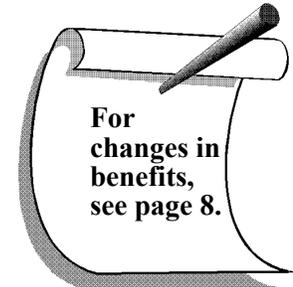




**A Health Maintenance Organization (High and Basic Option)**

**Serving:** Connecticut and Franklin, Hampden and Hampshire Counties in Massachusetts.

**Enrollment in this plan is limited. You must live or work in our Geographic service area to enroll. See page 7 for requirements.**



*This Plan has excellent accreditation from the NCQA.  
See the 2009 Guide for more information on accreditation.*

**Enrollment codes for this Plan:**

- TE1 High Option – Self Only**
- TE2 High Option – Self and Family**
- TE4 Basic Option – Self Only**
- TE5 Basic Option – Self and Family**

Authorized for distribution by the:



**United States  
Office of Personnel Management**  
Center for  
Retirement and Insurance Services  
<http://www.opm.gov/insure>

**Important Notice from ConnectiCare About  
Our Prescription Drug Coverage and Medicare**

OPM has determined that ConnectiCare's prescription drug coverage is, on average, comparable to Medicare Part D prescription drug coverage; thus you do not need to enroll in Medicare Part D and pay extra for prescription drug benefits. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

However, if you choose to enroll in Medicare Part D, you can keep your FEHB coverage and will coordinate benefits with Medicare.

Remember: If you are an annuitant and you cancel your FEHB coverage, you may not re-enroll in the FEHB Program.

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**Please be advised**

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If you lose or drop your FEHB coverage, you will have to pay a higher Part D premium if you go without equivalent prescription drug coverage for a period of 63 days or longer. If you enroll in Medicare Part D at a later date, your premium will increase 1 percent per month for each month you did not have equivalent prescription drug coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what most other people pay. You may also have to wait until the next open enrollment period to enroll in Medicare Part D.

**Medicare's Low Income Benefits**

*For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA) online at [www.socialsecurity.gov](http://www.socialsecurity.gov), or call the SSA at 1-800-772-1213 (TTY 1-800-325-0778).*

You can get more information about Medicare prescription drug plans and the coverage offered in your area from these places:

- Visit [www.medicare.gov](http://www.medicare.gov) for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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## Introduction

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This brochure describes the benefits under our contract (CS 2662) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. The address for ConnectiCare's administrative offices is:

ConnectiCare, Inc.

175 Scott Swamp Road

Farmington, CT 06032

This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your health benefits.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2009, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2009, and changes are summarized on page 8. Rates are shown at the end of this brochure.

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## Plain Language

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All FEHB brochures are written in plain language to make them responsive, accessible, and understandable to the public. For instance,

- Except for necessary technical terms, we use common words. For instance, "you" means the enrollee or family member, "we" means ConnectiCare.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the United States Office of Personnel Management. If we use others, we tell you what they mean first.
- Our brochure and other FEHB plans' brochures have the same format and similar descriptions to help you compare plans.

If you have comments or suggestions about how to improve the structure of this brochure, let OPM know. Visit OPM's "Rate Us" feedback area at [www.opm.gov/insure](http://www.opm.gov/insure) or e-mail OPM at [fehwebcomments@opm.gov](mailto:fehwebcomments@opm.gov). You may also write to OPM at the U.S. Office of Personnel Management, Insurance Services Programs, Program Planning & Evaluation Group, 1900 E Street, NW, Washington, DC20415-3650.

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## Stop Health Care Fraud!

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Fraud increases the cost of health care for everyone and increases your Federal Employees Health Benefits Program premium.

OPM's Office of the Inspector General investigates all allegations of fraud, waste, and abuse in the FEHB Program regardless of the agency that employs you or from which you retired.

**Protect Yourself From Fraud** – Here are some things that you can do to prevent fraud:

- Do not give your plan identification (ID) number over the telephone or to people you do not know, except for your health care providers, authorized health benefits plan, or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) statements that you receive from us.

- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:

Call the provider and ask for an explanation. There may be an error.

If the provider does not resolve the matter, call us at 1-800-251-7722 and explain the situation.

If we do not resolve the issue:

**CALL - THE HEALTH CARE FRAUD HOTLINE**

**202-418-3300**

**OR WRITE TO:**

**United States Office of Personnel Management**  
**Office of the Inspector General Fraud Hotline**  
**1900 E Street NW Room 6400**  
**Washington, DC 20415-1100**

- Do not maintain as a family member on your policy:

Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or

Your child over age 22 (unless he/she is disabled and incapable of self support).

- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage.
- You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEHB benefits or try to obtain services for someone who is not an eligible family member or who is no longer enrolled in the Plan.

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## **Preventing medical mistakes**

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An influential report from the Institute of Medicine estimates that up to 98,000 Americans die every year from medical mistakes in hospitals alone. That’s about 3,230 preventable deaths in the FEHB Program a year. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. By asking questions, learning more and understanding your risks, you can improve the safety of your own health care, and that of your family members. Take these simple steps:

### **1. Ask questions if you have doubts or concerns.**

- Ask questions and make sure you understand the answers.
- Choose a doctor with whom you feel comfortable talking.
- Take a relative or friend with you to help you ask questions and understand answers.

### **2. Keep and bring a list of all the medicines you take.**

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines that you take, including non-prescription (over-the-counter) medicines.
- Tell them about any drug allergies you have.

- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your medicine is what the doctor ordered. Ask the pharmacist about your medicine if it looks different than you expected.
- Read the label and patient package insert when you get your medicine, including all warnings and instructions.
- Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.

### **3. Get the results of any test or procedure.**

- Ask when and how you will get the results of tests or procedures.
- Don't assume the results are fine if you do not get them when expected, be it in person, by phone, or by mail.
- Call your doctor and ask for your results.
- Ask what the results mean for your care.

### **4. Talk to your doctor about which hospital is best for your health needs.**

- Ask your doctor about which hospital has the best care and results for your condition if you have more than one hospital to choose from to get the health care you need.
- Be sure you understand the instructions you get about follow-up care when you leave the hospital.

### **5. Make sure you understand what will happen if you need surgery.**

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, "Who will manage my care when I am in the hospital?"
- Ask your surgeon:
  - Exactly what will you be doing?
  - About how long will it take?
  - What will happen after surgery
  - How can I expect to feel during recovery?
- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reaction to anesthesia, and any medications you are taking.

Want more information on patient safety?

- [www.ahrq.gov/consumer/path/beactive.htm](http://www.ahrq.gov/consumer/path/beactive.htm). The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.
- [www.npsf.org](http://www.npsf.org). The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.
- [www.talkaboutrx.org/](http://www.talkaboutrx.org/). The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.
- [www.leapfroggroup.org](http://www.leapfroggroup.org). The Leapfrog Group is active in promoting safe practices in hospital care.
- [www.ahqa.org](http://www.ahqa.org). The American Health Quality Association represents organizations and health care professionals working to improve patient safety.
- [www.quic.gov/report](http://www.quic.gov/report). Find out what federal agencies are doing to identify threats to patient safety and help prevent mistakes in the nation's health care delivery system.

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## Section 1. Facts about this HMO plan

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This Plan is a health maintenance organization (HMO). To get covered benefits, we require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services. The Plan is solely responsible for the selection of these providers in your area. Contact the Plan for a copy of their most recent provider directory. We give you a choice of enrollment in a High Option and a Basic Option.

HMOs emphasize preventive care such as routine office visits, physical exams, well-baby care, and immunizations, in addition to treatment for illness and injury.

When you receive services from Plan providers, you will not have to submit claim forms or pay bills. You pay only the copayments, coinsurance, and deductibles described in this brochure. When you receive emergency services from non-Plan providers, you may have to submit claim forms.

**You should join an HMO because you prefer the plan's benefits, not because a particular provider is available. You cannot change plans because a provider leaves our Plan. We cannot guarantee that any one physician, hospital, or other provider will be available and/or remain under contract with us.**

### **Who provides my health care**

ConnectiCare is an Independent Practice Association (IPA) model Health Maintenance Organization (HMO). It offers you the services of more than 22,500 physicians, including general practitioners and specialists. For Plan records, all members and each family member must select a primary care doctor. However, members are free to choose the services of any participating doctor, including specialists, except as noted (see What you must do, specialty care.)

### **General features of our High and Basic Options**

#### **We have Open Access benefits**

Our HMO offers Open Access benefits. This means you can receive covered services from a participating provider without a required referral from your primary care physician or by another participating provider in the network.

#### **We have Flex Point-of-Service (FlexPOS) Benefits for our High Option**

Our FlexPOS plan allows members to receive a higher level of benefits when using ConnectiCare's participating providers or network providers. The In-Network level of benefits will be paid when any member uses a ConnectiCare participating provider when services are rendered in the State of Connecticut or Hampden, Hampshire and Franklin counties in Massachusetts. The In-Network level of benefits will also be paid when any member uses a PHCS Healthy Directions participating provider when receiving services outside of the State of Connecticut or the counties of Hampden, Hampshire and Franklin Massachusetts.

#### **How we pay providers**

We contract with individual physicians, medical groups, and hospitals to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your copayments, deductibles and /or coinsurance.

#### **Your rights**

OPM requires that all FEHB Plans provide certain information to their FEHB members. You may get information about us, our networks, and our network providers. OPM's FEHB Web site ([www.opm.gov/insure](http://www.opm.gov/insure)) lists the specific types of information that we must make available to you. Some of the required information is listed below.

- Years in existence: 27
- Profit status: For-profit

If you want more information about us, call 1-800-251-7722, or write to ConnectiCare, Inc., 175 Scott Swamp Road, Farmington, CT 06032. You may also contact us by fax at 860-674-2232 or visit our Web site at [www.connecticare.com](http://www.connecticare.com).

#### **Your medical and claims records are confidential**

We will keep your medical and claims records confidential. Please note that we may disclose your medical and claims information (including your prescription drug utilization) to any of your treating physicians or dispensing pharmacies.

**Service Area**

To enroll in this Plan, you must live in or work in our Service Area. Our service area is: the State of Connecticut along with Franklin, Hampden and Hampshire counties in Massachusetts.

If you or a covered family member move outside of our service area, you can enroll in another plan. If your dependents live out of the area (for example, if your child goes to college in another state), you should consider enrolling in a fee-for-service plan or an HMO that has agreements with affiliates in other areas. If you or a family member move, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

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## Section 2. How we change for 2009

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Do not rely only on these change descriptions; this Section is not an official statement of benefits. For that, go to Section 5 Benefits. Also, we edited and clarified language throughout the brochure; any language change not shown here is a clarification that does not change benefits.

### Changes to this Plan

Your share of the High Option and Basic Option (formerly Standard Option) premiums has increased for Self Only and Family coverage.

### 2009 Benefit Changes

#### High Option

- The High Option for 2009 now has a front-end deductible of \$500 per individual \$1,000 per family (deductible is waived for preventive care.)
- The office visit copayment for 2009 has changed from \$15 to \$20.
- The emergency room copayment for 2009 has changed from \$75 to \$150 after the plan deductible.
- The outpatient surgical copayment for 2009 has changed from \$100 to \$250 after the plan deductible.
- The inpatient hospital copayment for 2009 has changed from \$100 per day to a maximum of \$500 to \$250 per day to a maximum of \$1,250 after plan deductible.
- There were no out-of-network benefits except for emergencies in 2008. In 2009, there is coverage with a \$5,000/\$15,000 deductible, 50% coinsurance, \$6,000/\$18,000 out of pocket max.
- Rx coverage: The High Option pharmacy benefit for 2009 has changed from \$15/\$25/\$40 to \$15/\$30/50%, not to exceed \$60.

#### Basic Option

- The office visit copayment for 2009 has changed from \$20 to \$25.
- The specialist visit copayment for 2009 has changed from \$40 to \$45
- The emergency room copayment for 2009 has changed from \$100 to \$150.
- The outpatient/inpatient combined hospital deductible for 2009 has changed from \$1,500/\$3,000 to \$2,000/\$4,000.
- Rx coverage: The Basic Option pharmacy benefit for 2009 has changed from a \$50 deductible, then 15/\$25/\$40 to \$15/\$30/50%, not to exceed \$60.

