for non-emergency travel; special supplies or equipment; or special appliances.
2. TENS units are Covered only when certain medical criteria are met. **This benefit requires Pre-certification.**

Durable Medical Equipment (other than as specifically Covered under this SPD) including, but not limited to: TENS units (except as Covered under Durable Medical Equipment); blood pressure monitoring devices; car seats; arch supports; cervical collars; corrective shoes; corsets; elastic hose; false teeth; hearing aids; tilt tables; electronic communication devices; in-flight oxygen for non-emergency travel; special supplies or equipment; or special appliances.

Medical Supplies

Hearing Aids

Transplants

1. All transplants must be prescribed by your PCP or your Network Specialist(s) and must be Pre-certified by the Claims Administrator's Medical Director.
2. All transplants must be performed at Network Facilities that the Claims Administrator has specifically approved and designated to perform these procedures.
3. The Plan does not cover travel expenses, lodging, meals or other accommodations for donors or guests.
4. The Plan does not cover the cost of bone marrow storage for a Participant with current disease in anticipation of a transplant.

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5. The medical expenses of a non-Participant acting as a donor for a Participant are not Covered if the non-Participant's expenses will be covered under another health plan or program.
 6. Donor fees in connection with organ transplant surgery are not Covered (only donor search fees are Covered).
 7. Routine harvesting and storage of Stem Cells from newborn cord blood is not covered.
 8. **Experimental/Investigational Treatments.** In general the Plan will not cover experimental or investigational treatments except as Covered under the Experimental Treatment benefit.

Transplant services required by a Participant when the Participant serves as an organ donor are not Covered unless the recipient is a Participant. The medical expenses of a non-Participant acting as a donor for a Participant are not Covered if the non-Participant's expenses will be covered under another health plan or program. Donor fees in connection with organ transplant surgery are excluded. Routine harvesting and storage of Stem Cells from newborn cord blood is not Covered.

Home Health Care

1. Home Health Care is limited to the amount of visits shown in your Schedule of Benefits. Each visit of up to four hours by a home health aide is one visit.
2. Private duty and special duty nursing are not covered.
3. Supervision of home health aides by a RN or LPN is not covered.
4. Services supplied to family members of the Participant are not covered.
5. Homemaker services are not covered.
6. The Plan does not cover comfort or convenience items including, but not limited to: barber services; guest meals and accommodations; telephone, television or radio charges; travel expenses; or take-home supplies. The Plan also does not Cover the purchase or rental of household fixtures or equipment including, but not limited to: escalators; elevators; swimming pools; exercise cycles; treadmills, weight training or muscle strengthening equipment; air purifiers; air conditioners; water purifiers; allergenic pillows, mattresses or waterbeds.
7. The Plan does not cover custodial care, domiciliary care, long-term care, maintenance care, adult day care or rest cures. The Plan does not cover nursing care or personal care which is rendered to assist a Participant who, in the Claims Administrator's opinion, has reached the maximum level of physical or mental function possible and will not make further significant clinical improvement.

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8. The Plan does not Cover TENS units (except as Covered under Durable Medical Equipment); blood pressure monitoring devices; car seats; arch supports; cervical collars; corrective shoes; corsets; elastic hose; false teeth; hearing aids for members over the age of 12; tilt tables; electronic communication devices; in-flight oxygen for non-emergency travel; special supplies or equipment; or special appliances.
 9. Any rehabilitation services received under this benefit **that is part of the treatment plan and delivered by the Home Health Care Service or Agency** will not reduce the amount of services available under “Rehabilitation Services,” above. Conversely, Rehabilitation Services provided to you in your home that are not part of the treatment plan and are not delivered by the Home Health Care Service or Agency will be treated as Rehabilitation Service.

Private or special duty nursing.

P. Chemotherapy

- All treatment and services must be approved by the United States Food and Drug Administration (FDA) for the general use in treatment of cancer.
- Experimental/Investigational or ineffective surgical or medical treatments, procedures, drugs, or research studies including, but not limited to: transplants, stem cell retrieval, cancer chemotherapy protocols, AIDS clinical trials or I.V. therapies that are not recognized as acceptable medical practice and any such services where federal or other governmental agency approval is required but has not been granted. The Plan will make the determination as to whether the requested service is excluded in accordance with this provision. In certain instances, such procedures may be covered if they are approved in advance by the Claims Administrator’s Medical Advisory Board and provided in accordance with the provisions of this SPD.

