This is a sample Plan PDF Document

HealthyCT
Silver Enhanced Standard PPO
SCHEDULE OF BENEFITS

This is a brief schedule of benefits. Refer to your HealthyCT Policy for complete details on benefits, conditions, limitations and exclusions. All benefits described below are per member per calendar year. A referral from your primary care provider is not required.

The individual deductible applies if you have coverage only for yourself and not for any dependents. The family deductible applies if you have coverage for yourself and one or more eligible dependents. If you have family coverage, once any individual member of the family meets the individual deductible, the Plan will begin to pay claims for those benefits subject to the deductible for that individual. Also, once the family deductible is met by one or more members of the family, combined, the Plan will begin to pay claims for all members of the family (even if the individuals did not each meet the individual deductible).

Benefits	**In-Network (INET) Member Pays**	**Out-of-Network (OON) Member Pays**
Plan Deductible *Individual* *Family*	 $2,600 per member $5,200 per family	 $6,000 per member $12,000 per family
Separate Prescription Drug Deductible *Individual* *Family*	 $25 per member $50 per family	 $350 per member $700 per family
Out-of-Pocket Maximum *Individual* *Family* (Includes deductible, copayments and coinsurance)	 $6,600 per member $13,200 per family	 $12,500 per member $25,000 per family
Provider Office Visits		Provider Office Visits
Adult Preventive Physical Exam	No Cost	40% coinsurance per visit
Infant / Pediatric Preventive Physical Exam	No Cost	40% coinsurance per visit
Primary Care Provider Office Visits (includes services for illness, injury, follow-up care and consultations)	$30 copayment per visit	40% coinsurance per visit after OON deductible is met
Specialist Office Visits	$50 copayment per visit	40% coinsurance per visit after OON deductible is met
Mental Health and Substance Abuse Office Visit	$30 copayment per visit	40% coinsurance per visit after OON deductible is met

HealthyCT
Silver Enhanced Standard PPO
SCHEDULE OF BENEFITS

Outpatient Diagnostic Services		Outpatient Diagnostic Services
Advanced Radiology (CT/PET Scan, MRI) (Copayments for MRIs and CAT scans are limited to $375 from in-network providers annually. Copayments for PET scans are limited to $400 from in-network providers annually)	$75 copayment per visit	40% coinsurance per visit after OON deductible is met
Laboratory Services	$35 copayment per visit	40% coinsurance per visit after OON deductible is met
Non-Advanced Radiology (X-ray, Diagnostic) Mammography Ultrasound	$45 copayment per visit $20 copayment	40% coinsurance per visit after OON deductible is met
Prescription Drugs - Retail Pharmacy ***(30 day supply per prescription)***		Prescription Drugs - Retail Pharmacy *(30 day supply per prescription)*
Tier 1 Prescription Drugs	$5 copayment per prescription	40% coinsurance per prescription after OON prescription drug deductible is met
Tier 2 Prescription Drugs	$30 copayment per prescription	40% coinsurance per prescription after OON prescription drug deductible is met
Tier 3 Prescription Drugs	$55 copayment per prescription	40% coinsurance per prescription after OON prescription drug deductible is met
Tier 4 Prescription Drugs	$60 copayment per prescription after INET prescription drug deductible is met	40% coinsurance per prescription after OON prescription drug deductible is met
Prescription Drugs - Mail Order or Retail Pharmacy ***(90 day supply per prescription)***		Prescription Drugs - Mail Order or Retail Pharmacy *(90 day supply per prescription)*
Tier 1 Prescription Drugs	$10 copayment per prescription	Not Covered
Tier 2 Prescription Drugs	$60 copayment per prescription	Not Covered
Tier 3 Prescription Drugs	$110 copayment per prescription	Not Covered

HealthyCT
Silver Enhanced Standard PPO
SCHEDULE OF BENEFITS

Outpatient Rehabilitative and Habilitative Services		Outpatient Rehabilitative and Habilitative Services
Speech Therapy (40 visits per calendar year limit combined for physical, speech, and occupational therapy)	$30 copayment per visit	40% coinsurance per visit after OON deductible is met
Physical and Occupational Therapy (40 visits per calendar year limit combined for physical, speech, and occupational therapy)	$30 copayment per visit	40% coinsurance per visit after OON deductible is met
Other Services		Other Services
Chiropractic Services (up to 20 visits per calendar year)	$50 copayment per visit	40% coinsurance per visit after OON deductible is met
Diabetic Equipment and Supplies	40% coinsurance per equipment/supply	40% coinsurance per equipment/supply after OON deductible is met
Durable Medical Equipment (DME)	40% coinsurance per DME item	40% coinsurance per DME item after OON deductible is met
Home Health Care Services (up to 100 visits per calendar year)	No Cost	25% coinsurance per visit after $50 deductible is met
Outpatient Services (in a hospital or ambulatory facility)	$500 copayment per visit after INET deductible is met	40% coinsurance per visit after OON deductible is met
Inpatient Hospital Services		Inpatient Hospital Services
Inpatient Hospital Services (including mental health, substance abuse, maternity, hospice and skilled nursing facility*) *(skilled nursing facility stay is limited to 90 days per calendar year)	$500 copayment per day up to $2,000 per admission after INET deductible is met Hospice - $0 copayment per stay after INET deductible is met	40% coinsurance after OON deductible is met
Emergency and Urgent Care		Emergency and Urgent Care
Ambulance Services	No Cost	No Cost
Emergency Room	$150 copayment per visit	$150 copayment per visit
Urgent Care Centers	$75 copayment per visit after INET deductible is met	40% coinsurance per visit after OON deductible is met

HealthyCT
Silver Enhanced Standard PPO
SCHEDULE OF BENEFITS

Pediatric Dental Care (for children under age 19)		Pediatric Dental Care (for children under age 19)
Diagnostic & Preventive	No Cost	50% coinsurance per visit after OON deductible is met
Basic Services	40% coinsurance per visit	50% coinsurance per visit after OON deductible is met
Major Services	50% coinsurance per visit	50% coinsurance per visit after OON deductible is met
Orthodontia Services (medically necessary only)	50% coinsurance per visit	50% coinsurance per visit after OON deductible is met
Pediatric Vision Care (for children under age 19)		Pediatric Vision Care (for children under age 19)
Prescription Eye Glasses (one pair of frames and lenses per calendar year)	Lenses: $0; Collection frame: $0; Non–collection frame: members choosing to upgrade from a collection frame to a non-collection frame will be given a credit substantially equal to the cost of the collection frame and will be entitled to any discount negotiated by the carrier with the retailer.	Not Covered
Routine Eye Exam by Specialist (one exam per calendar year)	$50 copayment per visit	40% coinsurance per visit

WELCOME TO HealthyCT!

Thank You for choosing HealthyCT. We look forward to providing You with the responsive customer service that Our Members expect from Us and working with You and Your doctors to make sure You and Your family make the right choices to maximize the coverage available to You under this Plan.

IMPORTANT

Please read the "Managed Care Rules And Guidelines" section to learn this Plan's rules. Understanding the rules of this Plan will help You maximize Your coverage. The "Managed Care Rules and Guidelines" section will explain how this Preferred Provider Organization (PPO) Plan operates and whether Your Plan requires You to use Participating Providers, as well as whether You need to obtain a referral or Prior Authorization before receiving care. In addition, please read the "Exclusions And Limitations" section to find out what is not covered under this Plan.

RIGHT OF POLICY EXAMINATION

You are permitted to return this Policy by delivering or mailing it to the agent or broker through whom it was purchased, or to Us at the mailing address noted above within ten days after the date of delivery if, after examination of the Policy, You are not satisfied with it for any reason. If You return this Policy, it will be deemed void from the beginning and any and all claims paid will be retracted and any Premiums paid will be refunded.

GUARANTEED RENEWABLE

This Policy is guaranteed renewable provided the following requirements are satisfied:

- You continue to meet the eligibility requirements described in the "Eligibility and Enrollment" section of this Policy;
- You continue to pay the Premium due, as described in the "Premium Payment" section of this Policy; and
- Your membership has not been terminated, as described in the "Termination and Amendment" section of this Policy.

We may make changes to the benefits and/or Premium rates while this Policy is in effect:

- As described in the "Termination and Amendment" section of this Policy, or
- When renewed.

If We make any changes to the benefits, the changes apply to services that start on or after the Effective Date of the Policy changes. These changes (including any decrease in benefits or removal of benefits) apply to:

- Any claims or expenses,
- Incurred services, or
- Supplies furnished.

There are no vested rights to receive any benefits described in this Policy after the date the Policy changes or terminates. This applies even if the claim or expense took place after the Policy changes or ends but before You received the changed or new plan documents.

The following paragraph applies to You if You are enrolled in a plan that includes a Health Savings Account (HSA):

The HealthyCT HSA Plan has been designed to conform to federal Internal Revenue Service (IRS) guidelines on Health Savings Account (HSA) – qualified plans. However, the IRS has made no determination that this Plan is HSA-qualified. Whether or not an HSA used with this Plan will provide a Member with tax advantages depends on a number of circumstances, including the Member's personal coverage situation, contributions to and withdrawals from his/her HSA account, other coverage a Member may have and changes the IRS may make to its rules. Members should consult with a qualified tax advisor in determining whether and how this option may provide them with a tax benefit. We cannot guarantee that tax benefits will accrue to anyone covered under this Plan.

Approval by the State of Connecticut Insurance Department does not guarantee tax qualification. Please seek the counsel of a tax advisor.

Table of Contents

IMPORTANT TELEPHONE NUMBERS AND ADDRESSES

Questions When Applying For Coverage Or Determining Your Eligibility Or Premium Assistance And Cost-Share Reductions Access Health CT

(860) 757-5330

or
Connecticut Health Insurance Exchange
dba Access Health CT
280 Trumbull Street, 15th Floor
Hartford, CT 06103, or
www.accesshealthct.com

Member Services HealthyCT

(855) 208-1641

TDD/TYY services
(855) 643-5004
Fax
(877) 219-1735

Prior-Authorization HealthyCT

(855) 458-4928
Utilization management questions can be asked from 8:30 a.m. to 5:00 p.m. Monday through Friday and after hours, You may leave a voicemail message.

Prescription Drug Benefits

(855) 577-6549

Pediatric Dental Benefits

Delta Dental of New Jersey, Inc.
P.O. Box 222
Parsippany, New Jersey 07054
(800) 452-9310

Submitting Claims to Us from Non-Participating Providers

HealthyCT
Attn: Claims Submissions
P.O. Box 33728
Indianapolis, IN 46203-0728

Questions And Complaints -- HealthyCT (general questions and complaints except for the Connecticut Health Insurance Exchange)

HealthyCT Member Services
35 Thorpe Avenue, Suite 104
Wallingford, Connecticut 06492
(855) 458-4928

www.healthyct.org

Premium Payment Address

HealthyCT, Inc.
Dept. 46
P.O. Box 280
Hartford, CT 06141-0280

www.healthyct.org

MEMBERS' RIGHTS AND RESPONSIBILITIES

HealthyCT (HCT) is committed to treating its members in a manner that respects their rights and provides access to high quality health care. The following are the members' rights and responsibilities:

Member Rights

- A right to receive information about HCT, its services, its practitioners and providers and member rights and responsibilities.
- A right to be treated with respect and recognition of their dignity and their right to privacy.
- A right to participate with practitioners in making decisions about their health care.
- A right to a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
- A right to voice complaints or appeals about HCT or the care it provides.
- A right to make recommendations regarding HCT's member rights and responsibilities policy.

Member Responsibilities

- A responsibility to supply information (to the extent possible) that HCT and its practitioners and providers need in order to provide care.
- A responsibility to follow plans and instructions for care that they have agreed to with their practitioners.
- A responsibility to understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.

POLICY

This Policy is Our contract. You and Your Eligible Dependents must follow its terms and conditions to obtain benefits for health care services.

This Policy includes this document and the following documents:

- Exchange enrollment form
- Our Application/Change Form
- Benefit Summary
- Riders and supplementary inserts, if any

No statement by You in Your application shall void this Policy or be used in any legal proceeding unless such application or an exact copy thereof is included in or attached to the Policy.

Please read Your Benefit Summary for details regarding particular features of Your Plan, such as Coinsurance, Deductibles, exclusions and limitations.

When We refer to words like "We" or "Us," We mean HealthyCT. When We refer to "You," We mean You, the Subscriber. Words in this document that are in "Upper Case" have special meaning. You can find their meaning in the "Definitions" section.

This Policy replaces any agreement, contract, policy or program of the same coverage that We may have issued to You prior to the date We issued this Policy. It is written according to federal law and the laws of the State of Connecticut, including rules, regulations or other standards set forth by the Exchange and/or the State of Connecticut Insurance Department (Department). We have the right to make changes to this Policy, but only with approval from the Department. If We change this Policy, We will tell You about the change when it becomes effective.

The Plan may, in its sole discretion, cover services and supplies not specifically covered by the Certificate. This applies if the Plan determines such services and supplies are in lieu of more expensive services and supplies, which would otherwise be required for the care and treatment of a Member.

ACCEPTANCE OF AGREEMENT

This means that You agree to all the provisions of this Policy, including any Riders, when You receive Plan benefits, when You pay Premium to Us for coverage under this Plan, and when You maintain the Policy more than ten days after it is delivered to You.

HEALTHYCT ID CARD

Always carry Your HealthyCT ID Card and present it whenever You receive services at the doctor's office, in an emergency room or Urgent Care Center, or at any other health care facility or pharmacy. You should use Your ID card when You receive prescriptions at Participating Pharmacies. If You call or write Our Member Services Department, give the representative Your ID number, so that We can serve You better.

If You lose Your HealthyCT ID card, contact Our Member Services Department or visit Our web site at www.healthyct.org to request a replacement.

COVERAGE

The Exchange enrollment form, Our Application/Change Form, and any other forms We request must be received by Us before a Qualified Individual can be considered a Member under this Plan.

You are responsible for providing to Us information about yourself and Your dependents that is complete, accurate and true to the best of Your knowledge and belief. Coverage is being provided to You under this Plan on the basis that You are a Qualified Individual and the information that You have provided to Us is truthful. If You make a fraudulent or intentional misrepresentation of a material fact, coverage may be cancelled.

In the event that there is a change in the name(s), address, telephone number(s) or email address(es) that You have provided to Us, You are responsible for telling Us and the Exchange as soon as possible about the change(s).

The Exchange enrollment form, Our Application/Change Form, and any other forms or statements that We may request, must be received and accepted by Us before the Qualified Individual will be considered for membership under this Plan. We reserve the right to accept or deny requested coverage based on the completion of an Exchange enrollment form and Our Application/Change Form by the Qualified Individual. If additional information is requested and is not received by Us within 45 days of the request, the Qualified Individual may be asked to reapply. If a Qualified Individual is denied coverage under this Plan, he/she cannot re-apply for coverage for up to 12 months, as determined by Us and the Exchange.

ELIGIBILITY AND ENROLLMENT

ELIGIBILITY RULES

Your eligibility and the eligibility of Your family members for coverage in this Plan as Qualified Individuals are determined by the Exchange.

The Exchange will determine if You and Your dependents can enroll in this Plan as a Qualified Individual. The Exchange uses the following eligibility rules to make that determination.

If You have any questions about enrollment, You may contact the Exchange at the telephone number listed in the "Important Telephone Numbers And Addresses" section.

Citizenship

The applicant (the person applying for coverage) must be:

- A citizen of the United States, or a national of the United States, or
- A non-citizen who is lawfully present in the United States, and reasonably expected to be a citizen, national, or a non-citizen who is lawfully present for the entire benefit period.

Incarceration

The person applying for coverage must not be incarcerated (in prison), other than in prison pending the completion of charges.

Residency

The person applying for coverage must reside or intend to reside in the Exchange Service Area of this Plan.

General Rules About You (The Subscriber)

You (the Subscriber) are eligible for coverage under this Plan as a Qualified Individual because You are:

- A resident of the Exchange Service Area of this Plan;
- Age 18 or over, unless coverage is provided under a child only policy;
- Not eligible for or enrolled in Medicare or Medicaid;
- Listed as the applicant on the application; and
- Approved by the Exchange.

General Rules about Your Eligible Dependents

Your Eligible Dependents are eligible for coverage under this Plan as Qualified Individuals if they are:

1. Your **spouse** – Your spouse must have a legally valid existing marriage license or documentation of civil union legally recognized by the State of Connecticut, and Your spouse must live with You or in the Exchange Service Area of this Plan.
2. Your **child** – Your child may be eligible for coverage under this Plan. Coverage of a child shall terminate no earlier than the policy anniversary date on or after whichever of the following occurs first, the date on which the child becomes covered under a group health plan through the dependent's own employment; or attains the age of 26. Each such policy shall cover a stepchild on the same basis as a biological child.

   The following rules apply to children:

   - **Natural Children**. Your natural children can be covered.
   - **Adopted Children**. Children legally adopted by You can be covered if they meet the rules for natural children once the adoption is final. Before the adoption becomes final, a child can be signed up for coverage when You become legally responsible for at least partial support for the child.
   - **Step-Children**. Your step-children who are the natural or adopted children of Your spouse, or children for whom Your spouse is appointed legal guardian, can be covered.
   - **Guardianship**. Children for whom You are appointed the legal guardian can be covered.
   - **Handicapped Children**. To continue to be covered beyond the allowable age for dependent children, the child must:
     - Be unable to support himself/herself by working because of a mental or physical handicap, as certified by the child's physician,
     - Be dependent on You or Your spouse for support and care because he/she has a mental or physical handicap, and

- Have become handicapped and continuously remained handicapped while he/she would have been able to be signed up for dependent children coverage if he/she were not disabled.
- Proof of the handicap and the child's financial dependence must be given to Us within 31 days of the date when the child's coverage would end under another insurer's plan, or when You enrolled under this Plan if the handicap existed before You enrolled for coverage under this Plan. You must give Us proof that the child's handicap and financial dependence continue if We ask for such proof. We will not ask for proof more than once a year.

- **Qualified Medical Child Support Orders (QMCSO).** Special rules apply when a court issues a QMCSO requiring You to provide health insurance for Your child. Enrollment may be required even in circumstances in which the child was not previously enrolled in this Plan and might not otherwise be eligible for coverage. We will not require the children to live with You, but they must live in the State of Connecticut in order to be covered.

ADDING ELIGIBLE DEPENDENTS

Adding a New Spouse

- If You get married, You must apply for coverage to add Your new spouse to this Plan. Your spouse's eligibility for coverage is subject to him/her being a Qualified Individual and Our acceptance based on review of the information on Your new spouse's Exchange enrollment form and Our Application/Change Form and his/her meeting the Plan's eligibility requirements.
- Coverage for Your new spouse will begin on his/her Effective Date. You are not required to wait until the next open enrollment period to apply for coverage for Your new spouse.

Adding a Newborn, Adopted Child or Step-Child

- The newborn natural child of You and Your covered spouse receives coverage for the first 61 days after birth. Coverage for the child will end on the day Your coverage ends or at the end of this 61-day period, whichever occurs first, unless You have added the newborn child to this Policy and paid any additional Premium, if applicable. If no additional premium is required (i.e., the child is added to a family policy in which there are already three covered dependents under age 21), the newborn will be covered by HealthyCT and no notification is required.
- If Your child is covered under this Plan, their newborn child can receive coverage ONLY for the first 61 days after the child's birth, unless You or Your covered spouse becomes the child's legal guardian and You are signed up under this Plan.
- A newly adopted child or a child for whom You become the legal guardian must apply for coverage within 31 days of the date of the adoption (or the date on which You or Your spouse become at least partially legally responsible for the adopted child's support and maintenance) or the date You became the legal guardian. If no additional premium is required (i.e., the child is added to a family policy in which there are already three covered dependents under age 21), the child will be covered by HealthyCT and no notification is required.

- A step-child must apply for coverage within 61 days of the date of Your marriage or civil union legally recognized by the State of Connecticut to the step-child's parent. If no additional premium is required (i.e., the child is added to a family policy in which there are already three covered dependents under age 21), the step-child will be covered by HealthyCT and no notification is required.

EFFECTIVE DATE OF COVERAGE

GENERAL RULE

The Exchange enrollment form or, in certain circumstances, Our Application/Change Form, and any other forms or statements the Exchange or We need, must be received and accepted by the Exchange or Us before a Qualified Individual will be considered for membership under this Plan.

Your right to coverage for You and Your dependents is subject to the condition that all of the information You provide is true, correct, and complete to the best of Your knowledge and belief. In addition, You are responsible for providing notification of all name and address changes. This Policy will take effect on the Effective Date.

OPEN ENROLLMENT PERIODS

Initial Enrollment Period

October 1, 2013 through December 15, 2013

If the Exchange receives a Qualified Individual's selection to enroll in this Plan on or before December 15, 2013, and the Qualified Individual's share of the first month's premium has been received by HealthyCT prior to January 1, 2014, the Qualified Individual's Effective Date will be January 1, 2014.

From December 16, 2013 through March 31, 2014

If the Exchange receives a Qualified Individual's selection to enroll in this Plan after December 15th, and the Qualified Individual's share of the first month's premium has been received by HealthyCT prior to the first day of the following month, the Qualified Individual's Effective Date of coverage will be the first day of the following month.

For example, when a completed Exchange enrollment form is received and accepted by the Exchange on December 20, 2013, and HealthyCT receives the Qualified Individual's share of the first month's premium on January 20, 2014, the Qualified Individual's Effective Date will be February 1, 2014.

Annual Open Enrollment

An annual open enrollment period is provided for Qualified Individuals each year. The annual open enrollment period will be from October 15th through December 7th beginning in 2014 (for coverage years beginning 2015).

During an annual open enrollment, Qualified Individuals may enroll in a Qualified Health Plan (QHP), and enrollees may change QHPs according to rules established by the Exchange.

Qualified Individuals are only permitted to enroll in a QHP, or as an enrollee to change QHPs, during the annual open enrollment period or a special enrollment period when the Qualified Individual has experienced a qualifying event.

American Indians may enroll in a QHP and move from one QHP to another QHP once per month.

Effective Date For Annual Open Enrollment Period

When a Qualified Individual has made a QHP selection during the annual open enrollment period, the Qualified Individual's Effective Date will be January 1st of the next year.

Special Enrollment Period

A special enrollment period is a period during which a Qualified Individual or enrollee who experiences certain qualifying events or changes in eligibility may enroll in, or change enrollment in, a QHP through the Exchange or another individual plan outside of the Exchange.

A Qualified Individual or enrollee has 60 days from the date of one of the following triggering events to select this Plan.

The Exchange will allow Qualified Individuals to enroll in or change from one QHP to another as a result of the following triggering events:

1. A Qualified Individual or dependent loses Minimum Essential Coverage.

   Loss of Minimum Essential Coverage includes loss of eligibility for coverage as a result of:
   - Legal separation or divorce;
   - Cessation of dependent status, such as attaining the maximum age;
   - Death of a Subscriber; or
   - Any loss of eligibility for coverage after a period that is measured by reference to any of the following:
     - Individual who no longer resides in the Exchange Service Area for this Plan, and
     - A situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual.

   Loss of Minimum Essential Coverage does not include termination or loss due to:
     - Failure to pay Premiums on a timely basis, or
     - Situations allowing for a rescission such as fraud or intentional misrepresentation of material fact.

2. A Qualified Individual gains a dependent or becomes a dependent through:
   - Birth,
   - Adoption,
   - Placement for adoption, or
   - Marriage or civil union legally recognized by the State of Connecticut.

   In the event of the birth of a child , the insured has 61 days to notify the Exchange and pay the additional premium, if any. If no additional premium is required (i.e., the child is added to a family policy in which there are already three covered dependents under age 21), the newborn will be covered by HealthyCT and no notification is required.

3. An individual who was not previously a citizen, national, or lawfully present individual gains such status.

4. A Qualified Individual's enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Exchange or HHS, or its instrumentalities as determined by the Exchange. When this occurs, the Exchange may take action, as may be necessary, to correct or eliminate the effects of the error, misrepresentation or inaction.
5. An enrollee adequately demonstrates to the Exchange that the QHP in which he/she is enrolled substantially violated a material provision of its contract in relation to the enrollee.
6. An individual is determined newly eligible or newly ineligible for Advance Payments of Premium Tax Credit or has a change in eligibility for Cost-Sharing reductions, regardless of whether the individual is already enrolled in a QHP.
7. The Exchange will permit individuals whose existing coverage through an eligible employer-sponsored plan will no longer be affordable or no longer provide minimum value for his/her employer's upcoming plan year to access this special enrollment period prior to the end of his/her coverage through such eligible employer-sponsored plan.
8. A Qualified Individual or enrollee gains access to a new QHP as a result of a permanent move.
9. An American Indian, as defined by federal regulation, may enroll in a QHP or change from one QHP to another one time per month.
10. A Qualified Individual or enrollee demonstrates to the Exchange that he/she meets other exceptional circumstances as the Exchange may provide.
11. A Qualified Individual or enrollee experiences any COBRA qualifying event.

Effective Date Of Special Open Enrollment Period

When the Exchange receives the Qualified Individual's selection to enroll in this Plan between the 1st and the 15th of the month, and the Qualified Individual's share of the first month's premium has been received by HealthyCT, the Effective Date for coverage is the 1st day of the month following the date the Exchange receives a Qualified Individual's selection to enroll in this Plan and HealthyCT has received the Qualified Individual's share of the first month's premium.

For example, when a completed Exchange enrollment form is received and accepted by the Exchange on July 10th, and payment is received by HealthyCT prior to August 1st, the Qualified Individual's Effective Date will be August 1st.

When the Exchange receives the Qualified Individual's selection to enroll in this Plan between the 16th and the last day of the month, the Effective Date for coverage is the 1st day of the 2nd month following the date the Exchange receives a Qualified Individual's selection to enroll in this Plan.

For example, when a completed Exchange enrollment form is received and accepted by the Exchange on July 25th, and payment of the first month's premium is received by HealthyCT on August 16th, the Qualified Individual's Effective Date will be September 1st.

Special Effective Date Rules

In the case of birth, adoption or placement for adoption, the Effective Date will be the date of the birth, adoption or placement for adoption.

In the case of marriage or civil union legally recognized by the State of Connecticut, or where a Qualified Individual loses Minimum Essential Coverage as described in paragraph 1 of this "Special Enrollment Period" subsection, the Effective Date will be on the 1st day of the following month after the qualifying event and notice to the plan.

WHEN A MEMBER IS AN INPATIENT AT THE TIME OF ELIGIBILITY

If You or Your covered dependents become eligible for coverage under this Plan while an inpatient at a Hospital, Hospice, Skilled Nursing Facility, Rehabilitation Facility or Residential Treatment Facility, the coverage under this Plan will be effective. Such services are not covered if the Member is covered by another health plan on that date and the other health plan is responsible for the cost of the services. You must notify Us when an inpatient stay occurs under these circumstances.

APPLICATION OF POLICY TO HEALTH SERVICES

This Policy applies to Health Services rendered on and after the Effective Date of this Policy. Medically Necessary Health Services and supplies are not covered if the patient is not enrolled as a Member under this Plan at the time the service or supply is rendered or received.

CHANGES AFFECTING ELIGIBILITY

You or Your authorized representative must tell the Exchange or Us about any change that may affect You or Your dependents covered under this Plan within 31 days of the date of that change. Examples of such changes are:

- Marriage or civil union legally recognized by the State of Connecticut
- Divorce or end of civil union legally recognized by the State of Connecticut
- Birth of Your child or of a child of Your child
- Dependent child getting coverage as an employee under a group health plan
- Child reaching maximum age limit for coverage under this Plan
- Change of home address
- Loss of eligibility for other reasons specified in this document

Upon the birth of Your child or of a child of Your child, You have 61 days to notify the Exchange should additional premium be required. Changes must be made through the Exchange and capture on an Exchange enrollment form, which is available at www.accesshealthct.com. You must return the Exchange enrollment form to Your broker or to the Exchange.

ELIGIBILITY FOR ADVANCE PAYMENTS OF PREMIUM TAX CREDIT OR REDETERMINATIONS OF ELIGIBILITY

You must contact the Exchange for information about Your eligibility for Advance Payments of Premium Tax Credit or Redeterminations of Your eligibility and that of Your Eligible Dependents.

The Exchange telephone number is listed in the "Important Telephone Numbers and Addresses" section.

MANAGED CARE RULES AND GUIDELINES

Your ability to obtain the benefits provided under this Plan depends on Your following the managed care rules and guidelines of this Plan. This Plan includes managed care rules and guidelines for such things as:

- Selection Of A Primary Care Provider (PCP)
- When You Need Specialized Care
- Services Requiring Prior-Authorization
- Using Participating Providers and Non-Participating Providers
- After Hours Care
- Cost-Shares You Are Required To Pay
- Medical Necessity and Appropriate Setting Of Care
- Utilization Management
- Quality Assurance
- New Technology
- Experimental Or Investigational
- Insufficient Evidence Of Therapeutic Value
- Member's Rights And Responsibilities
- Delegated Programs

SELECTION OF A PRIMARY CARE PROVIDER (PCP)

You and Your covered dependents ARE NOT REQUIRED TO SELECT A PCP, but We strongly encourage You to do so. A PCP can be an invaluable resource in providing and coordinating Your medical care, including routine care and follow-up care after the receipt of Emergency Services and Inpatient Care. PCPs are like health care managers and are made up of: doctors who maintain a general practice, pediatricians, family practitioners, and practitioners of internal medicine, as well as nurse practitioners. You and Your covered dependents do not all have to have the same doctor as a PCP. Each of You can have a different one. You and Your covered dependents can change PCPs at any time by calling or writing Our Member Services Department at the telephone number or address listed in the Important Telephone Numbers and Addresses section or by visiting Us at Our web site at **www.healthyct.org**. You should use the most current version of Our Provider Directory (or check Our web site at **www.healthyct.org**) and call Our Member Services Department to verify that the provider still continues to participate as a PCP under this Plan. In addition, by logging on to Our web site, You can also obtain the professional qualifications of a PCP, by clicking on the individual provider's name.

In the event that Your PCP is no longer contracting with Us or if he or she will no longer be treating patients at a certain office where You may have been receiving care, You will be notified 30 days before the effective date of that change, if possible, or as soon as possible after We become aware of the change. You will then have the option of selecting a new PCP. Please call Us if You need assistance.

WHEN YOU NEED SPECIALIZED CARE

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

SERVICES REQUIRING PRIOR-AUTHORIZATION

Prior Authorization is the medical necessity review prior to an admission or the provision of a health care service or a course of treatment, that such service or treatment be approved, in whole or in part, prior to such service's or treatment's provision. See Prior Authorization Addendum for services requiring this review. Participating Providers or Network Providers must get Prior Authorization of certain services, supplies or drugs when they are treating a Member before the Member gets that service, supply or drug.

WHEN PRIOR AUTHORIZATION IS DENIED

No benefits will be provided under this Plan if You or Your Eligible Dependents receive services or supplies after Prior Authorization has been denied. If You fail to comply with the Prior Authorization requirements of this Plan, and the service or supply would have been approved had there been a Prior Authorization request, there will be a Benefit Reduction (the lesser of $500 or 50% of the Maximum Allowable Amount We will pay per admission and/or service or supply, as applicable). The only time this will not happen is in those instances where We say it is the responsibility of the Participating Provider or Network Provider to request Prior Authorization. In those instances, benefits will not be reduced or denied if the provider fails to request Prior Authorization. Note: Benefit reductions do not apply to Emergency Services.

If You receive an explanation of benefits stating a claim was denied where it was the responsibility of the Participating Provider or Network Provider to request the applicable Prior Authorization You should contact Our Member Services Department, so We can help You resolve the issue.

URGENT/EMERGENT SERVICES – REQUIREMENTS FOR AUTHORIZATION

Request for authorization of urgent and emergent services for inpatient admissions must be made within twenty four (24) hours or the next business day by You, Your authorized representative or Your physician. An urgent care request means a request for a health care service or course of treatment for which the time period for making a non-urgent care request determination:

- could seriously jeopardize Your life or health or Your ability to regain maximum function; or
- in the opinion of a health care professional with knowledge of Your medical condition, would subject You to severe pain that cannot be adequately managed without the health care service or treatment being requested; or

- for a substance use disorder or for a co-occurring mental disorder, or for a mental disorder requiring:
  - inpatient services;
  - partial hospitalization;
  - residential treatment; or
  - intensive outpatient services necessary to keep You from requiring an inpatient setting.

If the Prior Authorization request is not approved, You and Your physician will have the Appeal/Grievance process available to You, as described in this document.

Please refer to the Prior-Authorization Addendum for an updated list of services requiring Prior-Authorization.

USING PARTICIPATING PROVIDERS AND NON-PARTICIPATING PROVIDERS

Please refer to the BENEFITS section for the differences in coverage between using a Participating Provider and Non-Participating Provider.

AFTER HOURS CARE

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

COST-SHARES YOU ARE REQUIRED TO PAY

Please refer to Your Benefit Summary for the applicable Cost-Share amounts of this Plan and any maximums this Plan may have. This Plan is administered on a calendar year basis.

MEDICAL NECESSITY AND APPROPRIATE SETTING OF CARE

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

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

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

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

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

UTILIZATION MANAGEMENT

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

QUALITY ASSURANCE

HealthyCT is dedicated to increasing the quality of care, stabilizing insurance premium costs, and providing access to affordable insurance. To accomplish this mission, HealthyCT will:

- Adhere to consumer cooperative principles of services and management.
- Reduce operational costs through the use of contracted services to perform “back office” functions.
- Establish the patient-physician relationship and Patient Centered Medical Home as cornerstones of the care delivery model.
- Promote safe clinical practices by educating members and providers about patient safety Support a partnership among members, providers, regulators and employers to promote effective health management, health education and disease prevention, and facilitate appropriate use of health care resources and services.
- Produce safe clinical practices and better outcomes for HealthyCT members through improved provider relationships and through the promotion of evidence-based health care.

NEW TECHNOLOGY

HealthyCT evaluates new technology and the new application of existing technology for inclusion in Our benefit plans, including medical and behavioral healthcare procedures, pharmaceuticals and devices, to keep pace with changes and to ensure that Members have access to safe and effective care.

Prior to approving a new technology or new application of existing technology for medical and behavioral healthcare procedures, pharmaceuticals and devices, it will be reviewed by a clinically appropriate health care professional that is actively practicing in the state of Connecticut.