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## Section 3. How you get care

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<b>Identification cards</b>	<p>We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider, or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation letter (for annuitants), or your electronic enrollment system (such as Employee Express) confirmation letter.</p> <p>If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 1-800-251-7722 or write to us at ConnectiCare, Inc., 175 Scott Swamp Road, Farmington, CT 06032. You may also request replacement cards through our Web site at <a href="http://www.connecticare.com">www.connecticare.com</a>.</p>
<b>Where you get covered care</b>	<p>You get covered care from “Plan providers” and “Plan facilities.” You will only pay copayments, deductibles, and/or coinsurance.</p> <p>Our High Option Plan allows members a choice to use nonparticipating health care providers and facilities outside of the network. However, to receive the highest level of benefits members must utilize a participating provider or facility within the network.</p>
<ul style="list-style-type: none"><li>• <b>Plan providers</b></li></ul>	<p>Plan providers are physicians and other health care professionals in our service area that we contract with to provide covered services to our members. We credential Plan providers according to national standards.</p> <p>We list Plan providers in the provider directory, which we update periodically. The list is also on our Web site.</p>
<ul style="list-style-type: none"><li>• <b>Plan facilities</b></li></ul>	<p>Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these in the provider directory, which we update periodically. The list is also on our Web site.</p>
<b>What you must do to get covered care</b>	<p>It depends on the type of care you need. First, you and each family member must choose a primary care physician. This decision is important since your primary care physician provides or coordinates most of your health care. You can choose a PCP from our provider directory. If you don’t provide us with your PCP, we will select one for you, which you can change at any time by calling 1-800-251-7722.</p>
<ul style="list-style-type: none"><li>• <b>Primary care</b></li></ul>	<p>Your primary care physician can be a family practitioner, internist, general practitioner or a pediatrician. Your primary care physician will provide or coordinate most of your health care.</p> <p>If you want to change primary care physicians or if your primary care physician leaves the Plan, call us. We will help you select a new one.</p>
<ul style="list-style-type: none"><li>• <b>Specialty care</b></li></ul>	<p>Under this Plan, you and your covered dependents <b>ARE NOT</b> required to obtain a Referral in order to obtain benefits for services rendered by specialists. Although the Referral is not required, it is still a good idea to use your respective PCPs to coordinate your specialty care.</p>
<ul style="list-style-type: none"><li>• <b>Hospital care</b></li></ul>	<p>Your Plan primary care physician or specialist will make necessary hospital arrangements and supervise your care. This includes admission to a skilled nursing or other type of facility.</p>
<ul style="list-style-type: none"><li>• <b>If you are hospitalized when your enrollment begins</b></li></ul>	<p>We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 1-800-251-7722. If you are new to the FEHB Program, we will arrange for you to receive care and provide benefits for your covered services while you are in the hospital beginning on the effective date of your coverage.</p>

If you changed from another FEHB plan to us, your former plan will pay for the hospital stay until:

- You are discharged, not merely moved to an alternative care center; or
- The day your benefits from your former plan run out; or
- The 92<sup>nd</sup> day after you become a member of this Plan, whichever happens first.

These provisions apply only to the benefits of the hospitalized person. If your plan terminates participation in the FEHB Program in whole or in part, or if OPM orders an enrollment change, this continuation of coverage provision does not apply. In such cases, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

**Circumstances beyond our control**

Under certain extraordinary circumstances, such as natural disasters, we may have to delay your services or we may be unable to provide them. In that case, we will make all reasonable efforts to provide you with the necessary care.

**Services requiring our prior approval**

Your primary care physician has authority to refer you for most services. For certain services, however, your physician must obtain approval from us. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice.

We call this review and approval process Plan authorization.

Some of the services that your physician must obtain Plan authorization for are: Growth hormone therapy (GHT), hospital admissions (except out-of-service area emergencies), outpatient alcohol and substance abuse treatment, home health care, out-of-Plan services (nonparticipating providers), human organ transplants, and skilled nursing facilities. For a complete listing, call our Member Services Department at 1-800-251-7722.

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## Section 4. Your costs for covered services

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This is what you will pay out-of-pocket for covered care.

**Copayments** A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive certain services.

Example: In our Basic Option, when you see your primary care physician you pay a copayment of \$25 per office visit and when you go to a specialist you pay a copayment of \$45 per office visit.

**Cost-sharing** Cost sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance and copayments) for the covered care you receive.

**Deductible** A deductible is a fixed expense you must incur for certain covered services and supplies before we start paying benefits for them. Copayments do not count toward any deductible. Our High and Basic Options each have a deductible.

For example: Our High Option plan has a \$500 Individual and \$1,000 Family deductible.

For example: Our Basic Option has a combined inpatient and outpatient hospital deductible of \$2,000/\$4,000.

**Coinsurance** Coinsurance is the percentage of our allowance that you must pay for your care. Coinsurance doesn't begin until you meet your deductible.

Example: Durable Medical Equipment, Disposable Medical Supplies and Ostomy Supplies and Equipment have coinsurance.

**When Government facilities bill us** Facilities of the Department of Veterans Affairs, the Department of Defense and the Indian Health Services are entitled to seek reimbursement for certain services and supplies they provide to you or a family member. They may not seek more than their governing laws allow.

**Section 5. High and Basic Option Benefits**

See page 8 for how our benefits changed this year. Page 59 and page 61 are a benefits summary of each option. Make sure that you review the benefits that are available under the option in which you are enrolled.

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## Section 5. High and Basic Option Benefits Overview

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This Plan offers both a High and Basic Option. Both benefit packages are described in Section 5. Make sure that you review the benefits that are available under the option in which you are enrolled.

The High and Basic Option Section 5 is divided into subsections. Please read the *important things you should keep in mind* at the beginning of the subsections. Also read the General exclusions in Section 6, they apply to the benefits in the following subsections. To obtain claim forms, claims filling advice, or more information about High and Standard Option benefits, contact us at 1-800-251-7722 or at our Web site at [www.connecticare.com](http://www.connecticare.com).

Each option offers unique features.

### **High Option**

This plan has an up-front deductible for most services which must be satisfied first. Preventive services are EXCLUDED from the deductible. While in the ConnectiCare Network Access Area (The state of Connecticut, and Franklin, Hampden and Hampshire counties in Massachusetts) members must use ConnectiCare participating providers for the highest level of benefits. Outside of the ConnectiCare Network Access Area, members must use PHCS Healthy Directions participating providers to receive the highest level of benefits.

### **Basic Option**

This plan features a combined deductible for inpatient and outpatient services, as well as higher copayments and deductibles. Members can obtain services from any participating provider without a referral. The higher cost sharing reduces the member's payroll deductions while still providing coverage for a wide range of services.

**Section 5(a). Medical services and supplies provided by physicians and other health care professionals**

**Important things you should keep in mind about these benefits:**

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care in order for you to receive the highest level of benefits.
- A facility copay applies to services that appear in this section but are performed in an ambulatory surgical center or the outpatient department of a hospital.
- We have a contract-year plan deductible for our High Option (In-Network: \$500 per individual/\$1,000 per family, Out-Of-Network: \$5,000 per individual/\$10,000 per family.) We also have a combined inpatient and outpatient hospital deductible of \$2,000/\$4,000 in the Basic Option.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You pay	
<p><b>Note: The contract-year deductible applies to almost all benefits in this Section. We say “(No deductible)” when it does not apply.</b></p>		
Diagnostic and treatment services	High Option	Basic Option
Professional services of physicians <ul style="list-style-type: none"> <li>• In physician’s office</li> <li>• Office medical consultations</li> <li>• Second surgical opinion</li> </ul>	\$20 for Primary Care Physicians  \$40 for Specialists, per office visit after Plan Deductible  Out-Of-Network: 50% after Plan Deductible	\$25 for Primary Care Physicians  \$45 for Specialists per office visit
Professional services of physicians <ul style="list-style-type: none"> <li>• In an urgent care center</li> <li>• During a hospital stay</li> <li>• In a skilled nursing facility</li> </ul>	\$50 per office visit after Plan Deductible  Included in hospital services, no additional charges.  No member cost after Plan Deductible for up to 90 days per contract year.  Out-Of-Network: 50% after Plan Deductible	\$50 per office visit  Included in hospital services, no additional charges.  Nothing for up to 90 days per calendar year.  \$25 in a Primary Care Physician's office  \$45 in a Specialist's office
At home	\$20 for Primary Care Physicians  \$40 for Specialists, after Plan Deductible  Out-Of-Network: 50% after Plan Deductible	\$25 for Primary Care Physicians, \$45 for Specialists, per office visit

Benefit Description	You pay	
Lab, X-ray and other diagnostic tests	High Option	Basic Option
Tests, such as: <ul style="list-style-type: none"> <li>• Blood tests</li> <li>• Urinalysis</li> <li>• Non-routine Pap tests</li> <li>• Pathology</li> <li>• Electrocardiogram and EEG</li> <li>• X-rays</li> <li>• Non-routine mammograms</li> <li>• Ultrasound</li> <li>• CAT Scans/MRI</li> <li>• High-tech imaging</li> </ul>	Lab work: Nothing after Plan Deductible  \$10 for non-advanced radiology after Plan Deductible  \$75 for advanced radiology (includes MRI, PET, and CAT scan and nuclear cardiology) after Plan Deductible  Out-Of-Network: 50% after Plan Deductible	\$25 for Primary Care Physician's office  \$45 in a Specialist's office  \$10 for non-advanced radiology  \$75 for advanced radiology (includes MRI, PET, and CAT scan and nuclear cardiology)
Preventive care, adult	High Option	Basic Option
Routine physical every year which includes:  Routine screenings, such as: <ul style="list-style-type: none"> <li>• Total Blood Cholesterol</li> <li>• Colorectal Cancer Screening, including               <ul style="list-style-type: none"> <li>- Fecal occult blood test</li> <li>- Sigmoidoscopy or colonoscopy, age 50 or older, one per year</li> </ul> </li> </ul>	\$20 per office visit (No Deductible)  The following services, one per year, associated with preventive care are exempt from the deductible and are subject only to a \$20 office copayment. (Blood count, Pap Test, cholesterol screening, fasting plasma glucose, hematocrit or hemoglobin, lead screening, urinalysis, venipuncture)  Out-Of-Network: 50% after Plan Deductible	\$25 in a Primary Care Physician's office
Routine Prostate Specific Antigen (PSA) test – one annually for men age 45 and older	\$20 in a Primary Care Physician's office (No Deductible)  \$40 in a Specialist's office  Out-Of-Network: 50% after Plan Deductible	\$25 in a Primary Care Physician's office  \$45 in a Specialist's office
Routine Pap test  Note: You do not pay a separate copay for a Pap test performed during your routine annual physical; see <i>Diagnostic and treatment services</i> .	\$20 in a Primary Care Physician's office (No Deductible)  Out-Of-Network: 50% after Plan Deductible	\$25 in a Primary Care Physician's office
Routine mammogram – covered for women age 40 or older, one per year	Nothing (No Deductible)  Out-Of-Network: 50% after Plan Deductible	Nothing

*Preventive care, adult - continued on next page*

Benefit Description	You pay	
<b>Preventive care, adult (cont.)</b>	<b>High Option</b>	<b>Basic Option</b>
Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC):	\$20 in a Primary Care Physician's office (No Deductible)  Out-Of-Network: 50% after Plan Deductible	\$25 in a Primary Care Physician's office
<i>Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.</i>	<i>All charges</i>	<i>All charges</i>
<b>Preventive care, children</b>	<b>High Option</b>	<b>Basic Option</b>
Childhood immunizations recommended by the American Academy of Pediatrics <ul style="list-style-type: none"> <li>• Well-child care charges for routine examinations, immunizations and care</li> <li>• Examinations, such as:                             <ul style="list-style-type: none"> <li>- Eye exams through age 17 to determine the need for vision correction</li> <li>- Hearing exams through age 19 to determine the need for hearing correction</li> <li>- Examinations done on the day of immunizations (up to age 22)</li> </ul> </li> </ul>	\$20 in a Primary Care Physician's office (No Deductible)  Out-Of-Network: 50% after Plan Deductible	\$25 in a Primary Care Physician's office
<b>Maternity care</b>	<b>High Option</b>	<b>Basic Option</b>
Complete maternity (obstetrical) care, such as: <ul style="list-style-type: none"> <li>• Prenatal care</li> <li>• Delivery</li> <li>• Postnatal care</li> </ul> <p>Note: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> <li>• You will be covered if you remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery, (you do not need to precertify the normal length of stay.) We will extend coverage for your inpatient stay if medically necessary.</li> <li>• We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment.</li> <li>• We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b).</li> </ul>	\$20 copayment for initial visit only, after Plan Deductible  Out-Of-Network: 50% after Plan Deductible	\$25 copayment for initial visit only

