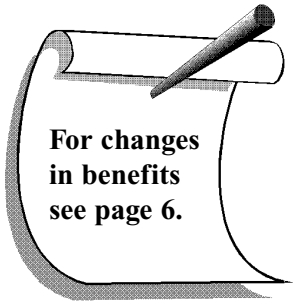
ConnectiCare

ConnectiCare

http://www.connecticare.com

2001

A Health Maintenance Organization



Serving: Connecticut

Enrollment in this Plan is limited; see page 5 for requirements.

This Plan has full accreditation from the NCQA. See the *2001 Guide* for more information on NCQA.

Enrollment codes for this plan:

TE1 Self Only

TE2 Self and Family

Authorized for distribution by the:

OPM

United States
Office of Personnel Management
Retirement and Insurance Service
http://www.opm.gov/insure

FEHB

Federal Employees
Health Benefits Program

RI 73-599

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Introduction

ConnectiCare, Inc.
30 Batterson Park Road, Farmington, CT 06032-2574

This brochure describes the benefits you can receive from ConnectiCare, Inc. under its contract (CS2662) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled for 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, 2001, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2001, and are summarized on page 6. Rates are shown at the end of this brochure.

Plain Language

The President and Vice President are making the Government's communication more responsive, accessible, and understandable to the public by requiring agencies to use plain language. In response, a team of health plan representatives and OPM staff worked cooperatively to make this brochure clearer. Except for necessary technical terms, we use common words. "You" means the enrollee or family member; "we" means ConnectiCare, Inc.

The plain language team reorganized the brochure and the way we describe our benefits. When you compare this Plan with other FEHB plans, you will find that the brochures have the same format and similar information to make comparisons easier.

If you have comments or suggestions about how to improve this brochure, let us know. Visit OPM's "Rate Us" feedback area at www.opm.gov/retire, www.opm.gov/insure or e-mail us at fehbwebcomments@opm.gov or write to OPM at Insurance Planning and Evaluation Division, P.O. Box 436, Washington, DC 20044-0436.

Section 1. Facts about this HMO plan

This Plan is a health maintenance organization (HMO). We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services.

HMOs emphasize preventive care such as routine office visits, physical exams, well-baby care, and immunizations, in addition to treatment for illness and injury. Our providers follow generally accepted medical practice when prescribing any course of treatment.

When you receive services from Plan providers, you will not have to submit claim forms or pay bills. You only pay the copayments and/or coinsurance 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.

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 or coinsurance.

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 5,000 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 below (see What you must do, specialty care). Your personal doctor may already participate in ConnectiCare. If so, you may receive comprehensive coverage with no change in your established doctor/patient relationship. Also, a wide range of hospitals, laboratories and pharmacies participate with ConnectiCare.

Patients' Bill of Rights
OPM requires that all FEHB Plans comply with the Patients' Bill of Rights, recommended by the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry. You may get information about us, our networks, providers, and facilities. OPM's FEHB website (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.
- ConnectiCare complies with all State and Federal health care regulations.
- Years in existence: 19
- Profit status: For-profit

If you want more information about us, call 1-800-251-7722, or write to ConnectiCare, Inc., 30 Batterson Park Road, Farmington, CT 06032-2574. You may also contact our Member Services Department by fax at 860-674-2232 or visit our website at www.connecticare.com

Service Area
To enroll with us, you must live in or work in our Service Area. This is where our providers practice. Our service area is: The state of Connecticut.

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency or urgent care. We will not pay for any other health care services.

If you or a covered family member moves 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. This Plan does provide emergency or urgent care for college students. If you or a family member move, you do not have to wait until Open Season to change plans. Contact your employer or retirement office.

Section 2. How we change for 2001

Program-wide changes

- The plain language team reorganized the brochure and the way we describe our benefits. We hope this will make it easier for you to compare plans.

- This year, the Federal Employees Health Benefits Program is implementing network mental health and substance abuse parity. This means that your coverage for mental health, substance abuse, medical, surgical, and hospital services from providers in our plan network will be the same with regard to copays, coinsurance, and day and visit limitations when you follow a treatment plan that we approve. Previously, we placed higher patient cost sharing on mental health and substance abuse services than we did on services to treat physical illness, injury, or disease.

- Many healthcare organizations have turned their attention this past year to improving healthcare quality and patient safety. OPM asked all FEHB plans to join them in this effort. You can find specific information on our patient safety activities by calling Member Services at 1-800-251-7722, or checking our website www.connecticare.com. You can find out more about patient safety on the OPM website, www.opm.gov/insure. To improve your healthcare, take these five steps:

  - Speak up if you have questions or concerns.
  - Keep a list of all the medicines you take.
  - Make sure you get the results of any test or procedure.
  - Talk with your doctor and health care team about your options if you need hospital care.
  - Make sure you understand what will happen if you need surgery.

- We clarified the language to show that anyone who needs a mastectomy may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure. Previously, the language referenced only women.

Changes to this Plan

Here are the changes for 2001:

- Currently, there is a $10/$20 prescription plan. For 2001, all generic prescriptions remain at a $10 co-pay. Name Brand Formulary Prescriptions will have a $20 co-pay. Name Brand Non-Formulary Prescriptions will have a $35 co-pay. When a generic is available, you will continue to share the cost difference between the generic and Name Brand Prescription plus the $10 co-pay.

