ConnectiCare

ConnectiCare http://www.connecticare.org **2002**

A Health Maintenance Organization

Serving: Connecticut

Enrollment in this Plan is limited. You must live or work in our Geographic service area to enroll. See page 4 for requirements.

This Plan has excellent accreditation from the NCQA. See the *2002 Guide* for more information on NCQA.

Enrollment codes for this Plan:
TE1 Self Only
TE2 Self and Family

Authorized for distribution by the:
United States
Office of Personnel Management
Retirement and Insurance Service
http://www.opm.gov/insure

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 of ConnectiCare, Inc. under our 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, 2002, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2002, and changes are summarized on page 5. Rates are shown at the end of this brochure.

Plain Language

Teams of Government and health plans' staff worked on all FEHB brochures 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, Inc.

- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the 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 us know. Visit OPM's "Rate Us" feedback area at www.opm.gov/insure or e-mail us at fehbwebcomments@opm.gov. You may also write to OPM at the Office of Personnel Management, Office of Insurance Planning and Evaluation Division, 1900 E Street, NW Washington, DC 20415-3650.

Inspector General Advisory

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 or write

THE HEALTH CARE FRAUD HOTLINE
202/418-3300
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 the person tries to obtain services for someone who is not an eligible family member, or is no longer enrolled in the Plan and tries to obtain benefits. Your agency may also take administrative action against you

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, 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.

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 8,000 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.

Your Rights
OPM requires that all FEHB Plans provide certain information to their FEHB members. 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: 20
- 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 in this Plan, 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 care benefits. We will not pay for any other health care services out of our service area unless the services have prior plan approval.

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.

Section 2. How we change for 2002

Do not rely on these change descriptions; this page 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.

Program-wide changes

- We increased speech therapy benefits by removing the requirement that services must be required to restore functional speech. (Section 5(a))

Changes to this Plan

- Your share of the non-Postal premium will increase by 14.0% for Self Only or 14.1% for Self and Family.
- We no longer limit total blood cholesterol tests to certain age groups. (Section 5(a))
- We now cover certain intestinal transplants. (Section 5(b))
- We changed the address for sending disputed claims to OPM. (Section 8)

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 to get covered care

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. Your primary care physician will provide most of your health care, or give you a referral to see a specialist.

If you want to change primary care physician 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, speech and occupational 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.

Here are other things you should know about specialty care:

- If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. Your primary care physician will decide what treatment you need. If he or she decides to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not 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.

- 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 doctor will both refer you and get Plan authorization for: hospital admissions (except out-of-service area emergencies), outpatient alcohol and substance abuse treatment, durable medical equipment, prostheses, orthopedic devices, home health care, out-of-Plan services (non-participating providers), human organ transplants, skilled nursing facilities and surgical treatment of morbid obesity. For a complete listing, call our Member Services Department at 1-800-251-7722.

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, facility, pharmacy, etc., 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, you pay $100 per admission.
• **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 catastrophic protection out-of-pocket maximum for deductibles, coinsurance, and copayments	We do not have an out-of-pocket maximum

Section 5. Benefits — OVERVIEW

(See page 5 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 office visit
Professional services of physicians · In an urgent care center · During a hospital stay · In a skilled nursing facility · Office medical consultations · Second surgical opinion	 $20 per office visit Nothing. Nothing for up to 90 days per calendar year. $10 per office visit. $10 per office 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.
Injuries received in connection with the commission of a felony	All charges.

Lab, X-ray and other diagnostic tests	
Tests, such as: · Blood tests · Urinalysis · Non-routine pap tests · Pathology · X-rays · Non-routine Mammograms · Cat Scans/MRI · Ultrasound · Electrocardiogram and EEG • Cardiovascular lab • Cardiac rehabilitation • Lab work • Pain management and behavioral medicine • Pulmonary rehabilitation • Radiology • Radiation therapy • Physical, speech and occupational therapy	Nothing if you receive these services during your office visit; otherwise, $10 per office visit
Preventive care, adult	
Routine screenings, such as periodic check-ups and routine immunizations including these tests as ordered by your doctor · Total Blood Cholesterol – once every three years · Colorectal Cancer Screening, including – Fecal occult blood test – Sigmoidoscopy, screening – every five years starting at age 50	$10 per office visit
Prostate Specific Antigen (PSA test) – one annually for men age 40 and older	$10 per office 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 64, one every calendar year · At age 65 and older, one every two consecutive calendar years	$10 per office visit.