Benefit Description	You pay	
	High Option	Basic Option
<p><b>Family planning</b></p> <p>A range of voluntary family planning services, limited to:</p> <ul style="list-style-type: none"> <li>• Voluntary sterilization (See Surgical procedures Section 5 (b))</li> <li>• Surgically implanted contraceptives</li> <li>• Injectable contraceptive drugs (such as Depo provera)</li> <li>• Intrauterine devices (IUDs)</li> <li>• Diaphragms</li> </ul> <p>Note: We cover oral contraceptives under the prescription drug benefit.</p>	<p>\$20 copayment for PCP or OB/GYN per visit after Plan Deductible</p> <p>Out-Of-Network: 50% after Plan Deductible</p>	<p>\$25 in a Primary Care Physician's office</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Reversal of voluntary surgical sterilization</i></li> <li>• <i>Genetic counseling</i></li> </ul>	<p><i>All charges</i></p>	<p><i>All charges</i></p>
<p><b>Infertility services</b></p> <p>Diagnosis and treatment of infertility such as:</p> <ul style="list-style-type: none"> <li>• Ovulation induction (to a maximum of four cycles without regard to the reasons for the ovulation induction).</li> <li>• Intrauterine insemination (to a maximum of three cycles per recipient, regardless of source).</li> <li>• Intravaginal insemination (IVI)</li> <li>• Intracervical insemination (ICI)</li> <li>• In-vitro fertilization (IVF), gamete intra-fallopian transfer (GIFT), zygote intra-fallopian transfer (ZIFT) or low tubal ovum transfer (to a maximum of two cycles <b>combined for all procedures</b>, with not more than two embryo implantations per cycle). These cycles are only covered when the Member has not been able to conceive or produce conception or sustain a successful pregnancy through the less expensive and medically viable treatments covered by this Plan.</li> <li>• Some pre-implantation genetic diagnosis may be covered when preformed while the Member is receiving an IVF, GIFT, ZIFT or low tubal ovum transfer procedure which is covered under the Plan.</li> <li>• Pre-implantation genetic diagnosis may be covered when Medically Necessary under certain circumstances when used to deselect embryos with genetic mutations.</li> </ul>	<p>\$20 copayment in a PCP or OB/GYN's office</p> <p>\$40 in a Specialist's office, after Plan Deductible</p> <p>Out-Of-Network: 50% after Plan Deductible</p>	<p>\$25 in a Primary Care Physician's office or OB/GYN's office</p> <p>\$45 in a Specialist's office</p>

*Infertility services - continued on next page*

Benefit Description	You pay	
<b>Infertility services (cont.)</b>	<b>High Option</b>	<b>Basic Option</b>
<ul style="list-style-type: none"> <li>• Pre-implantation genetic testing to determine the gender of an embryo is covered only when there is a documented history of an x-linked disorder such that deselection can be made on the basis of sex alone.</li> </ul> <p>Note: Medically Necessary diagnostic and testing procedures and therapy needed to treat diagnosed Infertility are <b>covered at the applicable Cost-Share amounts as shown on the Benefit Summary, up to the policy limits described</b> if Pre-Authorized by us for a Member up to his or her 40<sup>th</sup> birthday</p>	<p>\$20 copayment in a PCP or OB/GYN's office</p> <p>\$40 in a Specialist's office, after Plan Deductible</p> <p>Out-Of-Network: 50% after Plan Deductible</p>	<p>\$25 in a Primary Care Physician's office or OB/GYN's office</p> <p>\$45 in a Specialist's office</p>
<b>Allergy care</b>	<b>High Option</b>	<b>Basic Option</b>
<ul style="list-style-type: none"> <li>• Testing and treatment</li> <li>• Allergy injections</li> </ul>	<p>\$20 in a Primary Care Physician's office</p> <p>\$40 in a Specialist's office after Plan Deductible</p> <p>Out-Of-Network: 50% after Plan Deductible</p>	<p>\$25 in a Primary Care Physician's office</p> <p>\$45 in a Specialist's office</p>
Allergy serum	Nothing	Nothing
<b>Treatment therapies</b>	<b>High Option</b>	<b>Basic Option</b>
<ul style="list-style-type: none"> <li>• Chemotherapy and radiation therapy</li> </ul> <p>Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 26.</p> <ul style="list-style-type: none"> <li>• Respiratory and inhalation therapy</li> <li>• Dialysis – hemodialysis and peritoneal dialysis</li> <li>• Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy</li> <li>• Growth hormone therapy (GHT)</li> </ul> <p>Note: Growth hormone is covered under the prescription drug benefit.</p> <p>Note: – We only cover GHT when we preauthorize the treatment. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment; otherwise, we will only cover GHT services from the date you submit the information. If you do not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See <i>Services requiring our prior approval</i> in Section 3.</p>	<p>No charge after Plan Deductible</p> <p>Out-Of-Network: 50% after Plan Deductible</p>	<p>No charge</p>

Benefit Description	You pay	
<b>Physical and occupational therapies</b>	<b>High Option</b>	<b>Basic Option</b>
<p>60 visits combined per condition: per year</p> <ul style="list-style-type: none"> <li>qualified physical therapists and</li> <li>occupational therapists</li> </ul> <p>Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury.</p>	<p>\$40 copayment per visit after Plan Deductible</p> <p>Out-Of-Network: 50% after Plan Deductible</p>	<p>\$45 per outpatient visit</p> <p>Nothing per visit during covered inpatient admission</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li><i>Long-term rehabilitative therapy</i></li> <li><i>Exercise programs</i></li> </ul>	<p><i>All charges</i></p>	<p><i>All charges</i></p>
<b>Cardiac rehabilitation</b>	<b>High Option</b>	<b>Basic Option</b>
<p>Phase I cardiac rehabilitation is covered</p> <p>Medically necessary Phase II cardiac rehabilitation is covered if it is ordered by a physician and performed in a structured cardiac rehabilitation setting.</p>	<p>Nothing per visit after Plan Deductible and copayment</p> <p>Out-Of-Network: 50% after Plan Deductible</p>	<p>Nothing per visit during covered inpatient admission</p>
<p><i>Not covered:</i></p> <p><i>Cardiac rehabilitation is not covered for Phase III. It is available for Members who meet the criteria for enrollment into our HeartCare health management program and when the rehabilitation is approved by us. Cardiac rehabilitation is not covered for Phase IV.</i></p>	<p><i>All charges</i></p>	<p><i>All charges</i></p>
<b>Speech therapy</b>	<b>High Option</b>	<b>Basic Option</b>
<p>60 visits per condition per year</p>	<p>\$40 copayment per visit after Plan Deductible</p> <p>Nothing per visit during covered inpatient admission</p> <p>Out-Of-Network: 50% after Plan Deductible</p>	<p>\$45 per outpatient visit</p> <p>Nothing per visit during covered inpatient admission</p>
<b>Hearing services (testing, treatment, and supplies)</b>	<b>High Option</b>	<b>Basic Option</b>
<ul style="list-style-type: none"> <li>Hearing aids for children through age 12, (see <i>Preventive care, children</i>)</li> </ul>	<p>20% coinsurance after Plan Deductible to a max. of \$1,000 every 24 months for children under 12</p> <p>Out-Of-Network: 50% after Plan Deductible up to \$1,000 every 24 months for children under 12</p>	<p>20% coinsurance after Plan Deductible to a max. of \$1,000 every 24 months for children under 12</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li><i>All other hearing testing</i></li> <li><i>Hearing aids, testing and examinations for them</i></li> </ul>	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Benefit Description	You pay	
Vision services (testing, treatment, and supplies)	High Option	Basic Option
<p>Annual eye refractions (Routine Vision)</p> <p>Note: See <i>Preventive care, children</i> for eye exams for children.</p>	<p>\$20 copayment per visit (No Deductible)</p> <p>Out-Of-Network: 50% after Plan Deductible</p>	<p>\$25 per visit</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Eyeglasses or contact lenses,</i></li> <li>• <i>Eye exercises and orthoptics</i></li> <li>• <i>Radial keratotomy and other refractive surgery</i></li> </ul>	<p><i>All charges</i></p>	<p><i>All charges</i></p>
Foot care	High Option	Basic Option
<p>Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.</p>	<p>\$20 in a Primary Care Physician's office</p> <p>\$40 in a Specialist's office after Plan Deductible</p> <p>Out-Of-Network: 50% after Plan Deductible</p>	<p>\$25 in a Primary Care Physician's office</p> <p>\$45 in a Specialist's office</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above</i></li> <li>• <i>Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)</i></li> </ul>	<p><i>All charges</i></p>	<p><i>All charges</i></p>
Orthopedic and prosthetic devices	High Option	Basic Option
<ul style="list-style-type: none"> <li>• Artificial limbs and eyes; stump hose</li> <li>• Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy</li> <li>• Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: See 5(b) for coverage of the surgery to insert the device.</li> <li>• Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: Internal prosthetic devices are paid as hospital benefits; see Section 5(c) for payment information. Insertion of the device is paid as surgery; see Section 5(b) for coverage of the surgery to insert the device.</li> <li>• Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.</li> </ul>	<p>Covered under Durable Medical Equipment</p> <p>20% coinsurance after Plan Deductible up to \$1,500 per year. You pay all charges over the \$1,500 maximum.</p> <p>Out-Of-Network: 50% after Plan Deductible up to \$1,500 per year.</p>	<p>Covered under Durable Medical Equipment</p> <p>DME is subject to a \$200 deductible, 20% coinsurance up to a benefit maximum of \$1,500 per member per year</p> <p>You pay all charges over the \$1,500 maximum</p>

*Orthopedic and prosthetic devices - continued on next page*

Benefit Description	You pay	
<b>Orthopedic and prosthetic devices (cont.)</b>	<b>High Option</b>	<b>Basic Option</b>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• Orthopedic and corrective shoes</li> <li>• Arch supports</li> <li>• Foot orthotics</li> <li>• Heel pads and heel cups</li> <li>• Lumbosacral supports</li> <li>• Corsets, trusses, elastic stockings, support hose, and other supportive devices</li> <li>• Prosthetic replacements provided less than 3 years after the last one we covered</li> </ul>	<p><i>All charges</i></p>	<p><i>All charges</i></p>
<b>Durable medical equipment (DME)</b>	<b>High Option</b>	<b>Basic Option</b>
<p>We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include:</p> <ul style="list-style-type: none"> <li>• Oxygen;</li> <li>• Dialysis equipment;</li> <li>• Hospital beds;</li> <li>• Wheelchairs;</li> <li>• Crutches;</li> <li>• Walkers;</li> <li>• Blood glucose monitors; and</li> <li>• Insulin pumps.</li> </ul> <p>Note: Call us at 1-800-251-7722 as soon as your Plan physician prescribes this equipment. We will arrange with a health care provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call.</p>	<p>20% coinsurance after Plan Deductible to a max. of \$1,500 per year. You pay all charges over the \$1,500 contract year max.</p> <p>Out-Of-Network: 50% after Plan Deductible up top \$1,500 per year</p>	<p>DME is subject to a \$200 deductible, 20% coinsurance up to a benefit maximum of \$1,500 per member per year</p> <p>You pay all charges over the \$1,500 calendar year max.</p>
<b>Home health services</b>	<b>High Option</b>	<b>Basic Option</b>
<ul style="list-style-type: none"> <li>• Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide.</li> <li>• Services include oxygen therapy, intravenous therapy and medications.</li> </ul>	<p>Nothing (No Deductible)</p> <p>Out-Of-Network: 25%</p>	<p>Nothing</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• Nursing care requested by, or for the convenience of, the patient or the patient's family;</li> <li>• Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.</li> </ul>	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Benefit Description	You pay	
<b>Chiropractic</b>	<b>High Option</b>	<b>Basic Option</b>
<ul style="list-style-type: none"> <li>• Manipulation of the spine and extremities; 20 visits per calendar year</li> <li>• Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application</li> </ul>	\$40 copayment per visit after Plan Deductible  Out-Of-Network: 50% after Plan Deductible	\$45 per office visit
<b>Alternative treatments</b>	<b>High Option</b>	<b>Basic Option</b>
Naturopathic services	\$40 copayment per visit after Plan Deductible  Out-Of-Network: 50% after Plan Deductible	\$45 copayment per visit
<i>Not covered:</i> <ul style="list-style-type: none"> <li>• <i>Acupuncture</i></li> <li>• <i>Hypnotherapy</i></li> <li>• <i>Biofeedback</i></li> </ul>	<i>All charges</i>	<i>All charges</i>

**Section 5(b). Surgical and anesthesia services provided by physicians and other health care professionals**

**Important things you should keep in mind about these benefits:**

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- We have a contract-year plan deductible for our High Option (In-Network: \$500 per individual/\$1,000 per family, Out-Of-Network: \$5,000 per individual/\$10,000 per family.) We also have a combined inpatient and outpatient hospital deductible of \$2,000/\$4,000 in the Basic Option.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR SOME SURGICAL PROCEDURES.** Please refer to the precertification information shown in Section 3 and call Member Services to be sure which services require precertification.