- We again have a “Live or Work” enrollment provision

- You will now have 20 Chiropractic visits and 40 Physical Therapy (OT, Speech) visits, both at a $10 co-pay per visit, per condition, per calendar year.

- Your share of the non-Postal premium will increase by 2.8% for Self Only or decrease by 13.6% for Self and Family.

Section 3. How you get care

Identification Cards

We will send you an identification (ID) card. 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 (for annuitants), or your Employee Express confirmation letter.

To get your cards quickly, fax us a copy of your Health Benefits Election Form with the payroll code printed on the bottom. List your PCP and provider number for you and each family member on a separate page.

Fax everything to ConnectiCare's Enrollment Department at 860-409-8991. 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.

Where you get covered care

You get care from "Plan providers" and "Plan facilities." You will only pay copayments and/or coinsurance, and you will not have to file claims.

- **Plan providers**

Plan providers are physicians and other health care professionals in our service area with whom we contract to provide covered services to our members. We credential Plan providers according to national standards. We list Plan providers in the provider directory, which we update periodically. The list is also on our website. Since this list changes, it's best to contact us to confirm that a provider participates.

- **Plan facilities**

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 website.

What you must do

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 for 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.

- **Primary care**

Your primary care physician can be a family practitioner, internist, general practitioner or pediatrician.

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.

- **Specialty care**

Members may see any participating doctor for covered services without a referral with the following exceptions. You must get a referral from a participating doctor for: cardiovascular lab, cardiac rehabilitation, lab work, pain management and behavioral medicine, pulmonary rehabilitation, radiology, radiation therapy, and physical therapy.

- **Specialty care**

Your doctor will both refer you and get Plan authorization for: hospital admissions (except out-of-service area emergencies), use of surgical facilities, outpatient alcohol and substance abuse treatment, durable medical equipment, prostheses, orthopedic devices, home health care, speech therapy, occupational therapy, out-of-Plan services (non-participating providers), human organ transplants, skilled nursing facilities and surgical treatment of morbid obesity.

For information on how to obtain specialty care services, contact us at 1-800-251-7722. A Plan doctor can make arrangements for appropriate referrals. Do not go to a specialist for services listed above unless a referral or an authorization and a referral has been issued in advance.

Here are other things you should know about specialty care:

- If you are seeing a specialist when you enroll in our Plan and he or she doesn't participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan. Your primary care physician will decide what treatment you need.

- If you are seeing a specialist and your specialist leaves the Plan, call your primary care physician, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.

- If you have a chronic or disabling condition and lose access to your specialist because we:

  •• terminate our contract with your specialist for other than cause; or

  •• drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB Plan; or

  •• reduce our service area and you enroll in another FEHB Plan,

  you may be able to continue seeing your specialist for up to 90 days after you receive notice of the change. Contact us, or, if we drop out of the Program, contact your new plan.

If you are in the second or third trimester of pregnancy and you lose access to your specialist based on the above circumstances, you can continue to see your specialist until the end of your postpartum care, even if it is beyond the 90 days.

- **Hospital care**

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.

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.

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 92nd day after you become a member of this Plan, whichever happens first.

These provisions apply only to the benefits of the hospitalized person.

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 or specialist 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. Your physician must obtain Plan authorization for the following services: cardiovascular lab, cardiac rehabilitation, lab work, pain management and behavioral medicine, pulmonary rehabilitation, radiology, radiation therapy, and physical therapy.

Your doctor will both refer you and get Plan authorization for: hospital admissions (except out-of-service area emergencies), use of surgical facilities, outpatient alcohol and substance abuse treatment, durable medical equipment, prostheses, orthopedic devices, home health care, speech therapy, occupational therapy, out-of-Plan services (non-participating providers), human organ transplants, skilled nursing facilities and surgical treatment of morbid obesity.

For information on how to obtain specialty care services, contact us at 1-800-251-7722. A Plan doctor can make arrangements for appropriate referrals. Do not go to a specialist for services listed above unless a referral or an authorization and a referral has been issued in advance. Otherwise, the services may not be covered.

Section 4. Your costs for covered services

You must share the cost of some services.	**You are responsible for:**
• **Copayments**	A copayment is a fixed amount of money you pay to the provider when you receive services. Example: When you see your primary care physician, you pay a copayment of $10 per office visit and when you go in the hospital, it's covered 100%.
• **Deductible**	The only deductible this plan has is for Durable Medical Equipment, the (DME) benefit.
• **Coinsurance**	Coinsurance is the percentage of our negotiated fee that you must pay for your care. DME has coinsurance.
Your out-of-pocket maximum	We do not have an out-of-pocket maximum.

Section 5. Benefits — Overview

(See page 6 for how our benefits changed this year and page 47 for a benefits summary.)

NOTE: This benefits section is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. For more information about our benefits, contact us at 1-800-251-7722 or at our website at www.connecticare.com

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

IMPORTANT

Here are some important things to 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 for your care.
- We have no calendar year deductible, except for DME.
- 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 Medicare.