Preventive Care – continued on next page

Preventive care, adult *(continued)*	**You pay**
Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.	All charges.
Routine immunizations, limited to: · Tetanus-diphtheria (Td) booster – once every 10 years, ages19 and over (except as provided for under Childhood immunizations) · Influenza/Pneumococcal vaccines, annually, age 65 and over	Nothing if you receive these services during your office visit; otherwise $10 per visit.
Check with your doctor to see if this plan covers other immunizations.	
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.
· Well-child care charges for routine examinations, immunizations and care (up to age 22) · Examinations, such as: – Eye exams to determine the need for vision correction. – Ear exams up to age 18 to determine the need for hearing correction – Examinations done on the day of immunizations (up to age 22)	$10 per office 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 precertify your normal delivery. This is done by your Plan Provider. · 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	You pay
A broad range of voluntary family planning services, limited to: · Voluntary sterilization · Surgically implanted contraceptives (such as Norplant) · Injectable contraceptive drugs (such as Depo provera) · Intrauterine devices (IUDs) NOTE: We cover oral contraceptives, injectable contraceptive and diaphragms under the prescription drug benefit.	$10 per office visit
Not covered: reversal of voluntary surgical sterilization, genetic counseling	All charges.
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 office visit
Not covered: · Assisted reproductive technology (ART) procedures, such as: – in vitro fertilization – embryo transfer, gamete GIFT and zygote ZIFT – Zygote transfer · Services and supplies related to excluded ART procedures · Cost of donor sperm · Cost of donor egg	All charges.
Allergy care	
Testing and treatment Allergy injection	$10 per office visit
Allergy serum	Nothing
Not covered: provocative food testing and sublingual allergy desensitization	All charges.

Treatment therapies	You pay
· 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.
Physical and occupational therapies	
· 60 visits per condition per calendar year for the services of each of the following: – qualified physical therapists and – occupational therapists. 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 .	$10 per outpatient visit. Nothing per visit during covered inpatient admission.
· Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction, is provided as part of your rehabilitation.	Nothing.
· Chiropractic manipulation therapy is provided on an outpatient basis for up to 20 visits per calendar year.	$10 copayment per visit.
Not covered: · long-term rehabilitative therapy · exercise programs	All charges.
Speech therapy	
· 60 visits per condition per calendar year	$10 per outpatient visit. Nothing per visit during covered inpatient admission.
Not covered: · Non-authorized, non-medically necessary treatment	All charges.

Hearing services (testing, treatment, and supplies)	You pay
· First hearing aid and testing only when necessitated by accidental injury · Hearing testing for children through age 18 (see *Preventive care, children*)	$10 per office 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 below $250; 30% discount over $250 at plan routine vision providers
· Eye exam to determine the need for vision correction for children (see Preventive care, children)	$10 per office visit
· Annual eye refractions once per calendar year, when obtained by Plan providers	$10 per office 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. See orthopedic and prosthetic devices for information on podiatric shoe inserts.	$10 per office 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.

Orthopedic and prosthetic devices	You pay
· 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.	$10 per office visit
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 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.

Disposable medical supplies	You pay
Certain disposable medical supplies, which are used in conjunction with covered durable medical equipment or covered medical treatment received in the home are covered. Examples: BiPAP, CPAP masks. Not all disposable medical supplies are covered. See your doctor or call Member Services.	$100 deductible and 20% of charges up to a maximum Plan payment of $300 per calendar year. Note: Prior plan authorization is required.
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; · home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic or rehabilitative.	All charges.
Chiropractic	
· Manipulation of the spine and extremities · Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application	$10 per office visit 20 visits per calendar year.

Alternative treatments	You pay
Naturopathic Doctors if Plan Doctors	$10 per office visit
Not covered: · hypnotherapy · biofeedback	All charges.
Educational classes and programs	
Coverage is limited to: Diabetes, Heart, Asthma and Smoking Cessation 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 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.).
- 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	
A comprehensive range of services, such as: · Operative procedures · Treatment of fractures, including casting · Normal pre- and post-operative care by the surgeon · Correction of amblyopia and strabismus · Endoscopy procedures · Biopsy procedures · Removal of tumors and cysts · Correction of congenital anomalies (see reconstructive surgery)	$10 per office 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.