The Plan will Cover autologous bone marrow transplants combined with high dose chemotherapy when medically appropriate, for the treatment of: advanced neuroblastoma, second remission acute leukemia, relapsed Hodgkin’s disease, relapsed non-Hodgkin’s lymphoma, and metastatic breast cancer or any other diagnosis that the Claims Administrator Medical Advisory Board determines to be appropriate. Such treatment must be approved in advance by the Medical Advisory Board and provided in accordance with the provisions of this SPD.

Wigs are Covered only if prescribed by a licensed oncologist for a patient who suffers hair loss as a result of chemotherapy for the treatment of leukemia and outpatient chemotherapy following surgical procedures in connection with the treatment of tumors and may be subject to a dollar amount limitation as shown in your Schedule of Benefits.

Second Opinions

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- Providers who render a second or third opinion cannot perform the Pre-certified service. If the Claims Administrator Pre-certifies a service that is recommended by the second or the third provider, you will be asked to select another Network Provider to perform the actual service.
 - All other applicable exclusions and limitations as listed in the “Exclusions and Limitations” section.

Chiropractic Services
Exclusions and Limitations

- The Plan will not cover any equipment, clothing, vitamins, supplements or other items and services that may be offered by the Chiropractor.
- All other applicable exclusions and limitations as listed in the “Exclusions and Limitations” section.

Hypodermic Needles or Syringes

Exclusions and Limitations

All applicable exclusions and limitations as listed in the “Exclusions and Limitations” section.

T. Treatment of Leukemia and Removal of Tumors

All applicable exclusions and limitations as listed in the “Exclusions and Limitations” section.

Experimental Treatments

- The costs of investigational drugs or devices,
- The costs of non-health care services, the costs of managing research,
- Costs which would not be covered under this SPD for non-experimental or non-investigational treatments provided in such clinical trials.
Experimental/Investigational Treatments; the Plan will cover routine patient costs associated with Clinical Trials. These are costs that are associated with Physician fees, laboratory expenses, and expenses associated with the Hospitalization, administering of treatment and evaluation of the patient during the course of treatment or a condition associated with a complication of the underlying disease or treatment. The Plan shall not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs which would not be Covered under this SPD for non-experimental or non-investigational treatments provided in such clinical trials. In general, the Plan will not Cover experimental or investigational treatments. However, the Plan shall Cover an experimental or investigational treatment approved by an External Appeal entity

certified by the State. If an External Appeal entity approves coverage of an experimental or investigational treatment that is part of a clinical trial, the Plan will only Cover the cost of services required to provide treatment to you according to the design of the trial.

V. Pain Treatment

All applicable exclusions and limitations as listed in the “Exclusions and Limitations” section.

W. Food and Food Products for Inherited Metabolic Diseases Exclusions and Limitations

All applicable exclusions and limitations as listed in the “Exclusions and Limitations” section.

Medically Necessary Infant Formula and Specialized Formulas

Exclusions and Limitations

All applicable exclusions and limitations as listed in the “Exclusions and Limitations” section.

Lyme Disease Treatment

All applicable exclusions and limitations apply

Early Intervention Services/Birth to Three Program

Learning and behavioral disorders. Services for the evaluation or treatment (including remedial education) of: learning disabilities or minimal brain dysfunction; mental retardation; developmental and learning disorders or behavioral problems except as noted under the “Early Intervention Services/Birth to Three Program” section.

The Plan also does not Cover behavioral training, visual perceptual or visual motor training related to learning disabilities, or cognitive rehabilitation. Behavioral and learning disorders related to congenital abnormalities such as Down’s Syndrome are not Covered.

Outpatient Pulmonary Rehabilitation

1. All services must be provided by provider who has expertise in pulmonary rehabilitation.
2. Rehabilitation services or therapy on a long-term basis is not covered. The Plan will not cover therapy if a Participant has reached maximum level of physical or psychological function possible and will not make further significant clinical improvement.

Rehabilitation services or physical therapy on a long-term basis. Speech or occupational therapy to correct a condition that is not the result of a disease, injury or a congenital defect for which surgery has been performed.