IMPORTANT

Benefit Description	You pay
Diagnostic and treatment services	
Professional services of physicians • In physician's office	$10 per visit
Professional services of physicians • In an urgent care center • During a hospital stay • In a skilled nursing facility • Initial examination of a newborn child covered under a family enrollment • Office medical consultations • Second surgical opinion	 $20 per visit Nothing Nothing for up to 90 days per calendar year $10 per visit $10 per visit $10 per visit
At home	$10 per house call by a doctor
Diagnosis and treatment of illness or injury in physician's office, including specialty care	$10 per office visit
Diagnostic tests in hospital	Nothing
Vaccines for pediatric and adult immunizations Nondental treatment of temporomandibular joint (TMJ) syndrome Services for which a member has no responsibility to pay Services for intentionally inflicted injuries Services for injuries resulting from hazardous activities	Nothing if you receive these services during your office visit

Benefit Description	You pay
Lab, X-ray and other diagnostic tests	
• In physician's office • Blood tests • Urinalysis • Pathology • X-rays • Cat Scans/MRI Ultrasound Electrocardiogram and EEG • Diagnostic surgical procedures • Radiation therapy • Nuclear medicine studies and injections • Non-routine Pap tests • Non-routine Mammograms	Nothing, included in hospital stay or office visit
Preventive care, adult	
Routine screenings, such as well-baby care, periodic check-ups and routine immunizations including these tests as ordered by your doctor • Blood lead level • Total Blood Cholesterol • Colorectal Cancer Screening, including Fecal occult blood test	$10 per visit
•• Sigmoidoscopy, screening as ordered by your doctor	$10 per visit
Prostate Specific Antigen (PSA test) as ordered by your doctor	$10 per visit
Routine Pap test Note: The office visit is covered if Pap test is received on the same day; see *Diagnosis and Treatment,* above.	Nothing if you receive these services during your office visit; otherwise, $10 per visit
Routine mammogram–covered for women age 35 and older, as follows: • From age 35 through 39, one during this five year period • From age 40 through 49, one every one or two calendar years • From age 50 through 64, one every calendar year • At age 65 and older, one every two consecutive calendar years or as recommended by your doctor	Nothing
Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel, unless received according to preventive care schedule.	All charges
Routine Immunizations, limited to: • Tetanus-diphtheria (Td) booster–once every 10 years, ages 19 and over (except as provided for under Childhood immunizations) • Influenza/Pneumococcal vaccines, annually, age 65 and over • Lyme Disease vaccine Check with your doctor to see if this plan covers other immunizations	Nothing if you receive these services during your office visit; otherwise $10 per visit

Benefit Description	You pay
Preventive care, children	
• Childhood immunizations recommended by the American Academy of Pediatrics	Nothing if you receive these services during your office visit; otherwise $10 per visit
• Examinations, such as: ••Eye exams to determine the need for vision correction. ••Ear exams through age 18 to determine the need for hearing correction ••Examinations done on the day of immunizations (through age 22) • Well-child care charges for routine examinations, immunizations and care (through age 22)	$10 per visit
Maternity care	
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care Note: Here are some things to keep in mind: • You do not need to pre-certify your normal delivery. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • 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. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b).	$10 for initial visit; then nothing
Family planning	
• Voluntary sterilization • Surgically implanted contraceptives • Injectable contraceptive drugs • Intrauterine devices (IUDs)	$10 per visit
Not covered: reversal of voluntary surgical sterilization, genetic counseling.	All charges.

Benefit Description	You pay
Infertility services	
Diagnosis and treatment of infertility, such as: • Artificial insemination: ••intravaginal insemination (IVI) ••intracervical insemination (ICI) ••intrauterine insemination (IUI) Fertility drugs Note: We cover injectable fertility drugs under medical benefits and oral fertility drugs under the prescription drug benefit (up to $1,500 per calendar year).	$10 per visit
Not covered: • Assisted reproductive technology (ART) procedures, such as: ••in vitro fertilization ••embryo transfer and GIFT • Services and supplies related to excluded ART procedures • Any prescription medications used for or in preparation of any of these non-covered procedures • Cost of donor sperm	All charges
Allergy care	
Testing and treatment Allergy injection	$10 per visit
Allergy serum	Nothing
Not covered: provocative food testing and sublingual allergy desensitization	All charges

Benefit Description	You pay
Treatment therapies	
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants are limited to those transplants listed under Organ/Tissue Transplants on page 22. • Respiratory and inhalation therapy • Dialysis–Hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy–Home IV and antibiotic therapy • Growth hormone therapy (GHT) Note: We will only cover GHT when we pre-authorize the treatment. Your doctor would have to submit your case in writing to the Plan. Your case will be reviewed for medical necessity and, if approved, you may then seek treatment.	Nothing
Not covered: • Vision Therapies • Physiotherapy (such as therapeutic muscle exercises, galvanic or thanscutaneous nerve stimulation, vapocoolant sprays, ultrasound or diathermy)	All charges
Rehabilitative therapies	
Physical therapy, occupational therapy and speech therapy- • 40 visits per condition, per calendar year, for the services of each of the following: •• qualified physical therapists; •• speech therapists; and •• occupational therapists. Note: We only cover therapy to restore bodily function or speech when there has been a total or partial loss of bodily function or functional speech due to illness or injury. Speech therapy is limited to the treatment of certain speech impairments of organic origin. Occupational therapy is limited to services that assist the member to achieve and maintain self-care and improved functioning in other activities of daily living. Speech and occupational therapy require pre-authorization from the Plan.	$10 copay per visit
• Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction, is provided at a Plan facility when authorized in advance by the Plan.	Nothing
• Chiropractic manipulation therapy is provided on an outpatient basis for up to 20 visits per calendar year.	$10 copayment per visit