HealthyCT utilizes the following process to review medical appropriateness for new technology or new uses for existing technology of procedures, treatments, therapies, drugs, biological products, equipment, devices, or supplies, which may be considered experimental/investigational. All three conditions must exist for coverage:

- If a technology improves health outcomes when standard therapies have not been effective in significantly improving the condition of the member or would not be medically appropriate. The technology would improve: length of life, ability to function and/or quality of life. The evidence must demonstrate that the technology measures or alters the physiological changes related to a disease, injury, illness, or condition. In addition, there should be evidence or a convincing argument based on established medical facts that such measurement or alteration affects health outcomes.
- The technology has final approval from appropriate government regulatory bodies (e.g., FDA "Approval to Market").
- The evidence consists of well-designed and well-conducted investigations published in peer-reviewed journals. The quality of the body of studies and the consistency of the results is considered in evaluating the evidence. The proposed treatment must be based on at least two documents of medical and scientific evidence such as:
    - Peer-reviewed scientific studies published in or accepted for publication.
    - Peer-reviewed literature, biomedical compendia and other medical literature that meet the criteria of the National Institutes of Health's National Library of Medicine.
    - Medical journals recognized by the Secretary of Health and Human Service.
    - Peer-reviewed abstracts accepted for presentation at major medical association meetings.

HCT will not deny a procedure, treatment or the use of any drug as experimental if such procedure, treatment or drug, for the illness or condition being treated, or for the diagnosis for which it is being prescribed, has successfully completed a phase III clinical trial of the federal Food and Drug Administration.

Once We complete Our review, if We determine the New Technology should be covered, the New Technology rendered after Our determination will be covered. There will be no retroactive coverage of a New Technology. If We determine the New Technology should not be covered by this Plan, then the New Technology will continue to be excluded and classified as experimental/investigational.

If Our decision not to cover the New Technology requires an exclusion to be added to the Plan, the words describing the new exclusion will be added to this Policy at the next renewal date.

In the case where a New Technology is a prescription drug with FDA approval for the use for which it is being prescribed, the medication will be covered at the highest tier Cost-Share level until Our pharmacy benefits manager's Pharmacy and Therapeutics (P&T) Committee has an opportunity to review it, unless it is in a class of medication that are specifically excluded as described in the Exclusions And Limitations section or in the Prescription Drug Benefit section of this Policy, if applicable. Such a New Technology may also require Prior-Authorization. When the P&T Committee does its review, they will decide if the medication will remain at the highest Cost-Share level or be switched to a lower Cost-Share level, and also whether the medication will have Prior-Authorization requirements or dosage limits placed on it. When You receive a medication that is considered a New Technology, the conditions under which You can receive the medication might change after the P&T Committee completes its review.

To obtain information about whether a procedure, medication, service, device or supply is a New Technology, or if a New Technology requires Prior-Authorization, or to obtain information about whether We have made Our determination with respect to a New Technology, contact Our Member Services at the appropriate telephone number listed in the Important Telephone Numbers and Addresses section.

EXPERIMENTAL OR INVESTIGATIONAL

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

A Treatment will not be denied as Experimental or Investigational if it has successfully completed a Phase III clinical trial of the FDA for the condition being treated or for the diagnosis for which it is prescribed. You may appeal a denial of coverage of an Experimental or Investigation Treatment pursuant to the appeals provisions of this Policy.

INSUFFICIENT EVIDENCE OF THERAPEUTIC VALUE

Any Treatment for which there is Insufficient Evidence of Therapeutic Value for the use for which it is being prescribed is not covered. For a further explanation of insufficient Evidence of Therapeutic Value, please see the Definitions section.

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

MEMBER'S RIGHTS AND RESPONSIBILITIES

Please refer to the Member's Rights and Responsibilities section.

DELEGATED PROGRAMS

We may use outside companies to manage and administer certain categories of benefits or services provided under this Plan. For example, Prior-Authorization may have to be obtained from an outside company rather than from HealthyCT. In addition, claims for Health Services might be processed by a company other than HealthyCT, or when You disagree with a decision regarding covered Health Services, Your Appeal may also be performed by an outside company. In these cases, when this Agreement refers to determinations, Prior-Authorizations, Referrals, and other decisions made under the terms of that Delegated Program, such determinations, Prior-Authorizations and other decisions are made by the outside company on Our behalf.

Pharmacy Benefits: Catamaran is a prescription benefit management company that supports pharmacy claims adjudication, pharmacy network management, medication management, voluntary mail order services, utilization management, and prospective and retrospective drug utilization review. Their services also include prior authorization, e-prescribing, member materials, and website services.

Pediatric Dental Benefits: Delta Dental services include dental benefit plan designs and administration, including claims processing, enrollment administration and fulfillment services, provider relations and network management, fraud & abuse detection and data analytics.

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

The telephone numbers and addresses of these Delegated Programs are listed in the Important Telephone Numbers and Addresses section of this Policy.

BENEFITS

Benefits for Medically Necessary Health Services provided under this Plan are subject to all the rules of this document. If You use Participating Providers for Your care, You will be eligible for the highest level of benefits under this Plan. This is called the "In-Network Level of Benefits."

If You use Non-Participating Providers to order, arrange or provide Your care, then You will be eligible for a lower level of benefits, called the "Out-Of-Network Level of Benefits." Please review Your Benefit Summary for the amounts You have to pay (Copayment, Deductible, Coinsurance amounts), and the benefit maximums of this Plan.

BENEFITS WHILE TRAVELING OR TEMPORARILY OUT OF SERVICE AREA

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

CONDITIONS REQUIRING EMERGENCY SERVICES

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

Any continuing treatment of an illness or injury that is provided by Non-Participating Providers and can be delayed for 24 hours or greater will not be covered unless written Prior Authorization is obtained first, as described noted on the Prior Authorization Addendum.

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

PREVENTIVE AND WELLNESS CARE

Some Participating Provider preventive and wellness services, as defined by the United States Preventive Service Task Force and those services recommended by the Health Resource and Services Administration, are exempt from all Member Cost Shares (Deductible, Copayment and Coinsurance) under the federal Patient Protection and Affordable Care Act (PPACA). These services are identified by the specific coding Your provider submits to HealthyCT. The service rendered must be coded as a preventive service.

Preventive Services are covered according to the following evidence- based guidelines which are periodically updated:

- Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- United States Preventive Services Task Force (Rated A&B); and
- Health Resources and Services Administration

If any diagnostic x-rays, lab or other tests or procedures are ordered or given in connection with any of the Preventive Care benefits described below, those x-rays, lab or other tests or procedures will not be covered as Preventive Care benefits. Those that are covered expenses will be subject to the cost sharing that applies to those specific services under this Policy.

The following preventive services are **covered when provided in a doctor's office:**

ROUTINE EXAMS AND PREVENTIVE CARE

Adults

Preventive Care Medical Services

Office visits for adult preventive care services (routine exams and preventive care) are **covered** in accordance with national guidelines. The following is a suggested schedule for adult preventive care services

Ages 22 to 49	Every 1-3 Years, as appropriate
Age 50 and Over	Annually, as appropriate

Gynecological Preventive Exam Office Services

Office visits for gynecological preventive exam office services (routine exams and preventive care) are **covered**.

The Member's doctor decides the number of times she should get periodic health evaluations and checkups.

Infants/Children

Infant/Children Preventive Care Services

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

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

Under Age 2	At months 1, 2, 4, 6, 9, 12, 15, 18 and 24
Ages 3 to 6	Every Year
Ages 8 and 10	Every Year
Ages 11 to 21	Every Year

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

Routine Eye Care

Routine eye care, including refraction (a test to determine whether You are near-sighted or far-sighted) for Members under age 19 is **covered**.

There is no coverage for adults' (Members age 19 and over) routine eye care.

Preventive Exams and Preventive Care Limitations

Unless specified in this "Routine Exams and Preventive Care" subsection, services **not** covered under this subsection include:

- Services which are covered to any extent under any other part of this Policy;
- Services which are for diagnosis or treatment of a suspected or identified illness or injury;
- Exams given during Your inpatient stay for medical care;

- Services not given by a physician or under his/her direction; and
- Psychiatric, psychological, personality or emotional testing or exams.

Routine Cancer Screening

The following routine cancer screenings are **covered** as noted in the following provisions:

Blood Lead Screening Exams and Risk Assessments

If the Member's Primary Care Provider decides that blood lead screenings and risk assessments are needed, they are **covered** as follows:

Lead Screening Exams

- At least annually for a child from 9-35 months of age.
- For a child 3-6 years of age who has not been previously screened or is at risk.

Risk Assessments

- For lead poisoning at least annually for a child 3-6 years of age.
- At any time in accordance with Connecticut State guidelines for a child age 36 months or younger.

Cervical Cancer Screening (Pap Tests)

Cervical cancer screenings (pap tests) for Members are **covered**.

The United States Preventive Services Task Force (USPSTF) recommends screening for cervical cancer with cytology (Pap smear) every three years for individuals ages 21 to 65 years. For individuals ages 30 to 65 years who want to lengthen the screening interval, screening with a combination of cytology and human papillomavirus (HPV) testing every five years.

Colorectal Cancer Screenings

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

If the screening is preventive, and the claim submitted by the physician is coded as preventive, a Member can receive one screening per year.

- If the screening is not preventive, the Member's doctor decides the number of times he/she should receive colorectal cancer screenings.

You **may** have to pay a Cost-Share for these screenings. The amount depends on where the procedure is received and Your Plan. For example, if You have a procedure done at a doctor's office, You may be required to pay an office services Cost-Share amount, but if the service is performed on an outpatient basis, either in a Hospital or in an Ambulatory Surgery Center, You may be required to pay an ambulatory services Cost-Share amount.

This Plan will not require the Member to pay:

- A deductible for a procedure that a physician initially undertakes as a screening colonoscopy or a screening sigmoidoscopy; or
- A coinsurance, copayment, deductible or other out-of-pocket expense for any additional colonoscopy ordered in a policy year by a physician for an insured, unless the Member is enrolled in one of Our HSA-qualified high deductible health plans (HDHPs).

Mammogram Screenings

Mammogram screenings are **covered**.

The following suggests how often mammogram screenings should be obtained, but the Member's doctor decides the number of times a Member should receive mammogram screenings.

Mammogram Screenings

Mammogram screenings are **covered**. The following suggests how often mammogram screenings should be obtained, but the Member's doctor decides the number of times a Member should receive mammogram screenings.

Ages 35 to 39	One baseline screening
Age 40 and over	One mammogram screening per year

In addition to the mammogram screenings noted above, comprehensive ultrasound screening of an entire breast or breasts is also **covered**.

Ultrasound screening of an entire breast or breasts is **covered**, if:

- A mammogram demonstrates heterogeneous or dense breast tissue based on the Breast Imaging Reporting and Data System established by the American College of Radiology; or
- A woman is believed to be at increased risk for breast cancer due to family history or prior personal history of breast cancer, positive genetic testing or other indications as determined by her physician or advanced practice registered nurse.

Magnetic Resonance Imaging (MRI) of an entire breast or breasts is **covered** in accordance with guidelines established by the American Cancer Society.

Some types of breast cancer screenings (e.g., when a Member has or is thought to have a clinical genetic disorder) require Prior-Authorization.

Prostate Screening

Prostate screening tests are covered when discussed and ordered by Your doctor for men who are symptomatic, or whose biological father or brother has been diagnosed with prostate cancer, and for all men 50 years of age or older. Treatment of prostate cancer is covered, provided such treatment is medically necessary and in accordance with the guidelines established by the National Comprehensive Cancer Network, the American Cancer Society or the American Society of Clinical Oncology.

Routine Cancer Screening Limitations

Unless specified in this "Routine Cancer Screenings" subsection, **there is no coverage under this subsection** for other services that are covered to any extent under any other part of this Policy.

OTHER PREVENTIVE SERVICES

Hearing Screenings

Hearing screenings are **covered**:

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

Immunizations

Immunizations (vaccine and injection of vaccine) are **covered.**

The following immunizations are **NOT** covered:

- Immunizations a Member receives only because someone else says he/she needs them (for example, to get a job or to go to camp).
- Immunizations received for travel.
- Immunizations and vaccinations for cholera, plague or yellow fever.
- Vaccinations an employer is legally required to provide because of an employment risk.

Newborn Care

Newborn children are **covered for the first 61 days following birth**.

Continued coverage for a newborn child requires the newborn to be signed up in this Plan within 61 days of his/her birth for coverage to continue past this initial 61 days , and additional premium paid, if applicable. If no additional premium is required (i.e., the child is added to a family policy in which there are already three covered dependents under age 21), the newborn will be covered by HealthyCT and no notification is required. There is no coverage after 61 days for a newborn who does not qualify as Your dependent child.

OUTPATIENT SERVICES

This Plan **covers** Medically Necessary services provided in the doctor's office, including consultations. It also **covers** Medically Necessary services in the Member's home to treat an illness or injury.

Abortion Services

Benefits include services for a therapeutic abortion, that is an abortion recommended by a Provider performed to save the life or health of the mother, or as a result of incest or rape. The Plan will also cover elective abortions. The Affordable Care Act specifically prohibits use of federal funds to pay for elective abortion services. As per federal law, $1.00 of your premium per month will be moved to a segregated abortion fund in order for HealthyCT to pay for any elective abortion procedures. If you do not pay $1.00 or more per month in premium, you may be billed separately for this amount.

Allergy Testing

Allergy testing with allergenic extract (or RAST allergen specific testing) is **covered.** In addition, allergy testing for medicine, biological or venom sensitivity is **covered**.

Chiropractic Services

Medically Necessary short-term chiropractic services include office visits and manipulation. These services are **covered up to the maximum benefit as shown on Your Benefit Summary** if they are expected to return function to the same level the Member had before he/she became injured or ill.
Chiropractic services require prior authorization. Please refer to Prior Authorization Addendum.

There is no coverage for chiropractic therapy that is long term or maintenance in nature.

Gynecological Office Services

Gynecological services in a doctor's office are **covered.**

Laboratory Services

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

Some genetic testing requires Prior-Authorization. Please refer to Prior Authorization Addendum.

Maternity Care Office Services

Maternity services (pre-natal and post-partum) in a doctor's office are **covered.** There may be a Cost-Share that the Member will have to pay for care related to pregnancy for each visit, even after the initial pre-natal office visit. The Cost-Share amount depends on where the services are received.

Outpatient Habilitative and Rehabilitative Therapy, Including Physical, Occupational and Speech Therapy

Medically Necessary short term outpatient habilitative therapy and rehabilitative therapy (including those services a Member receives at a day program facility or in an office) are **covered up to the combined outpatient habilitative and rehabilitative therapy, including physical, occupational and speech therapy, maximum benefit, as shown on Your Benefit Summary.**

Physical, occupational, and speech therapy coverage is **covered** as follows:

- The services must be ordered by a physician; and
- The services are limited to short term physical, occupational and speech therapy.

Services are no longer covered once therapeutic goals have been met or when a home exercise program is appropriate to achieve further gains.

Outpatient Physical Therapy, Habilitative Therapy, Rehabilitative Therapy, and Occupational Therapy require Prior-authorization.

Physical therapy for the treatment of temporomandibular joint (TMJ) dysfunction is not **covered.**

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

Primary Care Provider Office Services

When a Member has an injury or illness that does not require a special doctor to treat it and the care can be obtained in a Primary Care Provider's office, the services are **covered**.

Radiological Services

Medically Necessary outpatient diagnostic x-rays and therapeutic procedures are **covered**.

The services performed in a Hospital or radiological facility are **covered**.

Some radiology services require Prior-Authorization to be covered. Covered radiology services are:

- Computerized Axial Tomography (CAT),
- Magnetic Resonance Imaging/Magnetic Resonance Angiogram (MRI/MRA),
- Positron Emission Tomography (PET),
- Nuclear cardiology, and
- Single-photon emission computed tomography (SPECT).

Specialist Office Services

When a Member has an injury or illness that requires a special doctor to treat it and the care can be obtained in a Specialty Physician's office, the services are **covered**.

EMERGENT/URGENT CARE

Ambulance/Medical Transport Services

Emergency Services

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

Non-Emergency Services

Non-Emergency land or air ambulance/medical transport services for non-routine care visits will be **covered** only when Medically Necessary and with Prior-Authorization if the Member's medical condition prevents safe transport to a health care facility by any other means, as determined by Us.

Ambulance/medical transportation services will also be **covered**, if the Member is in-patient at an acute care facility and needs air transportation to another acute care facility because Medically Necessary services to help the Member are not available in the facility where the Member is confined.

There is no coverage for ambulance services that are non-Medically Necessary, including chair car to and from a provider's office for routine care, or if the transport services are for a Member's convenience.

Emergency Services

Emergency Services provided both within and outside of the Service Area are **covered**, whether a Member receives Emergency Services from a Participating Provider or a Non-Participating Provider. You may be responsible to pay a bill submitted to You by Non-Participating Providers for their charges over and above the

amount paid by Us.

In the event of an Emergency, the Member should get medical assistance as soon as possible. In an emergency, 911 should be called and/or the Member should get care from:

- The closest emergency room; or
- A Participating Hospital emergency room.
- If possible, You or Your representative should contact Your Primary Care Provider (PCP) **or, for mental health care or alcohol and substance abuse Emergencies, Your practitioner or Our Behavioral Health Program** prior to obtaining care, so Your PCP, Your practitioner or Our Behavioral Health Program can be involved in the management of Your health care.

Determination of whether a condition is an Emergency rests with Us.

Urgent Care/Walk-In Care

Urgent Care

Urgent Care is **covered**. The following rules apply to the use of an Urgent Care Center:

- Use an Urgent Care Center only when Your doctor is unable to provide or arrange for the treatment of an illness or injury.
- If You want the follow up care to be covered at the highest level of benefits that this Plan offers, then You must use a Participating Provider.
- Continuing care and follow-up care in an Urgent Care Center are not covered, even if the center is a Participating Provider. However, the removal of stitches is covered, if the same Urgent Care Center used to obtain the stitches is used to take them out.

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

Walk-In Care

Walk-in care is **covered**. The following rules apply to the use of a Walk-In Care Clinic:

- Use a Walk-In Care Clinic only when Your doctor is unable to provide or arrange for the treatment of common ailments like:
    - Colds, flu symptoms, sore throat, cough or upper respiratory symptoms,
    - Ear or sinus pain,
    - Minor cuts, bruises, or scrapes,
    - Rash, hives, stings and bites,
    - Sprains

NOTE: The use of a Walk-In Care Clinic is usually less expensive than the use of an Urgent Care Center

There is no coverage for routine physical exams or follow-up care at an Urgent care Center or Walk-In Care Clinic.

AMBULATORY SERVICES (OUTPATIENT)

Medically Necessary ambulatory services (outpatient) are **covered.** Ambulatory services include procedures performed by a doctor on an outpatient basis, whether in a Hospital, at a Hospital Outpatient Surgical Facility,

at an Ambulatory Surgery Center, or at a birthing center.

There may be a Cost-Share that You will have to pay for Medically Necessary ambulatory surgery or certain radiological diagnostic procedures.

Some Ambulatory Services require Prior-Authorization. Please refer to Prior Authorization Addendum.

INPATIENT SERVICES

Hospital Services

Prior-Authorization Rules For Non-Emergencies

All non-Emergency Inpatient admissions must be Prior Authorized at least fifteen (15) business days before the Member is admitted.

Special Prior-Authorization rules apply to transplant services. Prior-Authorization must be obtained at least fifteen (15) business days before any evaluative transplant services are performed.

General Hospitalizations

Medically Necessary inpatient Hospital services generally performed and usually provided by acute care general Hospitals are **covered when the hospitalization is authorized.**

Examples of covered inpatient Hospital Health Services are:

- Anesthesia and oxygen services
- Autologous blood transfusions (self-donated blood)
- Doctor services
- Drugs and biologicals
- Intensive care unit and related services
- Laboratory, x-ray and other diagnostic tests
- Operating room and related facilities
- Room and board in a semi-private room
- Therapy: cardiac rehabilitation, inhalation, occupational, physical, pulmonary, radiation, and speech.

Dental Anesthesia

Medically Necessary anesthesia, nursing and related Hospital services for the treatment of dental conditions are only **covered** when:

- The services, supplies or medicines are Medically Necessary as determined by the Member's dentist or oral surgeon and his/her Primary Care Provider (PCP); and
- The treatment is Prior-Authorized; and
- A licensed dentist and a doctor specializing in primary care decide the Member has a complicated dental condition that requires treatment be done in a Hospital; or
- A licensed doctor specializing in primary care decides the Member has a developmental disability that puts the Member at serious risk.

Medically Necessary anesthesia for the treatment of dental conditions may also be covered in an outpatient

setting as long as all four conditions above are met.

Outpatient facility and anesthesia charges are **covered** if the Member needs to have dental services performed in an outpatient facility because the Member has a serious medical condition that requires close monitoring or treatment during the procedure. Please see Pediatric Dental section of this Policy for further information on coverage of dental services for children up to age 18.

Mastectomy Services

Health Services for a mastectomy or lymph node dissection are **covered**.

- If the Member is admitted to a Hospital, We will cover a minimum of a 48-hour length of stay following the mastectomy or lymph node dissection. We will cover a longer stay if the Member's doctor recommends it.
- If medically appropriate, and if the Member and his/her attending doctor approve, the Member may choose a shorter Hospital length of stay or have the services performed in an outpatient facility.

Maternity Services

Inpatient Services

Any Member who is admitted to a Hospital to have her baby will be covered for a minimum of a 48-hour length of stay for a vaginal delivery and a minimum of a 96-hour length of stay for a caesarean delivery. The time periods begin when the baby is delivered.

Post-Discharge Benefits

If the Member and her newborn baby stay in the Hospital for the 48 or 96-hour period, the following post-discharge home health services will be **covered**:

- One skilled nursing visit by a maternal child health nurse from a Home Health Agency (requires Prior-Authorization from Us).
- Comprehensive lactation visits at home up to two months after the delivery (requires Prior Authorization from Us).

Optional Early Discharge Programs

If medically appropriate, and if the Member and her attending doctor both approve, a Member may choose a shorter Hospital length of stay. If the Member agrees to an earlier discharge, the following care is available:

- A home visit within 48 hours of discharge; and
- An additional follow-up visit within 7 days of discharge.

In these situations, the same home health services noted above will be **covered.**

Testing for Bone Marrow

Expenses arising from human leukocyte antigen testing (also known as histocompatibility locus antigen testing) for A, B or DR antigens for use in bone marrow transplantation are **covered** when the testing is performed in a facility both accredited by the American Society for Histocompatibility and Immunogenetics and certified under

the Clinical Laboratory Improvement Act of 1967.

Coverage for the testing is limited as follows:

- To a Member who, at the time of the testing, completed and signed an informed consent form that also authorizes the results of the test to be used for participation in the National Marrow Donor Program.
- One testing per Member per lifetime.

Solid Organ Transplants and Bone Marrow Transplants

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

The following organ transplants are **covered**:

- Bone marrow
- Cornea
- Heart
- Heart-lung
- Intestinal
- Kidney
- Liver
- Lung
- Pancreas
- Pancreas-kidney

Bone marrow procedures such as autologous or allogeneic transplants, or peripheral stem cell rescue, or any procedure similar to these, are considered "organ transplants" under this Plan and are subject to its provisions.

Transplant Prior-Authorization Rules

Except for cornea transplants, all requests for transplants and related services require Prior-Authorization at the time of diagnosis. **Prior-Authorization must be obtained at least ten business days before any evaluative services have been received.**

If Prior-Authorization has not been obtained, payment for the transplant and related services, as well as for medical diagnosis and evaluation, will be reduced or denied as described in this document.

A Member may use any provider for transplants. However, to obtain the In-Network Level Of Benefits, You must use a Participating Provider. By using a Participating Provider You reduce Your out-of-pocket expenses.

Donor Benefits

Medically Necessary expenses of organ donation, including Medically Necessary services and tests to determine if the organ or the bone marrow/stem cell type is a suitable match, are **covered**.
Donor coverage is only available if the transplant recipient is Our Member and Prior-Authorization for evaluation has been obtained.

Transportation, Lodging and Meal Expenses for Transplants

Expenses for transportation, lodging and meals for the Member receiving the transplant and for one companion of the Member are covered

The transplant facility must be located outside of Connecticut and be more than 300 miles from where the Member receiving the transplant lives for this reimbursement to apply.

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

If air transportation is chosen, coverage includes round trip transportation for the transplant recipient and one other individual accompanying the recipient.

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

Lodging and meal expenses are covered for the transplant recipient and the individual accompanying the transplant recipient

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

In order for Us to approve payment, transportation, lodging and meal receipts must be sent to Us at the appropriate address listed in the information You will receive from Us.

There is no coverage for the following expenses:

- Any expenses for anyone other than the Member receiving the transplant and one companion.
- Any expenses other than the transportation, lodging and meals described in this provision.
- Local transportation costs while at the transplant facility.
- Rental car costs.

Skilled Nursing and Rehabilitation Facilities

Medically Necessary skilled nursing care is **covered up to the maximum benefit as shown in Your Benefit Summary** if such care is provided:

- At a Skilled Nursing Facility,
- At an acute Rehabilitation Facility, or
- On a specialized inpatient rehabilitation floor in an acute care Hospital.

Skilled Nursing and Rehabilitation Facilities Limitations

The following limitations and conditions apply to the Skilled Nursing Facility/Rehabilitation Facility benefits:

- In order to be covered, the skilled nursing care must be for intense rehabilitation or sub-acute medical services, or as a substitution for inpatient Hospitalization.
- The care must be ordered by a doctor. The doctor's order must specify the skills of qualified health professionals such as registered nurses, physical therapists, occupational therapists, or speech pathologists, required for the Member's care in the facility.

- Admissions and continued stay requests will be reviewed by Us using nationally recognized measures to determine if the skilled nursing care will result in significant functional gain or improvement to the Member's medical condition.
- The services in the Skilled Nursing Facility/Rehabilitation Facility must be provided directly by, or under the supervision of, a skilled health professional, and admission must be Prior-Authorized by Us.

There is no coverage for Long Term Care or Custodial Care.

BEHAVIORAL HEALTH (MENTAL HEALTH SERVICES)

Coverage for behavioral health (mental health services) under this Plan is administered under Our internal Behavioral Health Program. Decisions regarding mental health coverage are made by licensed mental health professionals.

Inpatient Mental Health Services

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

Prior-Authorization is required for certain Inpatient Mental Health Services, which are listed in the Prior Authorization Addendum.

Inpatient Alcohol and Substance Abuse Services

Medically Necessary inpatient services, supplies and medicine in connection with medical complications of alcoholism, such as cirrhosis of the liver, gastrointestinal bleeding, pneumonia and delirium tremens, , are **covered** in compliance with Connecticut state mandates just as they would be for any other illness or injury as described in the "Hospital Services" section. Benefits also include coverage for Medically Necessary inpatient services, supplies and medicine to treat substance abuse.

Prior-Authorization is required for inpatient alcohol and substance abuse services.

Outpatient Mental Health and Alcohol and Substance Abuse Treatment

Medically Necessary outpatient services for the diagnosis and treatment of mental illnesses are **covered** in compliance with CT State Mandates just as they would be for any other illness or injury as described in the "Outpatient Services" section. Benefits also include coverage for treatment for alcohol and substance abuse. The services must be provided by a licensed mental health provider.

There is no coverage for behavioral health conditions with the following diagnoses:

- Caffeine-related disorders,
- Communication disorders,
- Learning disorders,
- Mental retardation,
- Motor skills disorders,
- Relational disorders,

- Sexual deviation, or
- Other conditions not defined as mental disorders in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders."

OTHER SERVICES

Home Health Services

Medically Necessary home health services must be provided by a Home Health Agency and Prior-Authorized. Home health services are **covered**, if:

- We determine that Hospitalization or admission to a Skilled Nursing Facility would otherwise be required; or,
- The Member is diagnosed as terminally ill and his/her life expectancy is six months or less; or
- A plan of home health care is ordered by a physician and approved by Us.
- The home health services must be medical and therapeutic health services provided in the Member's home, including:
    - Nursing care by a registered nurse or licensed practical nurse;
    - Social services by a Masters-prepared social worker provided to, or on behalf of, a terminally ill Member;
    - Physical, occupational or speech therapy;
    - Hospice care for a terminally ill patient (i.e., having a life expectancy of six months or less); or
    - Certain medical supplies, medications and laboratory services.

There is no coverage for:

- Custodial Care
- Convalescent care
- Domiciliary care
- Long term care
- Rest home care, or
- Home health aide care that is not patient care of a medical or therapeutic nature.

The benefit maximum does not apply to Hospice care.

Disposable Medical Supplies and Durable Medical Equipment (DME), Including Prosthetics

Disposable Medical Supplies

Some, but not all, disposable medical supplies, which are used with covered durable medical equipment or covered medical treatment received in the home, are **covered**.

The following limitations and conditions apply:

- Disposable medical supplies must be ordered by a physician. Please note, having a doctor's order is not a guarantee that the disposable supplies are covered.
- Disposable medical supplies will also be covered if they are dispensed in:
    - A physician's office as part of the physician services; or

  - An emergency room as part of Emergency Services; or
  - An Urgent Care Center as part of Urgent Care.
- Any item which is not covered by the federal Medicare program is not covered by HealthyCT unless otherwise specified.
- We have the right to change the list of covered disposable medical supplies from time to time.

Durable Medical Equipment (DME), Including Prosthetics

Durable Medical Equipment (DME) including prosthetics consists of non-disposable equipment which is primarily used to serve a medical purpose that is generally not useful to a person in the absence of illness or injury and is appropriate for use in the home. DME is **covered**.

The following limitations and conditions apply:

- DME must be ordered by a physician. Please note, having a doctor's order is not a guarantee that the DME is covered.
- The equipment must be provided by a DME Participating Provider in order for the DME to be covered at the highest level of benefits.
- A number of DME requires Prior-Authorization before it will be covered. The DME that requires Prior-Authorization is listed in the "Prior-Authorization Addendum" section.
- We reserve the right to limit the payment of charges up to the most cost efficient and least restrictive level of service or item which can be safely and effectively provided.
- Any DME which is not covered by the federal Medicare program is not covered by HealthyCT unless otherwise specified.
- DME may be authorized for rental or purchase based on the expected length of medical need and the cost/benefit of a purchase or rental. We will decide whether DME is to be rented or purchased. If a rental item is converted to a purchase, the Cost Share the Member pays for the purchase will be based on only the balance remaining to be paid in order to purchase the equipment.
- DME will be covered without Prior-Authorization if it is dispensed in:
  - A physician's office as part of physician services;
  - An emergency room as part of Emergency Services; or
  - An Urgent Care Center as part of Urgent Care.
- Hearing aids for a Member age 12 and under are covered up to one hearing aid every 24 months.
- Wigs prescribed by an oncologist for a Member suffering hair loss as a result of chemotherapy or radiation therapy are covered without Prior-Authorization.
- To be covered, DME must not duplicate the function of any previously obtained equipment.

Disposable Medical Supplies and Durable Medical Equipment (DME), Including Prosthetics Exclusions And Limitations

There is no coverage for medical supplies, equipment or prosthetics that are not durable or that are not on Our list of covered equipment. Examples of excluded supplies and equipment include, but are not limited to:

- Any item not primarily medical in nature or not mainly used in the treatment of disease or injury
- Any item or service which is not covered by the federal Medicare program

- Assistive technology and adaptive equipment, including but not limited to:
  - Communication boards, computers, equipment or devices
  - Gait trainers
  - Prone standers
  - Supine boards
  - Other equipment not intended for use in the home
- Beds, bedding and bed-related items
- Clothing or body wear, except as otherwise covered in the "Benefits" section
- Comfort or convenience items
- Furniture or modifications to furniture
- Home climate control devices
- Tubs, spas or saunas
- Compression and cold therapy devices
- Compression or anti-embolism stockings
- Cryotherapy; polar packs
- Exercise equipment
- Foot orthotics, except if the Member is diabetic
- Hearing aids, except as described in this subsection
- Home or automobile equipment or modifications
- Items used to perform or assist with personal hygiene
- Lifts of any type
- Mechanical stretch devices for treatment of joint stiffness (pre- or post-surgery) or joint contractures
- Myoelectric or electronic prosthetic devices
- Power mobility devices, such as wheelchairs or scooters
- Pneumatic compression devices for the treatment of lymphedema or the prevention of deep vein thrombosis
- TENS units or other neuromuscular stimulators and related supplies, either internal or external, for the treatment of pain or other medical conditions
- Wigs, hair prosthetics, scalp hair prosthetics or cranial prosthetics, except as described in this subsection

Ostomy Supplies And Equipment

Medically Necessary disposable medical supplies and durable medical equipment for ostomy care are **covered**.

Examples of covered ostomy supplies and equipment are: collection devices, irrigation equipment and supplies, skin barriers and skin protectors.

Ostomy Supplies Limitations

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

- Ostomy supplies and equipment must be prescribed or ordered by a doctor as a result of surgery.
- To obtain the supply or equipment, the Member must present the prescription or doctor's order to

the provider that is selling the supply or equipment.

- Ostomy supplies or equipment will also be covered if dispensed in:
  - A doctor's office as part of doctor services,
  - An emergency room as part of Emergency Services, or
  - An Urgent Care Center as part of Urgent Care.

ADDITIONAL SERVICES

Autism Services

Medically Necessary diagnosis and treatment of Autism Spectrum Disorders (ASDs), identified and ordered in a treatment plan developed by a licensed doctor, psychologist or clinical social worker pursuant to a comprehensive evaluation are **covered**:

- Behavioral Therapy for children up until their 15th birthday, when provided or supervised by a behavioral analyst who is certified by the Behavioral Analyst Certification Board, or by a licensed doctor, or by a licensed psychologist.
- Direct psychiatric or psychological services and consultations provided by a licensed psychiatrist or by a psychologist.
- Occupational, physical, and speech/language therapy provided by a licensed therapist.
- This occupational, physical, and speech/language therapy benefit is not subject to any benefit maximum for outpatient rehabilitative therapy listed on Your Benefit Summary.
- Prescription drugs when prescribed by a physician, by a doctor's assistant or by an advanced practice registered nurse for the treatment of symptoms and comorbidities of ASD, as covered under Our Prescription Drug Benefit.

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

Birth to Three Program (Early Intervention Services)

Early intervention services consist of care as part of an Individualized Family Service Plan as prescribed by State law and are available for a Member from his/her birth until his/her third birthday.

Any Member Cost-Share amount depends on where the procedures are rendered.
Any benefit amount paid for early intervention services does not:

- Count towards any benefit maximums this Plan may have, except as permitted under the law, or
- Negatively affect the eligibility of coverage under this Plan to the child, the child's parent or the child's family members who are Members under this Plan, or
- Constitute a reason for Us to rescind or cancel the Member's coverage under this Plan.

Cardiac Rehabilitation

Cardiac rehabilitation is **covered.**

Phases I, II, and III cardiac rehabilitation are **covered** if it is ordered by a doctor and received in a structured setting.

Phase IV Cardiac rehabilitation is **not covered**.

Casts and Dressing Application

Application of casts and dressings is **covered**.

Clinical Trials

Certain routine care for a Member who is a patient in a disabling or life-threatening chronic diseases clinical trial, such as for cancer, is **covered** just as routine care would be covered under this Plan if the Member were not involved in a disabling or life-threatening chronic diseases clinical trial. All of the terms and conditions of this document apply.

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

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

The State of Connecticut Insurance Department has issued a standardized form that must be used when a Member asks Us to cover routine care costs in a clinical trial.

