Special Health Care Portability Plan

Issued by the Health Reinsurance Association

Health Reinsurance Association
628 Hebron Avenue, Suite 100
Glastonbury, CT 06033
1-800-842-0004

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Special Health Care Portability Plan

Issued By:

Health Reinsurance Association
628 Hebron Avenue, Suite 100
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This Policy describes the Special Health Care Portability plan and the terms and conditions under which the Subscriber and his or her enrolled Dependents are eligible to receive Covered Services.

Amendments to this Policy may occur, as approved by the State of Connecticut Insurance Department. The Effective Date of such changes shall be designated by the Health Reinsurance Association and notification to Subscribers will be provided by the Health Reinsurance Association.

The Health Reinsurance Association shall have discretionary authority to interpret all provisions, terms, conditions, limitations and exclusions of this Policy and the health benefit plan administered under this Policy, and shall have discretionary authority to make all decisions regarding eligibility for benefits, coverage and claims under this Policy and the health benefit plan administered under this Policy. The Member shall have recourse available under the terms of this Policy and applicable regulation and law.

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 the Health Reinsurance Association in Glastonbury, Connecticut within 10 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.

RENEWAL PROVISION

We will renew your Policy each time you send us the premium. Payment must be made on or before the due date or during the month that follows. Your Policy stays in force during this time. Nonrenewal will not affect an existing claim.

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SCHEDULE OF BENEFITS

This schedule generally describes the benefits available for Covered Services under this Policy. For a more detailed explanation of benefits provided, you should refer to the appropriate section of the Policy. This Schedule of Benefits is subject to all the terms, conditions and limitations set forth in this Policy.

Note: Services applicable after Deductible and Coinsurance.

COVERED SERVICES – Low Income Plan	
Individual Deductible	[$500]
Family Deductible	[$1,000]
Out of Pocket Maximum Applies to Low Income outside of CT.	Individual $2,500
Member Coinsurance	None after the annual deductible is met. After the annual deductible is met, this plan pays 75% of the Medicare reimbursement amount. If you are using Connecticut Doctors and Hospitals, this amount must be accepted as paid in full. The Connecticut providers may not bill you for any difference once the annual deductible is met. Additionally, if you use Doctors and Hospital outside of Connecticut, the plan pays 75% of the Medicare reimbursement amount. Doctors and Hospitals outside of Connecticut may bill you for any difference above what the plan pays.
Policy Lifetime Maximum	**$1,500,000 per individual**
PREVENTIVE SERVICES	
Well Child Care: 6 exams from birth to 1 year of age. 6 exams 1 through 5 years of age. 1 exam every 2 Calendar Years 6 through 10 years of age. 1 exam every Calendar Year 11 through 21 years of age.	Deductible

Adult Physical Examinations: 1 exam every 5 Calendar Years 22 through 29 years of age. 1 exam every 3 Calendar Years 30 through 39 years of age. 1 exam every 2 Calendar Years 40 through 49 years of age. 1 exam per Calendar Year 50 years of age and older.	Deductible
Routine gynecological visit: 1 visit per Calendar Year including pap smear.	Deductible
Mammography: One baseline screening for female 35 through 39 years of age. One screening mammogram every Calendar Year for female 40 and older or more frequently, if recommend by a physician.	Deductible
Immunizations and Vaccinations: Includes those needed for travel.	Deductible
Hearing Exams: 1 hearing exam every 2 Calendar Years.	Deductible
HOSPITAL SERVICES	
All Inpatient Admissions.	Deductible
Specialty Hospital: 60 days per Member per Calendar Year (for other than Mental Health and Substance Abuse Services only).	Same as Hospital Inpatient Cost-Share
Outpatient Surgery: In a licensed ambulatory surgical center (including colonoscopy.) Any additional colonoscopy ordered in a policy year by a physician for an insured will not be subject to any coinsurance, copayment, deductible or other out-of-pocket expense. The policy will not impose a deductible for a procedure that a physician initially undertakes as a screening colonoscopy or a screening sigmoidoscopy.	Deductible