Benefit Description	You pay	
Note: The contract-year deductible applies to almost all benefits in this Section. We say “(No deductible)” when it does not apply.		
Surgical procedures	High Option	Basic Option
A comprehensive range of services, such as: <ul style="list-style-type: none"> <li>• Operative procedures</li> <li>• Treatment of fractures, including casting</li> <li>• Normal pre- and post-operative care by the surgeon</li> <li>• Correction of amblyopia and strabismus</li> <li>• Endoscopy procedures</li> <li>• Biopsy procedures</li> <li>• Removal of tumors and cysts</li> <li>• Correction of congenital anomalies (see <i>Reconstructive surgery</i>)</li> <li>• Surgical treatment of morbid obesity (bariatric surgery)</li> <li>• Insertion of internal prosthetic devices . See 5(a) – <i>Orthopedic and prosthetic devices</i> for device coverage information</li> <li>• Voluntary sterilization (e.g., tubal ligation, vasectomy)</li> <li>• Treatment of burns</li> </ul>	\$40 copayment per office visit after Plan Deductible  Out-Of-Network: 50% after Plan Deductible	\$45 in a Specialist’s office

*Surgical procedures - continued on next page*

Benefit Description	You pay	
	High Option	Basic Option
<b>Surgical procedures (cont.)</b>		
Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.	\$40 copayment per office visit after Plan Deductible  Out-Of-Network: 50% after Plan Deductible	\$45 in a Specialist's office
<i>Not covered:</i>	<i>All charges</i>	<i>All charges</i>
<ul style="list-style-type: none"> <li>• <i>Reversal of voluntary sterilization</i></li> <li>• <i>Routine treatment of conditions of the foot; see Foot care</i></li> </ul>		
<b>Reconstructive surgery</b>	<b>High Option</b>	<b>Basic Option</b>
<ul style="list-style-type: none"> <li>• Surgery to correct a functional defect</li> <li>• Surgery to correct a condition caused by injury or illness if: <ul style="list-style-type: none"> <li>- the condition produced a major effect on the member's appearance and</li> <li>- the condition can reasonably be expected to be corrected by such surgery</li> </ul> </li> <li>• Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; and webbed fingers and toes.</li> <li>• All stages of breast reconstruction surgery following a mastectomy, such as: <ul style="list-style-type: none"> <li>- surgery to produce a symmetrical appearance of breasts;</li> <li>- treatment of any physical complications, such as lymphedemas;</li> <li>- breast prostheses and surgical bras and replacements (see <i>Prosthetic devices</i>)</li> </ul> </li> </ul> <p>Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.</p>	\$40 copayment per office visit after Plan Deductible  Out-Of-Network: 50% after Plan Deductible	\$45 in a Specialist's office
<i>Not covered:</i>	<i>All charges</i>	<i>All charges</i>
<ul style="list-style-type: none"> <li>• <i>Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury</i></li> <li>• <i>Surgeries related to sex transformation</i></li> </ul>		

Benefit Description	You pay	
<b>Oral and maxillofacial surgery</b>	<b>High Option</b>	<b>Basic Option</b>
<p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> <li>• Reduction of fractures of the jaws or facial bones;</li> <li>• Surgical correction of cleft lip, cleft palate or severe functional malocclusion;</li> <li>• Removal of stones from salivary ducts;</li> <li>• Excision of leukoplakia or malignancies;</li> <li>• Excision of cysts and incision of abscesses when done as independent procedures; and</li> </ul> <p>Other surgical procedures that do not involve the teeth or their supporting structures.</p>	<p>\$40 per office visit after Plan Deductible.</p> <p>Out-Of-Network: 50% after Plan Deductible</p>	<p>\$45 in a Specialist's office</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Oral implants and transplants</i></li> <li>• <i>Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)</i></li> </ul>	<p><i>All charges</i></p>	<p><i>All charges</i></p>
<b>Organ/tissue transplants</b>	<b>High Option</b>	<b>Basic Option</b>
<p>Solid organ transplants are subject to medical necessity and experimental/investigational review. Refer to <i>Other services</i> in Section 3 for prior authorization procedures. The medical necessity limitation is considered satisfied for other tissue transplants if the patient meets the staging description.</p> <ul style="list-style-type: none"> <li>• Cornea</li> <li>• Heart</li> <li>• Heart/lung</li> <li>• Single, double or lobar lung</li> <li>• Kidney</li> <li>• Liver</li> <li>• Pancreas</li> <li>• Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis</li> <li>• Intestinal transplants <ul style="list-style-type: none"> <li>- Small intestine</li> <li>- Small intestine with the liver</li> <li>- Small intestine with multiple organs, such as the liver, stomach and pancreas</li> </ul> </li> </ul>	<p>No additional charges for inpatient physician services. See Section 5(c) for hospital charges.</p> <p>Out-of-Network: 50% after Plan Deductible</p>	<p>No additional charges for inpatient physician services. See Section 5(c) for hospital charges.</p>
<p>Blood or marrow stem cell transplants limited to the stages of the following diagnoses:</p> <ul style="list-style-type: none"> <li>• Allogeneic transplants for <ul style="list-style-type: none"> <li>- Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia</li> </ul> </li> </ul>	<p>No additional charges for inpatient physician services. See Section 5(c) for hospital charges.</p> <p>Out-of-Network: 50% after Plan Deductible</p>	<p>No additional charges for inpatient physician services. See Section 5(c) for hospital charges.</p>

*Organ/tissue transplants - continued on next page*

Benefit Description	You pay	
<b>Organ/tissue transplants (cont.)</b>	<b>High Option</b>	<b>Basic Option</b>
<ul style="list-style-type: none"> <li>- Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL)</li> <li>- Advanced Hodgkin’s lymphoma</li> <li>- Advanced non-Hodgkin’s lymphoma</li> <li>- Chronic myelogenous leukemia</li> <li>- Hemoglobinopathy (i.e. Fanconi’s, Thalessemia major)</li> <li>- Myelodysplasia/Myelodysplastic syndromes</li> <li>- Severe combined immunodeficiency</li> <li>- Severe or very severe aplastic anemia</li> <li>- Amyloidosis</li> <li>• Autologous transplant for               <ul style="list-style-type: none"> <li>- Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia</li> <li>- Advanced Hodgkin’s lymphoma</li> <li>- Advanced non-Hodgkin’s lymphoma</li> <li>- Neuroblastoma</li> <li>- Amyloidosis</li> </ul> </li> <li>• Autologous tandem transplants for               <ul style="list-style-type: none"> <li>- Recurrent germ cell tumors (including testicular cancer)</li> <li>- Muliple myeloma</li> <li>- De-novo myeloma</li> </ul> </li> </ul>	<p>No additional charges for inpatient physician services. See Section 5(c) for hospital charges.</p> <p>Out-of-Network: 50% after Plan Deductible</p>	<p>No additional charges for inpatient physician services. See Section 5(c) for hospital charges.</p>
<p>Blood or marrow stem cell transplants for</p> <ul style="list-style-type: none"> <li>• Allogeneic transplants for               <ul style="list-style-type: none"> <li>- Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome)</li> <li>- Advanced neuroblastoma</li> <li>- Infantile malignant osteoporosis</li> <li>- Kostmann’s syndrome</li> <li>- Leukocyte adhesion deficiencies</li> <li>- Mucopolipidosis (e.g., Gaucher’s disease, metachromatic leukodystrophy, adrenoleukodystrophy)</li> <li>- Mucopolysaccharidosis (e.g., Hunter’s syndrome, Hurler’s syndrome, Sanfilippo’s syndrome, Maroteaux-Lamy syndrome variants)</li> <li>- Myeloproliferative disorders</li> <li>- Sickle cell anemia</li> <li>- X-linked lymphoproliferative syndrome</li> </ul> </li> <li>• Autologous transplants for</li> </ul>	<p>No additional charges for inpatient physician services. See Section 5(c) for hospital charges.</p> <p>Out-of-Network: 50% after Plan Deductible</p>	<p>No additional charges for inpatient physician services. See Section 5(c) for hospital charges.</p>

*Organ/tissue transplants - continued on next page*

Benefit Description	You pay	
	High Option	Basic Option
<b>Organ/tissue transplants (cont.)</b> <ul style="list-style-type: none"> <li>- Multiple myeloma</li> <li>- Testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors</li> <li>- Breast cancer</li> <li>- Epithelial ovarian cancer</li> <li>- Ependymoblastoma</li> <li>- Ewing’s sarcoma</li> <li>- Medulloblastoma</li> <li>- Pineoblastoma</li> <li>- Waldenstrom’s macroglobulinemia</li> </ul>	<p>No additional charges for inpatient physician services. See Section 5(c) for hospital charges.</p> <p>Out-of-Network: 50% after Plan Deductible</p>	<p>No additional charges for inpatient physician services. See Section 5(c) for hospital charges.</p>
<p>Mini-transplants (non-myeloblastic, reduced intensity conditioning) for covered transplants: Subject to medical necessity</p>	<p>See information above.</p>	<p>See information above.</p>
<p>Tandem transplants for covered transplants: Subject to medical necessity</p>	<p>See information above.</p>	<p>See information above.</p>
<p>Blood or marrow stem cell transplants covered only in a National Cancer Institute or National Institutes of Health approved clinical trial at a Plan-designated center of excellence and if approved by the Plan’s medical director in accordance with the Plan’s protocols for:</p> <ul style="list-style-type: none"> <li>• Allogeneic transplants for <ul style="list-style-type: none"> <li>- Chronic lymphocytic leukemia</li> <li>- Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL)</li> <li>- Early stage (indolent or non-advanced) small cell lymphocytic lymphoma</li> <li>- Myelodysplasia/Myelodysplastic syndromes</li> <li>- Multiple myeloma</li> <li>- Multiple sclerosis</li> </ul> </li> <li>• Nonmyeloablative allogeneic transplants for <ul style="list-style-type: none"> <li>- Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia</li> <li>- Myelodysplasia/myelodysplastic syndromes</li> <li>- Advanced Hodgkin’s lymphoma</li> <li>- Advanced non-Hodgkin’s lymphoma</li> <li>- Breast cancer</li> <li>- Chronic lymphocytic leukemia</li> <li>- Chronic myelogenous leukemia</li> <li>- Colon cancer</li> <li>- Early stage (indolent or non-advanced) small cell lymphocytic lymphoma</li> <li>- Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL)</li> </ul> </li> </ul>	<p>No additional charges for inpatient physician services. See Section 5(c) for hospital charges.</p> <p>Out-of-Network: 50% after Plan Deductible</p>	<p>No additional charges for inpatient physician services. See Section 5(c) for hospital charges.</p>

Benefit Description	You pay	
<b>Organ/tissue transplants (cont.)</b>	<b>High Option</b>	<b>Basic Option</b>
<ul style="list-style-type: none"> <li>- Multiple myeloma</li> <li>- Multiple sclerosis</li> <li>- Myeloproliferative disorders</li> <li>- Non-small cell lung cancer</li> <li>- Ovarian cancer</li> <li>- Prostate cancer</li> <li>- Renal cell carcinoma</li> <li>- Sarcomas</li> <li>• Autologous transplants for               <ul style="list-style-type: none"> <li>- Chronic lymphocytic leukemia</li> <li>- Chronic myelogenous leukemia</li> <li>- Early stage (indolent or non-advanced) small cell lymphocytic lymphoma</li> <li>- Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL)</li> <li>- Small cell lung cancer</li> <li>- Multiple sclerosis</li> <li>- Systemic lupus erythematosus</li> <li>- Systemic sclerosis</li> <li>- Scleroderma-SSc (severe, progressive)</li> </ul> </li> <li>• National Transplant Program (NTP) -</li> </ul> <p>Note: We cover related medical and hospital expenses of the donor when we cover the recipient.</p>	<p>No additional charges for inpatient physician services. See Section 5(c) for hospital charges.</p> <p>Out-of-Network: 50% after Plan Deductible</p>	<p>No additional charges for inpatient physician services. See Section 5(c) for hospital charges.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• Donor screening tests and donor search expenses, except those performed for the actual donor</li> <li>• Implants of artificial organs</li> <li>• Transplants not listed as covered</li> </ul>	<p><i>All charges</i></p>	<p><i>All charges</i></p>
<b>Anesthesia</b>	<b>High Option</b>	<b>Basic Option</b>
<p>Professional services provided in –</p> <ul style="list-style-type: none"> <li>• Hospital (inpatient)</li> <li>• Hospital outpatient department</li> <li>• Skilled nursing facility</li> <li>• Ambulatory surgical center</li> <li>• Office</li> </ul>	<p>No additional charges for inpatient physician services. See Section 5(c) for hospital charges.</p>	<p>No additional charges for inpatient physician services. See Section 5(c) for hospital charges.</p>

**Section 5(c). Services provided by a hospital or other facility, and ambulance services**

**Important things you should keep in mind about these benefits:**

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- We have a contract-year plan deductible for our High Option (In-Network: \$500 per individual/\$1,000 per family, Out-Of-Network: \$5,000 per individual/\$10,000 per family.) We also have a combined inpatient and outpatient hospital deductible of \$2,000/\$4,000 in the Basic Option.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are in Sections 5(a) or (b).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR HOSPITAL STAYS.** Please refer to Section 3 and call Member Services to be sure which services require precertification.