Denials are subject to the State of Connecticut utilization review external Appeal/Grievance program.

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

- Evidence that the Member meets all of the selection criteria for the trial;
- Evidence that the Member has given appropriate informed consent to the trial;
- Copies of any medical records, rules, test results or other clinical information used to enroll the Member in the trial;
- A summary of how the expected routine care costs would exceed the costs for standard treatment;
- Information about any items or services (including routine care) that may be paid for by another entity, including the name of the company paying for the trial; and/or
- Any other information We may reasonably need to review the request.

There is no coverage for the following:

- Cost of non-Health Services;
- Cost of Experimental Or Investigational medicines or devices not approved for sale by the FDA;
- Costs that are inconsistent with the most accepted and established regional or national standards of care for a particular diagnosis, or costs for services that are performed just to meet the requirements of the trial;
- Costs that would not be covered by this Plan for a non-Experimental or Investigational treatment;
- Facility, ancillary, professional services and medicine costs paid for by grants or funding for the trial;
- Routine costs that are payable by another entity; and/or
- Transportation, lodging, food or other travel expenses for the Member or any family member or

companion of the Member.

Corneal Pachymetry

Medically Necessary corneal pachymetry (measurement of the thickness of the cornea) is **covered**. Coverage is available for one complete test per lifetime without Prior-Authorization.

Craniofacial Disorders

Medically Necessary orthodontic treatment and appliances for the treatment of craniofacial disorders are **covered** for Members age 18 and younger, if the treatment and appliances are prescribed by a craniofacial team recognized by the American Cleft Palate-Craniofacial Association and if Prior-Authorized by Us.

Diabetes Services

All Medically Necessary laboratory and diagnostic tests for diabetes and all Medically Necessary services, supplies, equipment, and prescription drugs when ordered by a doctor for the treatment of diabetes (including treatment for routine foot care) are **covered**.

Education

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

Benefits cover:

- Up to ten hours of initial training for a Member who is first diagnosed with diabetes for the care and management of diabetes, including counseling in nutrition and proper use of equipment and supplies for the treatment of diabetes; and
- Up to four hours for Medically Necessary training and education as a result of an additional diagnosis by a doctor of a major change in the Member's symptoms or condition that requires a change of his/her program of self-management of diabetes; and
- Up to four hours for Medically Necessary training and education as a result of new techniques and treatment for diabetes.

Prescription Drugs and Supplies

Prescription drugs and supplies for the treatment of diabetes are **covered** subject to the rules of Our ***Prescription Drug Benefit***, including its Cost-Share provisions. If a Member obtains these same supplies for the treatment of diabetes from a supplier that is not a Participating Pharmacy, the supplies are covered as described in the "Disposable Medical Supplies" section.

Prescription drugs administered by a needle, which are not obtained from a doctor or from a Home Health Agency, are **covered** Health Services under Our ***Prescription Drug Benefit***.

Drug Ingestion Treatment (Accidental)

Medically Necessary services needed to treat the accidental ingestion or consumption of a controlled drug are **covered**.

Drug Therapy (Outpatient/Home)

Medically Necessary Drug Therapy is **covered**.

Some Drug Therapy requires Prior-Authorization.

Drug Therapy services include all drugs administered by a licensed provider in an outpatient Hospital facility, an infusion center or the Member's home.

Eye Care

Diseases and Abnormal Conditions Of The Eye

Medically Necessary medical and surgical diagnosis and treatment of diseases or other abnormal conditions of the eye and structures next to the eye are **covered**. This coverage includes annual retinal eye exams for Members with an existing condition of the eye, such as glaucoma or diabetic retinopathy. The Cost-Share amount depends on where the services are received.

Eyeglasses and Contact Lenses

Prescription lenses, frames, and prescription contact lenses for Members under age 19 are **covered up to the maximum benefit, as shown on Your Benefit Summary**.

There is no coverage for adults' (Members age 19 and over) eyeglasses and contact lenses.

Genetic Testing

The newborn genetic screening program as defined by the State of Connecticut is covered without prior authorization. Some molecular genetic testing is **covered** when a Member has or is thought to have certain clinical genetic conditions.

Coverage for molecular genetic testing will be available only:

- When the Member has obtained genetic counseling from either a genetic counselor or a board-certified or board-eligible geneticist; and
- An appropriate evaluation has been performed consisting of:
    - A complete history;
    - A complete physical examination;
    - Conventional diagnostic studies; and
- Three generation pedigree charts; and
- When a diagnosis cannot be made using routine history, physical examination, and diagnostic testing and there remains the possibility of a genetic condition that will affect the Member's health; and
- When the result of the molecular genetic testing will directly impact the Member's treatment.

Some genetic tests require Prior Authorization.

In addition to these genetic testing services, some pre-implantation genetic testing in the setting of in-vitro fertilization (IVF), gamete intra-fallopian transfer (GIFT), zygote intra-fallopian transfer (ZIFT) and low tubal ovum transfer procedures are **covered**. Please see the "Infertility Services" subsection for more information.

There is no coverage for:

- All other genetic testing services, as well as genetic testing panels not endorsed by ACOG or ACMG;
- Genetic testing kits available either direct to the consumer or via a physician prescription;
- Genetic testing only for the benefit of another family member;
- Genetic testing to guide personalized medicine, Pharmacogenetics or Pharmacogenomics; and
- Whole genome or whole exome genetic testing.

Hospice Care

Medically Necessary Hospice care is **covered** if the Member has a life expectancy of six months or less and if the care is Prior-Authorized by Us. The Member's doctor must contact Us to arrange Hospice care. Hospice care does not apply to any specific benefit maximums Your Plan may have.

Hospital Care

Visits a doctor makes to examine or treat a Member who is hospitalized are **covered**.

Infertility Services

This Plan covers Medically Necessary diagnostic and testing procedures and therapy needed to treat diagnosed Infertility **up to the limits described below,** if Prior-Authorized by Us for a Member up to his/her 40th birthday, including but not limited to:

- Ovulation induction (to a maximum of four cycles);
- Intrauterine insemination (to a maximum of three cycles per recipient, regardless of source);
- Uterine embryo lavage, in-vitro fertilization (IVF), gamete intra-fallopian transfer (GIFT), zygote intra-fallopian transfer (ZIFT) or low tubal ovum transfer (to a maximum of two cycles combined for all procedures, with not more than two embryo implantations per cycle). These cycles are only covered when the Member has been unable to conceive or produce conception or sustain a successful pregnancy through the less expensive and medically appropriate treatments covered by this Plan.

A particular Infertility treatment or procedure need not be tried first if the Member's treating Board Eligible or Board Certified Reproductive Endocrinologist certifies that such treatment or procedure is unlikely to be successful.

Pre-implantation genetic testing is covered when Medically Necessary and Prior-Authorized, as part of a Prior-Authorized IVF, GIFT, ZIFT or low tubal ovum transfer procedure, if embryos are at risk for known genetic mutations. Pre-implantation genetic testing to determine the gender of an embryo is covered only when there is a documented risk of an x-linked disorder.

Prescription drugs (medications) to treat Infertility also require Prior-Authorization. These drugs or medications are only available for the gender indicated by the federal Food and Drug Administration (FDA) and are covered subject to the rules of Our Prescription Drug Benefit.

There is no coverage for:

- Cryopreservation (freezing) or banking of eggs, embryos, or sperm;
- Genetic analysis and testing, except as described above or in the "Genetic Testing" section;

- Medicines and devices for sexual dysfunction;
- Recruitment, selection and screening and any other expenses of donors (donors of eggs, embryos or sperm);
- Reversal of surgical sterilization; or
- Surrogacy and all charges associated with surrogacy such as prescription drugs or egg harvesting, fertilization or implantation, except when the egg harvesting is performed on the Member.

Lyme Disease Services

Medically Necessary treatment of Lyme Disease is **covered** as follows:

- Up to a maximum of 30 days of intravenous antibiotic therapy, 60 days of oral antibiotic therapy, or both; and
- Further treatment if it is recommended by a board certified rheumatologist, infectious disease specialist or neurologist.

Antibiotic drugs are **covered**, subject to the rules of Our **Prescription Drug Benefit**.

Neuropsychological Testing

Neuropsychological testing of children diagnosed with cancer, ordered by a licensed physician, to assess the extent of any cognitive or development delays in such child due to chemotherapy or radiation treatment is **covered without Prior Authorization**. All other neuropsychological and psychological testing requires Prior Authorization to establish the medical necessity.

Medically Necessary psychological, neuropsychological or neurobehavioral testing is **covered** only when performed by an appropriately licensed neurologist, by a psychologist or by a psychiatrist.

Nutritional Counseling

Coverage for nutritional counseling services is limited to **two visits per Member per year**. Nutritional counseling must be for illnesses requiring therapeutic dietary monitoring, including the diagnosis of obesity. In addition, the services must be prescribed by a licensed health care professional and provided by a certified, registered or licensed health care professional.

Nutritional Supplements and Food Products

Enteral or Intravenous Nutritional Therapy

Medically Necessary enteral (tube feeding) or intravenous nutritional products are **covered** when ordered by a doctor, if they are needed for a medical illness or injury, are to be used for the total caloric needs of the Member.

Oral nutritional products (except for Modified Food Products for Inherited Metabolic Diseases and Other Specialized Formulas) that are specially changed to allow them to be taken through an irregular gastrointestinal tract are **covered** when:

- They are ordered by a doctor;
- They are needed due to a gastrointestinal illness or injury preventing them from being taken normally; and

- They are to be used for the total caloric needs of a Member.

Modified Food Products for Inherited Metabolic Diseases

Medically Necessary modified food products (low protein) and amino acid modified preparations are **covered** for the treatment of the following inherited metabolic diseases:

- Biotinidase deficiency
- Congenital adrenal hyperplasia
- Cystic fibrosis
- Galactosemia
- Homocystinuria
- Hypothyroidism
- Inborn errors of metabolism, as described by the Department of Public Health
- Maple syrup urine disease
- Phenylketonuria (for which newborn screening is required)
- Sickle cell disease

To be covered, the modified food products (low protein) and amino acid preparations must be ordered for the therapeutic treatment of one of the inherited metabolic diseases noted above by a doctor and administered under his/her direction.

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

Other Specialized Formulas

Specialized formulas are **covered** for a Member up to his/her 12th birthday when the formula does not have to be part of the general nutritional labeling requirements of the federal Food and Drug Administration and its intended use is solely for the dietary management of specific diseases or conditions. The formula must be Medically Necessary, ordered by a doctor, and administered under his/her direction.

Except as noted above, no other nutritional supplements, food supplements, infant formulas, enteral nutritional therapies or specialized formula are covered.

Pain Management Services

Medically Necessary pain management services provided by a doctor (including evaluation and therapy) for short or long term pain conditions are **covered**.

Prescription Contraception

Prescription contraception methods approved by the federal drug administration (FDA) are **covered at no Cost-Share when they are obtained at a Participating Pharmacy**.

Benefits include the following:

- Cervical caps

- Diaphragms
- Intrauterine Devices (IUDs)
- Oral contraceptives

Renal Dialysis

Medically Necessary renal dialysis for the treatment of kidney disease is **covered. HealthyCT requires notification when You start dialysis or are a new member to HealthyCT and are on dialysis**

Sleep Studies

Medically Necessary sleep studies are **covered**.

Coverage is available for one complete study per lifetime when provided at a sleep facility, an outpatient sleep center (accredited by the American Academy of Sleep Medicine under the supervision of a board-eligible or board-certified practitioner of Sleep Medicine) or at home, depending on Your medical condition. A complete sleep study may include more than one session. The management of this benefit may be delegated to an external entity. Sleep Studies performed outside the home are subject to Prior Authorization. Please see Prior Authorization addendum.

Surgery and Other Care Related To Surgery

Medically Necessary surgery provided by a doctor is **covered**. Some surgical procedures require Prior-Authorization. Please see the Prior Authorization Addendum for a list of surgical procedures requiring Prior Authorization.

Anesthesia Services

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

Breast Implants

The surgical removal of any breast implant which was implanted on or before July 1, 1994, no matter what the purpose of the implantation, is **covered** if the services are provided by a doctor. The surgical implantation of a prosthetic device required in connection with the surgical removal of a breast due to a tumor is **covered**.

Oral Surgery Services

Medically Necessary oral surgical services, subject to Prior Authorization, for the treatment of tumors, cysts, injuries of the facial bones and for the treatment of fractures and dislocations involving the face and jaw, including temporomandibular joint (TMJ) dysfunction surgery (for demonstrable joint disease only) or temporomandibular disease (TMD) syndrome provided by a physician are **covered**.

Reconstructive Surgery

The following reconstructive surgery provided by a doctor and when Prior-Authorized is **covered**:

- Procedures to correct a serious disfigurement or deformity resulting from:
    - Illness or injury or,
    - Surgical removal of tumor.

- Medically Necessary reconstructive surgery for the correction of a congenital anomaly restoring physical or mechanical use to that part of the Member's body.
- Other reconstructive surgery for the correction of congenital malformation is excluded. See the "Exclusions And Limitations" section.
- Medically Necessary breast reconstructive surgery on each breast on which a mastectomy has been performed and on a non-diseased breast (in conjunction with reconstruction after mastectomy) to produce a symmetrical appearance.

Sterilization

Sterilization services provided by a doctor are **covered**.

Vision Services

Pediatric Vision Care Services

Covered expenses include charges for children up to age 18 and made by a legally qualified ophthalmologist or optometrist for the following services**:**

- Routine eye exam: This plan covers expenses for one complete routine eye exam every year that includes refraction and glaucoma testing.

Pediatric Vision Care Supplies

Your covered dependents under age 19 are eligible for the following covered expenses for prescription lenses, frames, and prescription contact lenses:
Charges for:

- One pair of eyeglasses (lenses and frames) per year; or
- Contact lenses, if medically necessary, which include one fitting and set of lenses per year, up to the vision supply maximum listed on Your Schedule of Benefits.

Additional Vision Care Services

Covered expenses for all enrollees, including members age 19 and over, include charges for the following:

- Disease and abnormalities of the eye; and
- Corneal pachymetry.

Wound Care Supplies

Medically Necessary wound care supplies (including wound vacs) are **covered** when:

- Prescribed by a physician;
- Supplied by a participating health care provider or Home Care Agency;
- Prior-Authorized by Us under the home care benefit; and
- Provided in conjunction with authorized home care services.

If wound care supplies are not being provided in conjunction with authorized home care services, then the applicable Cost-Share amount will apply.

Wound Care Supplies for Epidermolysis Bullosa

Medically necessary wound care supplies administered under the direction of a physician for the treatment of epidermolysis bullosa are **covered**.

Health Management Programs

Health management programs are set up to help Members manage their long term health conditions.

Members in this Plan may be eligible to enroll in one or more of Our health management programs. In addition, Members may be contacted and managed by Our Complex Care Management Program. Through this program We can provide You with:

- Ways to further Your understanding of Your illness and how to manage it;
- Discussions of Your medications;
- Assistance in identifying warning signs that Your illness is getting worse;
- Assistance in getting a doctor's appointments while preparing You so that You make the most of Your visit;
- Assistance with locating community resources that You might find helpful; and
- Support with healthy lifestyle choices You decide to make.

EXCLUSIONS AND LIMITATIONS

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

1. Abdominoplasty, lipectomy, and panniculectomy.
2. All assistive communication devices.
3. Ambulance services that are non-Medically Necessary, including chair car to and from a provider's office for routine care or if the transport services are for a Member's convenience, except for transportation services related to transplants. See Benefits Section for Inpatient Services - Transportation, Lodging and Meal Expenses for Transplants.
4. Any Treatment for which there is Insufficient Evidence of Therapeutic Value for the use it is being prescribed for.
5. Any treatment or service related to the provision of a non-covered benefit, including educational and administrative services related to the use or administration of a non-covered benefit, as well as evaluations and medical complications resulting from receiving services that are not covered ("Related Services"), unless both of the following conditions are met:
    - The Related Services are Medically Necessary acute inpatient care services needed by the Member to treat complications resulting from the non-covered benefit when such complications are life threatening at the time the Related Services are rendered, as determined by Us, and
    - The Related Services would be a Health Service if the non-covered benefit was covered by the Plan.
6. Attorney fees.
7. Behavioral conditions with the following diagnoses:
    - Caffeine-related disorders,
    - Communication disorders,
    - Learning disorders,
    - Mental retardation,
    - Motor skills disorders,
    - Relational disorders,
    - Sexual deviation, or
    - Other conditions that may be a focus of clinical attention not defined as mental disorders in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders."
8. Benefits for services rendered before the Member's Effective Date under this Plan or after the Plan has been rescinded, suspended, canceled, interrupted or terminated, except as otherwise required by the law.
9. Blood, blood products, and related expenses.

10. Cardiac rehabilitation for Phase IV.
11. Care, treatment, services or supplies to the extent the Member has obtained benefits under:
    - Applicable law
    - Government program
    - Public or private grant, or
    - Any plan or program for which there would be no charge to the Member in the absence of this Plan.

    However, services obtained in a Veteran's Home or Hospital for a non-service connected disability, or as required by the law, are covered. Also covered is care, treatment or services that are otherwise Medically Necessary and provided in a Veteran's Hospital.
12. Chiropractic manipulation of the cervical spine that is long term or maintenance in nature and spinal manipulation services to treat children 12 years of age or younger for any condition.
13. Clinical trial services as follows:
    - Costs for non-Health Services,
    - Costs of Experimental Or Investigational medications or devices not approved for sale by the FDA,
    - Costs that are inconsistent with widely accepted and established regional or national standards of care for a particular diagnosis, or costs for services that are performed specifically to meet the requirements of the clinical trial,
    - Costs that would not be covered by Your Plan for a non-Experimental Or Investigational treatment,
    - Facility, ancillary, professional services and/or medication costs paid for by grants or funding for the trial, and/or
    - Transportation, lodging, food or other travel expenses for the Member or any family member or companion of the Member.
14. Concierge services (which means the fees a provider charges as a condition of selecting or using his/her services).
15. Cosmetic Treatments and procedures, including but not limited to:
    - Abdominoplasty, partial abdominoplasty, repair of diastasis recti, abdominal liposuction or suction assisted lipectomy of the abdomen,
    - Any medical or Hospital services related to Cosmetic Treatments or procedures,
    - Benign nevus or any benign skin lesion removal (except when the nevus or skin lesion causes significant impairment of physical or mechanical function),
    - Benign seborrheic keratosis,
    - Blepharoplasty unless the upper eyelid obstructs the pupil and blepharoplasty would result in a significant improvement in the upper field of vision.
    - Body piercing,
    - Breast augmentation, (except as described in the "Reconstructive Surgery" or "Durable

Medical Equipment (DME) Including Prosthetics" subsections of the "Benefits" section or as otherwise required by the law),

- Dermabrasion or other procedures to plane the skin, including, but not limited to:
- Acne related services such as blue light treatment of acne, injections to raise acne scars, and removal of acne cysts,
- Electrolysis,
- Excision of loose or redundant skin and/or fat after the Member has had a substantial weight loss,
- Facelift surgery or rhytidectomy,
- Injection of collagen or other fillers or bulking agents to enhance appearance,
- Liposuction,
- Otoplasty,
- Phototherapy or laser therapy for the treatment of skin conditions, except for the treatment of psoriasis,
- Reversal of inverted nipples,
- Scar revision, septorhinoplasty, or rhinoplasty, Skin tag removal,
- Spider vein removal (including, but not limited to sclerotherapy),
- Tattooing or removal,
- Thigh, leg, hip, or buttock lift procedures,
- Treatment of craniofacial disorders, except as otherwise described in the "Craniofacial Disorders" subsection of the "Benefits" section,
- Treatment of melasma,
- Varicose vein treatment, except when there is a history of ulcers or bleeding from a varicose vein and/or severe venous insufficiency as defined by HealthyCT, and
- Vascular birthmark removal.

16. Custodial Care, convalescent care, domiciliary care, long term care or rest home care. Also care provided by home health aides that is not patient care of a medical or therapeutic nature and care provided by non-licensed professionals.
17. Dental services, except as otherwise described in the "Benefits" section or any supplemental Rider or endorsement to this Policy.
18. Educational services, except as otherwise described in the "Autism Services" or "Birth To Three Program (Early Intervention Services)" sections:

    - Screening and treatment associated with learning disabilities
    - Special education and related services
    - Testing, training, rehabilitation for educational purposes.

19. Extracorporeal shock wave therapy for the treatment of musculoskeletal conditions.
20. Experimental or Investigational treatment, except as otherwise described in the "Bypassing The Internal Appeal/Grievance Process" subsection of the "Claims Filing, Questions And Complaints, and Appeal/Grievance Process" section.

21. Family planning and Infertility services, including but not limited to:
    - Contraceptive drugs and devices, except to the extent insurance law requires coverage for these items. When they are covered, they are covered under the "Prescription Contraception" subsection of the "Benefits" section,
    - Home births (except that complications of home births are covered),
    - Infertility services not specifically covered under the "Infertility Services" subsection of the "Benefits" section or under Our ***Prescription Drug Benefit***, including but not limited to:
        - Cryopreservation (freezing) or banking of eggs, embryos, or sperm,
        - Genetic analysis and testing, except as described in the "Infertility Services" or "Genetic Testing" subsections of the "Benefits" section including, but not limited to:
            - All other genetic testing services, as well as genetic testing panels not endorsed by ACOG or ACMG,
            - Genetic testing kits available either direct to the consumer or via a physician prescription,
            - Genetic testing only for the benefit of another family member,
            - Genetic testing to guide personalized medicine,
            - Pharmacogenetics or Pharmacogenomics, and
            - Whole genome or whole exome genetic testing,
    - Medications and devices for sexual dysfunction,
    - Recruitment, selection and screening, and any other expenses of donors (donors of eggs, embryos, and sperm),
    - Reversal of surgical sterilization,
    - Surrogacy and all charges associated with surrogacy such as prescription drugs or egg harvesting, fertilization or implantation, except when the egg harvesting is performed on the Member
    - Labor doulas and labor coaches.
22. Gynecomastia surgery.
23. Health club membership and exercise equipment.
24. Home health aide care that is not patient care of a medical or therapeutic nature.
25. Hypnosis, (except as an integral part of psychotherapy), biofeedback (except when ordered by a physician to treat urinary incontinence) and acupuncture (except for Pain Management when medically necessary).
26. Infant formulas, food supplements, nutritional supplements and enteral nutritional therapy, except as provided in the "Nutritional Supplements and Food Products" subsection of the "Benefits" section or under Our ***Prescription Drug Benefit***.
27. Massage, except when part of a prescribed physical or occupational therapy program if that program is a covered benefit.
28. Medical supplies, equipment or prosthetics that are not durable or that are not on Our list of covered equipment.

Examples of excluded equipment include, but are not limited to:

- Any item not primarily medical in nature or not mainly used in the treatment of disease or injury,
- Any item or service which is not covered by the federal Medicare program,,
- Assistive technology and adaptive equipment, including but not limited to:
  - Communication boards, computers, equipment or devices,
  - Gait trainers,
  - Prone standers,
  - Supine boards,
  - Other equipment not intended for use in the home,
- Beds, bedding and bed-related items,
- Clothing or body wear, except as otherwise covered in the "Benefits" section,
- Comfort or convenience items, including but not limited to:
  - Furniture or modifications to furniture,
  - Home climate control devices,
  - Tubs, spas or saunas,
- Compression and cold therapy devices,
- Compression or anti-embolism stockings,
- Cryotherapy; polar packs,
- Exercise equipment,
- Foot orthotics, except if the Member is diabetic,
- Hearing aids, except as described in this subsection,
- Home or automobile equipment or modifications,
- Items used to perform or assist with personal hygiene,
- Lifts of any type,
- Mechanical stretch devices for treatment of joint stiffness (pre- or post-surgery) or joint contractures,
- Myoelectric or electronic prosthetic devices,
- Power mobility devices, such as wheelchairs. scooters and stairway lifts
- Pneumatic compression devices for the treatment of lymphedema or the prevention of deep vein thrombosis,
- TENS units or other neuromuscular stimulators and related supplies, either internal or external, for the treatment of pain or other medical conditions,
- Wigs, hair prosthetics, scalp hair prosthetics or cranial prosthetics, except as described in the "Benefits" section.

29. New Technology for which We have not yet made a coverage policy.
30. Non-Medically Necessary ambulance/medical transportation services.
31. Non-licensed professionals.
32. Non-Medically Necessary services or supplies.

33. Non-medical supportive counseling services (individual or group) for alcohol or substance abuse (e.g., Alcoholics Anonymous).
34. Non-surgical treatment of Temporomandibular joint (TMJ) dysfunction or Temporomandibular disease (TMD) syndrome. This exclusion includes but is not limited to the following: behavioral modification, , physical therapy, appliance therapy such as occlusal Appliances (splints) or adjustments, and Prosthodontic therapy.
35. Overnight or day camps focused on illness or disability.
36. Over-the-counter (OTC) items of any kind, including but not limited to home testing or other kits and products, except as provided in the "Benefits" section.
37. Physical therapy, occupational therapy, speech therapy or chiropractic therapy that is long term or maintenance in nature.
38. Private room accommodations or private duty nursing in a facility.
39. Routine foot care (except when the Member is a diabetic), including, but not limited to: the evaluation or treatment of subluxations (structural misalignments of the joints) of the feet, and the elevation or treatment of flattened arches and the prescription of supportive devices.
40. Routine physical exams at an Urgent Care Center.
41. Sensory and auditory integration therapy, unless covered under the "Autism Services" or "Birth To Three Program (Early Intervention Services)" subsections of the "Benefits" section.
42. Services and supplies exceeding the benefit maximums.
43. Services and supplies not specifically included in this document.
44. Services or supplies rendered by a physician or provider to himself/herself, or rendered to his/her family members, such as parents, grandparents, spouse, children, step-children, grandchildren or siblings.
45. Services required by or received at a Wilderness Camp or a boarding school, including:
    - Medications, including prophylactic, Physical examinations, blood tests, Supplies,
    - Vaccinations/immunizations,
46. Services required by third parties or pursuant to a court order, including:
    - Blood tests,
    - Medications, including prophylactic,
    - Physical examinations,
    - Supplies,
    - Vaccinations/immunizations.
47. Services obtained for foreign or domestic travel, including:
    - Camp,
    - Employment,
    - Insurance,
    - Licensing,

- Pursuant to a court order,
- School.

48. Solid organ transplant and bone marrow transplant transportation costs, including, but not limited to:
    - Any expenses for anyone other than the transplant recipient and the designated traveling companion,
    - Any expenses other than the transportation, lodging and meals described in the "Benefits" section,
    - Local transportation costs while at the transplant facility,
    - Rental car costs.
49. Speech therapy for stuttering, lisp correction or any speech impediment not related to illness or injury, except as described in the "Benefits" section.
50. Sports medicine clinic services and treatments and the services of a personal trainer. In addition, there is also no coverage for any diagnostic services related to any of these programs, services or procedures.
51. Surgical procedures using an artificial disc.
52. Third party coverage, such as other primary insurance, Workers' Compensation and Medicare will not be duplicated.
53. Transportation, accommodation cost, and other nonmedical expenses related to Health Services (whether they are recommended by a physician or not), except as otherwise described in the "Benefits" section.
54. Treatment of snoring, including, but not limited to:
    - Laser-assisted uvulopalatoplasty,
    - Snore guards,
    - Somnoplasty, and any other snoring-related appliances.
55. Ventricular assist devices, except for bridge to heart transplantation.
56. Vision services including, but not limited to:
    - Adult routine eye care, eye glasses and contact lenses,
    - Eye surgeries and procedures primarily for the purpose of correcting refractive defects of the eyes, including, but not limited to:
        - Laser surgery,
        - Orthokeratology, and
        - Radial keratomy,
    - Vision and hearing examinations (except as described in the "Eye Care" and "Hearing Screenings" subsections of the "Benefits" section),
    - Vision therapy and vision training.
57. War related treatment or supplies, whether the war is declared or undeclared.
58. Web visits, e-visits, and other on-line consultations or health evaluations using internet resources, as well as telephone consultations.

59. Weight loss/control services, equipment and treatment,, including, but not limited to:

- Bariatric surgery,
- Commercial diet plans and any clinics and services in connection with such plans or programs,
- Exercise equipment,
- Weight loss or weight control programs.

PRESCRIPTION DRUG BENEFITS

Prescription drug benefits are subject to the terms and conditions of the Policy, as described further below.

BENEFITS

Pursuant to federal law, certain medications, as defined by the United States Preventive Service Task Force, are exempt from Member Cost-Shares (e.g., Deductible, Copayment and Co-insurance). As a result there may be times that You will not be required to pay the applicable Cost-Shares You usually pay for covered medications under this Policy. Subject to all of the provisions of this Policy, including the guidelines, and Exclusions and Limitations, benefits under this Policy apply only to prescription drugs included on the formulary drug list for Your plan. For a list of medications included on the formulary drug list, please call Member Services or visit Us at www.healthyct.org.

To be covered, prescription drugs must:

- Be FDA Approved and Medically Necessary;
- Be marketed in the United States at the time of purchase; and
- In most cases, bear the label: "Caution: Federal law prohibits dispensing without prescription." (Please see the "Over-The-Counter (OTC) Medications" subsection to find out when OTC medications are covered under this Policy.)

ADDITIONAL BENEFITS

Over-The-Counter (OTC) Medications

Certain over-the-counter (OTC) medications may be covered, subject to terms and conditions of this Benefit and the following:

1. The OTC medication must be listed as a covered OTC medication on the Formulary Drug List.
2. You must obtain a prescription for the OTC medication from Your doctor.
3. The OTC medication must be filled at a Participating Pharmacy by the pharmacist; otherwise it will not be covered.
4. OTC medications that are covered under the plan will be covered as described in the "Tiered Cost-Share" subsection of the "Prescription Drug Programs" section of this Benefit and at the applicable Cost-Share amount found on Your Benefit Summary.

The Cost-Share amounts You are required to pay for prescriptions are found on Your Benefit Summary. Please call Our Member Services Department or visit Us at www.healthyct.org to find out if an OTC medication may be covered under this Policy. We have the right to change the drugs on the list.

Specialty Drugs

Specialty drugs are those prescription drugs that are not needed immediately to treat a sudden medical condition and that require:

- A higher level of pharmacy expertise,

- Increased patient knowledge to administer, and
- Special handling.

You can determine if Your medication is a specialty drug by calling Our Member Services Department or visiting Us at www.healthyct.org.

Certain specialty drugs will be covered under Your plan if Your Prior Authorization is approved and Your prescription is filled by a specialty pharmacy, subject to terms and conditions of this Policy.

You may obtain the contact information for the in-network specialty pharmacy by calling Member Services. The specialty drugs will be shipped to Your doctor's office, Your home, or other location based on the type of drug or treatment. Specialized counseling and education is available to You from the specialty pharmacies regarding proper administration, storage, dosage, drug interactions, and side effects of these specialty drugs.

If You are out of a specialty drug or if the specialty drug ordered by a Preferred Provider does not arrive in time, We may authorize the specialty drug for up to a 30-day supply, so You can obtain the needed medication at a Participating Network Pharmacy.

If You are prescribed a specialty medication, Your provider will need to provide the necessary clinical information to HealthyCT to review and approve the Prior Authorization request.

Specialty prescription drugs, when Prior-Authorized by Us, will be dispensed for a maximum of 30-days.

The list of specialty medications covered under the plan may change at any time. Please call Member Services or visit Us at www.healthyct.org. We have the right to change the drugs on the list.

GUIDELINES

Certain Prescription Drugs/Supplies Require Prior Authorization

Certain prescription drugs and supplies require Prior Authorization from Us before they will be covered under this Policy. The list of drugs or supplies requiring Prior Authorization is found in the Appendix and is subject to change. Please call Member Services or visit Us at www.healthyct.org to find out if a prescription drug or supply requires Prior Authorization.

Always Use Your ID Card

You and Your covered dependents are required to use the HealthyCT ID card when obtaining a prescription drug or covered supply under this Policy. In the event You do not use Your ID card, You will be charged the discount lost because the prescription drug or covered supply was processed without the ID card, in addition to any Cost-Share amount or other charge due under this Policy.

Pharmacy Network

This Plan has a pharmacy network. If You go to an out-of-network pharmacy and try to use Your membership card to fill a prescription, the pharmacy may not be able to submit the claim directly to Us. When that happens, You will have to pay the full cost of Your prescription. In this case, the member can submit a paper claim that will be reimbursed in accordance with the members Cost Sharing requirements outlined in their benefit plan.

Paper claims should be submitted within 180 days from the date the drug or supplies were received on the appropriate claim form.

Using A Non-Participating Pharmacy

When You use a Non-Participating Pharmacy for prescriptions, You and Your Covered Dependents will still have coverage, but the out-of-pocket costs will be higher than they would be if You were to use a Participating Pharmacy. Your Benefit Summary will tell You the Cost-Share amount You are required to pay.

PRESCRIPTION DRUG PROGRAMS

The following provisions apply to Our Prescription Drug Programs.

Generic Substitution Program

1. This Plan uses a "Generic Substitution Program." This program applies to prescriptions filled at Participating Network Pharmacies (retail or specialty pharmacies) and Our designated mail order vendor.
2. In some plans, when You obtain a Brand Name Drug or Supply for which there is a Generic Equivalent, You must pay the applicable Cost-Share amount for the corresponding Generic Drug or Supply in addition to the difference in price between the Generic Equivalent Drug or Supply and the Brand Name Drug or Supply that You obtained.
3. If Your physician prescribes a Brand Name Drug or Supply for which there is a Generic Equivalent, the Participating Network Pharmacy will automatically switch the prescription to the Generic Equivalent Drug or Supply that is equivalent to the Brand Name Drug or Supply that was prescribed for You, unless Your physician has written on the prescription that there should be no substitution.

Tiered Cost-Share Program

This Plan has a "Tiered Cost-Share Program." This program applies to prescriptions filled at Participating Pharmacies, Our designated mail order vendor, or specialty pharmacies, as well as those OTC medications covered under this Policy (please refer to the "Over-The-Counter (OTC) Medications" subsection). Under this program, covered prescription drugs (including certain OTC medications) and supplies are put into categories (i.e., "tiers") to designate how they are to be covered and the Member's Cost-Share. Every drug on the plan's Formulary Drug List is in one of the five cost-sharing tiers. In general, the higher the cost-sharing tier, the higher Your cost for the drug. The placement of a drug or supply into one of the tiers is determined by the HealthyCT's pharmacy benefits manager and approved by the pharmacy benefits manager's Pharmacy & Therapeutics Committee based on the drug's or supply's clinical effectiveness and cost.

- Preventive Medications are covered entirely by HealthyCT without member cost sharing, as required by the Affordable Care Act.
- Cost-Sharing Tier 1 includes Generic drugs. This is the lowest cost-sharing tier.
- Cost-Sharing Tier 2 includes Preferred Brand drugs. This is the moderate cost-sharing tier.