Outpatient Cardiac Rehabilitation

Rehabilitation services or physical therapy on a long-term basis. Speech or occupational therapy to correct a condition that is not the result of a disease, injury or a congenital defect for which surgery has been performed.

Vision Care

Appliances including but not limited to contact lenses and eye glasses are excluded from coverage.

Refractive eye surgery is not covered including, but not limited to: LASIK, laser thermal keratoplasty, orthokeratology, standard eratomeluesis, astigmatic keratotomy, photoreactive keratotomy, radial keratotomy, epikeratoplasty, keratophakia keratomileusis.

Vision training or perceptual motor training services.

Vision correction services and supplies including, but not limited to: eyeglasses (lenses and frames), all manner of contact lenses or corrective lenses, visual training, orthoptics, radial keratotomy and other refractive keratoplasties.

Orthoptic Exercises and Corneal Topographic Procedures

1. This benefit is limited to the diagnosis and the amount of visits described above.
2. The Plan does not cover vision therapy, vision training or perceptual motor training services. Except as Covered under "Vision Care," the Plan does not Cover vision correction services and supplies including, but not limited to: eyeglasses (lenses and frames), all manner of contact lenses or corrective lenses. The Plan does not Cover eye exercises, visual training, vision therapy or orthoptics (exception: orthoptics are Covered for convergence insufficiency and amblyopia penalization patching for children). Refractive eye surgery is not Covered including, but not limited to: LASIK, Laser Thermal Keratoplasty, Orthokeratology, Standard Keratomeluesis, Astigmatic Keratotomy, Photoreactive Keratotomy, Radial Keratotomy, Epikeratoplasty, Keratophakia Keratomileusis.

Services Delivered in the Home

1. The Plan makes no assurance that all outpatient Covered Services are available in the home.
2. The Participant must be Homebound as defined above.
3. All Covered Services are limited to the amount of day, dollar and visit amounts shown in the Schedule of Benefits for the type of Covered Service received. For example: If physical therapy is received in the home, the amount of available therapy is limited to the amount of outpatient rehabilitation services shown in the Schedule of Benefits (minus any therapy actually received on an outpatient basis).

Treatment of Infertility

Exclusions and Limitations

- Pre-certification for all tests and procedures must be obtained.
- **All services must be provided by Network Providers.**
- Injectable infertility drugs such as Pergonal, Metrodin, etc.
- Gamete intrafallopian transfer (GIFT).
- Cost for an ovum donor or donor sperm.
- Sperm storage costs.
- Cryopreservation and storage of embryos.
- Ovulation predictor kits.
- In-vitro services for women who have undergone tubal ligation.
- Reversal of tubal ligations.
- Any infertility services if the male has undergone a vasectomy.
- All costs for and relating to surrogate motherhood (maternity services are Covered for Participants acting as surrogate mothers).

Services to reverse voluntary sterilizations

The following Infertility Services are not covered: injectable infertility drugs such as Pergonal, Metrodin, etc., Gamete intrafallopian transfer (GIFT), cost for an ovum donor or donor sperm, sperm storage costs, cryopreservation and storage of embryos, ovulation predictor kits, In vitro services for women who have undergone tubal ligation, reversal of tubal ligations, any infertility services if the male has undergone a vasectomy, or all costs for and relating to surrogate motherhood (maternity services are Covered for Participants acting as surrogate mothers). Services to reverse voluntary sterilizations are not Covered. Treatment of an underlying medical condition will not be denied (if the treatment is otherwise Covered under the SPD) solely because the medical condition results in infertility.

Cancer Clinical Trials

Craniofacial Disorders

Temporomandibular joint syndrome. Dental procedures and appliances for the treatment of temporomandibular joint syndrome or craniomandibular pain syndrome. Surgical and nonsurgical medical procedures are Covered if Pre-certified and approved by the Claims Administrator's Medical Director.

Autism Spectrum Disorders

Exclusions

- Services as treatments of sexual dysfunction and feeding disorders as listed in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.
- ASD services that extend beyond the period necessary for evaluation, diagnosis, the application of evidence based treatments or crisis intervention to be effective.