Benefit Description	You pay	
Note: The contract-year deductible applies only when we say below: “(calendar year deductible applies)”.		
Inpatient hospital	High Option	Basic Option
Room and board, such as <ul style="list-style-type: none"> <li>• Ward, semiprivate, or intensive care accommodations;</li> <li>• General nursing care; and</li> <li>• Meals and special diets.</li> </ul> Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	\$250 copayment per day up to \$1,250 per year after Plan Deductible  Out-Of-Network: 50% after Plan Deductible	\$2,000 benefit deductible per member/\$4,000 per family. All ambulatory services and inpatient hospitalization accumulate to this benefit deductible
Other hospital services and supplies, such as: <ul style="list-style-type: none"> <li>• Operating, recovery, maternity, and other treatment rooms</li> <li>• Prescribed drugs and medicines</li> <li>• Diagnostic laboratory tests and X-rays</li> <li>• Dressings, splints, casts, and sterile tray services</li> <li>• Medical supplies and equipment, including oxygen</li> </ul>	Nothing after deductible and copayment	Nothing after deductible
<ul style="list-style-type: none"> <li>• Anesthetics, including nurse anesthetist services</li> <li>• Take-home items</li> <li>• Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home (Note: calendar year deductible applies.)</li> </ul>	Nothing after deductible and copayment	Nothing after deductible
Not covered: <ul style="list-style-type: none"> <li>• Custodial care</li> <li>• Non-covered facilities, such as nursing homes, schools</li> </ul>	All charges	All charges

*Inpatient hospital - continued on next page*  
 High and Basic Option Section 5(c)

Benefit Description	You pay	
	High Option	Basic Option
<b>Inpatient hospital (cont.)</b>		
<ul style="list-style-type: none"> <li>• <i>Personal comfort items, such as telephone, television, barber services, guest meals and beds</i></li> <li>• <i>Private nursing care</i></li> </ul>	<i>All charges</i>	<i>All charges</i>
<b>Outpatient hospital or ambulatory surgical center</b>		
<ul style="list-style-type: none"> <li>• Operating, recovery, and other treatment rooms</li> <li>• Prescribed drugs and medicines</li> <li>• Diagnostic laboratory tests, X-rays, and pathology services</li> <li>• Administration of blood, blood plasma, and other biologicals</li> <li>• Blood and blood plasma, if not donated or replaced</li> <li>• Pre-surgical testing</li> <li>• Dressings, casts, and sterile tray services</li> <li>• Medical supplies, including oxygen</li> <li>• Anesthetics and anesthesia service</li> </ul> <p>Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.</p>	\$250 copayment after Plan Deductible  Out-Of-Network: 50% after Plan Deductible	\$2,000 benefit deductible per member/\$4,000 per family. All ambulatory services and inpatient hospitalization accumulate to this benefit deductible
<i>Not covered: Blood and blood derivatives not replaced by the member</i>	<i>All charges</i>	<i>All charges</i>
<b>Extended care benefits/Skilled nursing care facility benefits</b>		
<p>Skilled nursing facility (SNF): The Plan provides a comprehensive range of benefits for up to 90 days when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a Plan doctor and approved by the Plan. All necessary services are covered including:</p> <ul style="list-style-type: none"> <li>• Bed, board and general nursing care</li> <li>• Drugs, biologicals, supplies and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a Plan doctor.</li> </ul>	No cost after Plan Deductible  Out-Of-Network: 50% after Plan Deductible	Nothing for up to 90 days per calendar year. Prior authorization required
<i>Not covered: Custodial care</i>	<i>All charges</i>	<i>All charges</i>

Benefit Description	You pay	
<b>Hospice care</b>	<b>High Option</b>	<b>Basic Option</b>
<p>Hospice Care: Supportive and palliative care for a terminally ill member is covered in the home or hospice facility. Services include inpatient and outpatient care, and family counseling; these services are provided under the direction of a Plan doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less.</p>	<p>Nothing for outpatient hospice care; no charge after Plan Deductible for inpatient hospice care</p> <p>Out-Of-Network: 50% after Plan Deductible</p>	<p>Nothing</p>
<p><i>Not covered: Independent nursing, homemaker services</i></p>	<p><i>All charges</i></p>	<p><i>All charges</i></p>
<b>Ambulance</b>	<b>High Option</b>	<b>Basic Option</b>
<p>Local professional ambulance service when medically appropriate</p>	<p>No cost after Plan Deductible</p> <p>Out-Of-Network: 50% after Plan Deductible</p>	<p>Nothing</p>

## Section 5(d). Emergency services/accidents

### Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

### What is a medical emergency?

A medical emergency is the sudden and unexpected onset of a condition or an injury that you believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care. Some problems are emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Others are emergencies because they are potentially life-threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or sudden inability to breathe. There are many other acute conditions that we may determine are medical emergencies – what they all have in common is the need for quick action.

Emergency services rendered both within and outside of the Service Area are covered at the **In-Network Level of Benefits**, whether rendered in a Participating Hospital or Nonparticipating Hospital emergency room.

### What to do in case of emergency:

**Emergencies within our service area:** If you are in an urgent care situation within our service area, please call your primary care doctor (available 24 hours a day through their answering service). In extreme emergencies, contact the local emergency system (e.g., the 911 telephone system) or go to the nearest hospital emergency room. Be sure to tell the emergency room personnel that you are a Plan member so they can notify the Plan. You or a family member should notify the Plan within 24 hours of an admission to the hospital unless it was not reasonably possible to do so. It is your responsibility to ensure that the Plan has been timely notified.

If you need to be hospitalized in a non-Plan facility, the Plan must be notified within 24 hours or on the first working day following your admission, unless it was not reasonably possible to notify the Plan within that time. If you are hospitalized in non-Plan facilities and the Plan doctors believe care can be appropriately provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

Under your Basic Option benefits are available for care from non-Plan providers in a medical emergency only if delay in reaching a Plan provider would result in death, disability or significant jeopardy to your condition.

To be covered by this Plan, any follow-up care recommended by non-Plan providers must be approved by the Plan or provided by Plan providers.

The Plan pays reasonable charges for emergency services to the extent the services would have been covered if received from Plan providers.

**Emergencies outside our service area:** Benefits are available for any medically necessary health service that is immediately required because of injury or unforeseen illness.

If you need to be hospitalized, the Plan must be notified within 24 hours of an admission or on the first working day following your admission, unless it was not reasonably possible to notify the Plan within that time. If the Plan believes care can be appropriately provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

To be covered by this Plan, any follow-up care recommended by non-Plan providers must be approved by the Plan or provided by Plan providers.

Benefit Description	You pay	
<b>Emergency within our service area</b>	<b>High Option</b>	<b>Basic Option</b>
<ul style="list-style-type: none"> <li>Emergency care at a doctor's office</li> <li>Emergency care at an urgent care center</li> <li>Emergency care as an outpatient at a hospital , including doctors' services</li> </ul> <p>Note: We waive the ER copay if you are admitted to the hospital.</p>	<p>\$20 in a Primary Care Physician's office</p> <p>\$40 in a Specialist's office after Plan Deductible</p> <p>\$50 for covered emergency services after Plan Deductible</p> <p>\$150 for covered emergency services after Plan Deductible</p>	<p>\$25 in a Primary Care Physician's office</p> <p>\$45 in a Specialist's office</p> <p>\$50 for covered emergency services</p> <p>\$150 for covered emergency services</p>
<i>Not covered: Elective care or non-emergency care</i>	<i>All charges.</i>	<i>All charges.</i>
<b>Emergency outside our service area</b>	<b>High Option</b>	<b>Basic Option</b>
<ul style="list-style-type: none"> <li>Emergency care at a doctor's office</li> <li>Emergency care at an urgent care center</li> <li>Emergency care as an outpatient at a hospital, including doctors' services</li> </ul> <p>Note: We waive the ER copay if you are admitted to the hospital.</p>	<p>\$20 in a Primary Care Physician's office</p> <p>\$40 in a Specialist's office after Plan Deductible</p> <p>\$50 for covered emergency services after Plan Deductible</p> <p>\$150 for covered emergency services after Plan Deductible</p>	<p>\$25 in a Primary Care Physician's office</p> <p>\$45 in a Specialist's office</p> <p>\$50 for covered emergency services</p> <p>\$150 for covered emergency services</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li><i>Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area</i></li> </ul>	<i>All charges</i>	<i>All charges</i>
<b>Ambulance</b>	<b>High Option</b>	<b>Basic Option</b>
<p>Professional ambulance service when medically appropriate.</p> <p>Note: See 5(c) for non-emergency service.</p>	<p>No charge after Plan Deductible</p> <p>Out-Of-Network: 50% after Plan Deductible</p>	Nothing

**Section 5(e). Mental health and substance abuse benefits**

When you get our approval for services and follow a treatment plan we approve, cost-sharing and limitations for Plan mental health and substance abuse benefits will be no greater than for similar benefits for other illnesses and conditions.

**Important things you should keep in mind about these benefits:**

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION FOR THESE SERVICES.** See the instructions after the benefits description below.

Benefit Description	You pay	
Note: The contract-year deductible applies to almost all benefits in this Section. We say “(No deductible)” when it does not apply.		
Mental health and substance abuse benefits	High Option	Basic Option
All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure.  Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.	Your cost sharing responsibilities are no greater than for other illnesses or conditions.	Your cost sharing responsibilities are no greater than for other illnesses or conditions.
<ul style="list-style-type: none"> <li>• Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers</li> <li>• Medication management</li> </ul>	\$40 per visit after Plan Deductible  Out-Of-Network: 50% after Plan Deductible	\$45 per visit
<ul style="list-style-type: none"> <li>• Diagnostic tests</li> </ul>	\$40 per visit after Plan Deductible  Out-Of-Network: 50% after Plan Deductible	Nothing
<ul style="list-style-type: none"> <li>• Services provided by a hospital or other facility</li> <li>• Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment</li> </ul>	\$250 copayment per day up to \$1,250 per year after Plan Deductible  Out-Of-Network: 50% after Plan Deductible	\$2,000 benefit deductible per member/\$4,000 per family. All ambulatory services and inpatient hospitalization accumulate to this benefit deductible.
<p><i>Not covered: Services we have not approved.</i></p> <p><i>Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.</i></p>	<p><i>All charges</i></p>	<p><i>All charges</i></p>

<b>Preauthorization</b>	To be eligible to receive these benefits you must obtain a treatment plan and follow all of the following network authorization processes:
<b>Limitation</b>	We may limit your benefits if you do not obtain a treatment plan.

## Section 5(f). Prescription drug benefits

### Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- We have a contract-year plan deductible for our High Option (In-Network: \$500 per individual/\$1,000 per family, Out-Of-Network: \$5,000 per individual/\$10,000 per family.) We also have a combined inpatient and outpatient hospital deductible of \$2,000/\$4,000 in the Basic Option.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- We have an open formulary. If your physician believes a brand-name product is necessary or there is no generic available, your physician may prescribe a brand-name drug from a formulary list. The list of name brand drugs is a preferred list of drugs that we've selected to meet patient's needs at a lower cost. **We have the right to change the drugs or supplies in each tier, in our discretion, even in the middle of the year. You should call Member Services or visit the Web site to find out which tier (if any) a prescription drug or supply is in To order a formulary listing, go to our Web site [www.connecticare.com](http://www.connecticare.com).**
- **Some prescribed drugs and medications require preauthorization. Call our Member Services Department at 1-800-251-7722 or visit our Web site at [www.connecticare.com](http://www.connecticare.com) to find out if a prescription drug requires preauthorization.** Under this Plan, participating providers have the responsibility to obtain the necessary preauthorization when they are prescribing or administering a drug for you or your covered dependents. In addition, any drug that is newly available to the market will also require preauthorization until such time that we re-publish our list of drugs that require preauthorization. No benefits will be provided under this Plan if you or your covered dependents receive prescription drugs after preauthorization for them has been denied. Failure to comply with the requirements of this Plan will result in denial of benefits, except in those instances we mentioned where it is the responsibility of participating providers to request the applicable preauthorization. In those instances, benefits available under this Plan will not be reduced or denied if the participating provider who prescribed or administered the drug or medication fails to request preauthorization. If you receive an explanation of benefits stating the claim was denied where it was the responsibility of the participating provider to request the applicable preauthorization, call our Member Services Department at 1-800-251-7722 so we can help you resolve this issue.

### There are important features you should be aware of. These include:

- **Who can write your prescription.** A licensed physician must write the prescription – or – a plan physician or licensed dentist must write the prescription.
- **Where you can obtain them.** You may fill the prescription at a pharmacy that participates with Express Scripts, or by mail for a maintenance medication. The only exception is for out-of-area emergencies.