- Cost-Sharing Tier 3 includes Non-Preferred Brand drugs. This is a higher cost-sharing tier.
- Cost-Sharing Tier 4 includes Specialty drugs. This is the highest cost-sharing tier.

We have the right to change the drugs (including certain OTC medications) or supplies in each tier at Our discretion, even in the middle of the year. Please call Member Services or visit Us at www.healthyct.org to find out which tier (if any) a prescription drug or supply is in.

Drug Quantity Limitations Program

For some drugs, We will cover only a limited number of dosages per prescription and/or time period for the drug. These are drugs where We have determined, at Our discretion, that the number of dosages available for the drug should be limited in accordance with the proper medical use of the drug. We will make these determinations based on federal Food and Drug Administration (FDA) guidelines and medical literature, with input from physicians and the Pharmacy and Therapeutics (P&T) Committee. In certain cases, this Policy will cover additional units above the limited number of dosages per prescription and/or time period for the drug if We determine, at Our discretion, that, because of You or Your Covered Dependent's condition, these additional units are Medically Necessary. We will make this determination based on clinical evidence presented by Your physician to Us. When this occurs, You may be required to pay the applicable Cost-Share amount and/or deductible. In addition, We reserve the right to designate that certain prescriptions be filled or refilled for no more than a 30-day supply, regardless of whether Your Benefit Summary has a fill or refill limit. When coverage is limited to a 30-day supply at a time for a drug, You will not be able to purchase that drug through Our Voluntary Mail Order Program.

Voluntary Mail Order Program

This Plan has a "Voluntary Mail Order Program." Under the Voluntary Mail Order Program, You and Your Covered Dependents may fill Your prescriptions through Our designated mail order vendor. You and Your Covered Dependents may obtain up to a 90-day supply of prescription drugs or covered supplies through Our designated mail order vendor, subject to the Cost-Share amounts and/or Deductible outlined on Your Benefit Summary.

To obtain these benefits, Your physician must prescribe the 90-day supply of the prescription drugs or covered supplies. Detailed information about how to use the mail order program is provided to You in a separate flyer. If You have a prescription that for any reason cannot be filled by Our designated mail order vendor and You need to use a retail pharmacy to fill it instead, the retail pharmacy Cost-Share amount found on Your Benefit Summary applies.

We have the right to change or limit the drugs eligible for dispensing through this program at Our discretion, even in the middle of the year. Please call Member Services to determine if Your medication is eligible to be filled through the Voluntary Mail Order Program.

Excluded Therapeutic Equivalent Drugs/Supplies Program

This Plan has the "Excluded Therapeutic Equivalent Drug/Supplies Program." This program applies to prescriptions filled at Participating Pharmacies, Non-Network Pharmacies (retail or specialty pharmacies) and

Our designated mail order vendor.

Prescription drugs or supplies that are "Excluded Therapeutic Equivalent Drugs/Supplies" are not covered by this Benefit, except as described below. Instead, another drug or supply in the same therapeutic category that is determined by Us, in Our discretion, to be effective for the illness or injury treated by the drugs or supplies in that category will be covered by this Benefit. The excluded drugs or supplies are drugs or supplies in a therapeutic category of drugs or supplies where more than one drug or supply is effective for treating a certain illness or injury.

If Your physician prescribes an excluded drug or supply the Participating Pharmacy can call Your physician to determine whether he or she may switch the prescription to the covered drug or supply which is in the same therapeutic category as the drug or supply that was prescribed for You.

In certain cases, this Policy will cover the excluded drug or supply if We determine that the drug or supply is Medically Necessary for You. Coverage determinations may include comparisons to similar drugs or supplies covered under this Policy

The covered drugs and supplies are displayed on Our web site. Please call Member Services or visit Us at www.healthyct.org to find out if a prescription drug or supply is on this list. We have the right to change the drugs or supplies on the list in Our discretion.

Step Therapy Program

A step therapy program is a "step" approach to providing drug coverage. It is designed to encourage the use of cost-effective prescription drugs when appropriate. This means that You may first need to try an alternative, typically a generic drug, before We will cover certain medications prescribed by Your physician.

Step therapy programs are developed using Food and Drug Administration (FDA) guidelines, clinical evidence and research. They ensure that You are taking appropriate and cost-effective medications.

If You are currently taking a drug that is included in Our step therapy program, please talk to Your doctor. Together You can discuss which medication options are best for You. Your doctor can decide whether to write a new prescription or submit a written request for You to continue Your current medication.

Please call Member Services or visit Us at www.healthyct.org to find out if a prescription drug or supply is part of Our step therapy program. We have the right to change the drugs or supplies subject to step therapy in Our discretion. If the drugs or supplies subject to step therapy change, an endorsement or amendment to this contract will be made.

MEMBER COST-SHARING

With the exception of certain preventive medications, You and Your Covered Dependents will be required to pay a Cost-Share amount for prescription drugs and covered supplies obtained under this Policy. The Cost-Share amounts You are required to pay for prescriptions are found on Your Benefit Summary.

If You have a Plan that requires a prescription drug benefit Copayment, You will be required to pay that Copayment amount for the drug or supply or the amount We would pay for the drug or supply, whichever is the

lower amount.

If You have a Plan that requires a Prescription Drug Deductible, the Deductible amount must be met in any plan year for prescriptions subject to the prescription drug benefit Deductible before We will begin paying for those prescriptions. A Prescription Drug Deductible is considered to be met for a Member if the individual Deductible is met by the amounts paid for that Member for prescriptions covered by the Deductible. A family Deductible amount is met by combining the total expenses for prescriptions contributed by each family member, whereby no one family member incurs more than the individual member Deductible amount, up to the family Deductible amount.

For some plans Your pharmacy Deductible may apply to other Deductible amounts You may be required to pay for Health Services under the Plan. When a Deductible and Copayment or Coinsurance applies, You must pay the full prescription cost (at the amount We would pay for the drug) up to Your Deductible amount. Once the Deductible has been met, You will be charged the Copayment or Coinsurance amount listed on Your Benefit Summary for each prescription, plus any applicable cost difference in accordance with the generic substitution program.

If You have a Plan with a drug benefit Deductible and then a Copayment where You fulfill the Deductible requirement in a particular claim, You will pay the remaining Deductible amount for that year in addition to the remaining drug cost up to the drug's applicable Copayment amount. As an example, if the drug costs $26, You have $20 remaining on Your Deductible, and the prescription drug has a Copayment amount of $10, You would be required to first pay the $20 remaining on Your Deductible and then the remaining $6 of the total cost of the drug. You would pay $6, instead of the $10 Copayment amount, because the $6 balance for the drug is less than the $10 Copayment amount for that drug. In the same example, if the cost of the drug was $45, You would be required to first pay the $20 remaining on Your Deductible, and then You would be required to pay the $10 Copayment amount, because the $25 balance for the drug is more than the $10 Copayment.

Amounts paid by Members because they must pay a price difference for a Brand Name Drug count towards meeting any Deductible, Coinsurance, Copayment, or Out-of-Pocket Maximum.

BENEFIT LIMITS

Fill or Refill Limit

This Plan limits benefits for prescriptions filled or refilled at a retail pharmacy to a 30-day supply at a time, with the exception of certain maintenance medications, which may be allowed for up to a maximum of a 90-day supply. This Plan also limits benefits for prescriptions filled or refilled through the Voluntary Mail Order Program to a 90-day supply at a time.

Access to Prescriptions that are Not Covered

In accordance with 45 CFR 156.122(c), HealthyCT provides a process that allows You to request and gain access to clinically appropriate drugs that are not covered by HealthyCT. You, Your designee, Your prescribing physician or other prescriber may request an expedited exception review based on exigent circumstances, defined as:

- The Member is suffering from a health condition that may seriously jeopardize the member's life, health

or ability to regain maximum function, or

- The Member is undergoing a current course of treatment using a non-formulary drug.

HealthyCT will provide a decision on an exception request based on exigent circumstances and notify the Member (and the prescribing physician or other prescriber as appropriate) of the determination no later than 24 hours after receiving the request. For more information or to file a request contact Catamaran.

EXCLUSIONS AND LIMITATIONS

For the purposes of prescription drug benefits under this Policy, in addition to the exclusions and limitations contained throughout the Policy, the following exclusions and limitations also apply.

1. All drugs or medications not included in the formulary drug list for Your plan, unless deemed Medically Necessary in accordance with plan requirements.
2. Antibacterial soap/detergent, shampoo, toothpaste/gel, or mouthwash/rinse.
3. Appliances or devices and durable medical equipment, except as otherwise required by applicable law.
4. Compounded prescriptions, unless at least one ingredient in the compounded prescription is FDA approved and the FDA component(s) of the compound are covered.
5. Drugs or medications if they include the same active ingredient or a modified version of an active ingredient and they are therapeutically equivalent or therapeutically an alternative to a covered prescription drug, unless deemed Medically Necessary in accordance with plan requirements.
6. Prescription drugs or supplies:
    - Covered by Workers' Compensation law or similar laws, or covered by Workers' Compensation coverage, even if You choose not to claim those benefits, to the extent permissible by law.
    - Dispensed before the Member's effective date or after his or her termination date.
    - Dispensed in a Hospital or other inpatient facility.
    - Dispensed or prescribed in a manner contrary to normal medical practice.
    - Furnished by the United States Veterans' Administration.
    - Not required for the treatment or prevention of illness or injury.
    - Obtained for the use by another individual.
    - Obtained from outside of the United States by any means.
    - Provided in connection with treatment of an occupational injury or occupational illness, to the extent permissible by law.
    - Refilled in excess of the number the prescription calls for, or refilled after one year from the date of the order for the prescription drug.
    - Re-packaged in unit dose form.

- Unless the drug is included on the preferred drug guide (formulary) or a medical exception is granted.
- Not approved by the FDA.

GENERAL CONDITIONS

1. We will not be liable for any injury, claim, or judgment resulting from the dispensing of any prescription drug covered by this Policy.
2. We may use a third party administrator to administer the benefits available under this Policy.
3. All claims must be submitted to Us within 365 days from the date the drug or supplies were received with the appropriate claim form and as described in the Policy, "Claims Filing, Questions And Complaints, And Appeal Process" section, "Claims Filing" subsection. Please call Member Services to obtain the appropriate claim form.
4. Covered prescription drugs will not be denied as Experimental or Investigational if the drug has successfully completed a Phase III clinical trial conducted by the federal Food and Drug Administration (FDA).
5. We may require the Member's treating physician to furnish Us with information about the diagnosis or prognosis of an injury or illness related to a prescription drug and about the nature, quality, and quantity of the prescription drug prescribed in order to determine its Medical Necessity.
6. Upon approval of new medications by the FDA, We reserve the right to implement Prior-Authorization criteria and to set quantity limits to promote appropriate use and to avoid abuse.

PEDIATRIC DENTAL BENEFITS

About this Section

This section of the booklet describes the Pediatric Dental Coverage for You or Your Covered Dependent enrolled through HealthyCT. The Pediatric Dental Coverage is provided by HealthyCT and administered by Delta Dental of New Jersey, Inc. Pediatric Dental coverage is available to eligible persons under age 19. For additional information regarding Your rights and responsibilities, coverage, eligibility, enrollment, adding dependents, effective dates of coverage, ID cards, open and special enrollment, premium payments, grace periods, changes affecting eligibility, or termination of coverage, refer to the Table of Contents or go to the section of the booklet on Important Telephone Numbers and Addresses.

If You have any questions about eligibility and enrollment, please contact HealthyCT or the Connecticut Insurance Exchange at the telephone number listed in the "Important Telephone Numbers And Addresses" section.

About Delta Dental

Delta Dental of New Jersey, Inc. ("Delta Dental") is a New Jersey not-for-profit dental service corporation and a Connecticut licensed third party administrator. Delta Dental is a member of the Delta Dental Plans Association.

Selecting a Dentist to Provide Covered Pediatric Dental Services

This policy lets You get Covered Services from any Dentist. Your Dental Network, however, includes only Delta Dental PPO^{SM} Dentists. In most cases, You will maximize Your Benefits and lower Your out-of-pocket costs if You use a Delta Dental PPO^{SM} Dentist. Your in-network out-of-pocket maximum will only apply to Dental Services provided by a Delta Dental PPO^{SM} Dentist.

You may choose to obtain Dental Services from a Delta Dental Participating Dentist who is not part of the Delta Dental PPO^{SM} Network. If You do, You may be responsible for higher out-of-pocket costs than if You use a Delta Dental PPO^{SM} Dentist. If You do obtain services from a Delta Dental Participating Dentist who is not part of the Delta Dental PPO^{SM} Network, Your out-of-network out-of-pocket costs will also be calculated separately; and, You will have a higher out-of-pocket maximum payment level.

You may also choose to obtain services from a Non-Participating Dentist. If You do, Your out-of-pocket costs may be higher than if You used either a Delta Dental Participating Dentist or a Delta Dental PPO^{SM} Dentist. Your out-of-network out-of-pocket costs for Non-Participating Dentists will also be calculated separately and You will have a higher out-of-pocket maximum payment level.

Before You or Your Covered Dependents visit the Dentist, check to see whether Your Dentist is a Delta Dental PPO^{SM} Dentist.

At the time of Your first appointment, tell Your Dentist that You are covered under this Delta Dental PPO[SM] program. Give Your Dentist Your HealthyCT Member Identification card or Your HealthyCT ID number.

After the Dentist performs an examination, he or she may submit a Prior Authorization request asking that Delta Dental evaluate coverage for certain Dental Services before the service is provided. In order to receive the maximum benefits under this Pediatric Dental Coverage, some services require Prior Authorization. If a Prior Authorization is required and is denied, You will receive no benefit for that service. If You do not get the required Prior Authorization, and the service or item would have been approved had there been a Prior Authorization request, coverage for the service will be reduced and You will be responsible for paying a penalty. The penalty will be the lower of 50% of the scheduled benefit or $500. If you go to a Delta Dental PPO[SM] Dentist in Connecticut or New Jersey, or you go to a Delta Dental Participating Dentist in Connecticut or in New Jersey and he or she fails to obtain the required Prior Authorization, in certain circumstances you will have no financial responsibility for the charge. Refer to the section on "Prior Authorizations" below. Other services may be covered only if Dentally Necessary and Orthodontic Services are covered only if Medically Necessary. If the service is not Dentally Necessary or Medically Necessary, coverage for the service will be denied and You will be responsible for the full cost of the service. It is important to discuss the service with Your Dentist or to contact Delta Dental to confirm Your benefits and to determine how much of the charge for any future work You may be responsible for before the service is performed. Check Your Pediatric Dental Schedule of Benefits, Summary of Benefits, and the Pediatric Dental Prior Authorization Addendum for more information.

Before treatment is started, be sure You discuss with Your Dentist the total amount of his or her fee. This is especially important when using a Dentist who is not a Delta Dental PPO[SM] Dentist. Costs above the Delta Dental approved amount are Your responsibility. Although Delta Dental may authorize the Dentist to perform a service that needs to be Prior Authorized, the approval does not mean that the entire cost of the service will be paid under Your coverage. For other services, Your Dentist may request a Pre-Treatment Estimate to determine what benefits are available for that service. But keep in mind that a Pre-Treatment Estimate is only an estimate and is not a guarantee of payment.

Delta Dental PPO[SM] Dentists in Connecticut and Outside of Connecticut

You may obtain Dental Services from a Delta Dental PPO[SM] Dentist in Connecticut and outside of Connecticut. When You receive services from the Delta Dental PPO[SM] Dentist, You may have to pay Coinsurance and a Deductible, depending on the service performed, the health plan in which You are enrolled, and whether or not the required annual Coinsurance and Deductible amounts have been met; but for Covered Services, the Dentist can only Balance Bill You for the difference between Delta Dental's payment and the lowest of the fee filed by the PPO Dentist with Delta Dental or Another Delta Dental Plan, the fee that the PPO Dentist actually charged for the Dental Service, or the PPO Approved Fee. General Dentists and specialists that are Delta Dental PPO[SM] Dentists in Connecticut and outside of Connecticut will be paid for Covered Services based on a fee no greater than the PPO Approved Fee. Any payment You make for services obtained from a Delta Dental PPO[SM] Dentist is counted toward the in-network annual out-of-pocket maximum. Once You reach the in-network maximum out-of-pocket payment, all other Covered Services obtained through a Delta Dental PPO[SM] Dentist will be covered at

no cost to You. But, keep in mind that services You receive from a non-Delta Dental PPO[SM] Dentist (including a Delta Dental Participating Dentist who is not a Delta Dental PPO[SM] Dentist and a Non-Participating Dentist) are subject to a separate and higher out-of-pocket maximum calculation. Please also keep in mind that benefits can still be denied if required Prior Authorization is denied, reduced if not Prior Authorized when required, not charged to you at all under certain circumstances where a Delta Dental PPO[SM] Dentist in Connecticut or in New Jersey has failed to obtain a required Prior Authorization, or denied when not considered Dentally Necessary or Medically Necessary.

Delta Dental Participating Dentists in Connecticut and Outside of Connecticut who are not Delta Dental PPO[SM] Dentists

Although You may obtain Dental Services from a Participating Dentist who is not a Delta Dental PPO[SM] Dentist in Connecticut and outside of Connecticut, for Covered Services, Delta Dental bases its Benefit payment on a fee no greater than the PPO Approved Fee applicable to general dentists that are Delta Dental PPO[SM] Dentists in Connecticut. Although the Dentist's fee will be limited to the Participating Dentist Maximum Approved Charges (PMAC), for Covered Services, the Dentist may Balance Bill You for the difference between the amount Delta Dental pays and the PMAC. It will be Your responsibility to pay any applicable Deductible, Coinsurance, and the balance of the Dentist's fee. Limits to Your out-of-pocket expenses are higher when You do not receive services from a Delta Dental PPO[SM] Dentist. Please also keep in mind that benefits can still be denied if required Prior Authorization is denied, reduced if not Prior Authorized when required, not charged to you at all under certain circumstances where a Delta Dental Participating Dentist in Connecticut or New Jersey has failed to obtain a required Prior authorization or denied when not considered Dentally Necessary or Medically Necessary.

Non-Participating Dentists

While You may obtain Dental Services from a Dentist in Connecticut and outside of Connecticut that is a Non-Participating Dentist, for Covered Services, Delta Dental will base its Benefit payment on the lesser of the actual fee or the PPO Approved Fee applicable to general dentists that are Delta Dental PPO[SM] Dentists in Connecticut. The Non-Participating Dentist's fee will not be limited by Delta Dental and, therefore, the Dentist will bill You for the difference between Delta Dental's payment and his or her actual fee. The Dentist's fee for Covered Services will not be limited to the Participating Dentist Maximum Approved Charge (PMAC) as it would be if You obtained services from a Delta Dental Participating Dentist, or limited to the PPO Approved Fee as it would be if You obtained services from a Delta Dental PPO[SM] Dentist. It will be Your responsibility to pay any applicable Deductible, Coinsurance, and the balance of the Dentist's fee. Limits to Your out-of-pocket expenses are higher when You do not receive services from a Delta Dental PPO[SM] Dentist. Please also keep in mind that benefits can still be reduced if not Prior Authorized when required or denied when not considered Dentally Necessary.

Locating a Delta Dental PPO[SM] Dentist or a Delta Dental Participating Dentist

Delta Dental offers two ways to locate either a Delta Dental PPO[SM] Dentist or a Delta Dental Participating Dentist. You can access this information 24 hours a day, 7 days a week by:

- Calling 1-800-DELTA-OK (1-800-335-8265)
- Accessing Delta Dental's Website at: www.deltadentalnj.com

When You call, Delta Dental can identify for You Dentists in Your area who are Delta Dental PPO[SM] Dentists, and You can also get a customized list of Delta Dental PPO[SM] Dentists within the area of Your request. Delta Dental will mail the lists to Your home. By searching on the Delta Dental Website, You can identify if a particular Dentist is a Delta Dental PPO[SM] Dentist or a Delta Dental Participating Dentist. You can also get a customized list of Delta Dental PPO[SM] and Delta Dental Participating Dentists in a specific town. You can get listings of general Dentists or specialists. You can also get information on Delta Dental PPO[SM] Dentists and Delta Dental Participating Dentists for the whole country when You travel outside of Connecticut, but keep in mind that if You choose to use a non-PPO Dentist, You will be responsible for any charges that exceed the PPO Approved Fee applicable to general dentists that are Delta Dental PPO[SM] Dentists in Connecticut up to the Approved Amount and You may incur greater out-of-pocket costs.

Selecting a Delta Dental PPO[SM] Dentist

- All Delta Dental PPO[SM] Dentists have agreed, in writing, to comply with Delta Dental's claims processing procedures for Covered Services. For example, for Covered Services, Delta Dental PPO[SM] Dentists will limit their charges to You to the difference between what Delta Dental paid and the lesser of the Dentist's filed fee, usual fee, or the fee in PPO Approved Fees, apart from a Deductible and any applicable Coinsurance. Delta Dental Participating Dentists and Non-Participating Providers have not agreed to limit their charges to the same level. However, Delta Dental Participating Dentists (who are not Delta Dental PPO[SM] Dentists) have agreed to limit their charges to You to the lesser of their actual charge, the fee they file with Delta Dental, or Delta Dental's Approved Amount under the Delta Dental Premier Program[SM]. Therefore, Delta Dental Participating Dentists agree to charge You no more than the amount that shows in the "patient payment" part of the Explanation of Benefits.
- Both Delta Dental PPO[SM] Dentists and Delta Dental Participating Dentists send claims directly to Delta Dental on Your behalf. You may be asked to complete part of the form during Your visit.
- Delta Dental PPO[SM] Dentists and Delta Dental Participating Dentists will obtain benefit and covered service information straight from Delta Dental. You will receive an Explanation of Benefits that explains the services You received, the payments We made, and the amount You may owe for the services.

If You visit a Non-Participating Dentist, You will be responsible for making payment directly to the Dentist unless there has been a valid assignment of benefits consistent with applicable laws and/or regulations. Otherwise, Delta Dental will pay the benefit amount to You. You will also receive an Explanation of Benefits that explains the services You received and the payments made.

Your First Dental Visit

Before selecting a Dentist, check with him or her or contact Delta Dental to make sure the Dentist is a Delta Dental PPO[SM] Dentist. While a Dentist may participate with Delta Dental, he or she may not participate in the Delta Dental PPO[SM] Program. Tell Your Dentist that You are covered under this HealthyCT Policy. Also, give the Dentist Your HealthyCT Member ID card. The Dentist should contact Delta Dental and check Your eligibility as well as details about Your coverage, including what services are covered, what services are excluded, whether a service requires Prior Authorization, and other limits to Your benefits.

You may be required to submit a Prior Authorization request for certain services. You and Your Dentist can get information on the Dental Services that need Prior Authorization from the Pediatric Dental Prior Authorization Addendum attached to this booklet. Once Delta Dental receives the Prior Authorization request, Delta Dental will authorize or deny the request. It is important that services that require Prior Authorization be authorized in advance, regardless of whether You are using a Delta Dental PPO[SM] Dentist, a Delta Dental Participating Dentist or a Non-Participating Dentist. Without Delta Dental's Prior Authorization, Your benefit for a Dentally Necessary or Medically Necessary service may be reduced and You may be responsible for making a higher payment for the cost of the service.

Contacting Delta Dental
You can get information regarding Your Pediatric Dental Coverage on the web, by phone, or by mail:

On the Web
Visit Delta Dental at www.deltadentalnj.com to sign up for its secure Website. Once signed up, You can check Your eligibility, benefits, and Covered Services. You can also check claim payments, and view payments toward Your HealthyCT Deductibles and annual maximum out-of-pocket payments.

By Phone
Delta Dental Customer Service can be reached toll-free by calling 1-800-663-6435 during regular business hours (Monday through Thursday, 8am-6:30pm EST, and Friday, 8am-5pm EST). Customer Service Representatives can help You with the following:

- Confirm enrollment in the HealthyCT Pediatric Dental Benefit administered by Delta Dental of New Jersey.
- Help You understand Your Pediatric Dental Coverage Benefits.
- Check the status of a Prior Authorization Request.
- Check the status of a Claim.
- Determine how much of Your Deductible is left.
- Help You determine how much of Your out-of-pocket maximum payment is left.
- Locate a Delta Dental PPO[SM] Dentist or a Delta Dental Participating Dentist.

Calls to Delta Dental's toll-free number first go through an Interactive Voice Response (IVR) system. The IVR includes claim payment information, a directory of Delta Dental PPO[SM] Dentists and Delta Dental Participating Dentists, and contact information. You can also be transferred to a Customer Service Representative during business hours. A touch-tone phone is needed to use the IVR. Delta Dental also offers services for non-English speaking and the hearing impaired.

By Mail

c/o Delta Dental of New Jersey, Inc.
P.O. Box 222
Parsippany, NJ 07054

Contacting HealthyCT

While Delta Dental can answer most of Your questions regarding Your Pediatric Dental Benefit, there may be other questions that should be answered by HealthyCT. HealthyCT can answer questions regarding the following:

- Your eligibility and enrollment of dependents in coverage.
- Questions regarding Your Member ID card and replacement of Your ID card.
- Questions regarding termination of coverage or termination of coverage of a dependent.
- Questions regarding changes in pediatric dental coverage plans.
- Questions about Your premium payments.
- Questions regarding how much of Your out-of-pocket maximum payment is left.

You may contact HealthyCT by calling the Member Services number listed under Important Telephone Numbers and Addresses, or calling 1-800-DELTA-OK (1-800-335-8265) or on the web at Delta Dental's Website at: www.deltadentalnj.com.

Coverage Under More than One Insurance Plan, Policy, or Program that Provides Dental Coverage for Covered Dependents Under Age 19

In most cases, Your Pediatric Dental Coverage under this Policy will be the only dental coverage under which You or Your Covered Dependent is covered. But, if You or Your Covered Dependent has other insurance that provides dental benefits or is covered by a different dental plan, contact HealthyCT to discuss appropriate programs and health plan choices.

If You or Your Covered Dependent has dental coverage through more than one plan and Delta Dental is the secondary plan, benefits will be coordinated between the two plans based on Coordination of Benefits rules.

Coordination of Benefits for Pediatric Dental Coverage

Make sure You inform Your Dentist that You are covered by more than one plan. If You are covered by more than one plan written or administered by Delta Dental of New Jersey, Inc., You just need to submit the claim once, and We will coordinate Your benefits. If You are covered by Delta Dental and another plan, submit Your claim to the primary plan first and it will issue a statement of benefits that can then be sent to other plan(s).

ELIGIBILITY AND ENROLLMENT

Eligibility and enrollment for the Pediatric Dental Coverage is the responsibility of the Connecticut Insurance Exchange and HealthyCT. If You have questions regarding eligibility and enrollment, please contact the Connecticut Insurance Exchange or HealthyCT.

Persons eligible for pediatric dental benefits under this Policy include individuals from birth up to but not including age 19.

PREMIUM CHARGES, POLICY RENEWAL, AND TERMINATION

Premium charges for Pediatric Dental Coverage are included in the health plan premiums that are billed by and paid to HealthyCT. If You have a question regarding Your bill, premium payments, non-payment of premium, grace periods, renewal of Your policy, or a refund request, please contact HealthyCT.

Your application for coverage, enrollment for Pediatric Dental Coverage, the renewal of Your policy and the termination of Your policy is handled by the Connecticut Insurance Exchange and HealthyCT. If You have a question regarding Your application, renewal, or termination of Your policy or termination of the Pediatric Dental Coverage, contact the Connecticut Insurance Exchange or HealthyCT.

Pediatric Dental Coverage will terminate for a covered person once he or she reaches age 19.

PEDIATRIC DENTAL COVERAGE TERMS

Summary of Covered Dental Services
Your Pediatric Dental Coverage includes coverage for the following, subject to the Pediatric Dental Benefits Summary and General Exclusions:

- Diagnostic Services including the following procedures:
  - Oral Exams
  - X-rays
  - Periapicals
  - Bitewing Radiographs
  - Panorex
- Preventive Services including the following procedures:
  - Cleanings
  - Fluoride
  - Sealants (molars / premolars)
- Basic Restorative services including the following procedures:
  - Fillings
  - Simple Extractions
- Major Restorative services including the following procedures:
  - Surgical Extractions
  - Endodontics (i.e. Root Canal Treatment)
  - Crowns and Cast Restorations
  - Prosthodontics (i.e. Dentures)
- Orthodontics when Prior-Authorized and Medically Necessary Orthodontia (as determined by Delta Dental)

PEDIATRIC DENTAL BENEFITS SUMMARY

Diagnostic & Preventive (D&P) Dental Services to assist the Dentist in evaluating the existing oral condition to determine required dental treatment and Dental Services intended to prevent future dental disease.	
Covered Services	**Specific Limitations**
Dental evaluations including comprehensive, routine and emergency evaluations, as well as consultations	No Benefit will be paid for dental evaluations of any type as well as consultations when any mix of these Dental Services is performed more than twice (2) in a 12-month period. No allowance will be paid for Comprehensive evaluations, including an oral evaluation for a Patient less than three years of age, performed by the Same Dentist within 3 years. Evaluations within 3 years after a Comprehensive evaluation by the Same Dentist will be Benefited As periodic evaluations. A Comprehensive periodontal evaluation is Benefited As a periodic evaluation when performed by the Same Dentist on the same date as periodontal maintenance. No Benefit will be paid for separate charges for evaluation of hard and soft tissues of the oral cavity, periodontal charting, the evaluation and recording of dental caries, missing or unerupted teeth, restorations, existing prosthesis, occlusal relationships, hard and soft tissue anomalies, oral cancer evaluation and screening, blood pressure screenings, pulse, temperature, respiration, base EKG, treatment planning, evaluation of Patient's dental and medical history, general health assessments, diagnosis, pulp test (except limited oral evaluations-problem focused) when performed In Conjunction With an oral evaluation, consultation or other professional visit.
Intraoral complete mouth series (CMX) and panoramic x-rays	No Benefit will be paid for intraoral complete series and panoramic x-rays with or without bitewings when any mix of these Dental Services is performed more than once within 3 years. No Benefit will be paid for a subset of x-rays that are part of the full-mouth series, such as bitewings.
Intraoral periapical radiographs	No Benefit will be paid for intraoral radiographs taken as routine working and final treatment radiographs by the Same Dentist for endodontic treatment. Any combination of 10 or more periapical and bitewing radiographs is Benefitted As a full-mouth series and subject to a 3 year frequency limitation.
Bitewing x-rays (one set equals one or more bitewing films taken on the same day)	No Benefit will be paid for bitewing x-rays in excess of one (1) set in a 6 month period. A complete mouth series (CMX) or equivalent counts as one (1) set of bitewings in a 6 month period. If the fee for vertical bitewings is the same or exceeds the fee for a CMX, the Benefit Amount for the vertical bitewings will be limited to the Benefit that would be payable for a complete mouth series. All Benefit Limitations for a CMX will apply.
Cephalometric radiographic image	A cephalometric radiograph is limited to diagnosis for orthodontics and is limited to one (1) per lifetime.

Diagnostic & Preventive (D&P) Dental Services to assist the Dentist in evaluating the existing oral condition to determine required dental treatment and Dental Services intended to prevent future dental disease.	
Pulp vitality test	No Benefit will be paid for pulp vitality tests (a) when performed by the Same Dentist with any other Dental Service on the same day, except when the only Dental Services performed by the Same Dentist on the same day are limited oral evaluation-problem focused, radiographs, or palliative treatment, or (b) when performed for any reason other than for the diagnosis of emergency conditions. No Benefit will be paid for more than one (1) pulp vitality test per visit.
Diagnostic casts	Diagnostic casts are limited to diagnosis for orthodontics and are limited to one (1) per lifetime.
Prophylaxis (teeth cleaning)	No Benefit will be paid for prophylaxis when (a) any combination of prophylaxes and periodontal maintenance is performed more than once (1) in a 6 month period, (b) the prophylaxis is performed on the same day as periodontal maintenance by the Same Dentist, (c) the prophylaxis is performed by the Same Dentist during the time span beginning 14 days before and ending 90 days after a scaling and root planing or other periodontal treatment. Prophylaxes for persons age 14 and older are Benefited As adult prophylaxes. Prophylaxes for persons under age 14 are Benefited As child prophylaxes.
Office applied topical fluoride applications including fluoride varnish (per visit)	No Benefit will be paid for topical fluoride treatment more than once (1) per 6-month period. Fluoride treatments on persons age 14 through age 18 are Benefited As adult fluoride treatments. Fluoride treatments for persons under age 14 are Benefited As child fluoride treatments.
Space maintainers (includes teeth, clasps, rests and other components) for retaining space when a primary posterior tooth is prematurely lost	Benefits are limited to missing primary first and second molars to age 10. No Benefit will be paid for space maintainers: (a) more than once (1) per-missing tooth space in a lifetime, (b) for missing permanent teeth, (c) for missing primary anterior teeth, or (d) for persons age 10 and older.
Recementation of space maintainers	No Benefit will be paid for recementation of space maintainers more than once (1) per Patient in a lifetime.
Application of sealants Preventive resin restorations	No Benefit will be paid for preventive resin restorations and/or sealants: when applied to any tooth surface other than the occlusal surface of permanent molars and pre-molars which are free of restorations (including sealants and preventive resin restorations placed on the occlusal surface of the same tooth on the same day). No Benefit will be paid for more than one (1) per tooth in a five year period, or for children other than ages 5 – 16.
The following Specific Exclusions and Alternate Treatment Limitations apply to diagnostic and preventive services.	

Diagnostic & Preventive (D&P)

Dental Services to assist the Dentist in evaluating the existing oral condition to determine required dental treatment and Dental Services intended to prevent future dental disease.

Specific Exclusions

Any diagnostic or preventive service not listed as a Covered Service is Excluded. The following are also specifically **Excluded**:

- Images such as oral facial photographs, lateral skull and facial survey, cone beam capture, imaging, interpretation and manipulation.
- Tests such as bacteriologic tests, collection of microorganisms for culture and sensitivity, saliva tests, viral cultures, genetic tests, tests for susceptibility to caries (decay) and other oral diseases, screenings and assessments, caries risk assessment, pre-diagnostic cancer screening tests, medical tests, and screenings.
- Oral pathology laboratory procedures.
- Procedures such as nutritional and tobacco counseling, oral hygiene instructions, risk assessment, and counseling.
- Fluoride gels, rinses, tablets, or other preparations meant for home application.
- A prophylaxis paste containing fluoride or a fluoride rinse or swish.
- Repair and removal of space maintainers.
- Procedures mainly for plaque control.

Any combination of individually listed periapical, occlusal, or bitewing radiographs on the same date of service by the Same Dentist are Benefited As a complete series if the Approved Amount for individual radiographs equals or exceeds the Approved Amount for a complete series. The Delta Dental Benefit for the individual radiographs will not exceed the Benefit it would pay for a complete mouth series or radiographs.