Benefit Description	You pay
Rehabilitative therapies	
Not covered: • long-term rehabilitative therapy • exercise programs	All charges.
Hearing Services (testing, treatment, and supplies)	
• Hearing testing for children through age 18 *(see Preventive care, children)*	$10 per visit
Not covered: • all other hearing testing • hearing aids, testing and examinations for them • First hearing aid and testing only when necessitated by accidental injury	All charges.
Vision services (testing, treatment, and supplies)	
• Our vision program includes: frames and lenses, prescription contact lenses available only at Plan routine vision providers (offered at various discounts, not at $10 copay). For a full description of the Vision Care Coverage, please see the routine vision information located in the enrollment packet.	25% discount on frames and lenses at or blow $250; 30% discount over $250 at plan routine vision providers
• Eye exam to determine the need for vision correction for children (see preventive care)	$10 per visit
• Annual eye refraction once per calendar year, when obtained by Plan providers	$10 per visit
Not covered: • Eye exercises and orthoptics • Radial keratotomy and other refractive surgery	All charges.
Foot care	
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.	$10 per visit
Not covered: • 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 • 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)	All charges.

Benefit Description	You pay
Orthopedic and prosthetic devices	
• Artificial limbs and eyes; stump hose Note: Plan authorization is required and coverage is limited to the initial acquisition. This benefit paid under Durable Medical Equipment. • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy • 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.	You pay a $100 deductible per calendar year and 20% of charges, up to a maximum plan payment of $1,500 per calendar year.
Not covered: • orthopedic and corrective shoes • arch supports • foot orthotics • heel pads and heel cups • lumbosacral supports • corsets, trusses, elastic stockings, support hose, and other supportive devices • prosthetic replacements provided less than 3 years after the last one we covered	All charges.
Durable medical equipment (DME)	
Rental or purchase, at our option, including repair and adjustment, of durable medical equipment prescribed by your Plan physician, such as oxygen and dialysis equipment. Under this benefit, we also cover: • hospital beds; • wheelchairs (Motorized chairs covered *only* with plan approval of doctors written request detailing medical necessity.) • crutches; • walkers; • blood glucose monitors; and • insulin pumps. You must get your equipment from our vendors. Your doctor can help you or you can call member services at 1-800-251-7722.	$100 deductible per calendar year and 20% of charges up to a maximum Plan payment of $1,500 per calendar year. Note: Prior Plan authorization is required and coverage is limited to the initial acquisition.

Benefit Description	You pay
Ostomy Equipment and Supplies	
Ostomy equipment and supplies prescribed by your Plan physician.	$100 deductible per calendar year and 20% of charges up to a maximum Plan payment of $1,000 per calendar year. Note: Prior Plan authorization is required and coverage is limited to the initial acquisition.
Home health services	
• 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 aides when prescribed by your Plan doctor, who will periodically review the program for continuing appropriateness and need. • Services include oxygen therapy, intravenous therapy and medications.	Nothing
Not covered: • nursing care requested by, or for the convenience of, the patient or the patient's family; All charges.	All charges.
Alternative treatments	
Chiropractic services—Chiropractic manipulation therapy is provided on an inpatient or outpatient basis for up to 20 visits per calendar year.	$10 copayment per visit
Naturopathic Doctors if Plan Doctors	$10 copay
Not covered: • hypnotherapy • biofeedback	All charges
Educational classes and programs	
Coverage is limited to: Diabetes, Heart and Asthma programs are available. Information can be obtained by calling Member Services at 1-800-251-7722.	Nothing

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

IMPORTANT

Here are some important things to 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 no calendar year deductible.
- 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 Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Any costs associated with the facility charge (i.e. hospital, surgical center, etc.) are covered in Section 5 (c).
- YOU MUST GET PRECERTIFICATION OF SOME SURGICAL PROCEDURES. Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

IMPORTANT

Benefit Description	You pay
Surgical procedures	
• Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedure • Biopsy procedure • Removal of tumors and cysts • Correction of congenital anomalies (see reconstructive surgery)	$10 per visit
• Surgical treatment of morbid obesity–a condition in which an individual weighs 100 pounds or 100% over his or her normal weight according to current underwriting standards; eligible members must be age 18 or over and Plan must approve in advance.	Nothing when approved in advance by Plan
• Insertion of internal prosthetic devices must be medically necessary to restore bodily function and require a surgical incision (as opposed to an external prosthetic device). Examples: artificial joints, pacemakers, defibrillators and penile implants.	Nothing
• Voluntary sterilization • Norplant (a surgically implanted contraceptive) and intrauterine devices (IUDs) Note: Devices are covered under 5(a). • Treatment of burns	Nothing $10 per prescription Nothing

Benefit Description	You pay
Surgical procedures	
Not covered: • Reversal of voluntary sterilization • Routine treatment of conditions of the foot; see Foot care • Skin Tag removal	All charges
Reconstructive surgery	
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: •• the condition produced a major effect on the member's appearance and •• the condition can reasonably be expected to be corrected by such surgery • 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; webbed fingers; and webbed toes.	Nothing
• All stages of breast reconstruction surgery following a mastectomy, such as: •• surgery to produce a symmetrical appearance on the other breast; •• treatment of any physical complications, such as lymphedemas; •• breast prostheses and surgical bras and replacements (see Prosthetic devices) 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.	Nothing
Not covered: • 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 • Surgeries related to sex transformation	All charges