Pharmacy: You may obtain your prescriptions at any pharmacy that participates with Express Scripts (98% of U.S. Pharmacies.)

*Mail order:* Maintenance medication, those medications needed for conditions such as diabetes, high blood pressure, epilepsy and heart conditions, can be obtained either via mail order or at the pharmacy in a 100-day supply. If you choose mail order at 2 times the copayment, call Member Services at 1-800-251-7722 to request an order form. If you choose to go to your pharmacy, the copayment will be 3 times the copayment. All rules that apply to the regular Prescription Plan apply to the Mail Order Program as well. Note: Not all drugs are available via mail order and your doctor must write a maintenance prescription.

- **We use a formulary.** We work with our network physicians and our pharmacy network, Express Scripts, Inc., to build a Formulary Drug List. This Formulary Drug List includes over 80% of the drugs currently available in the market, including all generic and some name brand drugs. Formulary and Non-Formulary drugs are available at a cost difference when a generic is available. Our Formulary is available by calling Member Services at 1-800-251-7722 or on the Web at [www.connecticare.com](http://www.connecticare.com)

All members receive educational information describing the Formulary drug program. Members using non-Formulary drugs are sent a series of letters recommending that they speak to their physician about preferred alternatives.

We have an open formulary. If your physician believes a name brand product is necessary or there is no generic available, your physician may prescribe a name brand drug from a formulary list. This list of name brand drugs is a preferred list of drugs that we selected to meet patient needs at a lower cost. To order a prescription drug brochure, call 1-800-251-7722.

**These are the dispensing limitations.** Prescription drugs prescribed by a Plan or referral doctor and obtained at a Plan pharmacy will be dispensed for up to a 34-day supply, or up to a 100-day supply through mail order. When generic substitution is permissible and, you or your doctor request the name brand drug, you pay the price difference between the generic and name brand drug as well as the \$15 copayment per prescription. Drugs are prescribed by Plan doctors and dispensed in accordance with the Plan’s drug Formulary. If you are in the military and called to active duty due to an emergency, please contact us if you need assistance in filling a prescription before your departure.

- **A generic equivalent will be dispensed if it is available.** If you receive a name brand drug when a Federally-approved generic drug is available, then you have to pay the difference in cost between the name brand drug and the generic.
- **Why use generic drugs?** Per the FDA (Federal Drug Administration), generic drugs and name brand drugs share identical basic ingredients. The color and shape may differ but the result should be the same. Many generic patents are owned by the name brand drug companies. Generic drugs are an affordable alternative. You can always get the name brand, you just pay more.

NOTE: Not all prescriptions are available through the Maintenance Mail Order Program depending on the type of drug, etc. We follow FDA dispensing guidelines. If you send in your order too soon, it can’t be filled. Maintenance Mail Order refills should be requested after 75% of the prescription is used. Over the counter when you have 5 days left. If your prescription is for more than 34 days (1 month) prescription, you will be charged two and sometimes three copayments depending on how much was dispensed.

- **When you do have to file a claim.** There are no claims to file for prescription services received at Express Scripts, Inc. drug stores. If you are new to the plan and don’t have your card when you first join and need a prescription, you must pay for it and call Member Services at 1-800-251-7722 for a prescription reimbursement form. Refunds take up to 8 weeks so always use your card when you get it.

Benefit Description	You pay	
<b>Note: The contract-year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.</b>		
Covered medications and supplies	High Option	Basic Option
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program: <ul style="list-style-type: none"> <li>• Drugs and medicines that by Federal law of the United States require a physician’s prescription for their purchase, except those listed as <i>Not covered</i>.</li> <li>• Insulin</li> <li>• Diabetic supplies</li> <li>• Disposable needles and syringes for the administration of covered medications</li> <li>• Drugs for sexual dysfunction</li> </ul>	\$15 copayment for Tier 1 drugs  \$30 copayment for Tier 2 drugs  50% not to exceed \$60 copayment for Tier 3 drugs	\$15 copayment for Tier 1 drugs  \$30 copayment for Tier 2 drugs  50% not to exceed \$60 copayment for Tier 3 drugs

*Covered medications and supplies - continued on next page*

Benefit Description	You pay	
Covered medications and supplies (cont.)	High Option	Basic Option
<ul style="list-style-type: none"> <li>• Contraceptive drugs and devices</li> </ul>	<p>\$15 copayment for Tier 1 drugs</p> <p>\$30 copayment for Tier 2 drugs</p> <p>50% not to exceed \$60 copayment for Tier 3 drugs</p> <p>When a generic drug is available, but you or your doctor request the name brand drug, you pay the formulary price difference between the generic and name brand drug as well as the \$15 copayment per prescription unit or refill. Drugs are prescribed by Plan doctors and dispensed in accordance with the Plan’s drug Formulary.</p> <p>Our Formulary is open and available by calling Member Services at 1-800-251-7722 or by going to our Web site <a href="http://www.connecticare.com">www.connecticare.com</a>. Mail Order forms are also available by calling Member Services. Mail Order follows the same rules (cost sharing) and provides a 100-day supply for 2 times the copayment.</p>	<p>\$15 copayment for Tier 1 drugs</p> <p>\$30 copayment for Tier 2 drugs</p> <p>50% not to exceed \$60 copayment for Tier 3 drugs</p> <p>When a generic drug is available, but you or your doctor request the name brand drug, you pay the formulary price difference between the generic and name brand drug as well as the \$15 copay per prescription unit or refill. Drugs are prescribed by Plan doctors and dispensed in accordance with the Plan’s drug Formulary.</p> <p>Our Formulary is open and available by calling Member Services at 1-800-251-7722 or by going to our Web site <a href="http://www.connecticare.com">www.connecticare.com</a>. Mail Order forms are also available by calling Member Services. Mail Order follows the same rules (cost sharing) and provides a 100-day supply for 2 times the copayment.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Drugs and supplies for cosmetic purposes</i></li> <li>• <i>Drugs to enhance athletic performance</i></li> <li>• <i>Drugs obtained at a non-Plan pharmacy; except as described</i></li> <li>• <i>Vitamins, nutrients and food supplements even if a physician prescribes or administers them</i></li> <li>• <i>Nonprescription medicines</i></li> </ul>	<p><i>All charges</i></p>	<p><i>All charges</i></p>

**Section 5(g). Dental benefits**

**Important things you should keep in mind about these benefits:**

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be First/Primary payer of any benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9 Coordinating benefits with other coverage.
- Plan dentists must provide or arrange your care.
- We have a contract-year plan deductible for our High Option (In-Network: \$500 per individual/\$1,000 per family, Out-Of-Network: \$5,000 per individual/\$10,000 per family.) We also have a combined inpatient and outpatient hospital deductible of \$2,000/\$4,000 in the Basic Option.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You Pay	
<b>Accidental injury benefit</b>	<b>High Option</b>	<b>Standard Option</b>
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury.	\$20 in doctor’s office \$40 in specialist’s office \$50 in urgent care center \$150 in emergency room Out-Of-Network: 50% after Plan Deductible	\$25 in doctor’s office \$45 in specialist’s office \$50 in urgent care center \$150 in emergency room
<b>Dental benefits</b>		
We have no other dental benefits.		

**Section 5(h). Special features**

Feature	Description
<b>Flexible benefits option</b>	<p>Under the flexible benefits option, we determine the most effective way to provide services.</p> <ul style="list-style-type: none"> <li>• We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms. Until you sign and return the agreement, regular contract benefits will continue.</li> <li>• Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process.</li> <li>• By approving an alternative benefit, we cannot guarantee you will get it in the future.</li> <li>• The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits.</li> <li>• If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular benefits will resume if we do not approve your request.</li> <li>• Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.</li> </ul>
<b>Services for deaf and hearing impaired</b>	<p>Call the TDD/TTY number for the hearing impaired: 1-800-842-9710.</p>
<b>Our Web site www.connecticare.com</b>	<p>You can change or add your PCP, look up a doctor or check our drug formulary at our Web site</p>
<b>High risk pregnancies</b>	<p>ConnectiCare’s Birth Expectations program was created to provide information to help you take precautions against giving birth too early. We’ll send you a survey and follow up with a phone call if you’re in a high-risk category for premature delivery. You’ll learn about the signs of premature labor. We can then be in touch as needed and arrange for extra services that could help bring your pregnancy to full term. For instance, you may be eligible for home uterine monitoring, which ConnectiCare can coordinate with your doctor. By taking necessary precautions you can give your baby the healthiest possible start.</p>
<b>Centers of excellence</b>	<p>ConnectiCare’s members will have access to more than 235 elite transplant programs and more than 170 clinical experts across the country. These programs have been carefully selected using strict evaluation criteria that were developed in conjunction with transplant physicians and surgeons. United Resource Network’s (U.R.N.’s) Transplant Centers of Excellence network was developed through a process of quality measurement credentialing that is unique in the health care industry. Through this network ConnectiCare can assist the health care team and the member in determining the best transplant program for their specific need.</p>
<b>Travel benefit/services overseas</b>	<p>Severe chest pain. Trouble breathing. Severe bleeding. Poisoning. Seizures. These are all emergencies. And if an emergency ever happens to you, don’t wait. Get to the closest emergency room right away – anywhere in the world. Call 911 if you need help getting there. Please notify us at 1-860-674-5870 within 24 hours of being admitted to the hospital. A friend or family member can call for you. If you can’t act that quickly, notify us as soon as you or someone else is able to.</p>

<b>Alternative treatments</b>	Discounts on homeopathic treatments, massage therapy, etc. See flyer enclosed in your enrollment kit or, call Member Services at 1-800-251-7722 and ask for a “Healthy Alternatives” brochure.
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## Section 6. General exclusions – things we don't cover

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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 your Plan doctor determines it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition (see specifics regarding transplants.)**

We do not cover the following:

- Care by non-plan providers except for authorized referrals or emergencies (see *Emergency services/accidents*);
- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies 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;
- 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;
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program; or
- Services, drugs, or supplies you receive without charge while in active military service.

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## Section 7. Filing a claim for covered services

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When you see Plan physicians, receive services at Plan hospitals and facilities, or obtain your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment, coinsurance, or deductible.

You will only need to file a claim when you receive services from non-plan providers. Sometimes these providers bill us directly. Check with the provider. If you need to file the claim, call Member Services at 1-800-251-7722 to obtain an out-of-area claim form then follow the process below:

### **Medical and hospital benefits**

In most cases, providers and facilities file claims for you. Physicians must file on the form HCFA-1500, Health Insurance Claim Form. Your facility will file on the UB-92 form. For claims questions and assistance, call us at 1-800-251-7722.

When you must file a claim – such as for services you received outside the Plan’s service area – submit it on the HCFA-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

- Covered member’s name and ID number;
- Name and address of the physician or facility that provided the service or supply;
- Dates you received the services or supplies;
- Diagnosis;
- Type of each service or supply;
- The charge for each service or supply;
- A copy of the explanation of benefits, payments, or denial from any primary payer – such as the Medicare Summary Notice (MSN); and
- Receipts, if you paid for your services.

### **Submit your claims to:**

Member Services  
ConnectiCare, Inc.  
175 Scott Swamp Road  
Farmington, CT 06032

### **Deadline for filing your claim**

Send us all of the documents for your claim as soon as possible. You must submit the claim by December 31 of the year after the year you received the service, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.

### **When we need more information**

Please reply promptly when we ask for additional information. We may delay processing or deny benefits for your claim if you do not respond.

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## Section 8. The disputed claims process

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Follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your claim or request for services, drugs, or supplies – including a request for preauthorization/prior approval required by Section 3.

- 1** Ask us in writing to reconsider our initial decision. You must:
- a) Write to us within 6 months from the date of our decision; and
  - b) Send your request to us at: Member Services, 175 Scott Swamp Road, Farmington, CT 06032; and
  - c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and
  - d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.

- 2** We have 30 days from the date we receive your request to:
- a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or
  - b) Write to you and maintain our denial - go to step 4; or
  - c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.

- 3** You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have.

We will write to you with our decision.

- 4** If you do not agree with our decision, you may ask OPM to review it.

You must write to OPM within

- 90 days after the date of our letter upholding our initial decision; or
- 120 days after you first wrote to us - if we did not answer that request in some way within 30 days; or
- 120 days after we asked for additional information.

Write to OPM at: United States Office of Personnel Management, Insurance Services Programs, Health Insurance Group 3, 1900 E Street, NW, Washington, DC 20415-3630.

Send OPM the following information:

- A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;
- Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
- Copies of all letters you sent to us about the claim;
- Copies of all letters we sent to you about the claim; and
- Your daytime phone number and the best time to call.

Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.

Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request.

Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.

## 5

OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision within 60 days. There are no other administrative appeals.

If you do not agree with OPM's decision, your only recourse is to sue. If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.

OPM may disclose the information it collects during the review process to support their disputed claim decision. This information will become part of the court record.

You may not sue until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

Note: **If you have a serious or life threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and

- a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at 1-800-251-7722 and we will expedite our review; or
- b) We denied your initial request for care or preauthorization/prior approval, then:
  - If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
  - You may call OPM's Health Insurance Group 3 at (202) 606-0737 between 8 a.m. and 5 p.m. eastern time.

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## Section 9. Coordinating benefits with other coverage

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### **When you have other health coverage**

You must tell us if you or a covered family member has coverage under any other health plan or has automobile insurance that pays health care expenses without regard to fault. This is called “double coverage.”

When you have double coverage, one plan normally pays its benefits in full as the primary payer and the other plan pays a reduced benefit as the secondary payer. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners’ guidelines.

When we are the primary payer, we will pay the benefits described in this brochure.

When we are the secondary payer, we will determine our allowance. After the primary plan pays, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance.

### **What is Medicare?**

Medicare is a health insurance program for:

- People 65 years of age or older;
- Some people with disabilities under 65 years of age; and
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant).

Medicare has four parts:

- **Part A (Hospital Insurance).** Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE for more information.
- **Part B (Medical Insurance).** Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.
- **Part C (Medicare Advantage).** You can enroll in a Medicare Advantage plan to get your Medicare benefits. We offer a Medicare Advantage plan. Please review the information on coordinating benefits with Medicare Advantage plans on the next page.
- **Part D (Medicare prescription drug coverage).** There is a monthly premium for Part D coverage. If you have limited savings and a low income, you may be eligible for Medicare’s Low-Income Benefits. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA). For more information about this extra help, visit SSA online at [www.socialsecurity.gov](http://www.socialsecurity.gov), or call them at 1-800-772-1213 (TTY 1-800-325-0778). Before enrolling in Medicare Part D, please review the important disclosure notice from us about the FEHB prescription drug coverage and Medicare. The notice is on the first inside page of this brochure. The notice will give you guidance on enrolling in Medicare Part D.

### **• Should I enroll in Medicare?**

The decision to enroll in Medicare is yours. We encourage you to apply for Medicare benefits 3 months before you turn age 65. It’s easy. Just call the Social Security Administration toll-free number 1-800-772-1213 to set up an appointment to apply. If you do not apply for one or more Parts of Medicare, you can still be covered under the FEHB Program.

If you can get premium-free Part A coverage, we advise you to enroll in it. Most Federal employees and annuitants are entitled to Medicare Part A at age 65 **without cost**. When you don't have to pay premiums for Medicare Part A, it makes good sense to obtain the coverage. It can reduce your out-of-pocket expenses as well as costs to the FEHB, which can help keep FEHB premiums down.

Everyone is charged a premium for Medicare Part B coverage. The Social Security Administration can provide you with premium and benefit information. Review the information and decide if it makes sense for you to buy the Medicare Part B coverage.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare Advantage is the term used to describe the various private health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on whether you are in the Original Medicare Plan or a private Medicare Advantage plan.

- **The Original Medicare Plan (Part A or Part B)**

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share.

When you are enrolled in Original Medicare along with this Plan, you still need to follow the rules in this brochure for us to cover your care.

If your Plan physician does not participate in Medicare, you will have to file a claim with Medicare.

**Claims process when you have the Original Medicare Plan** – You will probably not need to file a claim form when you have both our Plan and the Original Medicare Plan.

When we are the primary payer, we process the claim first.

When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. To find out if you need to do something to file your claim, call us at 1-800-251-7722 or see our Web site at [www.connecticare.com](http://www.connecticare.com).

**We waive some costs if the Original Medicare Plan is your primary payer** – We will waive some out-of-pocket costs as follows:

- Medical services and supplies provided by physicians and other health care professionals.

**We do not waive any costs if the Original Medicare Plan is your primary payer.**

- **Medicare Advantage (Part C)**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private health care choices (like HMOs and regional PPOs) in some areas of the country. To learn more about Medicare Advantage plans, contact Medicare at 1-800-MEDICARE (1-800-633-4227) or at [www.medicare.gov](http://www.medicare.gov).

If you enroll in a Medicare Advantage plan, the following options are available to you:

**This Plan and our Medicare Advantage plan:**

**This Plan and another plan's Medicare Advantage plan:** You may enroll in another plan's Medicare Advantage plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area (if you use our Plan providers), but we will not waive any of our copayments, coinsurance, or deductibles. If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare.

**Suspended FEHB coverage to enroll in a Medicare Advantage plan:** If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare Advantage plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare Advantage plan premium.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage or move out of the Medicare Advantage plan's service area.

- **Medicare prescription drug coverage (Part D)**

When we are the primary payer, we process the claim first. If you enroll in Medicare Part D and we are the secondary payer, we will review claims for your prescription drug costs that are not covered by Medicare Part D and consider them for payment under the FEHB plan.

Medicare always makes the final determination as to whether they are the primary payer. The following chart illustrates whether Medicare or this Plan should be the primary payer for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly. **(Having coverage under more than two health plans may change the order of benefits determined on this chart.)**

<b>Primary Payer Chart</b>		
<b>A. When you - or your covered spouse - are age 65 or over and have Medicare and you...</b>	<b>The primary payer for the individual with Medicare is...</b>	
	<b>Medicare</b>	<b>This Plan</b>
1) Have FEHB coverage on your own as an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Have FEHB through your spouse who is an active employee		✓
4) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case) and you are not covered under FEHB through your spouse under #3 above	✓	
5) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and...		
• You have FEHB coverage on your own or through your spouse who is also an active employee		✓
• You have FEHB coverage through your spouse who is an annuitant	✓	
6) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge) and you are not covered under FEHB through your spouse under #3 above	✓	
7) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
8) Are a Federal employee receiving Workers' Compensation disability benefits for six months or more	✓ *	
<b>B. When you or a covered family member...</b>		
1) Have Medicare solely based on end stage renal disease (ESRD) and...		
• It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD <b>(30-month coordination period)</b>		✓
• It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD	✓	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and...		
• This Plan was the primary payer before eligibility due to ESRD <b>(for 30 month coordination period)</b>		✓
• Medicare was the primary payer before eligibility due to ESRD	✓	
3) Have Temporary Continuation of Coverage (TCC) and...		
• Medicare based on age and disability	✓	
• Medicare based on ESRD <b>(for the 30 month coordination period)</b>		✓
• Medicare based on ESRD <b>(after the 30 month coordination period)</b>	✓	
<b>C. When either you or a covered family member are eligible for Medicare solely due to disability and you...</b>		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
<b>D. When you are covered under the FEHB Spouse Equity provision as a former spouse</b>	✓	

\*Workers' Compensation is primary for claims related to your condition under Workers' Compensation.

**TRICARE and CHAMPVA**

TRICARE is the health care program for eligible dependents of military persons, and retirees of the military. TRICARE includes the CHAMPUS program. CHAMPVA provides health coverage to disabled Veterans and their eligible dependents. IF TRICARE or CHAMPVA and this Plan cover you, we pay first. See your TRICARE or CHAMPVA Health Benefits Advisor if you have questions about these programs.

**Suspended FEHB coverage to enroll in TRICARE or CHAMPVA:** If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these programs, eliminating your FEHB premium. (OPM does not contribute to any applicable plan premiums.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under TRICARE or CHAMPVA.

**Workers' Compensation**

We do not cover services that:

- You need because of a workplace-related illness or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determines they must provide; or
- OWCP or a similar agency pays for through a third-party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.

Once OWCP or similar agency pays its maximum benefits for your treatment, we will cover your care.

**Medicaid**

When you have this Plan and Medicaid, we pay first.

**Suspended FEHB coverage to enroll in Medicaid or a similar State-sponsored program of medical assistance:** If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these State programs, eliminating your FEHB premium. For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the State program.

**When other Government agencies are responsible for your care**

We do not cover services and supplies when a local, State, or Federal government agency directly or indirectly pays for them.

**When others are responsible for injuries**

When you receive money to compensate you for medical or hospital care for injuries or illness caused by another person, you must reimburse us for any expenses we paid. However, we will cover the cost of treatment that exceeds the amount you received in the settlement.

If you do not seek damages you must agree to let us try. This is called subrogation. If you need more information, contact us for our subrogation procedures.

**When you have Federal Employees Dental and Vision Insurance Plan (FEDVIP) coverage**

Some FEHB plans already cover some dental and vision services. When you are covered by more than one vision/dental plan, coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFEDS.com, you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

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## Section 10. Definitions of terms we use in this brochure

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<b>Calendar year</b>	January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.
<b>Coinsurance</b>	Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See page 11.
<b>Copayment</b>	A copayment is a fixed amount of money you pay when you receive covered services. See page 11.
<b>Cost-sharing</b>	Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.
<b>Covered services</b>	Care we provide benefits for, as described in this brochure.
<b>Custodial care</b>	Home Health Care, light duty services at your home. Custodial care that lasts 90 days or more is sometimes known as long-term care.
<b>Deductible</b>	A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See page 11.
<b>Experimental or investigational service</b>	How do you decide if a service is experimental or investigational? ConnectiCare uses outside medical experts and scientific literature reviews for determining whether a medical service is considered investigational and/or experimental.
<b>Group health coverage</b>	Health insurance sold only to group employers.
<b>Medical necessity</b>	Medical care provided for illness or injury that is determined by national standards to be Medically Necessary. Like a Mammogram, etc.
<b>Us/We</b>	Us and We refer to ConnectiCare.
<b>You</b>	You refers to the enrollee and each covered family member.

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## Section 11. FEHB Facts

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### Coverage information

- **No pre-existing condition limitation**

We will not refuse to cover the treatment of a condition you had before you enrolled in this Plan solely because you had the condition before you enrolled.

- **Where you can get information about enrolling in the FEHB Program**

See [www.opm.gov/insure/health](http://www.opm.gov/insure/health) for enrollment information as well as:

- Information on the FEHB Program and plans available to you
- A health plan comparison tool
- A list of agencies who participate in Employee Express
- A link to Employee Express
- Information on and links to other electronic enrollment systems

Also, your employing or retirement office can answer your questions, and give you a *Guide to Federal Benefits*, brochures for other plans, and other materials you need to make an informed decision about your FEHB coverage. These materials tell you:

- When you may change your enrollment;
- How you can cover your family members;
- What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire;
- What happens when your enrollment ends; and
- When the next open season for enrollment begins.

We don't determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office.

- **Types of coverage available for you and your family**

Self Only coverage is for you alone. Self and Family coverage is for you, your spouse, and your unmarried dependent children under age 22, including any foster children or stepchildren your employing or retirement office authorizes coverage for. Under certain circumstances, you may also continue coverage for a disabled child 22 years of age or older who is incapable of self-support.

If you have a Self Only enrollment, you may change to a Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event. The Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form; benefits will not be available to your spouse until you marry.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive benefits, nor will we. Please tell us immediately when you add or remove family members from your coverage for any reason, including divorce, or when your child under age 22 marries or turns 22.

If you or one of your family members is enrolled in one FEHB plan, that person may not be enrolled in or covered as a family member by another FEHB plan.

- **Children's Equity Act**

OPM has implemented the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self and Family coverage in the FEHB Program, if you are an employee subject to a court or administrative order requiring you to provide health benefits for your child(ren).

If this law applies to you, you must enroll for Self and Family coverage in a health plan that provides full benefits in the area where your children live or provide documentation to your employing office that you have obtained other health benefits coverage for your children. If you do not do so, your employing office will enroll you involuntarily as follows:

- If you have no FEHB coverage, your employing office will enroll you for Self and Family coverage in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option;
- If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self and Family in the same option of the same plan; or
- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self and Family in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option.

As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the FEHB Program, you cannot cancel your enrollment, change to Self Only, or change to a plan that doesn't serve the area in which your children live, unless you provide documentation that you have other coverage for the children. If the court/administrative order is still in effect when you retire, and you have at least one child still eligible for FEHB coverage, you must continue your FEHB coverage into retirement (if eligible) and cannot cancel your coverage, change to Self Only, or change to a plan that doesn't serve the area in which your children live as long as the court/administrative order is in effect. Contact your employing office for further information.

• **When benefits and premiums start**

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. **If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2007 benefits of your old plan or option.** However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan's 2006 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

• **When you retire**

When you retire, you can usually stay in the FEHB Program. Generally, you must have been enrolled in the FEHB Program for the last five years of your Federal service. If you do not meet this requirement, you may be eligible for other forms of coverage, such as Temporary Continuation of Coverage (TCC).