Alternate Treatment Limitations

The Benefit Amount for full mouth debridement will be determined based on the Benefit Amount for prophylaxis subject to the above Specific Limitations and Specific Exclusions applicable to prophylaxis. The Covered Person is responsible for the difference between the Benefit Amount for the prophylaxis and the Approved Amount for the Dental Service actually rendered.

Panoramic x-ray with or without bitewing x-rays performed on the same day is Benefited As a complete mouth series of x-rays and subject to the 3-year Frequency Limit. Ten (10) or more periapical x-rays performed on the same day by the Same Dentist are Benefited As a full mouth series of x-rays and subject to the 3-year Frequency Limit.

General Exclusions

General Exclusions also apply. See Pediatric Dental Coverage General Exclusion Section.

Basic Restorative Services – Fillings and Simple Extractions

Dental Services for the restoration of teeth solely due to dental caries (decay) or fracture primarily using silver amalgam or composite resin materials as fillings after the decay is removed.

Covered Services	Specific Limitations
Amalgam (silver) fillings Composite (tooth colored) fillings - anterior teeth only	No Benefit will be paid for amalgam (silver) fillings or composite (tooth colored) fillings: (a) more than once (1) per surface of the same tooth per 12-month period unless Dentally Necessary, or (b) when performed on the same day or within 12 months following a post and core on the same tooth unless necessary due to caries, as a crown repair for a fracture, or access opening for root canal treatment.
Non-surgical extraction of teeth	Includes local anesthesia, suturing if needed, and post-operative care including treatment of dry socket.

The following Specific Exclusions and Alternate Treatment Limitations apply to all basic restorative services.

Specific Exclusions

Any restorative procedure not specifically listed as a Covered Service. The following are also specifically Excluded:

- Multiple pins in the same tooth
- Any procedures, restorations, or appliances associated with periodontal splinting
- Any restorative procedure not due to decay or fracture
- Protective restorations
- Interim Restorations
- Reattachment of tooth fragment

Any restoration involving two or more contiguous surfaces is Benefited As one multiple surface restoration.

Alternate Treatment Limitations

Benefits will be paid for composite restorations only when placed in front teeth and first premolars. Benefits for posterior teeth other than first premolars will be based on amalgam restorations. The Benefit for composite restorations for posterior teeth other than first premolars will be determined based on the Benefit Amount for amalgam restorations subject to the above Specific Limitations and Specific Exclusions applicable to amalgam restorations. The Covered Person is responsible for the difference between the Benefit Amount for the amalgam restorations and the Approved Amount for the Dental Service actually rendered.

General Exclusions

General Exclusions also apply. See Pediatric Dental Coverage General Exclusion Section.

Major Restorative Services - Crowns

Dental Services involving restoration covering or replacing the major part, or the whole of the clinical crown of a tooth.

Covered Services	Specific Limitations
Indirectly fabricated single base metal crowns, post & cores, and core build-ups	No Benefits will be paid for indirectly fabricated single crowns, onlays, post & cores (prefabricated or cast), and core build-ups: (a) for primary (“baby”) teeth or (b) when replaced on the same day or within 5 years from the date of the prior major restorative Dental Services unless Dentally Necessary, even if Delta Dental did not cover the Patient and/or pay a Benefit toward the prior Dental Service.

Major Restorative Services - Crowns Dental Services involving restoration covering or replacing the major part, or the whole of the clinical crown of a tooth.	
	For purposes of applying this Frequency Limit, implant supported or natural teeth onlays, inlays, indirectly fabricated crowns, fixed partial dentures, removable partial dentures, immediate and complete dentures are counted against themselves and each other. No Benefit will be paid for a core buildup when performed with or in addition to an amalgam restoration, resin-based composite restoration, inlays, onlays, or any other type of post and core.
Prefabricated stainless steel and resin crowns	No Benefit will be paid for prefabricated stainless steel or resin crowns when replaced within a 24-month period of time unless Dentally Necessary. Benefits for prefabricated resin crowns or stainless steel crowns with resin windows or esthetic coated stainless steel crowns on primary teeth are limited to primary teeth letters C through H and R through M only.
Crown repairs and recementation of crown post and cores	No Benefit will be paid for recementation of crowns, post and cores: (a) on the same day or within 6 months after the first insertion by the Same Dentist, (b) more than once (1) in a 12-month period. No Benefit will be paid for recementation of a post when performed on the same day as a single crown or fixed partial denture recementation.

The following Specific Exclusions and Alternate Treatment Limitations apply to restorative – crowns and onlays:

Specific Exclusions
Any restorative procedure not specifically listed as a Covered Service. The following are also specifically Excluded:

- Inlays and recementation of inlays
- Onlays and recementation of onlays
- ¾ crowns and recementation of ¾ crowns
- Gold foil restorations
- Copings (considered a specialized technique)
- Provisional or temporary or interim crowns
- Any procedures, restorations, or appliances associated with periodontal splinting
- Any restorative procedure not due to decay or fracture
- Removal of posts
- Veneers
- Restorative foundation for an indirect restoration

No Benefit will be paid for indirectly fabricated crowns unless the teeth cannot be restored with silver amalgam or composite resins (or other material approved by Delta Dental at its sole discretion). No Benefit will be paid for this Dental Service unless the tooth cannot be restored by any other means.

Alternate Treatment Limitations
The Benefit for indirectly fabricated crowns, and posts and cores for children under 12 years of age will be

Major Restorative Services - Crowns Dental Services involving restoration covering or replacing the major part, or the whole of the clinical crown of a tooth.
determined based on the Benefit Amount for prefabricated resin crowns for front teeth or prefabricated stainless steel crowns for back teeth subject to the above Specific Limitations and Specific Exclusions applicable to prefabricated resin crowns for front teeth or prefabricated stainless steel crowns for back teeth. The Covered Person is responsible for difference between the Benefit Amount for the prefabricated resin crowns for front teeth or prefabricated stainless steel crowns for back teeth and the Approved Amount for the Dental Service actually rendered. The Benefit for indirectly fabricated crowns is limited to predominately base metal full crowns on molars and porcelain fused to predominately base metal full crowns on premolars and anterior teeth subject to the Specific Limitations and Exclusions applicable to predominately base metal full crowns on molars and porcelain fused to predominately base metal full crowns on premolars and anterior teeth. The Covered Person is responsible for the difference between the Benefit Amount for predominately base metal full crowns on molars and porcelain fused to predominately base metal full crowns on premolars and anterior teeth and the Approved Amount for the service actually rendered. The Benefit for a prefabricated stainless steel crown with resin window or a prefabricated esthetic coated stainless steel crown or a prefabricated resin crown when performed on a posterior permanent tooth will be determined based on the Benefit Amount for a permanent stainless steel crown subject to the above specific Limitations and Specific Exclusions applicable to the Benefit Amount for a permanent stainless steel crown. The Covered Person is responsible for the difference between the Benefit Amount for the permanent stainless steel crown and the Approved Amount for the Dental Service actually rendered. **General Exclusions** General Exclusions also apply. See Pediatric Dental Coverage General Exclusion Section.

Major Restorative Services - Endodontics Dental Services for pulpal therapy and root canal therapy to treat or remove the nerves inside the tooth chamber and roots.	
Covered Services	**Specific Limitations**
Root canal therapy (initial)	No Benefits will be paid for initial root canal treatment: (a) more than once (1) per lifetime per tooth, (b) for primary teeth, (c) if not finished, or (d) when performed In Conjunction With apexification.
Pulpotomy, pulpal debridement, and partial pulpotomy for apexogenesis	No Benefit will be paid for pulpotomy, pulpal debridement, and partial pulpotomy for apexogenesis: (a) if not finished, (b) more than once (1) per lifetime per tooth, or (c) when performed by the Same Dentist on the same day as root canal treatment. No Benefit will be paid for therapeutic pulpotomy for permanent teeth. No Benefit will be paid for partial pulpotomy for apexogenesis: (a) for primary teeth, or (b) when performed within 30 days prior to or the same day as root canal treatment or apexification/recalcification.
Apexification/ recalcification,	No Benefit will be paid for apexification/recalcification: (a) if not finished, (b) for primary teeth, or (c) more than once per tooth per lifetime.

<table>
<tr><th colspan="2">Major Restorative Services - Endodontics
Dental Services for pulpal therapy and root canal therapy to treat or remove the nerves inside the tooth chamber and roots.</th></tr>
<tr><td>apicoectomy/ periradicular surgery, and retrograde fillings on permanent teeth</td><td>No Benefit will be paid for apicoectomy/periradicular surgery and retrograde fillings: (a) more than once (1) per root in a lifetime, or (b) for primary teeth.</td></tr>
<tr><td>Retreatment of root canal therapy</td><td>No Benefit will be paid for retreatment of root canal treatment: (a) on the same day or within 24 months after the first root canal was finished, or (b) more than once (1) per tooth in a lifetime.

No Benefit will be paid for removal of a post, pin(s), old root canal filling material, and the procedures needed to prepare the canals and place the canal filling and root canal therapy when performed In Conjunction With endodontic retreatment.</td></tr>
<tr><td colspan="2">The following Specific Exclusions and Alternate Treatment Limitations apply to endodontic services:

Specific Exclusions
Any endodontic service not listed as a Covered Service. The following are specifically Excluded:
• Pulp caps
• Non-surgical treatment of root canal obstruction
• Internal repair of perforation defects
• Endodontic endosseous implant
• Intentional reimplantation
• Surgical procedure to isolate tooth with rubber dam
• Canal preparation and fitting of preformed dowel and post
• Any endodontic procedures related to implants, overdentures or inoperable or fractured teeth
• Temporary restorations and routine postoperative visits
• Pulpal regeneration
• Root amputation
• Hemi-section
• Periradicular surgery without apicoectomy
• Bone grafts and regenerative procedures in conjunction with periradicular surgery

General Exclusions
General Exclusions also apply. See Pediatric Dental Coverage General Exclusion Section.</td></tr>
</table>

Major Restorative Services - Periodontics Dental Services to treat diseases of the tissues (gums) and bone supporting the teeth.	
Covered Services	**Specific Limitations**
Periodontal scaling and root planing	No Benefit will be paid for periodontal scaling and root planing: (a) more than once (1) per quadrant on the same day or within twenty-four (24) months, or (b) on the same day or within 30 days before surgery or 90 days following periodontal surgery when performed by the Same Dentist unless Dentally Necessary. Scaling and root planing in the absence of 4mm pockets is Benefited As a prophylaxis.
Periodontal maintenance	Benefits are paid once every three (3) months following periodontal surgery only. No Benefit will be paid for periodontal maintenance: (a) more than twice (2) in a 12 month period, (b) when performed on the same day as non-incidental scaling and root planing. No Benefit will be paid for any combination of prophylaxes, and periodontal maintenance more than twice (2) in a 12-month period.
Surgical periodontal treatment, including any surgical re-entry (gingivectomy, osseous surgery, flap surgery, tissue regeneration procedures, distal or proximal wedge, and grafts)	No Benefit will be paid for surgical periodontal treatment, including any surgical re-entry (gingivectomy, osseous surgery, flap surgery, tissue regeneration procedures, distal or proximal wedge, and grafts): (a) more than once (1) in any combination in the same area of the mouth on the same day or within thirty-six (36) months except soft tissue grafts unless Dentally Necessary, (b) when performed for pre-restorative and crown lengthening) purposes, or (c) in the absence of 5mm pockets. No Benefit will be paid for soft and connective tissue grafts when more than one of the same or different type of soft and/or connective tissue graft is performed on the same day or within 36 months in the same part of the mouth. No Benefit will be paid for apically repositioned flaps, regenerative procedures, soft and connective tissue grafts, and/or osseous grafts when more than two (2) of any combination of these procedures is performed within any given quadrant are performed on the same date of service.

The following Specific Exclusions and Alternate Treatment Limitations apply to periodontic services:

Specific Exclusions

Any periodontal procedure not specifically listed as a Covered Service. The following are also specifically Excluded:

- Anatomical crown exposure, provisional splinting,
- Localized delivery of antimicrobial agents, curettage and mucogingival surgery
- Periodontal charting as a separate procedure
- Clinical crown lengthening or gingivectomy in conjunction with a crown or restorative procedure
- Unscheduled dressing change
- Laser disinfection and laser assisted new attachment procedures
- Gingival irrigation

Major Restorative Services - Periodontics

Dental Services to treat diseases of the tissues (gums) and bone supporting the teeth.

No Benefit will be paid for less Comprehensive procedures when performed on the same day in the same part of the mouth as a more Comprehensive procedure as listed in the following hierarchy (most Comprehensive to least Comprehensive):

- Osseous surgery
- Clinical crown lengthening (not a Covered Service)
- Apically positioned flap
- Surgical revision
- Gingival flap
- Distal or proximal wedge
- Anatomical crown exposure
- Gingivectomy
- Scaling and root planing
- Debridement
- Periodontal maintenance
- Prophylaxis

The following Dental Services are Benefited As quadrants or partial quadrant procedures:

- Gingivectomy, scaling and root planing qualify for the full quadrant Benefit if four or more diseased teeth distal to the midline are treated. Tooth Bounded Spaces are not counted in making this determination. When these periodontal procedures do not meet all of these criteria they are Benefited As a partial quadrant.

- Gingival flap procedures and osseous surgery qualify for the full quadrant Benefit if four or more diseased teeth or Tooth Bounded Spaces distal to the midline are treated. A Tooth Bounded Space counts as one space despite the number of teeth that would normally exist in the space. When these procedures do not meet all of these criteria the Benefit is limited to a partial quadrant.

No Benefit will be paid for postoperative care and/or finishing procedures (on the same day or within 90 days of periodontal surgery or scaling and root planing).

No Benefit will be paid for periodontal procedures not performed for natural teeth such as but not limited to being performed In Conjunction With implants, ridge augmentation and/or preservation, extraction sites, periradicular surgery.

No Benefit will be paid for prophylaxis and incidental scaling and root planing procedures by the Same Dentist when performed on the same day as periodontal maintenance.

No Benefit will be paid for prophylaxis and/or periodontal maintenance if the Dental Services are performed by the Same Dentist during the time period beginning 14 days before and ending 90 days after a scaling and root planing or other periodontal treatment unless Dentally Necessary.

No Benefit will be paid for biologic materials to aid in soft and osseous tissue regeneration on the same day as other periodontal regenerative and grafting procedures except when reported only with gingival flap procedures or osseous surgery.

Major Restorative Services - Periodontics Dental Services to treat diseases of the tissues (gums) and bone supporting the teeth.
No Benefit will be paid for guided tissue regeneration on the same day as soft tissue grafts in the same surgical area. No Benefit will be paid for routine prophylaxis (teeth cleaning) when provided In Conjunction With periodontal scaling and root planing. No Benefit will be paid for periodontal maintenance except after active periodontal therapy (surgical) has been performed. **General Exclusions** General Exclusions also apply. See Pediatric Dental Coverage General Exclusion Section.

Major Restorative Services – Prosthodontics-Fixed and Removable Dental Services to replace missing permanent teeth (not including third molars) where the chewing function is impaired.	
Removable complete and partial dentures	No Benefit will be paid for removable complete and partial dentures: (a) more than once in a 5-year period from the date of prior insertion even if Delta Dental did not cover the Patient and/or pay a Benefit toward the prior Dental Service unless Dentally Necessary, or (b) if the existing denture is satisfactory or can be made satisfactory. To obtain a Benefit for a removable partial denture, You must not have 8 or more posterior teeth in occlusion and no missing anterior teeth.
Fixed partial dentures (bridges), including retainers (crowns) pontics, core buildups, and post and cores	No Benefit will be paid for fixed partial dentures (bridges), including retainers (crowns) pontics, core buildups, and post and cores: (a) more than once (1) in a 7-year period from the date of prior insertion unless Dentally Necessary, or (b) if the existing fixed partial denture is satisfactory or can be made satisfactory. No Benefit will be paid for core buildups when performed In Conjunction With restorations or post and core of any type.
Adjustments, repairs, relines, and rebases to removable complete and partial dentures	No Benefit will be paid for adjustments, repairs, relines, rebases, and tissue conditioning to removable complete and partial dentures on the same day or within 6 months of insertion of the denture (except in the case of immediate dentures) by the Same Dentist. No Benefit will be paid for any combination of repairs, relines, rebases, and tissue conditioning more than twice (2) per denture unit on the same day or within 12 months. No **Benefit** will be paid for adjustments: (a) when performed by the **Same Dentist** on the same day or within 6 months of a reline or rebase, (b) more than once (1) on the same day, or (c) more than twice (2) within 12 months. No **Benefit** will be paid for a reline when performed by the **Same Dentist** on the same day or within six months of a rebase.

<table>
<tr><th colspan="2">Major Restorative Services – Prosthodontics-Fixed and Removable
Dental Services to replace missing permanent teeth (not including third molars) where the chewing function is impaired.</th></tr>
<tr><td>Recementation of fixed partial dentures (bridges)</td><td>No Benefit will be paid for recementation of fixed partial dentures (bridges): (a) on the same day or within 6 months of fixed partial denture cementation by the Same Dentist, or (b) more than once (1) on the same day or within 12 months.

No Benefit will be paid for post recementation when performed on the same day as a single crown or fixed partial denture recementation.</td></tr>
<tr><td>Repair of fixed partial dentures (bridges)</td><td>No Benefit will be paid for repair of fixed partial dentures (bridges): (a) on the same day or within 6 months of insertion of the first fixed partial denture by the Same Dentist, or (b) more than twice (2) in 36 months from then on.</td></tr>
</table>

The following **Specific Limitations**, **Specific Exclusions** and **Alternate Treatment Limitations** apply to fixed and removable prosthodontic services:

Specific Limitations
For purposes of determining frequency limitations, implant supported or natural tooth inlays, onlays, indirectly fabricated crowns, veneers, fixed partial dentures, removable partial dentures, and immediate and complete dentures are counted against themselves and each other.

Specific Exclusions
Any fixed or removable prosthodontic procedures not listed as **Covered Services** are **Excluded**. The following are also specifically **Excluded**:

- Interim or temporary complete and partial dentures
- Overdentures
- Maxillofacial prosthetics
- Any procedures, restorations, or appliances associated with periodontal splinting
- Implants and any procedures associated with implants, interim or provisional pontics and retainers, connector bars, stress breakers, precision attachments, copings, and pediatric fixed partial dentures
- Pontics exceeding the normal complement of teeth
- Replacement of missing natural teeth using more than the normal amount of retainers for the span
- Tissue conditioning
- Retainers that are inlays, onlays, or ¾ crowns

No Benefit will be paid for fixed or removable partial dentures if eight (8) or more posterior teeth are in occlusion and there are no missing anterior teeth.

The maximum Benefit Amount that will be paid for repair, and/or reline, and/or rebase, and/or adjustment of a fixed or removable partial denture or complete denture or combination is one-half the Benefit Amount that would be payable under this Policy for a new appliance.

Alternate Treatment Limitations
No Benefit will be paid for a fixed partial denture unless use of a removable prosthetic device is not sufficient. If a removable device is sufficient, the Benefit will be determined based on the Benefit Amount for a standard removable partial denture subject to the above Specific Limitations and Specific Exclusions applicable to a standard removable partial denture. The Covered Person is responsible for the difference between the Benefit

Major Restorative Services – Prosthodontics-Fixed and Removable Dental Services to replace missing permanent teeth (not including third molars) where the chewing function is impaired.
Amount for the standard removable partial denture and the Approved Amount for the Dental Service actually rendered. When more than three teeth (except third molars) are missing in an arch, the Benefit for a fixed partial denture will be determined based on the Benefit Amount for a removable partial denture subject to the above Specific Limitations and Specific Exclusions applicable to a standard removable partial denture. The Covered Person is responsible for the difference between the Benefit Amount for the removable partial denture and the Approved Amount for the Dental Service actually rendered. The Benefit Amount for personalized restoration, specialized techniques, such as but not limited to precision attachments, overdentures, and stress breakers as opposed to standard procedures will be determined based on the Benefit Amount for the standard procedure subject to the Specific Limitations and Specific Exclusions applicable to the standard procedure. The Covered Person is responsible for the difference between the Benefit Amount for the standard procedure and the Approved Amount for the Dental Service actually rendered. The benefit for fixed partial dentures will be limited to predominately base metal full crowns and pontics for molars and porcelain fused to predominately base metal full crowns and pontics for premolars and anterior teeth subject to the Specific Limitations and Exclusions for predominately base metal full crowns and pontics for molars and porcelain fused to predominately base metal full crowns and pontics for premolars and anterior teeth. The Covered Person is responsible for the difference between the Benefit Amount for predominately base metal full crowns and pontics for molars and porcelain fused to predominately base metal full crowns and pontics for premolars and anterior teeth and the Approved Amount for the service actually rendered. **General Exclusions** General Exclusions also apply. See Pediatric Dental Coverage General Exclusion Section.

Major Restorative Services – Oral Surgery Services Dental Services for the surgical extraction of teeth, as well as minor surgical preparation of the mouth for insertion of dentures.	
Non-surgical and surgical extraction of teeth Intraoral incision and drainage	No Benefit will be paid for removal of non-pathological impacted teeth. No Benefit will be paid for local anesthesia and suturing (if needed) when performed by the Same Dentist on the same day as oral and maxillofacial surgery. No Benefit will be paid for intraoral incision and drainage when performed by the Same Dentist in the same surgical area on the same date of service as endodontics, extractions, palliative treatment or other Definitive Procedure. No Benefit will be paid for routine postoperative care and treatment of dry socket: (a) when performed by the Same Dentist who performed the surgery, or (b) more than once (1) per visit. No Benefit will be paid for extraction, coronal remnants – deciduous tooth when performed by the Same Dentist in the same surgical area on the same date of service as any other surgery. No Benefit will be paid for root recovery when performed by the Same Dentist in the same surgical area on the same day as a surgical extraction. Extractions of impacted teeth are Benefited as determined by the anatomical position of the tooth rather than the surgical procedure necessary for removal.

Major Restorative Services – Oral Surgery Services Dental Services for the surgical extraction of teeth, as well as minor surgical preparation of the mouth for insertion of dentures.	
Alveoloplasty Removal of exostosis and tori, fibrous tuberosity reduction, frenulectomy, frenuloplasty, excision of pericoronal, and hyperplastic tissue Uncomplicated vestibuloplasty	No Benefit will be paid for alveoloplasty when performed on the same date of service as one or more surgical extractions. No Benefit will be paid for frenulectomy, frenuloplasty, excision of hyperplastic tissue, and excision of pericoronal gingiva when performed by the Same Dentist in the same surgical area on the same date as any other surgical procedure(s).

The following Specific Exclusions apply to Oral Surgery services:

Specific Exclusions

Any oral surgery service that is not listed is not a Covered Service. The following are specifically Excluded:

- Any oral surgical procedure related to implants, overdentures, ridge augmentation and/or preservation, transplants or intentional reimplantation, other specialized techniques, oral antral fistula closure, closure of a sinus perforation, tooth transplantation, exfoliative cytology, biopsy, brush biopsy, surgical repositioning, surgical placement of temporary anchorage devices, complicated vestibuloplasty, surgical excision of lesions, surgical incision (except intraoral excision and drainage), treatment of fractures, repair procedures except those listed as covered, tooth mobilization, appliance or splint removal treatment of temporal mandibular dysfunction and orthognathic surgery, coronectomy harvest of bone for use in grafting, and plasma or platelet rich protein (PRP) therapies.
- Any oral and maxillofacial surgical procedure for which the Covered Person is covered by another Policy including, but not limited to a medical policy.
- Placement of a device to aid eruption, transseptal/supra crestal fiberotomies, and surgical access of an unerupted tooth.

General Exclusions

General Exclusions also apply. See Pediatric Dental Coverage General Exclusion Section.

Medically Necessary Orthodontic Services Medically Necessary Orthodontic Services for the correction of handicapping malocclusions.	
Comprehensive orthodontic services to correct a severely handicapping malocclusion	All orthodontic cases require Prior Authorization. Medically Necessary orthodontic services are covered if one of the following conditions are met: • The Covered Person obtains 24 or more points on a correctly scored Salzmann Malocclusion Severity Assessment; or • The Covered Person demonstrates that the requested treatment will significantly improve a mental, emotional, or behavioral condition associated with the Covered Person's dental condition; or • The Covered Person presents evidence of a severe deviation affecting the mouth and/or underlying dentofacial structures.

The following **Specific Exclusions** and **Alternate Treatment Limitations** apply to Orthodontic Services: Medically Necessary Orthodontic Services are limited to one case per lifetime. Payment will be made in the sum of twenty percent (20%) of the Approved Amount for the Orthodontic Service in the Treatment Plan once the banding has been done. The balance of the Approved Amount for the Orthodontic Services in the Treatment Plan will be made monthly. Each monthly payment will be one-thirtieth ($1/30^{th}$) of the balance. The monthly payment will be made only if the patient is still receiving the approved services and is a Covered Person during that month. If coverage under this policy begins after orthodontic treatment has started, payments for Medically Necessary Orthodontic Services will be pro-rated according to the terms of this policy and the monthly payment schedule in this paragraph. Payments will cease when the patient is no longer a Covered Person or no longer receiving the Orthodontic Services, whichever occurs first. **General Exclusions** General Exclusions also apply. See Pediatric Dental Coverage General Exclusion Section.	

Adjunctive General Dental Services Anesthesia and **Dental Services** for the temporary relief of pain See also, Benefits section for Outpatient Services, Hospital Services and Dental Anesthesia Services covered under this Policy.	
Deep sedation/general anesthesia – first 30 minutes	Benefits are limited to Covered Persons under the age of eight (8) with a demonstrated need for behavior management related to the dental procedures to be performed.
Deep sedation/general anesthesia – each additional 15 minutes	Benefits are limited to Covered Persons under the age of eight (8) with a demonstrated need for behavior management related to the dental procedures to be performed.
Analgesia, Anxiolysis, Inhalation – NO2	Benefits are limited to Covered Persons of any age who have a diagnosis of Autism, Hyperactivity Disorder or severe/profound developmental delay with a demonstrated need for behavior management related to the dental procedures to be performed.
Intravenous Conscious Sedation/ Analgesia First 30 Minutes	Benefits are limited to Covered Persons of any age who have a diagnosis of Autism, Hyperactivity Disorder or severe/profound developmental delay with a demonstrated need for behavior management related to the dental procedures to be performed. Benefits are provided for Covered Persons over the age of twelve (12) solely for use with multiple oral surgical procedures performed at the same visit and in excess of two (2) surgical extractions or removal of impacted teeth.

<table>
<tr><td colspan="2">Adjunctive General Dental Services
Anesthesia and Dental Services for the temporary relief of pain
See also, Benefits section for Outpatient Services, Hospital Services and Dental Anesthesia Services covered under this Policy.</td></tr>
<tr><td>Intravenous Conscious Sedation/ Analgesia Each Additional 15 minutes</td><td>Benefits are limited to Covered Persons of any age who have a diagnosis of Autism, Hyperactivity Disorder or severe/profound developmental delay with a demonstrated need for behavior management related to the dental procedures to be performed.

Benefits are provided for Covered Persons over the age of twelve (12) solely for use with multiple oral surgical procedures performed at the same visit and in excess of two (2) surgical extractions or removal of impacted teeth.</td></tr>
<tr><td>Palliative treatment
Treatment of unusual post-surgical complications</td><td>No Benefit will be paid for Palliative treatment: (a) when any Dental Service other than limited radiographs, tests, evaluations, consults, and visits necessary to diagnose the emergency condition is performed by the Same Dentist on the same date, or (b) more than once (1) per date of service and/or c), more than 4 within a 12-month period.

No Benefit will be paid for routine post-operative care, routine post-operative radiographs, and routine post-operative evaluations when performed by the Same Dentist as rendered the operative care. No Benefit will be paid for treatment of dry socket: (a) when performed by the Same Dentist who performed the surgery, or (b) more than once (1) per visit.</td></tr>
<tr><td colspan="2">The following Specific Exclusions apply to adjunctive general services:

Specific Exclusions
Any adjunctive Service not listed as a Covered Service is Excluded. The following are also specifically Excluded:

• Anesthesia: local, regional and trigeminal block, non-intravenous conscious sedation.
• Professional visits: house, hospital and ambulatory surgical center calls; office visits; hospitalization costs; case presentation and treatment planning.
• Drugs: euphoric or prescription drugs, or writing prescriptions, therapeutic parenteral drugs, or other drugs or medicaments.
• Miscellaneous: desensitizing procedures, behavior management, repair, reline and adjustment of occlusal guard, athletic mouth guards, occlusal analysis including mounted case, occlusal adjustment, enamel microabrasion, odontoplasty, internal and external bleaching, or fixed partial denture sectioning.
• Deep sedation/general anesthesia or IV sedation time before the doctor administering the anesthetic agent initiates the appropriate anesthesia and non-invasive monitoring protocol.
• Deep sedation/general anesthesia or IV sedation time after the Patient may be safely left under the observation of trained personnel and the doctor may safely leave the room to look after other patients or duties.
• Deep sedation/general anesthesia or IV sedation to the extent it exceeds 1.5 hours per date of service.
• Deep sedation/general anesthesia, anxiolysis, inhalation-NO2, or IV sedation for procedures which are not Benefits.

No Benefits are provided for deep sedation/general anesthesia, analgesia, anxiolysis, inhalation-NO2 or</td></tr>
</table>

Adjunctive General Dental Services Anesthesia and **Dental Services** for the temporary relief of pain See also, Benefits section for Outpatient Services, Hospital Services and Dental Anesthesia Services covered under this Policy.
intravenous conscious sedation for Covered Persons over the age of eight (8) for the extraction of a single tooth or for non-surgical dental procedures or for the convenience and/or preference of the Covered Person. **General Exclusions** General Exclusions also apply. See Pediatric Dental Coverage General Exclusion Section.

GENERAL EXCLUSIONS (APPLICABLE TO ALL DENTAL SERVICES)

The reference to a Dental Service in this section does not mean that it would otherwise be a Covered Service.

- A covered person may transfer from the care of one Dentist to that of another Dentist and more than one dentist may render the same Dental Services to the covered person. In that case Delta Dental shall not pay more than the Benefit Amount it would pay if only one Dentist rendered all these Dental Services. Nor shall Delta Dental pay for duplication of Dental Services.

- The following are NOT due any Benefits and Delta Dental shall NOT make any payment under this policy for or toward:

    - Dental Services not specifically listed as Covered Services in the Pediatric Dental Benefits Schedule including but not limited to maxillofacial prosthetics, implants and any services associated with implants, and orthodontic services that are not Medically Necessary Orthodontic Services.
    - Dental Services for which a claim was not submitted within twelve (12) months after the date when the Dental Service was completed except for any oral and maxillofacial surgical procedure for which the Covered Person is covered by another policy including, but not limited to a medical policy, if the service is submitted to Delta Dental within twelve (12) months after the date that the claims administrator issued its claim determination.
    - Duplicative Dental Services performed on the same day.
    - Dental Services for injuries or conditions which are compensable under Workers Compensation or Employer's Liability laws; Dental Services that are provided by any Federal or Provincial government agency, or are provided without cost to the covered person by any municipality, county, or other political subdivision or community agency, except to the extent such payments are not enough to pay the Approved Amount.
    - Dental Services performed or items supplied for any conditions, disease, sickness, or injury occurring while the Covered Person is on active duty during military service, or for Dental Services or items provided under the laws of the United States of America or of any state of the United States or any foreign country or of any political subdivision or community agency, except to the extent such payments are not enough to pay the Approved Amount therefor.

- Dental Services covered by the Covered Person's medical benefit under this policy.
- Dental Services considered by Delta Dental to be part of a more Comprehensive Service.
- A subset of a more Comprehensive Service (or a lesser Dental Service considered included in the Comprehensive Service).
- Dental Services relating to more than the normal complement of teeth except for necessary oral surgery.
- Prescription drugs.
- Dental services of a trial, experimental or investigational nature. The determination of a trial, experimental or investigational is based on the service rendered and not the diagnosis. Please note that a dental service is not considered experimental if it has completed a Phase III clinical trial of the Food and Drug Administration. A dental service, treatment, procedure, modality, or material is deemed experimental or investigational under any of the following circumstances:
  i. There is insufficient credible evidence from juried scientific literature that it is valid and effective;
  ii. There is insufficient evidence that it demonstrates health and cost efficacy;
  iii. It does not differ significantly from what that which is currently covered;
  iv. It is not proven to be a necessary and effective means for treating a dental condition;
  v. It is not a generally accepted modality of care; or
  vi. It has not been recommended by the DeltaUSA Dental Policy Committee, the Delta Dental Plans Association National Scientific Advisory Committee, the American Dental Association, a specialty society recognized by the American Dental Association, or the American Association of Dental Consultants.
- Charges for hospitalization, including hospital visits. See Benefits section for Outpatient Services, Hospital Services and Dental Anesthesia Services covered under this Policy.
- Exploratory surgery or unsuccessful attempts at extractions.
- Lab tests and/or lab exams and/or medical tests, etc.
- Specialized techniques including but not limited to precision attachments, copings, swing locks, dolder bars, special staining, halder bars, connector bars, metal bases, cone beam capture and imaging, interpretation and manipulation, ridge augmentation and/or preservation.
- Dental Services submitted for payment as part of a Claim which has knowingly inaccurate information pertinent to the Claim (such as the Dental Service actually rendered, the date of service, the existence of other coverage, or the fee for the Dental Service).
- Any Dental Service or item which is decided by Delta Dental not to be Dentally Necessary.
- Tooth preparation, acid etching, temporary, interim, and provisional restorations and crowns, bases, direct and indirect pulp caps, polishing, caries removal, microabrasion, endodontic working and final treatment radiographs, occlusal adjustments, post removal, gingivectomy in conjunction with restorations, impressions, lab fees and material, local anesthesia services, and other Dental Services that Delta Dental considers to be part of a more comprehensive dental service.
- Broken appointments.
- Completion of claims; copying of radiographs; providing information and documentation

whether or not requested by Delta Dental; and requests for Prior Authorization; Pre-Treatment Estimates.