Benefit Description	You pay
Oral and maxillofacial surgery	
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures.	Nothing
Not covered: • Oral implants and transplants • Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)	All charges.
Organ/tissue transplants	
Limited to: • Cornea • Heart • Kidney • Liver • Lung: Single–Double • Allogeneic (donor) bone marrow transplants; autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin's lymphoma; advanced non-Hodgkin's lymphoma; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors Limited Benefits–Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in an NCI- or NIH-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. Note: We cover related medical and hospital expenses of the donor when we cover the recipient.	Nothing Note: Plan authorization is required at the time of diagnosis, prior to any evaluative services and will only be authorized at Plan facilities, contracted Centers of Excellence, or at facilities that have a pre-determined, negotiated, daily rate.
Not covered: • Donor screening tests and donor search expenses, except those performed for the actual donor • Implants of artificial organs • Transplants not listed as covered	All charges.

Benefit Description	You pay
Anesthesia	
Professional services provided in– • Hospital (inpatient)	Nothing
Professional services provided in– • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	Nothing when prescribed by a Plan doctor.

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

IMPORTANT

Here are some important things to 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 and you must be hospitalized in a Plan facility.
- 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 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 covered in Section 5(a) or (b).

IMPORTANT

Benefit Description	You pay
Inpatient hospital	
• Room and board, such as ward, semiprivate, or intensive care accommodations; general nursing care; and meals and special diets. NOTE: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	Nothing
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and x-rays • Administration of blood and blood products • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services	Nothing

Inpatient hospital continued on next page

Benefit Description	You pay
Inpatient hospital	
• Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home	Nothing
Not covered: • Custodial care • Non-covered facilities, such as nursing homes, extended care facilities, schools • Personal comfort items, such as telephone, television, barber services, guest meals and beds • Private nursing care	All charges.
Outpatient hospital or ambulatory surgical center	
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen * Anesthetics and anesthesia service 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.	Nothing

Benefit Description	You pay
Extended care benefits/skilled nursing care facility benefits	
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: • Bed, board and general nursing care • Drugs, biologicals, supplies, and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a Plan doctor.	Nothing for up to 90 days per calendar year
Not covered: custodial care	All charges.
Hospice care	
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.	Nothing
Not covered: Independent nursing, homemaker services	All charges.
Ambulance	
• Emergency Ambulance services are covered • Non-Emergency use must be requested by your doctor and pre-approved by the Plan	Nothing

Section 5 (d). Emergency services/accidents

IMPORTANT

Here are some important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure.
- We have no calendar year deductible.
- 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 Medicare.

IMPORTANT

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.

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 Plan doctors believe care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

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 a Plan doctor believes care can be better 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
Emergency within our service area	
• Emergency care at a doctor's office • Emergency care at an urgent care center within the service area • Emergency care as an outpatient or inpatient at a hospital, including doctors' services	$10 per visit $20 for emergency services that are covered benefits of this Plan. Copayment waived if emergency results in hospital admission. $40 for emergency services that are covered benefits of this Plan. Copayment waived if emergency results in hospital admission.
Not covered: Elective care or non-emergency care	All charges.
Emergency outside our service area	
• Emergency care at a doctor's office • Emergency care at an urgent care center outside of the service area • Emergency care outside of the service area, at an outpatient or inpatient at a hospital, including doctors' services	$10 per visit $20 for emergency services that are covered benefits of this Plan. Copayment waived if emergency results in hospital admission. $40 for emergency services that are covered benefits of this Plan. Copayment waived if emergency results in hospital admission.
Not covered: Elective care or non-emergency care	All charges.
Ambulance	
Professional ambulance service when medically appropriate. See 5(c) for non-emergency service.	Nothing

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

IMPORTANT

Parity
Beginning in 2001, all FEHB plans' mental health and substance abuse benefits will achieve "parity" with other benefits. This means that we will provide mental health and substance abuse benefits differently than in the past.

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.

Here are some important things to keep in mind about these benefits:

- All benefits are subject to the definitions, limitations, and exclusions in this brochure.
- 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 OF THESE SERVICES.** See the instructions after the benefits description below.

IMPORTANT

Benefit Description	You pay
Mental health and substance abuse benefits	
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.
• Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management	$10 per office visit
• Diagnostic tests	Nothing
• Services provided by a hospital or other facility	Nothing
• Services in approved alternative care settings such as partial hospitalization, residential treatment, full-day hospitalization, facility based intensive outpatient treatment	$10 per office visit or nothing depending on service.

Mental health and substance abuse benefits continue on next page

Benefit Description	You pay
Mental health and substance abuse benefits	
Not covered: Services we have not approved. 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.	All charges

Preauthorization

To be eligible to receive these benefits you must follow your treatment plan and all the following authorization processes: Please call 1-800-424-5669 for all mental health requests. This number is printed on the back of your ConnectiCare, Inc. member card as well.

Special transitional benefit

- If a mental health or substance abuse professional provider is treating you under our plan as of January 1, 2001, you will be eligible for continued coverage with your provider for up to 90 days under the following conditions:

  If your mental health or substance abuse professional provider with whom you are currently in treatment leaves the plan at our request for other than cause, or

- If this condition applies to you, we will allow you reasonable time to transfer your care to a Plan mental health or substance abuse professional provider. During the transitional period, you may continue to see your treating provider and will not pay any more out-of-pocket than you did in the year 2000 for services. This transitional period will begin with our notice to you of the change in coverage and will end 90 days after you receive our notice. If we write to you before October 1, 2000, the 90-day period ends before January 1 and this transitional benefit does not apply.