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- Any treatments or other specialized services designed for ASD that are not backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome and therefore are considered Experimental or Investigational.
 - Mental retardation as the primary diagnosis defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.
 - Relational problems as a primary diagnosis defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.
 - Tuition for services that are school-based for children and adolescents under the Individuals with Disabilities Education Act.
 - Learning, motor skills and primary communication disorders as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association and which are not a part of ASD.
 - Treatments for the primary diagnosis of learning disabilities, conduct and impulse control disorders, personality disorders, paraphilias and other mental illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practice, as reasonably determined by the Claims Administrator.
 - Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements, unless authorized by the Claims Administrator.
 - Services or supplies for the diagnosis or treatment of mental illness that, in the Claims Administrator's reasonable judgment, are not Medically Necessary or are any of the following:
 - Not consistent with generally accepted standards of medical practice for the treatment of such conditions.
 - Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore are considered Experimental or Investigational.
 - Typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective.
 - Not consistent with the Claims Administrator's level of care guidelines or best practices as modified from time to time.
 - Not clinically appropriate in terms of type, frequency, extent, site and duration of treatment, and considered ineffective for the patient's mental illness or condition based on generally accepted standards of medical practice and benchmarks.
 - The Claims Administrator may consult with professional clinical consultants, peer review committees or other appropriate sources for recommendations and information regarding whether a service or supply meets any of these criteria.

Hospital and Other Facility Based Services

Blood, blood plasma and blood derivatives, except as Covered under "Hospital and Other Facility-Based Services" in this SPD. Synthetic blood, apheresis or plasmapheresis are not covered.

Ambulatory Surgery Center

Skilled Nursing Facility

1. Coverage is limited to amount of days shown in your Schedule of Benefits.
2. Private or special duty nursing is not covered.
3. The Plan does not Cover, custodial care, convalescent care, domiciliary care, long-term care, maintenance care, adult day care or rest cures. The Plan does not cover room, board, nursing care or personal care which is rendered to assist a Participant who, in the Claims Administrator's opinion, has reached the maximum level of physical or mental function possible and will not make further significant clinical improvement.
4. The Plan does not cover rehabilitation services or physical therapy on a long-term basis.
5. Non-eligible institutions. Any services or supplies furnished by a non-eligible institution, which is defined as other than a Hospital or Skilled Nursing Facility, and which is primarily a place of rest, a place for the aged, or any similar institution, regardless of how denominated.

Custodial care, domiciliary care, long-term care, maintenance care, adult day care or rest cures. The plan does not Cover room, board, nursing care or personal care which is rendered to assist a Participant who, in the Claims Administrator's opinion, has reached the maximum level of physical or mental function possible and will not make further significant clinical improvement.

Hospice

1. Supportive Care and guidance for the immediate family is limited to a total of five visits. The family members must be covered under the Plan.
2. The Plan does not Cover: funeral arrangements; pastoral, financial or legal counseling; homemaker, caretaker or respite care.

Mental Health Services

- Services must be provided by providers who are certified by the appropriate state agency to provide such services and whose programs for such services have been approved by the Claims Administrator.
- The Plan does not cover learning and behavioral disorders. Services for the evaluation or treatment (including remedial education) of: learning disabilities or minimal brain dysfunction; mental retardation; developmental and learning disorders or behavioral problems except as noted under the "Early Intervention/Birth to Three Program" section are not covered. The Plan also does not cover behavioral training or cognitive rehabilitation.
- The Plan does not cover court ordered services or services that have been ordered as a condition of probation or parole. However, these services may be Covered if the Claims Administrator agrees that the services are Medically Necessary, are otherwise Covered, the

Participant has not exhausted their benefit for the Calendar Year, and the treatment is provided in accordance with the Claims Administrator's policies and procedures.

- The Plan does not cover non-medical services and long-term rehabilitation for physical therapy or the treatment of alcoholism or drug abuse, including rehabilitation services in a specialized inpatient or residential facility, except as specifically Covered under this SPD.
- The Plan does not cover non-medical services and long term rehabilitation services for the treatment of Mental Illness, including rehabilitation services in a specialized inpatient or residential facility.
- Covered Services for eligible Participants upon confinement in a Residential Treatment Facility must be based on an Individual Treatment Plan prescribed by the attending Physician and approved by the Claims Administrator's Medical Director. For the purpose of this benefit, eligible Participants must meet all of the following criteria: A) the Participant has a serious mental illness which substantially impairs the person's thought, perception of reality, emotional process, or judgment or grossly impairs behavior as manifested by recent disturbed behavior; B) the Participant has been confined in a Hospital for such illness for a period of at least three days immediately preceding such confinement in a Residential Treatment Facility; and such illness would otherwise necessitate continued confinement in a Hospital if such care and treatment were not available through a Residential Treatment Facility for children and adolescents.