- Periodontal charting.
- Infection control, sterile surgical setup, OSHA compliance, and other facility charges.
- Treatment rendered by persons other than a Dentist. This does not apply to any Dental Services which may be performed by a duly licensed dental hygienist or dental auxiliary if the treatment performed is within the scope of practice, as authorized by applicable law and/or regulation and, if required, performed under the supervision and guidance of a Dentist, and the claim for such treatment complies with all applicable governmental rules. If performed under these circumstances, the Benefit Amount for the Dental Services is determined as if the Dental Services have been rendered by a Dentist, or as otherwise governed by law.
- Dental Services or supplies that are cosmetic in nature. These Dental Services include but are not limited to charges for personalized or characterization of dentures.
- Replacement of lost, missing or stolen prosthetic, orthodontic, or other appliance. If the denture prosthesis was stolen or destroyed by a natural disaster, fire, or accident, substantiating documentation such as the original police, fire marshal or other responding official report must be included with the prior authorization request. If the denture prosthesis was lost or destroyed as a result of misuse, abuse or negligence, a replacement will not be authorized. The prior authorization request must also include a description and / or documentation that will justify the dental necessity for the replacement of the denture; dentures will not be replaced for cosmetic reasons.
- Crowns, prosthetic retainers, and pontics posts and cores, and core buildups are limited to one per tooth per Benefit Period without regard to whether the tooth has been sectioned.
- Desensitizing agents, home rinses and gels, other preparations for home use.
- Fees for Dental Services or supplies for which no charge is made that the Covered Person is legally required to pay or for which no charge would be made if the Covered Person did not have dental coverage.
- Dental Services performed by the Dentist for immediate family members of the dentist such as mother, father, spouse, children, brother, sister.
- Any duplicate prosthetic device or other duplicate appliance.
- Myofunctional therapy.
- Dental Services to correct developmental or congenital malformations, replace or repair teeth due to such conditions; procedures, appliances, or restorations for cosmetic purposes; procedures, appliances, or restorations to increase vertical dimension; restore occlusion; repair tooth structure lost by attrition; erosion; corrosion; abfraction; related to bruxism; to diagnose or treat jaw or joint disorders, including myofacial pain syndrome and/or temporomandibular joint dysfunction, or; occlusal equilibration, occlusal analysis and mounted case analysis, or occlusal adjustment. Please note that treatment for jaw or joint disorders is covered under the medical portion of this policy.
- Dental Services or supplies due to an accidental injury.
- Fees which are incurred for any injury or disease arising out of the ownership, maintenance or

use of a motor vehicle, except when such charges are excluded from coverage under any automobile insurance policy or program required or provided by statute covering such Covered Person, where such exclusion is due to either an optional choice of a medical cost, Deductible or an optional designation of the plan as the primary coverage.

- Dental Services for which the Completion is prior to or after the Coverage Period.
- Transportation costs.
- Sales tax and service charges.

This is a general description of Your dental plan to be used as a convenient reference, and some exclusions and limitations may not be listed here.

OTHER PAYMENT RULES THAT AFFECT THE PEDIATRIC DENTAL COVERAGE

To Receive Benefits, You Must Have Coverage on the Completion Date of the Dental Services

Delta Dental will make a benefit payment only for those Dental Services that are Covered Services. Not all Dental Services are covered under this Policy. Delta Dental will not pay a Benefit unless the person covered under the pediatric dental coverage is enrolled on the completion date of the Dental Services. Benefits are determined and paid based on the Completion Date of the Dental Services.

Dental Services Requiring Multiple Visits

Some Dental Services take multiple visits to complete. Examples include crowns, bridges, removable prosthetics, and endodontic procedures. Delta Dental pays for Covered Services that need multiple visits only upon the Completion Date of the Dental Services. The Completion Date is deemed to be the date of the service for these Dental Services.

In-Process Treatment

Dental Services started before Your coverage effective date under this Policy's Pediatric Dental Coverage are not entitled to any Benefit. No Benefit will be paid for any Dental Services provided to a person enrolled in the Pediatric Dental Coverage if the Dental Service started prior to enrollment for the Pediatric Dental Coverage under this policy. Dental Services that may be performed over more than one visit include, but are not limited to, fixed bridgework, full or partial dentures, crowns, and root canal therapy. If the covered person was not enrolled in the Pediatric Dental Coverage when the Dental Services were started, but enrolls after the Completion Date of the service, no benefit will be paid. If the Completion Date for a Dental Service is after the coverage expiration date, no benefit will be paid. For example, the Completion Date for removable prosthetic appliances, for fixed partial dentures, and for crowns, is the date of insertion or the date of cementation, no matter what type of cement is used. The Completion Date for root canal therapy is the date the canals are permanently filled.

Incomplete Treatment

One dentist may start a Dental Service, and another Dentist may finish it. If this happens, Delta Dental will pay no Benefit for the Dental Service performed by the Dentist who did not complete the Dental Service. Delta Dental's payment of a Benefit will be limited to the Dental Services rendered by the dentist who finishes the Dental Service.

Overpayments

Delta Dental has the right to recoup any payments to anyone where the payment is more than the amount the person was entitled to receive under this Pediatric Dental Coverage or if payment was made to the wrong payee. Delta Dental may also offset any such overpayment against any amount which would otherwise be due to a covered person under the Pediatric Dental Coverage or the policy. It may also recover payments made on Your behalf where a third-party was responsible for an accident or injury that required You to seek treatment or Dental Services, to the extent authorized by law.

Payments to Custodial Parent

There may be circumstances under which We have not made direct payment the Dentist for Dental Services received by Your Covered Dependent and the law requires Us to send the payment to the custodial parent who is not a Member under this Policy.

PRIOR AUTHORIZATIONS, PRE-TREATMENT ESTIMATES, AND DENTAL NECESSITY

This policy covers certain Dentally Necessary Dental Services and Medically Necessary Orthodontic Services. Routine Preventive and Diagnostic procedures do not require Prior Authorization. However, many other covered services do need to be Prior-Authorized. A list of Dental Services that require Prior Authorization is in the Prior Authorization Addendum.

If a Dental Service is not Dentally Necessary or if Orthodontic Services are not Medically Necessary, they will be denied and You will receive no Benefit under this plan.

If a Dental Service is required to be but is not Prior Authorized as required by the terms of this plan, and the service would have been approved had there been a Prior Authorization request, Your coverage will be reduced and You will be responsible for paying a penalty. The penalty will be the lower of 50% of the scheduled benefit or $500. If you go to a Delta Dental PPO^{SM} Dentist in Connecticut or New Jersey, or to a Delta Dental Participating Dentist in Connecticut or New Jersey and he or she fails to obtain the required Prior Authorization, in certain circumstances you will not be financially responsible for any portion of the charge for that service. For example, if you go to a Delta Dental PPO^{SM} Dentist in Connecticut and you ask for the service to be performed without waiting for a Prior Authorization, you will be financially responsible. But, if the Delta Dental PPO^{SM} Dentist in Connecticut performs the service without submitting the Prior Authorization or waiting for the Prior Authorization, you may not be responsible for any portion of the charge for that service.

A Dentist may send a Claim to Delta Dental showing the Dental Services he or she recommends for You. Delta Dental will then provide an estimate of Benefits under this Pediatric Dental Coverage of Your Policy. This is called a Pre-Treatment Estimate. A Pre-Treatment Estimate is also recommended for Dental Services that cost more than $300. A Pre-Treatment Estimate is not a guarantee of payment.

CLAIMS AND APPEALS

Filing a Claim
The following is a description of how a Claim is processed. If You use a Delta Dental PPO[SM] dentist or a Delta Dental Participating dentist, the dentist will send a claim on Your behalf. If You visit a Non-Participating Dentist, the Non-Participating Dentist may be required to send the claim for You or You may chose or need to file the claim yourself.

Non-Participating Dentist claim forms must be sent to:

Delta Dental of New Jersey, Inc.
P.O. Box 222
Parsippany, NJ 07054

To be entitled to a Benefit under this pediatric dental coverage, the claim must be submitted by You or Your Dentist within twelve (12) months of the date Dental Services are completed. Delta Dental will approve the Claim, deny the Claim, or ask for more information within the time frames prescribed by law and/or regulation.

Notice of Adverse Benefit Determination
If a Prior Authorization is denied, a service is found to be not Dentally Necessary, Medically Necessary, or a Claim is denied in whole or in part, Delta Dental will notify You and the treating Dentist of the denial in writing. Delta Dental will send an Explanation of Benefits within the time and way required by law and/or regulation.

The **Explanation of Benefits** will include the following information:

- The specific reason(s) why the Dental Service was denied, including a reference to any specific rule on which the denial is based; whether a specific rule, guideline or protocol was relied upon in making the Adverse Benefit Determination and if so, that a copy will be provided free of charge upon request; and a description of any extra information needed to perfect the claim, as well as the reason why such information is necessary.

- The relevant scientific or clinical judgment will be included if the Adverse Benefit Determination is related to dental need, experimental treatment or other similar exclusion or limitation.

- A description of Delta Dental's informal appeal and formal claim appeal processes and the time limits applicable to the processes.

Claims Review and Appeals Procedures
You have the right to appeal any Adverse Benefit Determination.

Examples of Adverse Benefit Determinations include decisions on Prior Authorization Requests and Claim decisions by Delta Dental that a dental service is not entitled to a Benefit because:

- It is not Dentally Necessary
- Orthodontic Services are not Medically Necessary
- It is not a Covered Service
- It is Excluded from coverage
- It is subject to a Benefit Limitation under the Pediatric Dental Coverage of this policy.

Please see the Appeals/Grievance Process section of this Policy for information on submitting an appeal or grievance.

Authorized Representative
You may authorize a representative to act on Your behalf in pursuing a claim review or claim appeal. Delta Dental may require that You name Your authorized representative to Us in writing, in advance. For an urgent care claim, You may name a dental care professional who is knowledgeable about Your dental condition to act on Your behalf. We will deal with Your authorized representative rather than You for matters involving the claim or appeal.

PARTICIPATING PROVIDERS NOT OUR AGENTS
Delta Dental PPO^{SM}, Delta Dental Premier^{SM}, or participating providers of Another Delta Plan are not employees or agents of Delta Dental and Delta Dental is not responsible for Your decision to receive treatment, services, or supplies provided by such Dentist(s) or for the result or outcome of a treatment, service or supply.

GOVERNING LAW
This Plan will be administered according to federal law, the laws of the State of Connecticut and other laws or standards adopted by the Exchange or the Connecticut Insurance Department.

PEDIATRIC DENTAL POLICY DEFINITIONS

Adverse Benefit Determination: a decision Delta Dental makes that results in a Benefit Amount that is less than the amount submitted on the Claim. This includes Delta Dental's not paying any Benefit for the Dental Service.

Allowed Amount: the amount used in calculating the Benefit for the given Covered Service. The Benefit may be less than the Approved Amount due to Benefit Limitations.

Alternate Treatment Limitation: the Benefit under this pediatric dental coverage is based on the least costly Covered Service Delta Dental determines is sufficient for the diagnosis or treatment of the dental problem. For example, white composite fillings are not payable on Your back teeth and an alternate benefit for a silver amalgam filling will be allowed.

Amalgam: a silver metallic material use to restore or "fill" decay in a tooth.

Another Delta Dental Plan: a Delta Dental member company or affiliate of such corporation other than Delta Dental of New Jersey.

Approved Amount: the total fee which the Delta Dental Participating Dentist or Delta Dental PPO[SM] Dentist has agreed to accept as payment in full for the Dental Service provided. It includes both Delta Dental's Benefit Amount and the Covered Person's payment obligation. For Dental Services performed by a Non-Participating Dentist, it is the amount actually charged.

Balance Bill: the ability of a Delta Dental PPO[SM] Dentist or a Delta Dental Participating Dentist to bill the difference between the amount paid by Delta Dental and the Approved Amount, and for a Non-Participating Dentist to bill the difference between the amount paid by Delta Dental and the amount submitted for the Dental Service.

Benefit or Benefit Amount: the dollar amount which Delta Dental will pay under this Policy toward a Covered Service.

Benefit Limitations: restrictions on the Benefit Amounts payable under this Policy.

Benefits Schedule: the detailed Table of Covered Services, Specific Limitations, Specific Exclusions and Alternate Treatment Limitations, entitled "Pediatric Dental Benefit Schedule."

Benefitted As: a Dental Service that is performed or pre-estimated, but the Benefit Amount is based on a different Dental Service or category of Dental Service. When this happens, all the Benefit Limitations and Exclusions apply to the Dental Service for which Delta Dental pays the Benefit.

Bitewing: a dental x-ray showing approximately the coronal (crown) halves of the upper and lower jaw.

Calendar Year: for benefit determinations based on a calendar year, the period of one year beginning with January 1 and ending December 31.

Claim: a request to Delta Dental to pay a Benefit under this Policy.

Claim Form: the paper form the dentist must file for reimbursement for services rendered.

Coinsurance: the percentage of the Allowed Amount for a Covered Service paid by the Subscriber or Covered Dependent after any applicable Benefit Limitations.

Completion Date: the date a Dental Service is completed. For example, Completion Date is the insertion date for dentures and partial dentures; or the cementation date (regardless of the type of cement used) for crowns and fixed bridges.

Composite: a white resin material used to fill cavities. It is used primarily because the color more closely resembles the natural tooth than does the color of amalgam. This type of filling is only allowable on Your front teeth.

Consultation: a discussion between the patient and the dentist where the dentist offers professional advice for the proposed treatment plan.

Coverage Percent: the percentage of the Allowed Amount to be paid by Delta Dental for a Covered Service.

Covered Dependent: an eligible dependent under age nineteen (19) covered under this pediatric dental program.

Covered Person: a person entitled to Pediatric Dental Coverage under this Policy.

Covered Services: Dental Services rendered to Covered Persons under age nineteen (19) that are listed in the Pediatric Dental Benefits Schedule in this Section. Covered Services are eligible for payment of Benefits under this Policy subject to applicable Benefit Limitations, Prior Authorization requirements, and Exclusions.

Deductible: the amount of dental expense required to be paid by You or on behalf of Your Covered Dependent before Delta Dental approves payment of Benefits. Deductible may be an annual or a one-time charge.

Definitive Procedure: any Dental Service which has been given a Current Dental Terminology (CDT) procedure code. **Definitive Procedures** may be combined for payment purposes. That a Dental Service has been assigned a CDT procedure code does not mean it is a Covered Service.

Delta Dental: Delta Dental of New Jersey, Inc.

Delta Dental PPO^{SM} Dentist: a Dentist who has a Delta Dental PPO^{SM} Dentist agreement with Delta Dental or Another Delta Dental Plan or is identified by Delta Dental or Another Delta Dental Plan as a Delta Dental PPO^{SM} Dentist.

Delta Dental PPO^{SM} Program: Delta Dental's preferred provider option (PPO) dental program.

Delta Dental Participating Dentist: a Dentist who has signed a participation agreement with Delta Dental or Another Delta Dental Plan to accept the PMAC as payment in full for Covered Services but who is not a Delta Dental PPO^{SM} Dentist as defined in this Policy.

Dentally Necessary or **Dental Necessity:** Dental Services that a Dentist, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury,

disease or its symptoms, and that are: (1) In accordance with generally accepted standards of dental practice; (2) clinically appropriate, in terms of type, frequency, extent, site and duration and considered effective for the patient's illness, injury or disease; and (3) not primarily for the convenience of the patient, dentist or other health care provider and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease. For the purposes of this definition, "generally accepted standards of dental practice" means standards that are based on credible scientific evidence published in peer-reviewed dental literature generally recognized by the relevant dental community or otherwise consistent with the standards set forth in policy issues involving clinical judgment.

Dental Network: Delta Dental PPO^{SM} Dentists.

Dental Service(s): dental treatment and related procedures rendered by a Dentist or other person duly licensed to render that treatment by the state or country in which they were rendered.

Dentist: person licensed to practice dentistry by the appropriate authority in the area where the Dental Service is provided.

Emergency Dental Services: Covered Dental Services necessary for the immediate relief of pain and/or infection.

Endodontist: a Dentist who specializes in diseases of the tooth pulp, performing such services as root canals.

Excluded or Exclusion: Dental Services and/or charges for which no Benefit is payable under this Policy. They may be Specific Exclusions or General Exclusions (see the Benefits Schedule in this Section).

Explanation of Benefits: a statement from Delta Dental that You will receive after Delta Dental processes a Claim for You or Your Covered Dependents describing how Delta Dental determined the Benefit for the Dental Services submitted on the Claim.

General Dentist: a Dentist who provides a full range of Dental Services for the entire family

General Exclusion: the Exclusions listed in this Section.

Hygienist: a person licensed to practice as a dental hygienist by the appropriate authority in the area where the hygiene service is given.

Interactive Voice Response (IVR): a system accessed by touch-tone telephone 24 hours a day providing eligibility, benefits, claim information, and claim form ordering.

Medically Necessary Orthodontia: orthodontic services that meet the criteria for "Dental Necessity" as defined in this policy and meets at least one of the following conditions:

a. The Covered Person obtains 24 or more points on a correctly scored Salzmann Malocclusion Severity Assessment; or
b. The Covered Person demonstrates that the requested treatment will significantly ameliorate a mental, emotional, or behavioral condition associated with the Covered Person's dental condition; or
c. The Covered Person presents evidence of a severe deviation affecting the mouth and/or underlying dentofacial structures.

Non-Participating Dentist: any Dentist other than a Delta Dental Participating Dentist or Delta Dental PPO[SM] Dentist as defined in this Policy.

Notification of Delta Dental Benefits: statement that explains how Your claim was processed, payment by Delta Dental, Your responsibility, and other pertinent information. Also referred to as an Explanation of Benefits (EOB) or Notification of Payment (NOP).

Oral Pathologist: a Dentist who is concerned with recognition, diagnosis, and management of the diseases of the mouth, jaws, and surrounding structures.

Oral Surgeon: a Dentist who removes teeth, including impacted wisdom teeth, repairs fractures of the jaw and performs surgery on the mouth, jaws, and surrounding structures.

Orthodontist: a Dentist who corrects misaligned teeth and jaws, usually by applying braces.

Out-of-Pocket Cost: an amount paid by the patient to Dentist for Dental Services.

Participating Dentist: a Delta Dental Participating Dentist.

Participating Dentist Maximum Approved Charge (PMAC): the highest amount which Delta Dental approves for purposes of compensating the Delta Dental Participating Dentist for a Dental Service. This includes the amount payable by both Delta Dental and the Covered Person.

Patients: people who receive the Dental Services, Prior Authorizations for Dental Services, or a Pre-Treatment Estimate for Dental Services.

Pediatric Dental Coverage: the coverage under this policy for Dental Services rendered to persons under age nineteen (19), the coverage for which is administered by Delta Dental of New Jersey.

Pediatric Dentist: a Dentist who generally limits his/her practice to children, teenagers, and the handicapped. Also known as Pedodontist.

Periodontist: a Dentist who treats diseases of the gums.

Policy: this document.

PMAC: the Participating Dentist Maximum Approved Charge.

PPO Approved Fees: the fees approved by Delta Dental or Another Delta Dental Plan for Dental Services rendered by Delta Dental PPO[SM] Dentists in the respective state. They may be changed from time to time by Delta Dental or by Another Delta Dental Plan.

Prior Authorization: a determination by Delta Dental. It responds to a request for approval of Dental Services as Dentally Necessary or orthodontic services as Medically Necessary. Medically Necessary Orthodontic Services are limited to one case per lifetime.

Pre-Treatment Estimate: a determination by Delta Dental, after a Dentist submits a treatment plan, of one or more of the following: (a) Patient's eligibility, (b) Covered Services, (c) Benefit Amount, and (d) Coinsurance Percent, Deductibles, Benefit Maximums, Benefit Limitations, and Exclusions. A Pre-Treatment Estimate is only an estimate, not a guarantee of payment.

Prophylaxis: the prevention of disease by removal of calculus, stains, and other extraneous materials from the teeth, usually through the cleaning of the teeth by a Dentist or dental hygienist.

Prosthodontist: a Dentist who generally specializes in ways to replace missing natural teeth with bridges and dentures.

Schedule of Covered and Non-Covered Services: a listing of the specific Covered Services and Benefit Limitations and Exclusions for Dental Services provided under this Policy can be found in the Pediatric Dental Benefit Schedule.

Specific Exclusion: the Specific Exclusions listed in the Pediatric Dental Benefit Schedule for a Dental Service.

Specific Limitations: the Specific Limitations listed in the Pediatric Dental Benefit Schedule for a Dental Service.

Sealant: an adhesive material bonded to the tooth surface to slow down decay by shielding the tooth from exposure to the oral environment.

Treatment Plan: a written report prepared by a Dentist showing the Dentist's recommended treatment of any dental disease, defect, or injury.

We, Us, and Our means Delta Dental of New Jersey, Inc.

You and **Your** means the Member and/or the Covered Dependents.

PEDIATRIC DENTAL COVERAGE

ADDENDUM 1

PEDIATRIC DENTAL SERVICES THAT REQUIRE PRIOR AUTHORIZATION

THE FOLLOWING PEDIATRIC DENTAL SERVICES MUST BE AUTHORIZED IN ORDER FOR YOU TO RECEIVE THE MAXIMUM BENEFIT OR PAYMENT UNDER THE TERMS OF THE POLICY. PLEASE REFER TO YOUR POLICY FOR ADDITIONAL INFORMATION REGARDING PRIOR AUTHORIZATION, LIMITATIONS, AND EXCLUSIONS FOR PEDIATRIC DENTAL SERVICES.

Code	DENTAL SERVICES	Prior-Authorization Required Notes if appropriate
DIAGNOSTIC **D0100 - D0999**		
Clinical Oral Evaluations		
0150	Comprehensive oral evaluation - new or established patient	If > 1 per dentist and 3 years has not elapsed since previous
0160	Detailed and extensive oral evaluation - problem focused, by report	
0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	
0180	Comprehensive periodontal evaluation - new or established patient	
0340	Cephalometric radiographic image	Part of Ortho PA
0470	Diagnostic casts	Part of Ortho PA
RESTORATIVE **D2000 - D2999**		
Amalgam restorations - (including polishing)		
2140	Amalgam - one surface, primary or permanent	Only if tooth #s A, B, I, J, K, L, S, or T and > 9 yrs old
2150	Amalgam - two surfaces, primary or permanent	
2160	Amalgam - three surfaces, primary or permanent	
2161	Amalgam - four or more surfaces, primary or permanent	
Resin based composite restorations - direct		
2330	Resin-based composite - one surface, anterior	Only if tooth #s D, E, F, G, N, O, P, or Q and > 6 yrs old or tooth #s C, H, M, or R and > 9yrs old
2331	Resin-based composite - two surfaces, anterior	
2332	Resin-based composite - three surfaces, anterior	
2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	
2390	Resin-based composite crown, anterior	
2391	Resin-based composite - one surface, posterior	Only if tooth #s A, B, I, J, K, L, S, or T and > 9yrs old
2392	Resin-based composite - two surfaces, posterior	Only if tooth #s A, B, I, J, K, L, S, or T and > 9yrs old
2393	Resin-based composite - three surfaces, posterior	Only if tooth #s A, B, I, J, K, L, S, or T and

Code	DENTAL SERVICES	Prior-Authorization Required Notes if appropriate
		> 9yrs old
2394	Resin-based composite - four or more surfaces, posterior	Only if tooth #s A, B, I, J, K, L, S, or T and > 9yrs old
Crowns - single restorations only		
2710	Crown - resin (indirect)	Where Prior Authorized, will be subject to the alternate benefit of a base metal crown
2720	Crown - resin with high noble metal	Where Prior Authorized, will be subject to the alternate benefit of a base metal crown
2721	Crown - resin with predominantly base metal	Where Prior Authorized, will be subject to the alternate benefit of a base metal crown
2722	Crown - resin with noble metal	Where Prior Authorized, will be subject to the alternate benefit of a base metal crown
2740	Crown - porcelain/ceramic substrate	Where Prior Authorized, will be subject to the alternate benefit of a base metal crown
2750	Crown - porcelain fused to high noble metal	Where Prior Authorized, will be subject to the alternate benefit of a base metal crown
2751	Crown - porcelain fused to predominantly base metal	
2752	Crown - porcelain fused to noble metal	Where Prior Authorized, will be subject to the alternate benefit of a base metal crown
2790	Crown - full cast high noble metal	Where Prior Authorized, will be subject to the alternate benefit of a base metal crown
2791	Crown - full cast predominantly base metal	
2792	Crown - full cast noble metal	Where Prior Authorized, will be subject to the alternate benefit of a base metal crown
2794	Crown - titanium	Where Prior Authorized, will be subject to the alternate benefit of a base metal crown
Other restorative services		
2930	Prefabricated stainless steel crown - primary tooth	
2931	Prefabricated stainless steel crown - permanent tooth	
2932	Prefabricated resin crown	
2933	Prefabricated stainless steel crown with resin window	
2934	Prefabricated esthetic coated stainless steel crown - primary tooth	
2950	Core buildup, including any pins	
2951	Pin retention - per tooth, in addition to restoration	
2952	Cast post and core in addition to crown	
2953	Each additional cast post - same tooth	
2954	Prefabricated post and core in addition to crown	
2957	Each additional prefabricated post - same tooth	
2980	Crown repair, necessitated by restorative material failure	
ENDODONTICS **D3000 - D3999**		
Pulp capping		
3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	
3222	Partial pulpotomy for apexogenesis-permanent tooth with incomplete root development	
Endodontic therapy (including treatment plan, clinical procedures, and follow-up care)		

Code	DENTAL SERVICES	Prior-Authorization Required Notes if appropriate
3310	Anterior (excluding final restoration)	
3320	Bicuspid (excluding final restoration)	
3330	Molar (excluding final restoration)	
Endodontic retreatment		
3346	Retreatment of previous root canal therapy - anterior	
3347	Retreatment of previous root canal therapy - bicuspid	
3348	Retreatment of previous root canal therapy - molar	
3351	Apexification/recalcification - initial visit (apical closure/calcification repair of perforations, root resorption, etc.)	
3353	Apexification/recalcification - final visit	
Apicoectomy/periradicular services		
3410	Apicoectomy/periradicular surgery - anterior	
3421	Apicoectomy/periradicular surgery - bicuspid (first root)	
3425	Apicoectomy/periradicular surgery - molar (first root)	
3426	Apicoectomy/periradicular surgery (each additional root)	
3430	Retrograde filling - per root	
PERIODONTICS **D4000 - D4999**		
Surgical Services (including usual post-operative care)		
4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces per quadrant	
4211	Gingivectomy or gingivoplasty - one to three teeth, per quadrant	
4240	Gingival flap procedure, including root planing - four or more contiguous teeth or bounded teeth spaces per quadrant	
4241	Gingival flap procedure, including root planing - one to three teeth, per quadrant	
4245	Apically positioned flap	
4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces per quadrant	
4261	Osseous surgery (including flap entry and closure) - one to three teeth, per quadrant	
4263	Bone replacement graft - first site in quadrant	
4264	Bone replacement graft - each additional site in quadrant	
4265	Biologic materials to aid in soft and osseous tissue regeneration	
4266	Guided tissue regeneration - resorbable barrier, per site	
4267	Guided tissue regeneration - nonresorbable barrier, per site (includes membrane removal)	
4268	Surgical revision procedure, per tooth	
4270	Pedicle soft tissue graft procedure	
4273	Subepithelial connective tissue graft procedures	
4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area)	
4275	Soft tissue allograft	
4276	Combined connective tissue and double pedicle graft	
4277	Free soft tissue graft procedure (including donor site surgery), first tooth or edentulous tooth position in graft	

Code	DENTAL SERVICES	Prior-Authorization Required Notes if appropriate
4278	Free soft tissue graft procedure (including donor site surgery), each additional contiguous tooth or edentulous tooth position in same graft site.	
Non-surgical Periodontal Services		
4341	Periodontal scaling and root planing - four or more contiguous teeth or bounded teeth spaces per quadrant	
4342	Periodontal scaling and root planing - one or two teeth, per quadrant	
4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	
PROSTHODONTICS (REMOVABLE) **D5000 - D5890**		
5110	Complete denture - maxillary	
5120	Complete denture - mandibular	
5130	Immediate denture - maxillary	
5140	Immediate denture - mandibular	
5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	
5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	
5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	
5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	
Adjustments to dentures		Not unless > 3 year
Repairs to complete and partial dentures		
5510	Repair broken complete denture base	
5520	Replace missing or broken teeth - complete denture (each tooth)	
5610	Repair resin denture base	
5620	Repair cast framework	
5630	Repair or replace broken clasp	

Code	DENTAL SERVICES	Prior-Authorization Required Notes if appropriate
5640	Replace broken teeth - per tooth	
5650	Add tooth to existing partial denture	
5660	Add clasp to existing partial denture	
5670	Replace all teeth and acrylic on cast metal framework (maxillary)	
5671	Replace all teeth and acrylic on cast metal framework (mandibular)	
Denture rebase /reline procedures		
5710	Rebase complete maxillary denture	If > 1 per denture/year
5711	Rebase complete mandibular denture	
5720	Rebase maxillary partial denture	
5721	Rebase mandibular partial denture	
5730	Reline complete maxillary denture (chairside)	If > 1 per denture/year
5731	Reline complete mandibular denture (chairside)	
5740	Reline maxillary partial denture (chairside)	If > 1 per denture/year
5741	Reline mandibular partial denture (chairside)	
5750	Reline complete maxillary denture (laboratory)	
5751	Reline complete mandibular denture (laboratory)	
5760	Reline maxillary partial denture (laboratory)	
5761	Reline mandibular partial denture (laboratory)	
PROSTHODONTICS, FIXED D6200 - D6999		
6205	Pontic - indirect resin based composite	Where Prior Authorized, will be subject to the alternate benefit of base metal
6210	Pontic - cast high noble metal	Where Prior Authorized, will be subject to the alternate benefit of base metal
6211	Pontic - cast predominantly base metal	
6212	Pontic - cast noble metal	Where Prior Authorized, will be subject to the alternate benefit of base metal
6214	Pontic - titanium	Where Prior Authorized, will be subject to the alternate benefit of base metal
6240	Pontic - porcelain fused to high noble metal	Where Prior Authorized, will be subject to the alternate benefit of base metal
6241	Pontic - porcelain fused to predominantly base metal	

Code	DENTAL SERVICES	Prior-Authorization Required Notes if appropriate
6242	Pontic - porcelain fused to noble metal	Where Prior Authorized, will be subject to the alternate benefit of base metal
6245	Pontic - porcelain/ceramic	Where Prior Authorized, will be subject to the alternate benefit of base metal
6250	Pontic - resin with high noble metal	Where Prior Authorized, will be subject to the alternate benefit of base metal
6251	Pontic - resin with predominantly base metal	Where Prior Authorized, will be subject to the alternate benefit of base metal
6252	Pontic - resin with noble metal	Where Prior Authorized, will be subject to the alternate benefit of base metal
6710	Crown - indirect resin based composite	Where Prior Authorized, will be subject to the alternate benefit of base metal
6720	Crown - resin with high noble metal	Where Prior Authorized, will be subject to the alternate benefit of base metal
6721	Crown - resin with predominantly base metal	Where Prior Authorized, will be subject to the alternate benefit of base metal
6722	Crown - resin with noble metal	Where Prior Authorized, will be subject to the alternate benefit of base metal
6740	Crown - porcelain/ceramic	Where Prior Authorized, will be subject to the alternate benefit of base metal
6750	Crown - porcelain fused to high noble metal	Where Prior Authorized, will be subject to the alternate benefit of base metal
6751	Crown - porcelain fused to predominantly base metal	
6752	Crown - porcelain fused to noble metal	Where Prior Authorized, will be subject to the alternate benefit of a base metal crown
6790	Crown - full cast high noble metal	Where Prior Authorized, will be subject to the alternate benefit of a base metal crown
6791	Crown - full cast predominantly base metal	
6792	Crown - full cast noble metal	Where Prior Authorized, will be subject to the alternate benefit of a base metal crown
6794	Crown - titanium	Where Prior Authorized, will be subject to the alternate benefit of a base metal crown
6980	Fixed partial denture repair, necessitated by restorative material failure	
ORAL SURGERY **D7000 - D7999**		
7111	Coronal remnants - deciduous tooth	Prior-authorization only if primary teeth near exfoliation Tooth #s A, B, C, H, I, J, K, L, M, R, S, or T and ≥ 9 years OR Tooth #s D, E, F, G, N, O, P, or Q and ≥ 6 years
7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	
7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of	

Code	DENTAL SERVICES	Prior-Authorization Required Notes if appropriate
	tooth	
7220	Removal of impacted tooth - soft tissue	
7230	Removal of impacted tooth - partially bony	
7240	Removal of impacted tooth - completely bony	
7241	Removal of impacted tooth - completely bony, with unusual surgical complications	
7250	Surgical removal of residual tooth roots (cutting procedure)	
7310	Alveoloplasty in conjunction with extractions-four or more teeth or tooth spaces, per quadrant	
7311	Alveoloplasty in conjunction with extractions-one to three teeth or tooth spaces, per quadrant	
7320	Alveoloplasty not in conjunction with extractions-four or more teeth or tooth spaces, per quadrant	
7321	Alveoloplasty not in conjunction with extractions-one to three teeth or tooth spaces, per quadrant	
7340	Vestibuloplasty-ridge extension (secondary epithelialization)	
7471	Removal of lateral exostosis (maxilla or mandible)	
7472	Removal of torus palatinus	
7473	Removal of torus mandibularis	
7485	Surgical reduction of osseous tuberosity	
7510	Incision and drainage of abscess-intraoral soft tissue	
7960	Frenulectomy-also known as frenectomy or frenotomy-separate procedure not incidental to another	
7970	Excision of hyperplastic tissue-per arch	
7971	Excision of pericoronal gingival	
7972	Surgical reduction of fibrous tuberosity	
ORTHODONTICS **D8000- D8999**		Detailed prior authorization is required including complete treatment plan with Salzmann index
ADJUNCTIVE GENERAL SERVICES **D9000 - D9999**		
Anesthesia		
9220	Deep sedation/general anesthesia - first 30 minutes	
9221	Deep sedation/general anesthesia - each additional 15 minutes	
9230	Analgesia, anxiolysis, inhalation of nitrous oxide	
9241	Intravenous conscious sedation/analgesia - first 30 minutes	
9242	Intravenous conscious sedation/analgesia - each additional 15 minutes	
9310	Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)	
9940	Occlusal guard	

CLAIMS

CLAIMS FILING, QUESTIONS AND COMPLAINTS, AND APPEAL/GRIEVANCE PROCESS

We have the right to review any claims and the discretion to interpret and apply the terms of this Plan to determine whether benefits are payable.

CLAIMS FILING

Claims must be received by Us within 180 days from the date the services, medications or supplies were received. Claims submitted more than 180 days after the date the services, medications or supplies were received will not be reimbursed. You can check on the status of Your medical claims by contacting Member Services.

Bills from a Participating Provider

When You receive covered Health Services from a Participating Provider, You are responsible for paying for any non-covered services and all the Cost-Share amounts of this Plan, including the Plan Deductible, Copayment amounts, and any Coinsurance amounts. The Participating Provider who treated the Member will file a claim with Us, and any payment from Us will be made to the billing provider.

An explanation of benefits ("EOB") will be sent to You, which will indicate:

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

Any amount owed to the Participating Providers must be paid directly to the provider. Contact Us if the Participating Provider bills You for more than the EOB says You must pay.

If You have any questions about Your claims, call Our Members Services Department.