Limitation

We may limit your benefits if you do not follow your treatment plan.

Section 5 (f). Prescription drug benefits

IMPORTANT

Here are some important things to keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- 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 Medicare.

IMPORTANT

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

- **Who can write your prescription.** A licensed physician must write the prescription.
- **Where you can obtain them.** You must fill the prescription at a PCS pharmacy, or by mail for a maintenance medication. The only exception is for out-of-area emergencies.

  Pharmacy: You may obtain your prescriptions at any PCS, Inc. pharmacy. (In 98% of US 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 2X the co-pay, call Member Services at 1-800-251-7722 to request an order form. If you choose to go to your pharmacy, the co-pay will be 3X the co-pay. 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 an Open Formulary.** We work with our network physicians and our pharmacy network, PCS, 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

  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.

- **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; 240 milliliters of liquid (8oz.); 60 grams of ointment, creams or topical preparation; or one commercially prepared unit (i.e., one inhaler, one vial ophthalmic medication or Insulin) of medication per prescription or refill. You pay a $10 copay per prescription unit or refill for generic drugs or for name brand Formulary drugs when generic substitution is not permissible. When generic substitution is permissible and, you or your doctor request the Formulary name brand drug, you pay the price difference between the generic and name brand drug as well as the $10 copay per prescription unit or refill. Drugs are prescribed by Plan doctors and dispensed in accordance with the Plan's drug Formulary. Non-Formulary drugs will be covered when prescribed by a Plan doctor, but at a higher copay.

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 sometime three copays depending on how much was dispensed.

If you choose a non-Formulary drug when a generic or Formulary name brand drug is available, you pay a $10 copayment in addition to the cost difference between the Formulary and non-Formulary drug, up to 50% of the cost of the drug. If the cost is less than the copayment, you pay the lesser amount.

- **When you have to file a claim.** There are no claims to file for prescription services received at PCS, 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
Covered medications and supplies	
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program: • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except as excluded below. • Insulin • Disposable needles and syringes for the administration of covered medications • Drugs for sexual dysfunction (Contact the plan for dose limits) • Contraceptive drugs and devices(oral and injectable plus diaphragms) • Intraveneous fluids and medicine for home use (covered implantable drugs and covered injectable drugs are covered under medical and surgical benefits).	You pay a $10 copay per prescription unit or refill for generic drugs, a $20 copay for name brand Formulary drugs and a $35 copay for non-Formulary drugs. When a generic drug is available, but you or your doctor request the Formulary name brand drug, or non-Formulary brand drug, you pay the price difference between the generic and name brand drug as well as the $10 copay per prescription unit or refill. Drugs are prescribed by Plan doctors and dispensed in accordance with the Plan's drug Formulary. Our Formulary is open and available by calling Member Services at 800-251-7722 or by going to our website www.connecticare.com. 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 2X the copay.
Limited Coverage: Fertility drugs are subject to a $1,500 annual limit.	

Prescription drug benefits continue on next page

Benefit Description	You pay
Covered medications and supplies	
Here are some things to keep in mind about our prescription drug program: • 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, you have to pay the difference in cost between the name brand drug and the generic. • 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 formulary listing, call 1-800-251-7722.	
Not covered: • Drugs and supplies for cosmetic purposes • Vitamins, nutrients and food supplements, even if a physician prescribes or administers them • Nonprescription medicines	All Charges

Section 5 (g). Special Features

Feature	Description
Services for deaf and hearing impaired	Call the TDD/TTY number for the hearing impaired: 1-800-251-7722.

Section 5 (h). Non-FEHB benefits available to Plan members

The benefits on this page are not part of the FEHB contract or premium, and you cannot file an FEHB disputed claim about them. Fees you pay for these services do not count toward FEHB deductibles or out-of-pocket maximums.

Medicare+Choice plan: We offer this plan for people age 65 or older and for those who are eligible for Social Security benefits because of a disability. To be eligible, you must live in the ConnectiCare service area for this plan (Hartford/New Haven County), be entitled to Medicare Parts A and be enrolled in Medicare Part B. You must continue to pay your Medicare Part B premium.

If you or a family member qualify for coverage, please let us know. You may also remain enrolled with us. Medicare will determine who is responsible for paying for medical services and we will coordinate the payments. On occasion, you may need to file a Medicare claim form.

If you are an annuitant or former spouse, you can suspend your FEHB coverage and enroll in our Medicare+Choice plan. For information on suspending your FEHB enrollment and changing to a our Medicare+Choice plan, 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. If you involuntarily lose coverage, or move out of the Medicare+Choice service area, you may re-enroll in the FEHB Program at any time.

If you do not have Medicare Part A or B, you can still be covered under the FEHB Program and your benefits will not be reduced. We cannot require you to enroll in Medicare.

For more information on the ConnectiCare65 Medicare+Choice plan or a free brochure, call 1-800-883-6565.

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

The exclusions in this section apply to all benefits. **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 and we agree, as discussed under "*What Services Require Our Prior Approval*" on page 9.**

We do not cover the following:

- Care by non-Plan providers except for authorized referrals or emergencies (see Emergency Benefits);
- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies that are not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs or devices;
- 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
- Expenses you incurred while you were not enrolled in this Plan.