For purposes of this benefit, the following definitions apply:

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

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

Care of Alcohol and Substance Abuse Conditions

All other applicable exclusions and limitations are listed in the "Exclusions and Limitations" section.

Emergency Hospital Admissions

Improper use of an emergency room or emergency admissions. Routine care and treatment for conditions that the Claims Administrator determines were not Medical Emergencies, when received in an emergency room, are not Covered. If you receive treatment at a non-Network facility which could reasonably have been foreseen (such as routine maternity and delivery), the treatment will not be Covered.

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1. Improper use of an emergency room or emergency admissions are not Covered. Routine care and treatment for conditions that the Plan determines were not Medical Emergencies, when received in an emergency room, are not Covered.
 2. Follow-up care provided in a Hospital emergency room is not covered.

Urgent Care

1. Routine care is not covered in an Urgent Care Center. Follow-up care is not covered in an Urgent Care Center.

General Exclusions and Limitations

Unless coverage is specifically provided under this SPD or provided in an attachment to this SPD, the following services and benefits are not Covered.

Services which are not Medically Necessary. If there is a dispute between a Network Provider and the Claims Administrator about the Medical Necessity of a service or supply, you or your Network Physician may appeal the Claims Administrator's decision. Any disputed service or supply will not be Covered during the appeal process (please refer to the "Utilization Review Appeal" provision of this SPD).

In no event will the Plan seek reimbursement from a Participant for the cost of any Covered Service provided under this SPD that the Claims Administrator determines is not Medically Necessary when such service was rendered by the Participant's PCP or upon referral of the PCP.

Important: If you and a Network Provider agree that you will be responsible for the costs of Covered Services that the Claims Administrator has determined are not Medically Necessary, the Plan will not reimburse you.

Services provided by non-Network Providers except: 1) for Medical Emergencies and Urgent Care, 2) for those instances when you are instructed to seek treatment from a non-Network Provider by a Medical Management Coordinator or your PCP and, 3) when the Claims Administrator has Pre-certified your use of a non-Network Physician.

Autopsies are not covered.

Acupuncture therapy.

Care for conditions that by federal, state or local law must be treated in a public facility including, but not limited to, commitments for mental illness. Additionally, to the extent allowed by law, the Plan does not Cover care or treatment provided in a non-Network Hospital that is owned or operated by any federal, state or other governmental entity.

Comfort or convenience items including, but not limited to: barber services; guest meals and accommodations; telephone, television or radio charges; travel expenses; or take-home supplies. The Plan also does not cover the purchase or rental of household fixtures or equipment including,

but not limited to: escalators; elevators; swimming pools; exercise cycles; air purifiers; air conditioners; water purifiers; allergenic pillows, mattresses or waterbeds.

Court ordered services or services that have been ordered as a condition of probation or parole. However, these services may be Covered if the Claims Administrator agrees that the services are Medically Necessary, are otherwise Covered, the Participant has not exhausted their benefit for the Calendar Year, and the treatment is provided in accordance with the Plan's policies and procedures.

When Medicare is the primary payor, the Plan Covers the Services provided by this SPD only to the extent they are not Covered under Medicare.

Military service related conditions except for a Medical Emergency. Conditions that are connected with a Participant's service in the military and for which the Participant is legally entitled to receive services at a government facility provided the facilities are reasonably available to the Participant (maximum three hour drive time).

No-fault automobile insurance. Any Covered Services that are payable as personal injury benefits under mandatory no-fault automobile insurance. Where permitted by state law, any Covered Services which are eligible for payment under the provisions of an automobile insurance contract or pursuant to any federal or state law which mandates indemnification for such services to persons suffering bodily injury from motor vehicle accidents.

Non-eligible institutions. Any services or supplies furnished by a non-eligible institution, which is defined as: other than a Hospital or Skilled Nursing Facility, and which is primarily a place of rest, a place for the aged, or any similar institution, regardless of how denominated.

The Plan does not cover non-medical services and long-term rehabilitation services, including rehabilitation services in a specialized inpatient or residential facility for: physical therapy treatment of alcoholism or drug abuse; or treatment of mental illness.