Bills from a Non-Participating Provider

If You or Your Eligible Dependents receive care from a Non-Participating Provider, a claim must be submitted to Us at the appropriate address listed in the "Important Telephone Numbers and Addresses" section.
The claim should include the following information:

1. The Subscriber's name
2. The patient's name and HealthyCT ID number (including suffix)
3. A complete, itemized bill for services, which includes both a description of the service and the diagnosis.
4. Charge card receipts and "balance due" statements are not acceptable.
5. If the claim was a result of an Emergency or Urgent Care You or Your Eligible Dependents needed while outside of the United States, make sure the itemized bill is written or translated in English and that it shows the amount You paid in U.S. dollars. We recommend that You include Your charge receipt with the itemized bill.

Generally, Our payment for covered Health Services provided by a Non-Participating Provider is made directly to You, and You are responsible for paying the provider of service, unless You assign the benefits to the provider on the claim form which instructs Us to pay the provider. We will pay an ambulance company provider when there is a law that permits Us to do so. We may also pay You directly, if the Non-Participating Provider does not provide Us with information that We request for claim payment.

Payment to Custodial Parent

In situations where We have not paid Your Eligible Dependent children's claims directly to the provider, the law may require that We send the payment directly to the custodial parent if We are notified in writing, even if that parent is not a participant under this Plan.

Claims for Emergency Services

Review a claim for payment for Emergency Services provided by Non-Participating Hospitals or other Non-Participating Providers to make sure it is complete before You send the claim to Us. In some cases, emergency room claims sent to Us by a Hospital may be denied if they have missing, incomplete or improperly coded information.

Claim Overpayments

Whenever We have made payments for Health Services, including prescription drugs, either in error or in excess of the maximum amount allowed under this Plan, We have the right to recover these payments from:

- Any person to or for whom the payments were made,
- Any insurance companies, and
- Any other person or organization.

You have no right to expect future coverage for non-covered services, supplies or medicines, because of payments made by Us in error.

Our right to recover incorrect payments may include subtracting amounts from future benefit payments. You, personally and on behalf of Your Eligible Dependents, must complete and send Us any documents We ask for and do whatever is necessary to protect Our right to recover any erroneous or excess payments.

QUESTIONS AND COMPLAINTS

You or Your authorized representative can ask questions or send Us complaints or Appeals/Grievances about benefits and other issues concerning this Plan. Since most questions or complaints can be resolved informally, We suggest that You contact Our Member Services Department first.

Representatives are available Monday through Friday, during regular business hours, to explain policies and procedures and answer Your questions. If You are calling after normal business hours, You should leave a detailed voice mail message, including Your HealthyCT ID number and Your telephone number. An associate will return Your telephone call during regular business hours.

In the event a problem or complaint cannot be informally resolved, a formal Appeal/Grievance process is available, as outlined below.

APPEAL/GRIEVANCE PROCESS

If You are not satisfied with a decision We or Our Delegated Programs have made regarding Health Services, benefits, Prior-Authorization or claims, then You or Your authorized representative may request an Appeal/Grievance. Such Appeals/Grievances are sometimes successful.

Of course, before pursuing the Appeal/Grievance process, You should consider seeking immediate assistance from Our Member Services Department, as described in the "Questions and Complaints" subsection. Often, questions and complaints can be resolved quickly and informally by speaking with one of Our representatives. You may also choose to have Your health care professional confer with a clinical peer of the carrier after You or Your representative or Your health care professional is notified of an initial Adverse Determination of a concurrent or prospective utilization review or of a benefit request that was based, at least in part, on medical necessity and if the covered person, representative, or health care professional has not already filed a grievance of the initial adverse determination. However, if You choose to make use of the Appeal/Grievance process, We will not subject You to any sanctions or impose any penalties on You. You may also contact the Member Services Department to request reasonable access to and copies (free of charge) of all documents, records and other information relevant to Your benefit request.

The Appeal/Grievance process is divided into two categories.

1. One category deals with the **Medical Necessity Appeal/Grievance** of a particular Health Service, such as a denial of a request for Prior-Certification of an inpatient admission or the Prior-Authorization of a certain surgical procedure.
2. The other category deals with the **Administrative (Non-Medical Necessity) Appeal/Grievance**, such as a decision that interprets the application of Plan rules and that does not relate to Medical Necessity.

In either case, the Appeal/Grievance request may be initiated orally, electronically or by mail by calling, faxing or writing Us. Our Appeal and Grievance Department can be contacted as follows:

Telephone: (855) 458-4928
Facsimile: (877) 219-1735

HealthyCT
Appeals / Grievances
35 Thorpe Ave, Suite 104
Wallingford, CT 06492

If Your appeal or grievance pertains to pediatric dental benefits, which are administered by Delta Dental of New Jersey on behalf of HealthyCT, please use the following contact information:

Telephone: (800) 452-9310

Delta Dental of New Jersey, Inc.
Appeals / Grievances
P.O. Box 910
Parsippany, NJ 07054

The Appeal/Grievance must be filed with HealthyCT (or Delta Dental of New Jersey for dental benefits) as soon as possible after You receive the original decision, but no later than 180 calendar days after the Prior Authorization request was denied or 180 calendar days after the claim for benefits was denied, whichever comes first. If You fail to submit Your request within the 180 calendar days, You lose Your right to an Appeal/Grievance.

You may contact the Commissioner of the State of Connecticut Insurance Department or the Office of Healthcare Advocate at any time free of charge for assistance, complaints or upon the completion of Our internal Appeal/Grievance process. Their contact information is as follows:

State of Connecticut Insurance Department
Insurance Commissioner
PO Box 816
Hartford, Connecticut 06142-0816
860-297-3900

Or

The Consumer Affairs Unit
1-800-203-3447

Office of the Healthcare Advocate
P.O. Box 1543
Hartford, CT. 06144

(Toll Free) 1-866-466-4446

http://www.ct.gov/oha
Email: healthcare.advocate@ct.gov

Medical Necessity Appeal

For substance abuse, qualifying mental disorders and other qualifying urgent issues related to jeopardy of life or health, loss of function or severe pain, please refer to **Urgent Care Appeals/Grievances**.

Internal Appeal Process

If You disagree with a decision regarding the **Medical Necessity** of a particular Health Service, such as a denial of a request for Prior-Authorization, You may Appeal/Grieve that decision.

We will investigate Your Appeal/Grievance request. If during this investigation, We acquire new or additional evidence or new or an additional scientific or clinical rationale, it will be reviewed as part of Your Appeal/Grievance. We will provide such newer additional information to You or Your representative for review. You will have five business days to respond to the new or additional information.

1. Your Appeal/Grievance will be reviewed by a clinical peer who was not involved in the original decision. If the physician reviewer agrees with Our decision to deny coverage, but uses new or additional information for his/her decision, then You or Your authorized representative will be provided with the new or additional information and will have five business days to respond to the new or additional information before the

decision is issued.

2. You or Your authorized representative and Your practitioner will be sent a decision in writing or by electronic means no later than 30 calendar days for pre-service and concurrent Appeals/Grievances or 60 calendar days for post service Appeals/Grievances.
3. If the Appeal/Grievance involves an Adverse Determination of a concurrent review request, the treatment can be continued without liability to You until You have been notified of the review decision.
4. If You are not satisfied with the decision, You or Your authorized representative or any provider with Your consent may be able to have the decision reviewed by health care professionals who have no association with Us by submitting a request for an external review through the State of Connecticut Insurance Department when the Adverse Determination involves Medical Necessity, appropriateness, health care setting, level of care or effectiveness. Please refer to the "External Review and Expedited External Review" provision in this subsection.

Urgent Care Appeals/Grievances

You may file an Appeal/Grievance on an urgent basis with Us if We have issued an Adverse Determination for coverage:

- And the time period for making a non-urgent care request determination could seriously jeopardize Your or Your covered dependent's life or health or ability to regain maximum function, or
- In the opinion of a health care professional with knowledge of the medical condition, You or Your covered dependent would be subject to severe pain that could not be adequately managed without the Health Services or treatment related to the Appeal/Grievance, or
- For a substance abuse disorder or for a co-occurring mental disorder, or
- For a mental disorder requiring (i) inpatient services, (ii) partial hospitalization, (iii) residential treatment, or (iv) intensive outpatient services necessary to keep You or Your covered dependent from requiring an inpatient setting.

Your Appeal/Grievance will be reviewed by:

- A clinical peer who holds a non-restricted license in any state in the same or similar specialty as typically manages the medical condition, procedure, or treatment that is the subject of the Appeal/Grievance who was not involved in Our original decision; or
- A clinical peer who holds a national board certification in child and adolescent psychiatry or a doctoral level psychology degree with training and clinical experience in treating child and adolescent substance use or mental disorder, as applicable in order for the review or benefit determination concerning a substance use or mental disorder in a child or adolescent.
- A clinical peer who holds a national board certification in psychiatry or a doctoral level psychology degree with training and clinical experience in the treatment of adult substance use or mental disorder, as applicable in order for the review or benefit determination concerning a substance use or mental disorder in an adult.

You or Your authorized representative and Your practitioner will be notified of the decision as soon as possible, taking into account Your condition. If We receive all of the necessary information with Your Appeal/Grievance, You or Your authorized representative and Your practitioner will receive a decision within two business days of receipt of all necessary information but no later than 72 hours after We have received Your Appeal/Grievance. If We need additional information in order to make the decision, then We will contact You or Your authorized representative or Your practitioner. We will make the decision no later than 72 hours from the date/time the Appeal/Grievance was received when the requested information is not provided to make the determination. If the urgent Appeal/Grievance involves an Adverse Determination involving a request for services and treatment for the mental or substance use disorder as described under Urgent Care Appeals/Grievances, You or Your representative or Your practitioner will receive a decision within 24 hours.

If the urgent Appeal/Grievance involves an Adverse Determination of a concurrent review urgent care request, the treatment can be continued without liability to You until You have been notified of the review decision.

If You are not satisfied with the urgent Appeal/Grievance decision made by Us, then You, Your authorized representative or any provider with Your consent may request an external review through the State of Connecticut Insurance Department when the Adverse Determination or final Adverse Determination involves an issue of Medical Necessity, appropriateness, health care setting, level of care or effectiveness. Please refer to the "External Review and Expedited External Review" provision in this subsection.

Bypassing the Internal Appeal/Grievance Process

If any of the following circumstances apply, You may be able to bypass Our internal Appeal/Grievance process and file a request for an expedited external review:

- You have a medical condition for which the time period for completion of an expedited internal Appeal/Grievance would seriously jeopardize Your life or health or would jeopardize Your ability to regain maximum function, or
- The Adverse Determination involves a denial of coverage based on a determination that the recommended or the requested Health Service or treatment is Experimental Or Investigational and Your treating health care professional certifies in writing that such recommended or requested Health Service or treatment would be significantly less effective if not promptly initiated.

You, or Your provider acting on Your behalf with Your consent, may simultaneously file a request for an internal Appeal/Grievance and an expedited external review. The independent review organization will determine whether You will be required to complete the internal Appeal/Grievance process prior to conducting the expedited external review.

Please refer to the “External Review and Expedited External Review” provision in this subsection for details on filing for an expedited external review.

External Review and Expedited External Review

You or Your authorized representative may file a request for an expedited external review if:

- You have a medical condition for which the time period for completion of an external review would seriously jeopardize Your life or health or would jeopardize Your ability to regain maximum function;
- The final Adverse Determination concerns an admission, availability of care, continued stay or Health Service for which You received Emergency Services but You have not been discharged from a facility;
- The Adverse Determination involves a substance abuse disorder, a co-occurring mental disorder, or a mental disorder requiring (i) inpatient services, (ii) partial hospitalization, (iii) residential treatment, or (iv) intensive outpatient services necessary to keep You or Your covered dependent from requiring an inpatient setting; or
- The denial of coverage was based on a determination that the recommended or requested Health Service or treatment is Experimental or Investigational and Your treating health care professional certifies in writing that such recommended or requested Health Service or treatment would be significantly less effective if not promptly initiated.

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

1. The external review or expedited external review request must be submitted to the State of Connecticut Insurance Department in writing. The address and telephone number is as follows:

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

1-860-297-3910

2. The external review request must be made within 120 calendar days of Your receipt of the final denial letter. However, an expedited external review may be filed without receipt of Our final denial letter. You do not need a final denial letter in order to file for an external review if We fail to strictly adhere to the requirements under the law with respect to making utilization review and benefit determinations.
3. When filing a request for an external review, You will be required to authorize the release of any medical records that may be required to be reviewed for the purpose of making a decision on such request.
4. The review will require a fee of $25 payable to the State of Connecticut Insurance Department. There is a maximum fee of $75 per Member per year. This fee may be waived if You cannot afford to or are deemed unable to pay by the State of Connecticut Insurance Commissioner. The fee is refunded if the Adverse Determination is reversed or revised.
5. If You request an external review or an expedited external review, You will receive additional information including instructions on how to supply additional comments or materials related to Your benefit request.
6. You or Your authorized representative will be provided with a written decision within 45 calendar days

for a standard external review, 20 calendar days for an external review involving a health care service or treatment that is experimental or investigational, 72 hours for an expedited external review or five calendar days for an expedited external review involving a health care service or treatment that is experimental or investigational, and 24 hours for an expedited external review involving services and treatment for the mental or substance abuse disorder.

Administrative (Non-Medical Necessity) Appeal/Grievance

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

1. If You file an Appeal/Grievance, We will notify You no later than three business days after We receive Your Appeal/Grievance that You or Your authorized representative are/is entitled to submit written materials to Us to be considered when conducting a review of Your Appeal/Grievance.
2. When the Appeal/Grievance is received, it will be forwarded for review.
3. A staff member who was not involved in the original decision will review the Appeal/Grievance.

You or Your authorized representative will be provided with a written decision no later than 20 business days after We receive Your Appeal/Grievance request. If We are unable to comply with this time period due to circumstances beyond Our control, the time period may be extended by Us for up to ten business days, provided that on or before the 20th business day We provide You or Your authorized representative written notice of the extension and reason for the delay.

TERMINATION AND AMENDMENT

This Plan and Your coverage under this Plan will terminate as follows.

When a Member Terminates Coverage

The Exchange will permit a Member to terminate coverage under this Plan, as long as the Member provides the Exchange or Us with notice.

Effective Dates of Termination

When a Member's coverage terminates under this Plan at his/her request, the last day of coverage is as follows.

- The termination date requested by the Member, as long as the Member provides reasonable notice of at least 14 days.
- If the Member has not given reasonable notice of at least 14 days, the termination date will be 14 days after the Member provides notice.
- On a date determined by Us, if We are able to terminate in less than 14 days and the Member requests an earlier termination date.
- The day before coverage begins when the Member is newly eligible for Medicaid, the Children's Health Insurance Program or a Basic Health Plan.

Termination of Coverage For Other Reasons

Termination of coverage may occur for other reasons besides the Member's request.

When termination occurs for any of the reasons that follow, We will provide the Member with notice that includes the reason why coverage ended. That notice will be sent to the Member at least 30 days before the last day of coverage. In addition, We will also notify the Exchange of the termination effective date and the reason for the termination.

We will make reasonable accommodations for all Qualified Individuals with disabilities, as required by federal law, before We terminate his/her coverage.

Termination of a Member's coverage occurs in the following circumstances:

1. The Member is no longer eligible for coverage in this Plan.

   Coverage will end on the last day of the month following the month in which the Exchange notifies Us that the member is no longer eligible for coverage (unless the Member requests an earlier termination date with appropriate notice).

   Except, however, coverage for a child dependent shall terminate no earlier than the policy anniversary date (i.e., January 1) on or after whichever of the following occurs first: (1) the date on which the child becomes covered under a group health plan through the dependent's own employment; or (2) the date on which the child attains the age of twenty-six (26).

2. Non-payment of Premium.

   - The three month grace period required for Members receiving Advance Payments Of The Premium Tax Credit has been exhausted, or

- The standard one month grace period has been exhausted.

Coverage will end the last day of the first month of the three month grace period, if termination is because the three month grace period has been exhausted.

Coverage will end on the last day of the standard grace period, if termination is because the standard grace period has been exhausted.

3. The Member's coverage is rescinded, in the event a Member has committed fraud (as determined by a court of competent jurisdiction), or has willfully concealed or misrepresented any material fact or circumstance in applying for enrollment or in obtaining Plan Benefits.
4. The Member switches from this Plan to another QHP during an open enrollment period or special enrollment period.

   Coverage will end at midnight of the day before the Member becomes effective in the new QHP.
5. Your death

   Coverage will end the day following Your death.

   When You die, Your surviving spouse, if covered under this Plan, will become the Subscriber. If Your surviving spouse was not covered under this Plan, Your Eligible Dependents will continue to be covered provided Premium payments are made on time and they remain eligible for coverage as described in the "Eligibility and Enrollment" section.
6. However, We may not contest the Member's coverage under this subsection beyond two years from the Member's Effective Date of coverage under this Policy.
7. Upon a Member's commission of acts of physical or verbal abuse (which are unrelated to his or her physical or mental condition), which pose a threat to or create an intimidating, hostile or offensive working environment for:
   - Providers;
   - Other Members; or
   - Our employees, Our affiliates or Our subcontractors.
8. For a Member's persistent refusal to comply with treatment that is prescribed and Medically Necessary.
9. For a Member's failure to take such reasonable actions as may be necessary to secure Our rights under this Plan.
10. In the event the Member has repeatedly failed to make the required Cost-Sharing payments to providers.

AMENDMENT

Any amendment to this Policy which reduces or eliminates benefits or coverage or which increases benefits or coverage with a corresponding increase in Premium is subject to Your approval, except if the increased benefit or coverage is required by law.

PREMIUM PAYMENT

We determine the amount, time and manner of the payment of Premium. Our determination is subject to approval by the Connecticut Insurance Department and the Exchange.

1. All Premiums must be sent to Us in accordance with Our payment instructions, and according to the rates in force on behalf of the number of Members covered under this Plan, even if Premium is being made in the aggregate for Members of a tribe, tribal organization, or urban tribal organization.
2. All Premiums are due and payable on the first day of the month for which coverage applies and the first day of each calendar month after that, if a grace period is allowed. This means that if payment is not made on or before the date it is due, it may be paid during the grace period. Please refer to the "Grace Periods" subsection below.
3. We may add a late payment charge of one percent (1%) per month for any Premium paid after the grace period.
4. Our bills take into account the membership changes We have been notified of and that We have processed. Premium payment must be sent as billed. Membership changes received and processed afterward will be reflected on the next bill.
5. The amount, time, and manner of payment of Premium shall be determined by Us and shall be subject to the approval of the State of Connecticut Insurance Department and the Exchange.
6. In the event of any change in Premium, the Subscriber will be given notice at least 30 days prior to such change. Payment of the Premium by the Subscriber shall serve as the Subscriber's acceptance of the Premium change.
7. You must notify Us 14 days prior to the date on which a Member's coverage is to terminate under this Plan in order for termination to be effective on that date. This notification must be sent to Us in writing.
8. You must tell the Exchange and Us when Your address changes right away. We will process any appropriate changes in Premium that may result from that change and that change in Premium will be effective the day You move. You are responsible for any increase in Premium because of an address change from the date You change Your address, even if You do not tell Us about the change until after You move.

GRACE PERIODS

If You do not pay the full amount of the Premium by the Premium due date, a grace period is triggered. A grace period is an additional period of time during which coverage remains in effect. If You do not pay the required premium by the end of the grace period, Your Policy is cancelled.

We will provide You with notice when the Premium is past due.

Standard Grace Period

This Policy has a standard grace period of 31 days. This means if You do not make payment during the standard grace period, the Policy will terminate on the last day of the grace period. You will be liable to Us for the payment due including those for the grace period.

Payment must reach Us in time for Us to complete Our posting process in order for it to be considered paid by the end of the grace period. If Premium is not paid as described above, coverage under this Plan will end.

Advance Payment of The Premium Tax Credit (APTC) Grace Period

1. If a Member is receiving Advance Payment of the Premium Tax Credit (APTC) and has previously paid at least one month's Premium, We will provide a grace period of 90-days.
2. During this grace period:
   - We will pay all incurred claims during the first month of this grace period.
   - Any claims that were incurred in the second and third months may be pended, subject to Our right to cancel Your Policy.
   - If this occurs, We will notify providers that claims may be denied.
   - The application of this grace period to claims is based on the date of service and not on the date the claim was submitted.
   - We will notify the United States Department of Health and Human Services of the non-payment of Premium.
   - We will apply any payment received to the first billing cycle in which payment was delinquent.

Payment must reach Us in time for Us to complete Our posting process in order for it to be considered paid by the end of the grace period. If Premium is not paid as described above, coverage under this Plan will end.

GENERAL PROVISIONS

1. You agree to cooperate with Us and to follow Our rules and instructions in all administrative matters required for the administration of this Plan.
2. You must meet the eligibility requirements of the Exchange. It is Your responsibility to notify the Exchange and Us within 31 days if You change Your residence.
3. If You move within the Exchange Service Area of this Plan, Premium rates will be adjusted, if necessary, to adjust to Your new address and the current ages of Your Eligible Dependents, effective at the beginning of the Premium Period following the change of residence.
4. We contract with Participating Providers to make sure that You will not be billed for any Health Services that are covered by this Plan. You are responsible for services billed that are subject to subrogation and coordination of benefits and all of the copayments, deductibles, and coinsurance You are required to pay if You or Your Eligible Dependents are covered by another plan and that other plan is determined to be the primary plan. In this case, a Participating Provider may bill You for copayments, deductibles, and coinsurance due under that other plan (the primary plan). Check the "Other Insurance, Rights Of Recovery, Subrogation, And Reimbursement" section to find out Your responsibilities.
5. By being covered under this Plan, You, and Your Eligible Dependents accept all of the rules of this Plan.
6. Written notice of a claim must be given to Us within twenty days after the occurrence or commencement of any loss covered by this policy, or as soon thereafter as is reasonably possible. We, upon receipt of a notice of claim, shall furnish to the Member such forms as are usually furnished for filing proofs of loss. If such forms are not furnished within 15 days after the giving of such notice, the Member shall be deemed to have complied with the requirements of this Policy as to proof of loss, upon submitting, within the time fixed in the Policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.
7. Written proof of loss should be provided to Us in any case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within ninety days after the termination of the period for which the insurer is liable and in case of claim for any other loss within ninety days after the date of such loss. Failure to furnish such proof within the time required will not invalidate or reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.
8. Indemnities payable under this policy for any loss other than loss for which this policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid at least monthly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.
9. Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which are prescribed in this policy and effective at the time of payment. If no

such designation or provision is then effective, such indemnity will be payable to the estate of the insured. Any other accrued indemnities unpaid at the insured's death may, at the option of Us, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the insured.

10. We, at Our own expense, have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.
11. No legal action may be taken to recover benefits within 60 days after notice of claim has been given as specified above, nor may any action be brought after three years from the date covered Health Services are received. No liability shall be imposed upon Us other than for benefits provided herein.
12. The right to change of beneficiary is reserved to You and the consent of the beneficiary or beneficiaries will not be requisite to surrender or assignment of this policy or to any change of beneficiary or beneficiaries, or to any other changes in this policy.
13. We will have no liability for benefits other than as provided by this Plan.
14. The benefits of this Policy are not transferable and may not be assigned to any third party, except when the Member indicates on the claim form that payment should be sent directly to the provider of the covered Health Service or when an ambulance company provider is entitled to be paid directly according to the law.
15. We may establish reasonable policies, procedures, rules, and interpretations to promote the orderly and efficient administration of this Plan.
16. Reinstatement: If ended for any reason, other than termination for nonpayment of Premium, this Policy may be reinstated if We received Your request for reinstatement within 10 days of the termination date and all outstanding Premiums are paid in full.

    If any Premium is not paid within the time granted by this Policy, a subsequent acceptance of Premium by Us will reinstate the Policy.

    In all other respects You and We will have the same rights as both of Us had under the Policy immediately before the due date of the defaulted Premium. Any Premium accepted in connection with a reinstatement will be applied to a period of Premium that has not been previously paid.
17. Entire Contract: Changes: This document, including the Exchange enrollment form, Our Application/Change Form, which includes the Benefit Summary, Riders, and supplemental inserts, is the entire contract of insurance and understanding between You and Us. Except as otherwise described in this document, this document may be changed, waived, discharged or ended only when done in writing and signed by an executive officer of the party against which enforcement of the change, waiver, discharge or termination is sought, unless such approval is endorsed hereon or attached hereto. No agent has authority to change this Policy or to waive any of its provisions. .
18. If any portion of this document is or becomes, for any reason, invalid or unenforceable, that portion will be ineffective only to the extent of the invalidity or unenforceability and the remaining portion or portions will nevertheless be valid, enforceable, and of full force and effect.
19. This Plan will be administered according to federal law, the laws of the State of Connecticut and the rules,

regulations or other standards set forth by the Exchange and/or the State of Connecticut Insurance Department.

20. Participating Providers are not Our employees or agents. They are independent contractors with the responsibility for determining and providing health care for their patients.
21. A Participating Provider may refuse to provide services or treatment to You or Your Eligible Dependents if You do not pay the required Cost-Share amounts required under this Plan.
22. We are not responsible for Your decision to receive treatment, services or supplies provided by Participating Providers, nor are We responsible or liable for the treatment, services or supplies provided by Participating Providers.
23. As the result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), if Your or Your Eligible Dependent's coverage ends under the Plan, We will automatically provide You with a Certificate of Creditable Coverage. You may request additional Certificates for a period of up to 24 months from the date Your or Your Eligible Dependent's coverage ends. In some instances, Your Employer performs these duties for Us.
24. This Plan does not limit coverage for conditions just because You had the condition before You became covered under the Plan.
25. Time Limit on Certain Defenses: This Policy shall be incontestable, except for nonpayment of premium, after it has been in force for two years from its date of issue.
26. We will not be liable under the Policy unless proper notice is furnished to Us that covered Health Services have been rendered to a Member. Written notice must be given within 60 days after completion of the covered Health Services. The notice must include the data necessary for Us to determine benefits. An expense will be considered incurred on the date the service or supply was received.
27. Failure to give Us notice within the time specified will not reduce any benefit if it is shown to Our satisfaction that the notice was given as soon as reasonably possible, but in no event will We be required to accept notice more than 180 days after covered Health Services are received.
28. This Plan calculates benefits on a calendar year basis. This means that benefit changes to Your benefit plan become effective on January 1 of each year.
29. If You are injured or contract a sickness after having changed Your occupation to one classified by Us as more hazardous than that stated in Your policy or while doing for compensation anything pertaining to an occupation so classified, We will pay only such portion of the indemnities provided in this policy as the premium paid would have purchased at the rates and within the limits fixed by Us for such more hazardous occupation. If You change Your occupation to one classified by Us as less hazardous than that stated in this policy, We, upon receipt of proof of such change of occupation, will reduce the premium rate accordingly, and will return the excess pro-rata unearned premium from the date of change of occupation or from the policy anniversary date immediately preceding receipt of such proof, whichever is the more recent. In applying this provision, the classification of occupational risk and the premium rates will be such as have been last filed by Us prior to the occurrence of the loss or prior to the date of proof of change in occupation.

30. Misstatement of Age: If You have misstated Your age, all amounts payable under this policy will be such as the premium paid would have purchased at the correct age.
31. If the total monthly amount of loss of time benefits promised for the same loss under all valid loss of time coverage upon You, whether payable on a weekly or monthly basis, exceeds the monthly earnings of You at the time disability commenced or Your average monthly earnings for the period of two years immediately preceding a disability for which claim is made, whichever is greater, We will only be liable for such proportionate amount of such benefits under this policy as the amount of such monthly earnings or such average monthly earnings of the insured bears to the total amount of monthly benefits for the same loss under all such coverage upon the insured at the time such disability commences and for the return of such part of the premiums paid during such two years as exceeds the pro-rata amount of the premiums for the benefits actually paid hereunder; but this will not operate to reduce the total monthly amount of benefits payable under all such coverage upon You below the sum of two hundred dollars or the sum of the monthly benefits specified in such coverages, whichever is the lesser. It also shall not operate to reduce benefits other than those payable for loss of time.
32. Upon the payment of a claim under this policy, any premium then due and unpaid or covered by any note or by written order may be deducted therefrom.
33. We may cancel this Plan at any time by written notice delivered to You and to any dependents who were listed on the application and any subsequent revisions thereto, or mailed to their last address as shown by the records of Us, stating when, not less than 90 days thereafter, such cancellation will be effective. If this Plan is cancelled, and unless HealthyCT withdraws from the Connecticut health insurance market, another plan will be offered to You. In the event HealthyCT withdraws from the Connecticut health insurance market, 180 days advance notice shall be provided. In the event of cancellation, We will return promptly the unearned portion of any premium paid. Cancellation will be without prejudice to any claim originating prior to the effective date of cancellation.
34. Insurance With Other Insurers: If there be other valid coverage, not with HealthyCT, providing benefits for the same loss on a provision-of service basis or on an expense-incurred basis and of which HealthyCT has not been given written notice prior to the occurrence or commencement of loss, the only liability under any expense-incurred coverage of this policy shall be for such proportion of the loss as the amount which would otherwise have been payable hereunder plus the total of the like amounts under all such other valid coverages for the same loss of which HealthyCT had notice bears to the total like amounts under all valid coverages for such loss and for the return of such portion of the premiums paid as shall exceed the pro rata portion for the amount so determined. For the purpose of applying this provision when other coverage is on a provision-of-service basis, the "like amount" of such other coverage shall be taken as the amount which the services rendered would have cost in the absence of such coverage.

DEFINITIONS

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

ADVANCE PAYMENTS OF THE PREMIUM TAX CREDIT (APTC)

Payment of the tax credits, which are provided by the federal government on an advance basis to HealthyCT on behalf of an eligible individual enrolled in a Qualified Health Plan (QHP) through an Exchange.

ADVERSE DETERMINATION

The denial, reduction, termination or failure to provide or make payment, in whole or in part, for a benefit under this Plan requested by a Member or a Member's treating health care professional, based on a determination by Us or Our Delegated Program:

- Upon application of any utilization review technique, such benefit does not meet Our requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness,
- Is determined to be Experimental Or Investigational, Of a Member's eligibility to participate in this Plan, or
- Any prospective review, concurrent review or retrospective review determination that denies, reduces or terminates or fails to provide or make payment, in whole or in part, for a benefit under this Plan requested by a Member or a Member's treating health care professional.

An Adverse Determination includes a rescission of coverage determination for Appeal/Grievance purposes.

AMBULATORY SURGERY CENTER

An entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients not requiring Hospitalization and whose expected stay in the center does not exceed 24 hours. It is further defined as a facility that is not owned by a Hospital and which bills for its services under its own unique tax identification number.

AMERICAN INDIAN

An individual who is a member of a Federally Recognized Indian tribe. A tribe is defined as any Indian tribe, band, nation, or other organized group or community, including any Alaska native village or regional or village corporation which is recognized as eligible for the special programs and services provided by the United States because of their status as Indians.

APPEAL/GRIEVANCE (GRIEVE)

A written complaint or, if the complaint involves an urgent care request, an oral complaint, submitted by or on behalf of a Member regarding:

1. The availability, delivery or quality of Health Services, including a complaint regarding an Adverse Determination made pursuant to utilization review;
2. Claims payment, handling or reimbursement for Health Services; or
3. Any matter pertaining to the contractual relationship between the Member and Us.

APPLICATION/CHANGE FORM

The Application/Change Form provided or approved by Us, used to enroll or disenroll You and/or Your covered dependents.

AUTISM SPECTRUM DISORDERS (ASD)

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

BEHAVIORAL THERAPY

Any interactive Behavioral Therapy derived from evidence-based research, including but not limited to "Applied Behavioral Analysis," cognitive behavioral therapy, or other therapies supported by empirical evidence of the effective treatment of individuals diagnosed with ASD. "Applied Behavioral Analysis" means the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, including the use of direct observation, measurement and functional analysis of the relationship between environment and behavior, to produce socially significant improvement in human behavior. Supervision requires at least one hour of face-to-face supervision of the autism services provider for each ten hours of Behavioral Therapy.

BENEFIT REDUCTION

A Benefit Reduction is a reduction in benefits, which applies when a Member fails to obtain the Prior-Authorization or Prior-Certification for certain Medically Necessary health care services that require Prior-Authorization or Prior-Certification prior to the receipt of these services from or arranged by a Non-Participating Provider.

BENEFIT SUMMARY

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

BRAND NAME DRUG OR SUPPLY

A drug or supply manufactured and approved by federal FDA standards that has a proprietary trade name selected by the manufacturer used to describe and identify it.

CASE MANAGEMENT

The process for identifying Members with specific health care needs in order to help in the development and implementation of a plan that efficiently uses health care resources to help the Member manage his/her health.

CASE MANAGER

An individual, usually a registered nurse, who is responsible for developing and implementing a plan of care that takes into account benefit structure, accepted industry and internal standards, and cost effectiveness in order to help the Member mange his/her health.

COINSURANCE

Coinsurance means the percentage of the Maximum Allowable Amount that You are legally responsible to pay after any applicable Deductible is met.

When Coinsurance applies as a result of the In-Network Level Of Benefits, except as otherwise required by law, the Coinsurance amount will be calculated based on the lesser of:

1. The physician's or provider's charge for the Health Service at the time it is provided; or
2. The contracted rate with the physician or provider for the Health Service.

When Coinsurance applies as a result of the Out-Of-Network Level of Benefits, except as otherwise required by law, the Coinsurance amount will be calculated based on the Maximum Allowable Amount. A charge by a physician or provider for a Health Service eligible for the Out-Of-Network Level Of Benefits that is in excess of the Maximum Allowable Amount is not considered Coinsurance and shall be the Member's financial responsibility.

COINSURANCE MAXIMUM

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

COPAYMENT MAXIMUM

Generally, the Member's maximum payment liability per year for Copayments for Health Services covered at the In-Network Level of Benefits as listed in the Member's Benefit Summary. Check the "Managed Care Rules and Guidelines" section for more information about how the Copayment Maximum applies to Your Plan.

COPAYMENTS

A flat dollar amount that You pay per day per provider (or provider group) or per service for certain Plan Benefits under this Plan.

COSMETIC TREATMENTS

Any medical or surgical treatment for which the primary purpose is to change appearance as We determine in Our sole discretion.

COST-SHARE

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

COST-SHARE MAXIMUM

Generally, the Member's maximum payment liability per year for Deductibles, Copayments and Coinsurance as listed in the Benefit Summary. Check the "Managed Care Rules and Guidelines" section for more information about how the Cost-Share Maximum applies to Your Plan.

CUSTODIAL CARE

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

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

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

DEDUCTIBLE

The total amount that You must pay during the year toward certain benefits under this Plan before We will begin paying for those benefits. Check Your Benefit Summary to see which benefits are subject to a Deductible.

DELEGATED PROGRAM

An outside company that We may use to manage and administer certain categories of benefits or services provided under this Plan. When this document refers to determinations, Prior-Authorizations or other decisions made under the terms of that Delegated Program, such determinations, Prior-Authorizations, Referrals or other decisions are made by the outside company on Our behalf.

DRUG THERAPY

A product administered by a health care professional for use in the diagnosis, cure, treatment, or prevention of disease.