Section 7. Filing a claim for covered services

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 emergency services from non-plan providers. Sometimes these providers bill us directly. Check with the provider. If you need to file the claim, call Member Servicers at 800 251-7722 to obtain an out-of-area claim form. Then, here is the process:

Medical, hospital, and drug benefits

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

When you must file a claim—such as for out-of-area care—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 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.
  30 Batterson Park Road
  Farmington, CT 06032-2574

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 your claim if you do not respond.

Section 8. The disputed claims process

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 ñ including a request for pre-authorization:

Step	Description

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 30 Batterson Park Road, Farmington, CT 06032-2574; 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: Office of Personnel Management, Office of Insurance Programs, Contracts Division III, Branch II, P.O. Box 436, Washington, D.C. 20044-0436.

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 different claims, 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 provide 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.

Step	Description

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.

6 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. 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 pre-authorization/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 pre-authorization/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 can call OPM's Health Benefits Contracts Division III, Branch II at 202/606-0737 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

You must tell us if you are covered or a family member is covered under another group health plan or have 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 and older.
•• Some people with disabilities, under 65 years of age.
•• People with End-State Renal Disease (permanent kidney failure requiring dialysis or a transplant).

Medicare has two parts:
•• Part A (Hospital Insurance). Most people do not have to pay for Part A.
•• Part B (Medical Insurance). Most people pay monthly for Part B.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare + Choice is the term used to describe the various health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on the type of Medicare managed care plan you have.

- **The Original Medicare Plan**

The Original Medicare Plan is available everywhere in the United States. It is the way most people get their Medicare Part A and Part B benefits. You may go to any doctor, specialist, or hospital that accepts Medicare. Medicare pays its share and you pay your share. Some things are not covered under Original Medicare, like prescription drugs.

When you are enrolled in this Plan and Original Medicare, you still need to follow the rules in this brochure for us to cover your care. Your care must continue to be authorized by your Plan PCP, or precertified as required.

When Medicare is primary, we will cover what they don't assuming all other rules have been followed.

(Primary payer chart begins on next page.)

The following chart illustrates whether Original 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.

Primary Payer Chart

A. When either you—or your covered spouse—are age 65 or over and...	**Then the primary payer is**	
	Original Medicare	**This Plan**
1) Are an active employee with the Federal government (including when you or a family member are eligible for Medicare solely because of a disability),		✓
2) Are an annuitant,	✓	
3) Are a reemployed annuitant with the Federal government when... (a) The position is excluded from FEHB, or..... ✓ (b) The position is not excluded from FEHB..... ✓ Ask your employing office which of these applies to you.		
4) 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),	✓	
5) Are enrolled in Part B only, regardless of your employment status,	✓ (for Part B services)	✓ (for other services)
6) Are a former Federal employee receiving Workers' Compensation and the Office of Workers' Compensation Programs has determined that you are unable to return to duty,	✓ (except for claims) related to Workers' Compensation)	
B. When you—or a covered family member—have Medicare based on end stage renal disease (ESRD) and...		
1) Are within the first 30 months of eligibility to receive Part A benefits solely because of ESRD,		✓
2) Have completed the 30-month ESRD coordination period and are still eligible for Medicare due to ESRD,	✓	
3) Become eligible for Medicare due to ESRD after Medicare became primary for you under another provision,	✓	
C. When you or a covered family member have FEHB and...		
1) Are eligible for Medicare based on disability, (a) And are an annuitant or ..... ✓ (b) And are an active employee..... ✓		

In most cases, if you inform your provider that your have two coverages, they will send the claims to the carriers. But, this is something they do as a convenience. You are always ultimately responsible to submit your claims to the carriers you deal with.

Claims process–You probably will never have to file a claim form when you have both our Plan and Medicare.

- 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 claims will be coordinated automatically and we will pay the balance of covered charges. You will not need to do anything. To find out if you need to do something about filing your claims, call us at 1-800-251-7722.

- **Medicare managed care plan**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare managed care plan. These are health care choices (like HMOs) in some areas of the country. In most Medicare managed care plans, you can only go to doctors, specialists, or hospitals that are part of the plan. Medicare managed care plans cover all Medicare Part A and B benefits. Some cover extras, like prescription drugs. To learn more about enrolling in a Medicare+Choice plan, contact Medicare at 1-800-MEDICARE (1-800-633-4227) or at www.medicare.gov. If you enroll in a Medicare+Choice plan, the following options are available to you:

This Plan and our Medicare+Choice plan: You may enroll in our Medicare+Choice plan and also remain enrolled in our FEHB plan. In this case, we do waive any of our copayments, coinsurance, or deductibles for your FEHB coverage because the +Choice plan picks up the bill.

This Plan and another Plan's Medicare+Choice plan: You may enroll in another plan's Medicare+Choice plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare+Choice plan is primary and will supplement that plan assuming you went to our providers and follow our rules..

Suspended FEHB coverage and a Medicare+Choice plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage and enroll in a Medicare+Choice plan. 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+Choice service area.

- **Enrollment in Medicare Part B**

Note: If you choose not to enroll in Medicare Part B, you can still be covered under the FEHB Program. We cannot require you to enroll in Medicare.

TRICARE

TRICARE is the health care program for members, eligible dependents of military persons and retirees of the military. TRICARE includes the CHAMPUS program. If both TRICARE and this Plan cover you, we pay first. See your TRICARE Health Benefits Advisor if you have questions about TRICARE coverage.