Surgical procedures continued on next page.

Surgical procedures *(continued)*	**You pay**
· Voluntary sterilization · Treatment of burns 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.	$10 per office visit
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.	$10 per office visit
· 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.	See above.
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.

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.	$10 per office visit
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	**You pay**
Limited to: · Cornea · Heart · Heart/lung · Kidney · Kidney/Pancreas · Liver · Lung: Single –Double · Pancreas · 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; advanced neuroblastoma; breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors · Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas · National Transplant Program (NTP) 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 predetermined, negotiated, daily rate.

Organ/tissue transplants	You pay
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.
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 remember 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 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 covered in Sections 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 · Medical supplies and equipment, including oxygen · Anesthetics, including nurse anesthetist services 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
Not covered: · Custodial care · Non-covered facilities, such as nursing homes, 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	You pay
· 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
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 with 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	$10 per office visit.
· Emergency care at an urgent care center within the service area	$20 for emergency services that are covered benefits of this Plan. Copayment waived if emergency results in hospital admission.
· Emergency care as an outpatient or inpatient at a hospital, including doctors' services	$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	$10 per office visit.
· Emergency care at an urgent care center outside of the service area	$20 for emergency services that are covered benefits of this Plan. Copayment waived if emergency results in hospital admission.
· Emergency care outside of the service area, at an outpatient or inpatient at a hospital, including doctors' services	$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 · Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area · Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area	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

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
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 illness 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.
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.

Limitation

We may limit your benefits if you do not obtain a 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 with Medicare.
- 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.

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 Express Scripts 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 Express Scripts, Inc. pharmacy. (in 98% of US Pharmacies)

  Mail order: Maintenance medication, those medications needed for conditions such as diaget5es, 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 copay, call Member Services at 1-800-251-7722 to request and 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 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

  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; 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 a $20 copay 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.
- **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 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 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
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 those listed as *Not covered.* · 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) · Fertility drugs are subject to a $1,500 annual limit · 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.
Not covered: · Drugs and supplies for cosmetic purposes · Drugs to enhance athletic performance · Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies · Vitamins, nutrients and food supplements even if a physician prescribes or administers them · Nonprescription medicines	All charges.

Section 5 (g). Special features

Feature	Description
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. · We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. · Alternative benefits are subject to our ongoing reviews. · By approving an alternative benefit, we cannot guarantee you will get it in the future. · The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits. · Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.
Services for deaf and hearing impaired	Call the TDD/TTY number for the hearing impaired: 1-800-251-7722.
Our website www.connecticare.com	You can change or add your PCP, look up a doctor or check our drug formulary at our website.
Alternative treatments	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.

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 8.**

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; or
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program.
- 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 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.
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 – including a request for preauthorization:

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 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 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 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.

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 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 can call OPM's Health Benefits Contracts Division 3 at 202/606-0755 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-Stage 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. 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. (Someone who was a Federal employee on January 1, 1983 or since automatically qualifies.) 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.

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 (Original Medicare) is a plan that 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. Some things are not covered under Original Medicare, like prescription drugs.

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. *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 **the Original Medicare Plan** 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, and a) Are an annuitant, or	✓	
b) Are an active employee,		✓
c) Are a former spouse of an annuitant, or	✓	
d) Are a former spouse of 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 when you have the Original Medicare – You probably will never have 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 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.

We do not waive any costs when you have Medicare.

- **Medicare managed care plan**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from another type of Medicare+Choice plan—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 provide all the benefits that Original Medicare covers. 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 managed care plan, the following options are available to you:

This Plan and another plan's Medicare Managed Care plan: You may enroll in another plan's Medicare managed care and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare managed care plan is primary and will supplement that plan assuming you went to our providers and follow our rules. If you enroll in a Medicare managed care plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare managed care plan so we can correctly coordinate benefits with Medicare.

Suspended FEHB coverage to enroll in a Medicare Managed Care plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage and enroll in a Medicare managed care 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 managed care plan's service area.

If you do not enroll in Medicare Part A or Part B

If you do not have one or both Parts of Medicare, you can still be covered under the FEHB Program. We will not require you to enroll in Medicare Part B and, if you can't get premium-free Part A, we will not ask you to enroll in it.