No-show charges. If a Provider charges a fee for a missed appointment, you will be responsible for the payment of the fee.

Occupational conditions, ailments, or injuries arising out of and in the course of employment except for (1) a sole proprietor or business partner who is not covered by the provisions of Chapter 568 or who accepts the provisions of said Chapter 568 pursuant to subdivision (6) of section 31-275 or (2) an employee of a corporation and who is a corporate officer, regardless of any election by such individual to be excluded from coverage under Chapter 568 pursuant to subparagraph (E) of subdivision (5) of section 31-275. Such conditions, ailments or injuries are not Covered if they are subject to coverage, in whole or in part, under any workers' compensation, occupational disease or similar law. This applies even if the Participant's rights have been waived or qualified.

Outpatient prescription drugs.

Recreational, educational or sleep therapy and related diagnostic testing.

Routine foot care including nail trimming, corn and callous removal, cleaning, soaking or any other hygienic maintenance or care.

Sex, marital or religious counseling, including sex therapy and treatment of sexual dysfunction.

Sex Transformations. Any procedure or treatment designed to alter the physical characteristics of a Participant from the Participant's biological sex to those of the opposite sex regardless of any diagnosis of gender role or psychosexual orientation problems.

Supplements and vitamins.

Special medical reports not directly related to treatment. Appearances in court or at a hearing.

Third party requests for physical examinations, diagnostic services and immunizations in connection with: obtaining or continuing employment; obtaining or maintaining any license issued by a municipality, state or federal government; obtaining insurance coverage; school admissions or attendance including examinations required for participation in athletic activities. Court ordered psychological or behavioral evaluations or counseling related to marital disputes, divorce proceedings, or child custody proceedings are not Covered.

Coverage outside of the United States. No coverage is available outside of the United States **if the Participant traveled out-of-the-country to obtain medical treatment**, drugs or supplies (with the exception of Canada, Mexico and U.S. possessions). Additionally, the Plan will not Cover any treatment, drugs or supplies that are unavailable or illegal in the United States.

When a Participant is traveling for other purposes, only Medical Emergencies and Urgent Care will be Covered outside of the United States (with the exception of Canada, Mexico and U.S. possessions).

Weight Control. All services, supplies, programs and surgical procedures for the purpose of weight control.

Unnecessary Care. In general, the Plan will not Cover any health care service that in the sole judgment of the Claims Administrator, determine is not Medically Necessary. If an External Appeal Agent certified by the State overturns the denial, however, the Plan shall Cover the procedure, treatment, service, pharmaceutical product, or durable medical equipment for which coverage has been denied, to the extent that such procedure, treatment, service, pharmaceutical product, or durable medical equipment is otherwise Covered under the terms of this SPD.

Any service, supply or treatment not specifically listed in this SPD as a Covered Service, supply or treatment. Any supply or treatment for which the Participant has no legal obligation

to reimburse the provider. Any supply or treatment provided by a member of the Participant's family (mother, step-mother, father, step-father, sister, step-sister, brother, step-brother, any "in-law," aunt, uncle, niece, nephew or cousin).

Blue Cross® and Blue Shield® Service Benefit Plan

<http://www.fepblue.org>

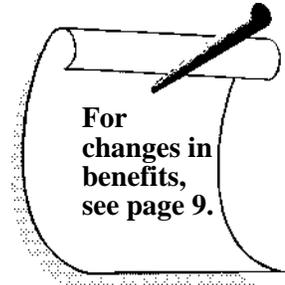


2012

A fee-for-service plan (standard and basic option) with a preferred provider organization

Sponsored and administered by: The Blue Cross and Blue Shield Association and participating Blue Cross and Blue Shield Plans

Who may enroll in this Plan: All Federal employees and annuitants who are eligible to enroll in the Federal Employees Health Benefits Program



Enrollment codes for this Plan:

- 104 Standard Option - Self Only
- 105 Standard Option - Self and Family
- 111 Basic Option - Self Only
- 112 Basic Option - Self and Family



See the 2012 FEHB Guide for more information on accreditation

Authorized for distribution by the:



United States
Office of Personnel Management

Healthcare and Insurance
<http://www.opm.gov/insure>



RI 71-005

Section 6. General exclusions – things we don't cover

The exclusions in this section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of this brochure. **Although we may list a specific service as a benefit, we will not cover it unless we determine it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition. For information on obtaining prior approval for specific services, such as transplants, see Section 3 (*You need prior Plan approval for certain services*).**