Workers' Compensation

We do not cover services that:

- you need because of a workplace-related disease 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 benefits. You must use our providers.

Medicaid

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

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.

Section 10. Definitions of terms we use in this brochure

Calendar year	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.
Copayment	A copayment is a fixed amount of money you pay when you receive covered services. See page 10.
Coinsurance	Coinsurance is the percentage of our allowance that you must pay for your care. See page 10.
Covered services	Care we provide benefits for, as described in this brochure.
Custodial care	Home Health Care, light duty services at your home.
Deductible	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 10.
Experimental or investigational services	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.
Group health coverage	Health Insurance sold only to group employers
Medical necessity	Medical care provided for illness or injury that is determined by national standards to be Medically Necessary. Like a Mammogram, etc.
Us/We	Us and we refer to ConnectiCare, Inc.
You	You refers to the enrollee and each covered family member.

Section 11. FEHB facts

No pre-existing condition limitation

We will not refuse to cover the treatment of a condition that 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. Also, your employing or retirement office can answer your questions, and give you a *Guide to Federal Employees Health Benefits Plans,* brochures for other plans, and other materials you need to make an informed decision about:

- 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;
- 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 health 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.

When benefits and premiums start

The benefits in this brochure are effective on January 1. If you are new to this Plan, your coverage and premiums begin on the first day of your first pay period that starts on or after January 1. Annuitants' premiums begin on January 1.

Your medical and claims records are confidential

We will keep your medical and claims information confidential. Only the following will have access to it:

- OPM, this Plan, and subcontractors when they administer this contract;
- This Plan, and appropriate third parties, such as other insurance plans and the Office of Workers' Compensation Programs (OWCP), when coordinating benefit payments and subrogating claims;
- Law enforcement officials when investigating and/or prosecuting alleged civil or criminal actions;
- OPM and the General Accounting Office when conducting audits;
- Individuals involved in bona fide medical research or education that does not disclose your identity; or
- OPM, when reviewing a disputed claim or defending litigation about a claim.

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.

- **Spouse equity coverage**

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. But, you may be eligible for your own FEHB coverage under the spouse equity law. 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 Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees,* or other information about your coverage choices.

- **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.

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

Get the RI 79-27, which describes TCC, and the RI 70-5, *the Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees,* from your employing or retirement office or from www.opm.gov/insure.

- **Converting to individual coverage**

You may convert to an 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

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.

Inspector General Advisory

Stop health care fraud! Fraud increases the cost of health care for everyone. If you suspect that a physician, pharmacy, or hospital 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: The United States Office of Personnel Management, Office of the Inspector General Fraud Hotline, 1900 E Street, NW, Room 6400, Washington, DC 20415.

- **Penalties for Fraud**

Anyone who falsifies a claim to obtain FEHB Program benefits can be prosecuted for fraud. Also, the Inspector General may investigate anyone who uses an ID card if they try to obtain services for a person who is not an eligible family member, or are no longer enrolled in the Plan and try to obtain benefits. Your agency may also take administrative action against you.

Index

Do not rely on this page; it is for your convenience and does not explain your benefit coverage.

Summary of benefits for ConnectiCare, Inc.—2001

- **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.

Benefits	You Pay	Page
Medical services provided by physicians: • Diagnostic and treatment services provided in the office.....	Office visit copay: $10 primary care; $10 specialist	11
Services provided by a hospital: • Inpatient ..... • Outpatient	Nothing Day surgery, Nothing Walk-In, $20 copay	11
Emergency benefits: • In-area..... • Out-of-area	 $40 per $40 per	26
Mental health and substance abuse treatment	$10 copay outpatient 100% inpatient	28
Prescription Drugs	$10 Generic $20 Name Brand Formulary $35 Name Brand Non-Formulary Cost sharing applies when generic is available	30
Dental Care	No benefit	—
Vision Care	$10 Routine Exam, Discounts available on eyewear and contacts	17
Special features: Services for deaf and hearing impaired	Nothing	32
Protection against catastrophic costs (your out-of-pocket maximum).....	You must share the cost of some services. This is called either a copayment (a set dollar amount) or coinsurance (a set percentage of charges). Please remember you must pay this amount when you receive services.	47

2001 Rate Information for ConnectiCare

Authorized for distribution by the:
United States Office of
Personnel Management

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

Postal rates apply to most career U. S. Postal Service employees. In 2001, two categories of contribution rates, referred to as Category A rates and Category B rates, will apply for certain career employees. If you are a career postal employee but not a member of a special postal employment class, refer to the category definitions in "*The Guide to Federal Employees Health Benefits Plans for United States Postal Service Employees,*" RI 70-2, to determine which rate applies to you.

Postal rates do not apply to non-career postal employees, postal retirees, certain special postal employment classes or associate members of any postal employee organization. Such persons not subject to postal rates must refer to the applicable *"Guide to Federal Employees Health Benefits Plans."*

		Non-Postal Premium				**Postal Premium**	
		Biweekly		**Monthly**		**Biweekly**	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
All of Connecticut							
High Option Self Only	**TE1**	**$73.73**	**$24.58**	**$159.76**	**$53.25**	**$87.25**	**$11.06**
High Option Self + Family	**TE2**	**$193.09**	**$64.36**	**$418.36**	**$139.45**	**$228.49**	**$28.96**