EFFECTIVE DATE

The date that coverage under this Policy became effective. The Effective Date is subject to Our receipt and approval of a completed Exchange enrollment form and Our Application/Change Form, which includes the health statement.

ELIGIBLE DEPENDENTS

Persons, other than You (the Subscriber), who are eligible to be enrolled as Members under this Policy and as described in the “Eligibility and Enrollment” section of this Policy.

EMERGENCY

The sudden and unexpected onset of an illness or injury with severe symptoms whereby a Prudent Layperson,

acting reasonably, would believe that emergency medical treatment is needed.
An Emergency related to mental health care exists when a Member is at risk of suffering serious physical impairment or death; or of becoming a threat to himself/herself or others; or of significantly decreasing his/her functional capability if treatment is withheld for greater than 24 hours.
The presenting symptoms of the patient, as coded by the provider on the appropriate claim form or the final diagnosis, whichever reasonably indicates an emergency medical condition, shall be the basis for determining whether such services are for an Emergency.

EMERGENCY SERVICES

Any health care service provided to a Member after the sudden onset of a medical condition that manifests itself by acute symptoms of sufficient severity or severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (i) placing the health of the Member, or, with respect to a pregnant Member, the health of the Member of her unborn child, in serious jeopardy; (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part.

EXCHANGE (ACCESS HEALTH CT)

The Connecticut Health Insurance Exchange (Access Health CT) was established as a quasi-public agency to satisfy the requirements of the federal Affordable Care Act. The Exchange is a marketplace where eligible individuals and small groups will be able to shop for and purchase health insurance coverage, beginning in October 2013.

EXPERIMENTAL OR INVESTIGATIONAL

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

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

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

GENERIC DRUG OR SUPPLY (GENERICS)

A drug or supply manufactured and approved by federal FDA standards that has the same active ingredients as the original Brand Name Drug or Supply and is classified as a generic by a nationally recognized source and

recognized by Us as a Generic Drug or Supply.

GENERIC EQUIVALENT

A Generic Drug or Supply that is therapeutically equivalent to the Brand Name Drug or Supply and that meets the composition, safety, strength, purity, and quality standards of the federal FDA and that We require to be substituted for a Brand Name Drug or Supply. Not all Brand Name Drugs or Supplies with Generic Equivalents are required to be substituted.

HEALTH SERVICES

Those diagnostic and therapeutic, medical, surgical, and behavioral health services and supplies that are Medically Necessary and available to You and Your Eligible Dependents under this Plan. Health Services must be provided or rendered by a licensed health care provider within the scope of his/her its license or authorization in accordance with the laws and regulations of the governmental authority having jurisdiction.

HEALTHYCT, WE, US OR OUR

HealthyCT Inc., the company insuring this Plan.

HOME HEALTH AGENCY

A duly licensed agency where:

1. Nursing care is provided by a registered nurse or licensed practical nurse;
2. Home health aide services consisting of patient care of a medical or therapeutic nature are provided by someone other than a registered or licensed practical nurse;
3. Physical, occupational or speech therapy is provided;
4. Certain medical supplies, drugs and medicines prescribed by a physician and laboratory services to the extent such services would be covered if Medically Necessary, as We determine, are provided; and
5. Medical social services are provided by a qualified Masters-prepared social worker to or for the benefit of a terminally ill Member (i.e., having a life expectancy of six months or less).

HOSPICE

An agency that provides counseling and incidental medical services for a terminally ill (i.e., having a life expectancy of six months or less) individual. To be a Hospice, the agency must:

1. Be licensed in accordance with all laws;
2. Provide 24-hour-a-day, seven days-a-week service;
3. Be under the direction of a duly qualified physician;
4. Have a nurse coordinator who is a registered graduate nurse with clinical experience, including experience in caring for terminally ill patients;
5. Have as its main purpose the provision of hospice services;
6. Have a full-time administrator;
7. Maintain written records of services given to the patient; and
8. Maintain malpractice insurance coverage.

For purposes of this Plan, a Home Health Agency that provides hospice care in the home or a hospice, which is

part of a Hospital, will be considered a Hospice.

HOSPITAL

An institution duly licensed as a hospital by the governmental authority having jurisdiction and a mobile field hospital when isolation care and Emergency Services are provided.

HOSPITALIZATION

Health Services rendered by a Hospital as either:

INPATIENT HOSPITALIZATION

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

PARTIAL HOSPITALIZATION / DAY TREATMENT PROGRAM

Those covered behavioral health services which are rendered in a facility or Hospital-based program that provides services for at least 20 hours per week.

HOSPITAL OUTPATIENT SURGICAL FACILITY (HOSF)

A facility owned by a Hospital or hospital system offering a surgical procedure and related care that in the opinion of the attending physician can be safely performed without requiring overnight inpatient Hospital care. A HOSF is included within the Hospital license and the Medicare or Medicaid certification of the Hospital itself. Services rendered by the HOSF are billed utilizing the Hospital's own tax identification number or a tax identification number unique to the Hospital or hospital system.

INDIVIDUAL PRACTICE ASSOCIATION OR IPA

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

INFERTILITY

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

IN-NETWORK LEVEL OF BENEFITS

Generally, the maximum level of benefits under this Plan available for Health Services provided to a Member by a Participating Provider. The In-Network Level Of Benefits under this Plan is described in the Member's Benefit Summary.

INSUFFICIENT EVIDENCE OF THERAPEUTIC VALUE

Insufficient Evidence Of Therapeutic Value occurs when We determine in Our sole discretion that either:

1. There is not enough evidence to prove that the service, supply, device, procedure or medication (collectively called "Treatment") directly results in the restoration of health or function for the use for

which it is being prescribed, whether or not alternative Treatments are available; or

2. There is not enough evidence to prove that the Treatment results in outcomes superior to those achieved with reasonable alternative Treatments which are less intensive or invasive, or which cost less and are at least equally effective for the use for which it is being prescribed.

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

INTENSIVE OUTPATIENT (IOP)

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

MAXIMUM ALLOWABLE AMOUNT

The amount on which We base Our reimbursement for covered Health Services provided by Non-Participating providers, which may be less than the amount billed for those covered Health Services. We calculate the Maximum Allowable Amount as the lesser of the amount billed by the Non-Participating Provider or, where applicable, the amount determined by one of the methods described below. In addition, the Maximum Allowable Amount is not the amount that We pay for a covered Health Service. The actual payment will be reduced by applicable Deductibles(s), Coinsurance, Copayment(s), Benefit Reduction amounts and other applicable adjustments described in this document. In no case will Our reimbursement exceed the maximum benefit described in this document.

We have the sole authority to determine what We use for the Maximum Allowable Amount. The Maximum Allowable Amount can change from time to time, as well as the criteria We will use to determine the Maximum Allowable Amount.

Only charges that You are legally required to pay for a Health Service will count towards the Maximum Allowable Amount. So, if the physician or provider is not charging You for part or all of the Health Service and You are therefore not legally obligated to pay for that waived amount, We will not count that waived amount towards the Maximum Allowable Amount.

1. We may contract with vendors that have fee arrangements with Non-Participating Providers (Third Party Networks). If You utilize a Non-Participating Provider in a Third Party Network, the Maximum Allowable Amount will be determined based on Our contract with the Third Party Network. Where the terms of Our contract with the Third Party Network require, We will use the contract fee between the Non-Participating Provider and the Third Party Network as the Maximum Allowable Amount. For other arrangements, We will determine the Maximum Allowable Amount as the lesser of the contract fee, or billed charges or the amount determined by one of the methods described below.

2. We may, at Our option, negotiate a rate with a Non-Participating Provider for a covered Health Service. In that situation, if the Non-Participating Provider agrees to a negotiated Maximum Allowable Amount, You will not be responsible for the difference between the Maximum Allowable Amount and the billed charges. You will be responsible for any applicable Deductible(s), Coinsurance and/or Copayment(s) at the Out Of Network Level Of Benefits, as well as any Benefit Reduction amounts.
3. For physician and other professional covered Health Services, We may utilize a designated percentage of Resource Based Relative Value System (RBRVS) determined by Us based on a percentage of Medicare. When no amount specified by the Centers for Medicare and Medicaid Services (CMS) at a percentage of RBRVS exists, a percentage of charges, as determined by Us, will be used instead.

    - For inpatient and outpatient Hospital covered Health Services, We may utilize a method developed by a company that uses Hospital cost to charge (C2C) ratio. This method analyzes charges based upon the Hospitals': financial and statistical information as submitted to the federal government; cost of providing covered Health Services; and the median mark up by revenue center for Hospitals in that geographic area. These values are then compared to the actual billed charges. If the Hospital accepts the C2C determination, it will become the Maximum Allowable Amount for the services rendered, at that time.
    - Where prescription drugs (e.g., IV therapy claims) are administered by a Non-Participating Provider, and covered as a medical benefit, We will determine the Maximum Allowable Amount using the Average Wholesale Price (AWP), as determined by Us.
    - For a prescription drug or supply obtained at a pharmacy, the Maximum Allowable Amount will be the lesser of the actual charge for the medication or supply or the negotiated contracted rate for that medication or supply that We would have paid, if the medication or supply had been obtained at a Participating Pharmacy.
    - In the event that the billed charges for the Non-Participating Provider are more than the Maximum Allowable Amount, You are responsible for any amounts charged in excess of the Maximum Allowable Amount, except where the Non-Participating Provider's fee is determined by references to a Third Party Network contract or the Non-Participating Provider agrees to a negotiated Maximum Allowable Amount.
    - Whenever You obtain covered Health Services from a Non-Participating Provider, You are responsible for applicable Deductibles(s), Coinsurance, Copayment(s) and/or Benefit Reduction Amounts.

MEDICAID

A government program sponsored by the federal government and the individual states, including Connecticut, that provides health coverage for lower income individuals and families, older individuals and families, and people with disabilities.

MEDICALLY NECESSARY OR MEDICAL NECESSITY

Health Services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose

of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

1. In accordance with generally accepted standards of medical practice;
2. Clinically appropriate, in terms of type, frequency, extent, site and duration and considered effective for the patient's illness, injury or disease; and
3. Not primarily for the convenience of the patient, physician or other health care provider and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For the purposes of this definition, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community or otherwise consistent with the standards set forth in policy issues involving clinical judgment.

MEDICARE
A government program sponsored by the federal government that provides health coverage primarily for individuals age 65 or older and people with disabilities.

MEMBER, YOU, AND YOUR ELIGIBLE DEPENDENTS
A person enrolled in this Plan, including You and Your Eligible Dependents.

MINIMUM ESSENTIAL COVERAGE
Any of the following programs:

- Medicare,
- Medicaid,
- CHIP,
- TRICARE for Life, veteran's health care program;
- Coverage under an eligible employer-sponsored plan;
- Coverage under a health plan offered in the individual market within a State;
- Coverage under a grandfathered health plan, and such other health benefits coverage, such as a State health benefits risk pool, or as the Secretary of HHS recognizes.

NEW TECHNOLOGY
New Technology is a new supply, service, device, procedure or medication, or new use of existing supplies, services, devices, procedures or medications, for which We have not yet made a coverage policy. New Technology does not include FDA-approved drugs used to treat a covered illness or sickness.

NON-PARTICIPATING HOSPITAL
A Hospital that is not a Participating Hospital.

NON-PARTICIPATING PHARMACY

A pharmacy that does not have a contract with Us to provide covered prescription drugs and supplies to You and Your covered dependents. A Non-Participating Pharmacy is a pharmacy that when used by a Member typically provides the lowest level of benefits, because out of pocket Cost-Shares are the highest.

NON-PARTICIPATING PHYSICIAN OR NON-PARTICIPATING PROVIDER

A provider that does not have a contract with Us to provide Health Services to You. You may pay more to see a Non-Participating Provider.

OUT-OF-NETWORK LEVEL OF BENEFITS

Generally, a lesser level of benefits than the In-Network Level of Benefits under this Plan available for Health Services provided to a Member when the Health Services are not eligible for benefit coverage at the In-Network Level of Benefits. Except in cases of Emergencies or as otherwise provided in this document, Health Services obtained from or arranged by Non-Participating Providers are payable at the Out-Of-Network Level Of Benefits. The Out-Of-Network Level of Benefits for benefits under this Plan is the Coinsurance percentage described in the Member's Benefit Summary multiplied by the Maximum Allowable Amount charges after any Copayments or Deductible is applied. If the Out-Of-Pocket Maximum is met for a Member in a year, then the Out-Of-Network Level of Benefits is modified as described in the definition of Out-Of-Pocket Maximum for the remainder of that year.

OUT-OF-POCKET MAXIMUM

Generally, the Member's maximum payment liability per year for Health Services, as listed in the Member's Benefit Summary.

PARTICIPATING HOSPITAL

A Hospital that has entered into an agreement with Us, to provide certain Health Services to You and Your Eligible Dependents. A Participating Hospital is a Hospital that when used by a Member typically provides a higher level of benefits, because out-of-pocket Cost-Shares are lower.

PARTICIPATING NETWORK PHARMACY

A select pharmacy that has entered into an agreement with Us to provide covered prescription drugs, medications and supplies to You and Your covered dependents.

PARTICIPATING PHARAMACY

A select pharmacy that has entered into an agreement with Us, to provide covered prescription drugs, medications and supplies to You and Your Eligible Dependents. A Participating Pharmacy is a pharmacy that when used by a Member typically provides a higher level of benefits, because out-of-pocket Cost-Shares are lower.

A Participating Pharmacy does not include a Hospital pharmacy, even if the Hospital is a Participating Hospital

PARTICIPATING PHYSICIAN

A health care professional duly licensed to practice as a physician who has entered into an agreement with Us, to provide certain Health Services to You and Your Eligible Dependents.
A Participating Physician is a provider who when used by a Member typically provides a higher level of benefits, because out-of-pocket Cost-Shares are lower.

PARTICIPATING PROVIDER
A health care practitioner or facility, including a Participating Physician, Participating Pharmacy, Participating Hospital or other similar practitioner or facility, that is duly licensed to provide health care services and that has entered into an agreement with Us, to provide certain Health Services to You and Your Eligible Dependents.
A Participating Provider is a provider who when used by a Member typically provides a higher level of benefits, because out-of-pocket Cost-Shares are lower. Participating Providers may not include Hospital-based clinics, even if the Hospital is a Preferred Participating Hospital or a Hospital, unless the Hospital clinic is specifically contracted with Us.

PLAN
The program, which is operated by Us, provides coverage for Health Services to Members.

PLAN BENEFITS
Health Services covered as specified in this document.

POLICY
This document, the Benefit Summary, Riders, insert pages, Exchange enrollment form, the Application/Change Form, and any amendments thereto.

PREMIUM
The regular payments required to be made to Us by You under this Plan for coverage to remain in effect.

PREMIUM PERIOD
The span of time, which begins at the first of the month based on Your Effective Date and ends one month later.

PRESCRIPTION DRUG DEDUCTIBLE
This Plan may have a Prescription Drug Deductible that applies separately to certain prescription drugs. The Prescription Drug Deductible must be met by the Member each year before We will begin paying for certain prescription drugs. Check Your Benefit Summary to see if a Prescription Drug Deductible applies to this Plan.

PRIMARY CARE PROVIDER OR PCP
A physician, advanced practice registered nurse (APRN), or a nurse practitioner who is a Participating Provider selected by or assigned to the Member, who is normally engaged in one of the following primary care specialties:

- Family medicine

- Internal medicine
- Obstetrics and Gynecology
- Pediatrics; and who is listed as a PCP in the HealthyCT Provider Directory.

PRIOR-AUTHORIZATION OR PRIOR-AUTHORIZED

The authorization, based on Medical Necessity, needed from Us, or the applicable Delegated Program, in advance of the Member's receipt of certain specified Health Services.

Prior-Authorization also includes the written authorization from Us, or the applicable Delegated Program, needed in advance of the Member's receipt of Health Services from a Non-Participating Provider in order to have those services or supplies covered at the highest level of benefits under the Plan.

PROVIDER DIRECTORY

The listing of Participating Providers or compiled and prepared for Our benefit plans.

PRUDENT LAYPERSON

A person who is without medical training and who draws on his/her practical experience when making a decision regarding whether Emergency medical treatment is needed. A Prudent Layperson will be considered to have acted "reasonably" if other similarly situated laypersons would have believed, on the basis of observation of the medical symptoms at hand, that Emergency medical treatment was necessary.

QUALIFIED HEALTH PLAN OR QHP

A health plan that has in effect a certification issued or recognized by each Exchange through which such health plan is offered.

QUALIFIED INDIVIDUAL

An individual who has been determined eligible to enroll through the Exchange in a QHP in the individual market.

REHABILITATION FACILITY

A Hospital or other facility that provides restorative physical and occupational therapy treatment and is licensed and accredited as a rehabilitation facility by the governmental or other authority having jurisdiction.

RENEWAL DATE

January 1st of each year whereby coverage under this Policy is continued subject to the terms of this Policy, as long as the Subscriber pays the Premium due.

RESIDENTIAL TREATMENT FACILITY

A treatment center for children and adolescents that provides residential care and treatment for emotionally disturbed individuals and is licensed and accredited by the governmental authority having jurisdiction.

RIDER

A written amendment that modifies the terms and conditions of this document.

SERVICE AREA
Those geographic areas where Participating Providers provide benefits for covered Health Services as described in this Policy.

SKILLED NURSING FACILITY
An institution or distinct part of an institution that is duly licensed as a skilled nursing facility by the governmental authority having jurisdiction.

SPECIALIST PHYSICIAN
A physician specialist (other than the Member's PCP) who focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of health care.

SUBSCRIBER OR YOU
You, when You are enrolled in this Plan and eligible to receive Plan Benefits.
You will also be considered the Subscriber in the case of child only coverage, where the Policy has been issued in Your name. When that child only Policy has been issued to You, it is Your responsibility to assure a child complies with any and all the terms and conditions outlined in the Policy.

THERAPEUTIC EQUIVALENT DRUG OR SUPPLY
A drug or supply in the same category as an excluded drug or supply, and determined by Us to be an effective alternative.

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

URGENT CARE CENTER
A facility duly licensed to provide Urgent Care.

UTILIZATION MANAGEMENT
The process of evaluating and determining the coverage for and the appropriateness of medical care services, as well as providing any needed assistance to the clinician or the patient in cooperation with other parties, to ensure appropriate use of resources. Utilization Management includes Prior-Authorization, concurrent review, retrospective review, discharge planning and Case Management.

WALK-IN CARE CLINIC
A facility designed to treat common ailments. Examples of common ailments include, but are not limited to:

- Colds, flu symptoms, sore throat, cough or upper respiratory symptoms,

- Ear or sinus pain,
- Minor cuts, bruises, or scrapes
- Rash, hives, stings and bites,
- Sprains

Walk-In Care Clinic provide basic primary health care and are typically staffed by a nurse practitioner or at the most physician's assistant.

WILDERNESS CAMP

A camp that provides behavioral health intervention for children and adolescents with emotional, addiction, and or psychological problems. The intervention typically involves immersion in the wilderness or wilderness like setting, group living with peers, the administration of individual and group therapy sessions, and educational/therapeutic curricula, including back country travel, wilderness living skills and horseback riding.

PRIOR-AUTHORIZATION ADDENDUM

You need Prior-Authorization for the following:

Inpatient Services

- Medical/Surgical Inpatient Admissions
- Skilled Nursing facility Admissions
- Acute Inpatient Rehabilitation
- Residential Treatment Facilities
- Sub-Acute Care Admissions
- Inpatient Hospice
- Acute Behavioral Health Admissions
- Partial Behavioral Health Programs

Services/Procedures/Devices/Programs

- Ambulance: Non-Emergent Air and Ground
- Autism services – Physical Therapy, Occupational Therapy and Applied Behavioral Analysis (after the equivalent of 10 visits annually)
- Behavioral Health Intensive Outpatient Program
- Blepharoplasty and Brow Ptosis Repair
- Biofeedback
- Chiropractic Services (after the first 10 visits annually)
- Clinical Trials
- Cosmetic Procedures (See Attachment 1)
- DME: Hospital Bed (and mattress), Custom Wheelchair
- Experimental/Investigational Procedures
- Genetic Testing: Breast, Ovarian and Colorectal cancers
- Habilitative Services (after the first 10 visits annually)
- Home Health Care: all services
- Infertility Services/Treatments
- Neuropsychological testing, except for children with cancer
- Non-participating provider when requesting in-network level of coverage
- Orthognathic /Jaw Surgery
- Occupational Therapy: Habilitative and Rehabilitative (after the first 10 visits annually)
- Physical Therapy: Habilitative and Rehabilitative (after the first 10 visits annually)
- Prosthetics: whole limb or part of limb
- Psychological Testing
- Radiology: CT, MRI/MRA, SPECT, PET and Nuclear Cardiology
- Septoplasty
- Services related to Gender Dysphoria

- Sleep Studies other than location of home
- Spinal Surgery: Inpatient and Outpatient
- Temporomandibular joint (TMJ) surgery
- Transplants: Pre-evaluation and at time of transplant (except cornea)
- Varicose Vein Treatment

Notification Requirements

- Maternity after First Pre-Natal Visit
- Birth to Three Program
- Dialysis

Potentially Cosmetic Procedures Requiring Prior Authorization including, but not limited to:

- Breast Reduction Surgery
- Breast reduction/Mastopexy
- Breast Repair/Reconstruction (Not Following Mastectomy)
- Breast Augmentation
- Canthoopexy/Canthoplasty
- Cerivicoplasty
- Chemical Peels
- Laser Treatment for Cutaneous Vascular Lesions
- Rhinophyma Surgical/Laser Treatment
- Repair of Vestibular Stenosis

Prescription Drugs or Supplies Requiring Prior Authorization

When a Participating Physician writes a prescription for a drug or supply that requires Prior Authorization, it is the responsibility of the Participating Physician to obtain the Prior Authorization from Us. A Non-Participating Physician may choose not to obtain Prior Authorization from Us, and it is Your responsibility to work with Your Physician to obtain the necessary Prior Authorization. You should check with Your doctor to make sure he or she has obtained Prior Authorization BEFORE You go to the pharmacy.

When Prior Authorization is obtained, it is Your responsibility to make sure the authorization is still applicable when You go to the pharmacy to have Your prescription filled. If the authorization has expired You will need to obtain a new Prior Authorization or pay the full cost for the prescription. If a Prior Authorization was approved for an amount less than what You were prescribed, only the approved amount will be subject to Your benefits. Please note that ST after the name of the drug indicates that it is subject to the Step Therapy program. For a description of HealthyCT's Step Therapy program, please refer to page 61.

Therapeutic Category	BRAND (generic)
Anti-Infectives	
Antiretrovirals, Hepatitis B	BARACLUDE (entecavir)
	HEPSERA (adefovir)
	TYZEKA (telbivudine)
Antiretrovirals, HIV	FUZEON (enfuvirtide)
	SELZENTRY (maraviroc)
	TRUVADA (emtricitabine/tenofovir)
Cardiology	
Antilipemic	JUXTAPID (lomitapide)
	KYNAMRO (mipomersen sodium)
Angiotensin Receptor Blockers ST	ATACAND (candesartan) ST
	EDARBI (azilsartan medoxomil) ST
	EDARBYCLOR (azilsartan/chlorthalidone) ST
	TEVETEN (eprosartan mesylate) ST
	TEVETEN HCT (eprosartan mesylate/hydrochlorothiazide) ST
Benign Prostatic Hyperplasia (BPH)	CIALIS (tadalafil)
Pulmonary Arterial Hypertension (PAH)	ADCIRCA (tadalafil)
	FLOLAN (epoprostenol)
	LETAIRIS (ambrisentan)
	OPSUMIT (macitentan)
	REMODULIN (treprostinil)
	REVATIO (sildenafil)
	TRACLEER (bosentan)
	TYVASO (treprostinil)
	VELETRI (epoprostenol)
	VENTAVIS (iloprost)
Central Nervous System	

Anticonvulsants	SABRIL (vigabatrin)
Atypical Antipsychotics ST	FANAPT (iloperidone) ST
	INVEGA (paliperidone) ST
	SAPHRIS (asenapine maleate) ST
Depressant	XYREM (sodium oxybate)
Neurotoxins	BOTOX (onabotulinumtoxinA)
	DYSPORT (abobotulinumtoxinA)
	MYOBLOC (rimabotulinumtoxinB)
	XEOMIN (incobotulinumtoxinA)
Parkinson's	APOKYN (apomorphine)
Migraine (Triptans) ST	ALSUMA (sumatriptan succinate) ST
	AXERT (almotriptan malate) ST
	FROVA (frovatriptan succinate) ST
	SUMAVEL (sumatriptan succinate) ST
	TREXIMET (sumatriptan/naproxen sodium) ST
	ZOMIG NASAL (zolmitriptan) ST
Endocrinology & Metabolism	
Androgens, Testosterone ST	ANDRODERM (testosterone) ST
	AXIRON (testosterone) ST
	FORTESTA (testosterone) ST
	STRIANT (testosterone) ST
	TESTIM (testosterone) ST
Bisphosphonates ST	ACTONEL (risedronate) ST
	ATELVIA (risedronate) ST
Fertility	BRAVELLE (urofollitropin purified)
	FOLLISTIM (follitropin beta)
	GONAL-F (follitropin alfa)
	MENOPUR (menotropins)
	NOVAREL (chorionic gonadotropin)
	OVIDREL (choriogonadotropin alfa)
	PREGNYL (chorionic gonadotropin)
	REPRONEX (menotropins)
GLP-1 Receptor Agonists ST	VICTOZA (liraglutide) ST
Gonadotropins	ELIGARD (leuprolide)
	FIRMAGON (degarelix)
	LUPRON (leuprolide)
	LUPRON DEPOT (leuprolide)
	SUPPRELIN LA (histrelin acetate)
	TRELSTAR (triptorelin)
	VANTAS (histrelin)
	ZOLADEX (goserelin)
Growth Hormones & Related Therapy	EGRIFTA (tesamorelin)
	GENOTROPIN (somatropin)
	HUMATROPE (somatropin)
	INCRELEX (mecasermin)
	NORDITROPIN (somatropin)

	NUTROPIN (somatropin)
	NUTROPIN AQ (somatropin)
	OMNITROPE (somatropin)
	SAIZEN (somatropin)
	SEROSTIM (somatropin)
	SOMAVERT (pegvisomant)
	TEV-TROPIN (somatropin)
	ZORBTIVE (somatropin)
Insulin (short-acting) ST	APIDRA (insulin glulisine) ST
	HUMALOG (insulin lispro) ST
	HUMULIN (insulin) ST
Insulin (long-acting) ST	LEVEMIR (insulin detemir) ST
Osteoporosis	PROLIA (denosumab)
	RECLAST (zoledronic acid)
Somatostatins	SANDOSTATIN (octreotide)
	SANDOSTATIN LAR (octreotide)
	SIGNIFOR (pasireotide)
	SOMATULINE DEPOT (lanreotide)
Miscellaneous	ACTHAR H.P. (corticotropin)
Enzyme-Related	
Alpha-1 proteinase inhibitor	ARALAST (alpha-1 proteinase inhibitor)
	GLASSIA (alpha-1 proteinase inhibitor)
	PROLASTIN (alpha-1 proteinase inhibitor)
	ZEMAIRA (alpha-1 proteinase inhibitor)
Cystine-depleting Agents	CYSTARAN (cysteamine)
	PROCYSBI (cysteamine bitartrate)
Enzyme Replacement	ADAGEN (pegademase)
	ALDURAZYME (laronidase)
	CARBAGLU (carglumic acid)
	CEREZYME (imiglucerase)
	ELAPRASE (idursulfase)
	ELELYSO (taliglucerase)
	FABRAZYME (agalsidase beta)
	LUMIZYME (alglucosidase alfa)
	MYOZYME (alglucosidase alfa)
	NAGLAZYME (galsulfase)
	RAVICTI (glycerol phenylbutyrate)
	VPRIV (velaglucerase)
	ZAVESCA (miglustat)
Enzyme, Gout	KRYSTEXXA (pegloticase)
Phenylketonuria Treatment Agents	KUVAN (sapropterin)
Gastroenterology	
Proton Pump Inhibitors ST	ACIPHEX SPRINKLES (rabeprazole sodium) ST
	ACIPHEX (rabeprazole) ST
	DEXILANT (dexlansoprazole) ST
	ESOMEPRAZOLE STRONTIUM (esomeprazole strontium) ST

	PREVACID SOLUTABS (lansoprazole) [ST]
	PRILOSEC PACKETS (omeprazole magnesium) [ST]
	ZEGERID SUSPENSION (omeprazole/ sodium bicarbonate) [ST]
Short Bowel Syndrome	GATTEX (teduglutide)
Immunology	
Anti-inflammatory Biologic Agents	ACTEMRA (tocilizumab)
	CIMZIA (certolizumab)
	ENBREL (etanercept)
	HUMIRA (adalimumab)
	KINERET (anakinra)
	ORENCIA (abatacept)
	REMICADE (infliximab)
	SIMPONI (golimumab)
	STELARA (ustekinumab)
	XELJANZ (tofacitinib)
Hematopoietic Agents	ARANESP (darbepoetin alfa)
	EPOGEN (epoetin alfa)
	LEUKINE (sargramostim)
	MOZOBIL (plerixafor)
	NEULASTA (pegfilgrastim)
	NEUMEGA (oprelvekin)
	NEUPOGEN (filgrastim)
	NPLATE (romiplostim)
	OMONTYS (peginesatide)
	PROCRIT (epoetin alfa)
	PROMACTA (eltrombopag)
	SOLIRIS (eculizumab)
Hepatitis C Agents	INCIVEK (telaprevir)
	INFERGEN (interferon alfacon-1)
	PEGASYS (peginterferon alfa-2a)
	PEG-INTRON (peginterferon alfa-2b)
	VICTRELIS (boceprevir)
Immune Globulins	BIVIGAM (immune globulin)
	CARIMUNE (immune globulin)
	CYTOGAM (cytomegalovirus immune globulin)
	FLEBOGAMMA (immune globulin)
	GAMASTAN (immune globulin)
	GAMMAGARD (immune globulin)
	GAMMAKED (immune globulin)
	GAMMAPLEX (immune globulin)
	GAMUNEX (immune globulin)
	HIZENTRA (immune globulin)
	OCTAGAM (immune globulin)
	PRIVIGEN (immune globulin)
Interleukins	ARCALYST (rilonacept)
	ILARIS (canakinumab)

Multiple Sclerosis	AMPYRA (dalfampridine)
	AUBAGIO (teriflunomide)
	AVONEX (interferon beta-1a)
	BETASERON (interferon beta-1b)
	COPAXONE (glatiramer)
	EXTAVIA (interferon beta-1b)
	GILENYA (fingolimod)
	NOVANTRONE (mitoxantrone)
	REBIF (interferon beta-1a)
	TECFIDERA (dimethyl fumarate)
	TYSABRI (natalizumab)
Transplant	NULOJIX (belatacept)
	ZORTRESS (everolimus)
Miscellaneous	BENLYSTA (belimumab)
Obstetrics & Gynecology	
Hormone Replacement	MAKENA (hydroxyprogesterone caproate)
Oncology	
Alkylating Agents	MYLERAN (busulfan)
	TEMODAR (temozolomide)
Antiandrogen	XTANDI (enzalutamide)
	ZYTIGA (abiraterone)
Antimicrotubular	HALAVEN (eribulin)
	JEVTANA (cabazitaxel)
Interferons	INTRON A (interferon alfa-2b)
	SYLATRON (peginterferon alfa-2b)
Kinase and Molecular Target Inhibitors	AFINITOR (everolimus)
	BOSULIF (bosutinib)
	CAPRELSA (vandetanib)
	COMETRIQ (carbozantinib)
	ERIVEDGE (vismodegib)
	GILOTRIF (afatinib)
	GLEEVEC (imatinib)
	ICLUSIG (ponatinib)
	INLYTA (axitinib)
	JAKAFI (ruxolitinib)
	KYPROLIS (carfilzomib)
	MEKINIST (trametinib)
	NEXAVAR (sorafenib)
	PERJETA (pertuzumab)
	SPRYCEL (dasatinib)
	STIVARGA (regorafenib)
	SUTENT (sunitinib)
	TAFINLAR (dabrafenib)
	TARCEVA (erlotinib)
	TASIGNA (nilotinib)
	TYKERB (lapatinib)

	VELCADE (bortezomib)
	VOTRIENT (pazopanib)
	XALKORI (crizotinib)
	ZALTRAP (ziv-aflibercept)
	ZELBORAF (vemurafenib)
Miscellaneous	DACOGEN (decitabine)
	ERWINAZE (asparaginase)
	ISTODAX (romidepsin)
	SYNRIBO (omacetaxine)
	TARGRETIN (bexarotene)
	VIDAZA (azacitidine)
	XELODA (capecitabine)
	ZOLINZA (vorinostat)
	ZOMETA (zoledronic acid)
Monoclonal Antibody	ADCETRIS (brentuximab)
	HERCEPTIN (trastuzumab)
	KADCYLA (ado-trastuzumab emtansine)
	RITUXAN (rituximab)
	XGEVA (denosumab)
	YERVOY (ipilimumab)
Thalidomide-related Agents	POMALYST (pomalidomide)
	REVLIMID (lenalidomide)
	THALOMID (thalidomide)
Respiratory	
Asthma/COPD	XOLAIR (omalizumab)
Cystic fibrosis	CAYSTON (aztreonam)
	KALYDECO (ivacaftor)
	PULMOZYME (dornase alfa)
	TOBI (tobramycin)
Inhaled Corticosteroids [ST]	FLOVENT (fluticasone propionate) [ST]
Inhaled Corticosteroids /LABAs [ST]	ADVAIR (fluticasone propionate/salmeterol) [ST]
	BREO ELLIPTA (fluticasone furoate/vilanterol) [ST]
Intranasal Steroids [ST]	BECONASE AQ (beclomethasone dipropionate) [ST]
	DYMISTA (azelastine hcl/fluticasone) [ST]
	OMNARIS (ciclesonide) [ST]
	QNASL (beclomethasone dipropionate) [ST]
	RHINOCORT AQUA (budesonide) [ST]
	VERAMYST (fluticasone furoate) [ST]
	ZETONNA (ciclesonide) [ST]
Respiratory Syncytial Virus Agents	SYNAGIS (palivizumab)
Miscellaneous	
Collagenase	XIAFLEX (collagenase clostridium histolyticum)
Diagnostic	THYROGEN (thyrotropin alfa)
Movement Disorder Agents	XENAZINE (tetrabenazine)
Toxicology	EXJADE (deferasirox)
	FERRIPROX (deferiprone)

Viscosupplements	EUFLEXXA (sodium hyaluronate)
	GEL-ONE (cross-linked hyaluronate)
	HYALGAN (sodium hyaluronate)
	ORTHOVISC (sodium hyaluronate)
	SUPARTZ (sodium hyaluronate)
	SYNVISC (sodium hyaluronate)
	SYNVISC-ONE (sodium hyaluronate)