We do not cover the following:

- Services, drugs, or supplies you receive while you are not enrolled in this Plan.
- Services, drugs, or supplies that are not medically necessary.
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice in the United States.
- Services, drugs, or supplies billed by Preferred and Member facilities for inpatient care related to specific medical errors and hospital-acquired conditions known as Never Events (see definition on page 131).
- Experimental or investigational procedures, treatments, drugs, or devices (see specifics regarding transplants).
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest.
- Services, drugs, or supplies related to sex transformations, sexual dysfunction, or sexual inadequacy (except for surgical placement of penile prostheses to treat erectile dysfunction).
- Services, drugs, or supplies you receive from a provider or facility barred or suspended from the FEHB Program.
- Services or supplies for which no charge would be made if the covered individual had no health insurance coverage.
- Services, drugs, or supplies you receive without charge while in active military service.
- Charges which the enrollee or Plan has no legal obligation to pay, such as excess charges for an annuitant age 65 or older who is not covered by Medicare Parts A and/or B (see page 25), doctor's charges exceeding the amount specified by the Department of Health & Human Services when benefits are payable under Medicare (limiting charge, see page 26), or State premium taxes however applied.
- Services or supplies furnished by immediate relatives or household members, such as spouse, parents, children, brothers, or sisters by blood, marriage or adoption.
- Services or supplies furnished or billed by a noncovered facility, except that medically necessary prescription drugs; oxygen; and physical, speech and occupational therapy rendered by a qualified professional therapist on an outpatient basis are covered subject to Plan limits.
- Services, drugs, or supplies you receive from noncovered providers except in medically underserved areas as specifically described on page 12.
- Services, drugs, or supplies you receive for cosmetic purposes.
- Services, drugs, or supplies for the treatment of obesity, weight reduction, or dietary control, except for office visits and diagnostic tests for the treatment of morbid obesity; gastric restrictive procedures, gastric malabsorptive procedures, and combination restrictive and malabsorptive procedures (see page 53); and, those nutritional counseling services specifically listed on pages 31, 35, 37, and 70.
- Services you receive from a provider that are outside the scope of the provider's licensure or certification.
- Any dental or oral surgical procedures or drugs involving orthodontic care, the teeth, dental implants, periodontal disease, or preparing the mouth for the fitting or continued use of dentures, except as specifically described in Section 5(g), *Dental benefits*, and Section 5(b) under *Oral and maxillofacial surgery*.
- Orthodontic care for malposition of the bones of the jaw or for temporomandibular joint (TMJ) syndrome.
- Services of standby physicians.
- Self-care or self-help training.

- Custodial care.
- Personal comfort items such as beauty and barber services, radio, television, or telephone.
- Furniture (other than medically necessary durable medical equipment) such as commercial beds, mattresses, chairs.
- Routine services, such as periodic physical examinations; screening examinations; immunizations; and services or tests not related to a specific diagnosis, illness, injury, set of symptoms, or maternity care, except for those preventive services specifically covered under *Preventive care, adult and child* in Sections 5(a) and 5(c) and screenings specifically listed on pages 34-37 and 72; and certain routine services associated with covered clinical trials (see page 127).
- Recreational or educational therapy, and any related diagnostic testing, except as provided by a hospital during a covered inpatient stay.
- Applied behavior analysis (ABA).
- Topical Hyperbaric Oxygen Therapy (THBO).
- Research costs (costs related to conducting a clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes).
- Professional charges for shift differentials.
- Services not specifically listed as covered.

Government Employees Health Association, Inc. Benefit Plan

(800) 821-6136

<http://www.geha.com>



2012

A fee-for-service (high and standard option) health plan with a preferred provider organization

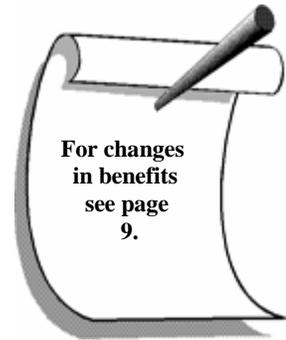
Sponsored and administered by:

Government Employees Health Association, Inc.