TRICARE

TRICARE is the health care program for 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 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. 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

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.
Coinsurance	Coinsurance is the percentage of our allowance that you must pay for your care. See page 9.
Copayment	A copayment is a fixed amount of money you pay when you receive covered services. See page 9.
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 9.
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 and questions, 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 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. 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.

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.

•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 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 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. It explains what you have to do to enroll.

- **Converting 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. If you wish to continue on individual coverage, you must call HRA (Health Reinsurance Association), the state uninsured pool at 800-842-0004. They will send you information as to how you can continue your coverage. If, for some reason you are ineligible to join the pool, you must contact us within 31 days. However, if you are a family member who is losing coverage, the employing or retirement office will **not** notify you.

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 (www.opm.gov/insure/health); refer to the "TCC and HIPAA" frequently asked question. 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 have information about Federal and State agencies you can contact for more information.

Long Term Care Insurance Is Coming Later in 2002!

The Office of Personnel Management (OPM) will sponsor a high-quality long term care insurance program effective in October 2002. As part of its educational effort, OPM asks you to consider these questions:

- It's insurance to help pay for long term care services you may need if you can't take care of yourself because of an extended illness or injury, or an age-related disease such as Alzheimer's.
- LTC insurance can provide broad, flexible benefits for nursing home care, care in an assisted living facility, care in your home, adult day care, hospice care, and more. LTC insurance can supplement care provided by family members, reducing the burden you place on them.
- Welcome to the club!
- 76% of Americans believe they will never need long term care, but the facts are that about half them will. And it's not just the old folks. About 40% of people needing long term care are under age 65. They may need chronic care due to a serious accident, a stroke, or developing multiple sclerosis, etc.
- We hope you will never need long term care, but everyone should have a plan just in case. Many people now consider long term care insurance to be vital to their financial and retirement planning.
- Yes, it can be very expensive. A year in a nursing home can exceed $50,000. Home care for only three 8-hour shifts a week can exceed $20,000 a year. And that's before inflation!
- Long term care can easily exhaust your savings. *Long term care insurance can protect your savings.*
- Not FEHB. Look at the "*Not covered*" blocks in sections 5(a) and 5(c) of your FEHB brochure. Health plans don't cover custodial care or a stay in an assisted living facility or a continuing need for a home health aide to help you get in and out of bed and with other activities of daily living. Limited stays in skilled nursing facilities can be covered in some circumstances.
- Medicare only covers skilled nursing home care (the highest level of nursing care) after a hospitalization for those who are blind, age 65 or older or fully disabled. It also has a 100 day limit.
- Medicaid covers long term care for those who meet their state's poverty guidelines, but has restrictions on covered services and where they can be received. *Long term care insurance can provide choices of care and preserve your independence.*
- Employees will get more information from their agencies during the LTC open enrollment period in the late summer/early fall of 2002.
- Retirees will receive information at home.
- Our toll-free teleservice center will begin in mid-2002. In the meantime, you can learn more about the program on our web site at www.opm.gov/insure/ltc.

Index

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

Summary of benefits for ConnectiCare, Inc.—2002

- **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	24-25
Emergency benefits: · In-area..... · Out-of-area.....	$40 per…. $40 per…	27 27
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	29-31
Dental Care.....	No benefit.	—
Vision Care.....	$10 Routine Exam, Discounts available on eyewear and contacts	16
Special features: *Flexible benefits, services for deaf and hearing impaired, ConnectiCare website, alternative treatments*	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.	9

2002 Rate Information for ConnectiCare

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 career Postal Service employees. Most employees should refer to the FEHB Guide for United States Postal Service Employees, RI 70-2. Different postal rates apply and special FEHB guides are published for Postal Service Nurses, RI 70-2B; and for Postal Service Inspectors and Office of Inspector General (OIG) employees (see RI 70-2IN).

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 FEHB Guide.

Type of **Enrollment**	Code	***Non-Postal Premium***				***Postal Premium***	
		Biweekly		**Monthly**		**Biweekly**	
		Gov't Share	Your Share	Gov't Share	Your Share	**USPS** Share	**Your** Share
All of Connecticut							
High Option **Self Only**	**TE1**	**$84.11**	**$28.03**	**$182.23**	**$60.74**	**$99.52**	**$12.62**
High Option Self & Family	**TE2**	**$220.28**	**$73.42**	**$477.26.**	**$159.09**	**$260.66**	**$33.04**