**When you lose benefits**

• **When FEHB coverage ends**

You will receive an additional 31 days of coverage, for no additional premium, when:

- Your enrollment ends, unless you cancel your enrollment, or
- You are a family member no longer eligible for coverage.

You may be eligible for spouse equity coverage or Temporary Continuation of Coverage (TCC), or a conversion policy (a non-FEHB individual policy.)

- **Upon divorce** If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse’s enrollment. This is the case even when the court has ordered your former spouse to provide health coverage for you. However, you may be eligible for your own FEHB coverage under either the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse’s employing or retirement office to get RI 70-5, the *Guide to Federal Benefits for Temporary Continuation of Coverage and Former Spouse Enrollees*, or other information about your coverage choices. You can also download the guide from OPM’s Web site, [www.opm.gov/insure](http://www.opm.gov/insure).

- **Temporary Continuation of Coverage (TCC)** If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal job, if you are a covered dependent child and you turn 22 or marry, etc.

You may not elect TCC if you are fired from your Federal job due to gross misconduct.

**Enrolling in TCC.** Get the RI 79-27, which describes TCC, and the RI 70-5, the *Guide to Federal Benefits for Temporary Continuation of Coverage and Former Spouse Enrollees*, from your employing or retirement office or from [www.opm.gov/insure](http://www.opm.gov/insure). It explains what you have to do to enroll.

- **Converting to individual coverage**

You may convert to a non-FEHB individual policy if:

- Your coverage under TCC or the spouse equity law ends (If you canceled your coverage or did not pay your premium, you cannot convert);
- You decided not to receive coverage under TCC or the spouse equity law; or
- You are not eligible for coverage under TCC or the spouse equity law.

If you leave Federal service, your employing office will notify you of your right to convert. You must apply in writing to us within 31 days after you receive this notice. However, if you are a family member who is losing coverage, the employing or retirement office will **not** notify you. You must apply in writing to us within 31 days after you are no longer eligible for coverage.

Your benefits and rates will differ from those under the FEHB Program; however, you will not have to answer questions about your health, and we will not impose a waiting period or limit your coverage due to pre-existing conditions.

- **Getting a Certificate of Group Health Plan Coverage**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a Federal law that offers limited Federal protections for health coverage availability and continuity to people who lose employer group coverage. If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. Your new plan must reduce or eliminate waiting periods, limitations, or exclusions for health related conditions based on the information in the certificate, as long as you enroll within 63 days of losing coverage under this Plan. If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may also request a certificate from those plans.

For more information, get OPM pamphlet RI 79-27, *Temporary Continuation of Coverage (TCC) under the FEHB Program*. See also the FEHB Web site at [www.opm.gov/insure/health](http://www.opm.gov/insure/health); refer to the “TCC and HIPAA” frequently asked questions. These highlight HIPAA rules, such as the requirement that Federal employees must exhaust any TCC eligibility as one condition for guaranteed access to individual health coverage under HIPAA, and information about Federal and State agencies you can contact for more information.

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## Section 12. Three Federal Programs complement FEHB benefits

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### Important information

OPM wants to be sure you are aware of three Federal programs that complement the FEHB Program.

First, the **Federal Flexible Spending Account Program**, also known as FSAFEDS, lets you set aside pre-tax money from your salary to reimburse you for eligible dependent care and /or health care expenses. You pay less in taxes so you save money. The result can be a discount of 20% to more than 40% on services/products you routinely pay for out-of-pocket.

Second, the **Federal Employees Dental and Vision Insurance Program (FEDVIP)** provides comprehensive dental and vision insurance at competitive group rates. There are several plans from which to choose. Under FEDVIP you may choose self only, self plus one, or self and family coverage for yourself and any eligible dependents.

Third, the **Federal Long Term Care Insurance Program (FLTCIP)** can help cover long term care costs, which are not covered under the FEHB Program.

### The Federal Flexible Spending Account Program – *FSAFEDS*

#### What is an FSA?

It is an account where you contribute money from your salary **BEFORE** taxes are withheld, then incur eligible expenses and get reimbursed. You pay less in taxes so you save money. **Annuitants are not eligible to enroll.**

There are three types of FSAs offered by FSAFEDS. Each type has a minimum annual election of \$250 and a maximum annual election of \$5,000.

- **Health Care FSA (HCFSA)** – Reimburses you for eligible health care expenses (such as copayments, deductibles, over-the-counter medications and products, vision and dental expenses, and much more) for you and your dependents, which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance.
- **Limited Expense Health Care FSA (LEX HCFSA)** – Designed for employees enrolled in or covered by a High Deductible Health Plan with a Health Savings Account. Eligible expenses are limited to dental and vision care expenses for you and your dependents which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance.
- **Day Care FSA (DCFSA) (formerly known as the Dependent Care FSA)** – Reimburses you for eligible non-medical day care expenses for your child(ren) under age 13 and/or for any person you claim as a dependent on your Federal Income Tax return who is mentally or physically incapable of self-care. You (and your spouse if married) must be working, looking for work (income must be earned during the year), or attending school full-time to be eligible for a DCFSA.

#### Where can I get more information about FSAFEDS?

Visit [www.FSAFEDS.com](http://www.FSAFEDS.com) or call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (1-877-372-3337), Monday through Friday, 9 a.m. until 9 p.m., Eastern time. TTY: 1-800-952-0450.

### The Federal Employees Dental and Vision Insurance Program – *FEDVIP*

#### Important Information

The Federal Employees Dental and Vision Insurance Program (FEDVIP) is a program, separate and different from the FEHB Program, established by the Federal Employee Dental and Vision Benefits Enhancement Act of 2004. This Program provides comprehensive dental and vision insurance at competitive group rates with no pre-existing condition limitations.

FEDVIP is available to eligible Federal and Postal Service employees, retirees, and their eligible family members on an enrollee-pay-all basis. Employee premiums are withheld from salary on a pre-tax basis.

**Dental Insurance**

Dental plans provide a comprehensive range of services, including all the following:

- Class A (Basic) services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants and x-rays.
- Class B (Intermediate) services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments.
- Class C (Major) services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges and prosthodontic services such as complete dentures.
- Class D (Orthodontic) services with up to a 24-month waiting period

**Vision Insurance**

Vision plans provide comprehensive eye examinations and coverage for lenses, frames and contact lenses. Other benefits such as discounts on LASIK surgery may also be available.

**Additional Information**

You can find a comparison of the plans available and their premiums on the OPM website at [www.opm.gov/insure/dentalvision](http://www.opm.gov/insure/dentalvision). This site also provides links to each plan's website, where you can view detailed information about benefits and preferred providers.

**How do I enroll?**

You enroll on the Internet at [www.BENEFEDS.com](http://www.BENEFEDS.com). For those without access to a computer, call 1-877-888-3337 (TTY number, 1-877- 889-5680).

The Federal Long Term Care Insurance Program – *FLTCIP*

**It's important protection**

The Federal Long Term Care Insurance Program (FLTCIP) can help you pay for the potentially high cost of long term care services, which are not covered by FEHB plans. Long term care is help you receive to perform activities of daily living – such as bathing or dressing yourself - or supervision you receive because of a severe cognitive impairment. To qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. You must apply to know if you will be approved for enrollment. To request an Information Kit and application, call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) or visit [www.ltcfeds.com](http://www.ltcfeds.com).

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Do not rely on this page; it is for your convenience and may not show all pages where the terms appear.

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## Summary of benefits for the High Option - 2009

- **Do not rely on this chart alone.** All benefits are provided in full unless indicated and are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan physicians, except in emergencies.

Note: The contract-year deductible applies to almost all benefits in this section. We say "no deductible" when it does not apply.

High Option Benefits	You pay	Page
<b>Medical services provided by physicians:</b>		
<b>Diagnostic and treatment services provided in the office</b>	Office visit copayment: \$20 primary care; \$40 specialist, after Plan Deductible. No Deductible for routine preventive care.  Out-Of-Network: 50% after Plan Deductible	15
<b>Services provided by a hospital:</b>		
• <b>Inpatient</b>	\$250 copayment per day to a maximum of \$1,250 per member per year after Plan Deductible.  Out-Of-Network: 50% after Plan Deductible	30
• <b>Outpatient</b>	\$250 copayment after Plan Deductible  Out-Of-Network: 50% after Plan Deductible	31
<b>Emergency benefits:</b>		
• <b>In-area</b>	\$150 per visit after Plan Deductible	34
• <b>Out-of-area</b>	\$150 per visit after Plan Deductible	34
<b>Mental health and substance abuse treatment:</b>		
	Regular cost sharing	35
<b>Prescription drugs:</b>		
	\$15 generic \$30 Brand-name formulary 50% not to exceed \$60  Cost sharing applies when generic is available	37-39
<b>Dental care:</b>		
	No benefit.	—
<b>Vision care:</b>		
	\$20 routine exam, discounts available on eyewear and contacts.	21
<b>Special features:</b>		
	Flexible benefits for the deaf and hearing impaired, ConnectiCare Web site alternative treatments	41

High Option Benefits	You pay	Page
<b>Radiology:</b>	Non-advanced: \$10 copayment; after Plan Deductible Advanced: \$75 copayment after Plan Deductible	16
<b>Protection against catastrophic costs</b> (out-of-pocket maximum):	All medically necessary catastrophic costs are paid by the plan up to the limits noted in this document. There is a \$1,000,000 per member lifetime max. on Out-Of-Network services only.	10

## Summary of benefits for the Basic Option - 2009

- **Do not rely on this chart alone.** All benefits are provided in full unless indicated and are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan physicians, except in emergencies.

Basic Option Benefits	You Pay	Page
<b>Medical services provided by physicians:</b>		
<b>Diagnostic and treatment services provided in the office</b>	Office visit copayment: \$25 primary care; \$45 specialist	15
<b>Services provided by a hospital:</b>		
<ul style="list-style-type: none"> <li>• <b>Inpatient</b></li> </ul>	\$2,000 benefit deductible per member/\$4,000 benefit deductible per family, then 100%.  All ambulatory services and inpatient hospitalization services (including medical, mental health and alcohol and substance abuse) accumulate to this benefit deductible.	30
<ul style="list-style-type: none"> <li>• <b>Outpatient</b></li> </ul>	\$2,000 benefit deductible per member/\$4,000 benefit deductible per family, then 100%.	31
<b>Emergency benefits:</b>		
<ul style="list-style-type: none"> <li>• <b>In-area</b></li> </ul>	\$150 per visit	34
<ul style="list-style-type: none"> <li>• <b>Out-of-area</b></li> </ul>	\$150 per visit	34
<b>Mental health and substance abuse treatment:</b>	Regular cost sharing	35
<b>Prescription drugs:</b>	\$15 generic \$30 Brand-name Formulary 50% not to exceed \$60  Cost sharing applies when generic is available	37-39
<b>Dental care:</b>	No benefit.	—
<b>Vision care:</b>	\$25 routine exam, discounts available on eyewear and contacts.	21
<b>Special features:</b>	Flexible benefits for the deaf and hearing impaired, ConnectiCrae Web site alternative treatments.	41
<b>Radiology:</b>	Non-advanced :\$10 copay Advanced: \$75 copay	16
<b>Protection against catastrophic costs (out-of-pocket maximum):</b>	All medically necessary catastrophic costs are paid by the plan up to the limits noted in this document.	10

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## 2009 Rate Information for ConnectiCare, Inc.

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**Non-Postal rates** apply to most non-Postal employees. If you are in a special enrollment category, refer to the Guide to Federal Benefits for that category or contact the agency that maintains your health benefits enrollment.

**Postal rates** apply to career Postal Service employees. Most employees should refer to the Guide to Benefits *for Career United States Postal Service Employees*, RI 70-2, and to the rates shown below.

The rates shown below do not apply to *Postal Service Inspectors*, Office of Inspector General (OIG) employees and Postal Service Nurses. Rates for members of these groups are published in special Guides. Postal Service Inspectors and OIG employees should refer to the *Guide to Benefits for United States Postal Inspectors and Office of Inspector General Employees* (RI 70-2IN). Postal Service Nurses should refer to the *Guide to Benefits for United States Postal Nurses* (RI 70-2NU).

Postal rates do not apply to non-career postal employees, postal retirees, or associate members of any postal employee organization who are not career postal employees. Refer to the applicable Guide to Federal Benefits.

Type of Enrollment	Enrollment Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
High Option Self Only	TE1	\$155.66	\$68.37	\$337.26	\$148.14	\$179.45	\$44.58
High Option Self and Family	TE2	\$352.56	\$157.18	\$763.88	\$340.56	\$406.42	\$103.32
Basic Option Self Only	TE4	\$135.52	\$45.17	\$293.63	\$97.87	\$156.30	\$24.39
Basic Option Self and Family	TE5	\$308.34	\$102.78	\$668.07	\$222.69	\$355.62	\$55.50