Who may enroll in this Plan: All Federal employees and annuitants who are eligible to enroll in the Federal Employees Health Benefits Program may become members of GEHA. You must be, or must become a member of Government Employees Health Association, Inc.

To become a member: You join simply by signing a completed Standard Form 2809, Health Benefits Registration Form, evidencing your enrollment in the Plan.

Membership dues: There are no membership dues for the Year 2012.



ACCREDITED
HEALTH NETWORK



ACCREDITED
HEALTH UTILIZATION
MANAGEMENT



2011



Enrollment codes for this Plan:

- 311 High Option - Self Only**
- 312 High Option - Self and Family**
- 314 Standard Option - Self Only**
- 315 Standard Option - Self and Family**

URAC accreditation: GEHA for Health Network

URAC UM accreditation: InforMed for Health Utilization Management

NCQA accreditation: Healthcare Effectiveness Data and Information Set (HEDIS) Audit

JCAHO accreditation: Medco for Home Care Pharmacy Dispensing Services

Authorized for distribution by the:



**United States
Office of Personnel Management**

Healthcare and Insurance
<http://www.opm.gov/insure>

RI 71-006

Section 6. General exclusions – things we don't cover

The exclusions in this section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of this brochure. Although we may list a specific service as a benefit, we will not cover it unless we determine it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition. For information on obtaining prior approval for specific services, such as transplants, (see Section 3 *When you need prior Plan approval for certain services*).

We do not cover the following:

- Services, drugs, or supplies you receive while you are not enrolled in this Plan.
- Services, drugs, or supplies that are not medically necessary.
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice.
- Experimental or investigational procedures, treatments, drugs or devices (see specifics regarding transplants).
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest.
- Services, drugs, or supplies related to sex transformations; sexual dysfunction or sexual inadequacy.
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program.
- Services or supplies for which no charge would be made if the covered individual had no health insurance coverage.
- Services, drugs, or supplies you receive without charge while in active military service.
- Services or supplies furnished by immediate relatives or household members, such as spouse, parents, children, brothers or sisters by blood, marriage or adoption.
- Services or supplies furnished or billed by a noncovered facility, except that medically necessary prescription drugs and physical, occupational and speech therapy rendered by a qualified professional therapist on an outpatient basis are covered subject to Plan limits.
- Services or supplies for cosmetic purposes.
- Surgery to correct congenital anomalies for individuals age 18 and older unless there is a functional deficit.
- Services or supplies not specifically listed as covered.
- Services or supplies not reasonably necessary for the diagnosis or treatment of an illness or injury, except for routine physical examinations and immunizations.
- Any portion of a provider's fee or charge ordinarily due from the enrollee but that has been waived. If a provider routinely waives (does not require the enrollee to pay) a deductible, copay or coinsurance, we will calculate the actual provider fee or charge by reducing the fee or charge by the amount waived.
- Charges which the enrollee or Plan has no legal obligation to pay, such as excess charges for an annuitant age 65 or older who is not covered by Medicare Parts A and/or B (see page 20, doctor charges exceeding the amount specified by the Department of Health and Human Services when benefits are payable under Medicare (limiting charge) (see page 21), services, drugs or supplies related to avoidable complications and medical errors, Never event policies (see page 88) or State premium taxes however applied.
- Charges in excess of the "Plan allowance" as defined on pages 89-90.
- Biofeedback, educational, recreational or milieu therapy, either in or out of a hospital.
- Inpatient private duty nursing.
- Stand-by physicians and surgeons.
- Clinical ecology and environmental medicine.
- Chelation therapy except for acute arsenic, gold, or lead poisoning.
- Treatment for impotency, even if there is an organic cause for impotency. (Exclusion applies to medical/surgical treatment as well as prescription drugs).
- Treatment other than surgery of temporomandibular joint dysfunction and disorders (TMJ).
- Computer devices to assist with communications.
- Surgical treatment of hyperhidrosis unless alternative therapies such as botox injections or topical aluminum chloride and pharmacotherapy have been unsuccessful.
- Computer programs of any type, including but not limited to those to assist with vision therapy or speech therapy.
- Weight loss programs.
- Home test kits including but not limited to HIV and drug home test kits.
- Telephone consultations.
- Genetic counseling and genetic screening.
- Services, drugs, or supplies ordered or furnished by a non-covered provider.