DIAGNOSTIC SERVICES	
Diagnostic Services: **Magnetic resonance imaging (MRI) or computed axial tomography (CAT) scan.** Maximum charge - $75 per magnetic resonance imaging or computed axial tomography. Annual Maximum Copay $375 **Positron emission tomography (PET) scan.** Maximum charge - $100 per positron emission tomography **(**PET) scan Annual Maximum Copay $400	**MRI and CAT Scan** No cost share after a $75 copayment. Annual Maximum Copay $375 **PET Scan** No cost share after a $100 copayment. Annual Maximum Copay $400
THERAPY SERVICES	
Outpatient Rehabilitation: Outpatient rehabilitative and restorative physical, occupational and speech therapy for up to 30 combined visits per Calendar Year. Chiropractic therapy for up to 20 visits per Calendar Year.	Deductible
Other Therapy Services: • Outpatient cardiac rehabilitation therapy for up to 36 visits per cardiac episode • Radiation therapy; • Chemotherapy for the treatment of cancer; • Electroshock therapy; • Kidney Dialysis in a free standing dialysis center.	Deductible
MEDICAL EMERGENCY / URGENT CARE SERVICES	
Emergency Room Treatment. **Urgent Care Services.**	Deductible
Ambulance: Maximum land or air: The plan will pay up to the maximum allowable charges under the Department of Public Health.	Deductible

PHYSICIAN MEDICAL/ SURGICAL SERVICES	
Medical Office Visit.	Deductible
Services of a Physician or Surgeon. (other than a medical office visit)	Deductible
MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES	
Outpatient treatment for Mental Health Care and Substance Abuse Care **Inpatient Hospital Services:** In a Hospital or Residential Treatment Center for Mental Health Care. **Inpatient Rehabilitation treatment:** Substance Abuse care in a Hospital or Substance Abuse Treatment Facility.	Deductible Same as Hospital Inpatient Cost- Share
OTHER MEDICAL SERVICES	
Skilled Nursing Facility: Limited to 120 days per Calendar Year.	Same as Hospital Inpatient Cost Share
Private Duty Nursing: Limited to $20,000 Per Calendar Year.	Deductible
Diabetic equipment, drugs and supplies purchased at a Pharmacy that is not a Durable Medical Equipment supplier.	Deductible
Human Organ and Tissue Transplant Services.	Deductible
Wigs: Maximum of $350 per Member per calendar year.	Deductible
Home Health Care: • Nursing and therapeutic services. • Home health care aid services. • 80 visits maximum per calendar year. Maximum of $50 Deductible per calendar year.	Deductible
Infusion Therapy.	Deductible

Durable Medical Equipment. Diabetic equipment and supplies purchased at a Durable Medical Equipment supplier. Hearing Aid Coverage available for dependent children age 12 years and under.	Deductible
Infertility Services: (Please refer to the OTHER PROVISIONS section of this document) • **Office Visit** • **Outpatient Hospital** • **Inpatient Hospital** **Infertility Drugs (with infertility diagnosis)** The maximum supply of a drug for which benefits will be provided when dispensed under any one prescription is a 30 day supply or a 100 unit dose, whichever is greater.	Deductible Same as Outpatient Hospital Cost-Share Same as Inpatient Hospital Cost-Share
Ostomy Related Services. Medically necessary appliances and supplies: Coverage limited to one thousand dollars annually.	Deductible
Hospice Care: (Inpatient) 60 days per Calendar Year.	Deductible
Allergy Office Visit/Testing: • Allergy Injections. • Immunotherapy or other therapy. • Maximum of 80 visits over a three year period.	Deductible
Specialized Formula	Deductible
PRESCRIPTION DRUGS	
Prescription Drugs are only covered if they are prescribed for conditions related to: • **Pain Management** • **Lyme Disease** • **Diabetes.** • **Oral Chemotherapy** • **Infertility** **All other prescription Drugs are not covered.**	Deductible & Copayment

Penalty for failure to authorize a Covered Service; The combined penalty amount for the Facility Benefit and the Admitting Physician Benefit will be the lesser of $200 or 50% of the charge.

This deductible is not included in the calculation of the Out-Of-Pocket maximum.

DEFINITIONS

ACUTE PSYCHIATRIC CARE: The term Acute Psychiatric Care means psychotherapy provided on an individual or group basis by a Physician or health care team under the supervision of a Physician.

ADMISSION: The term Admission means the period from the date the Member enters the Hospital, Skilled Nursing Facility, Substance Abuse Treatment Facility, Residential Treatment Facility, Hospice or other Inpatient Facility as an Inpatient until the date of discharge. When counting days of Inpatient services, the date of entry and date of discharge are combined to count together as one day.

ELECTIVE ADMISSION: The term Elective Admission means an Inpatient Admission which is Medically Necessary and scheduled in advance where the Member does not require immediate medical treatment to prevent death, disability or serious impairment of bodily part or function.

APPLIANCE(S): The term Appliance(s) means leg, arm, back or neck braces, or artificial legs, arms or eyes, and any prosthesis with supports, including replacement if a Member's physical condition changes.

AUTHORIZE: The term Authorize (Authorization) means that approval has been obtained from United Healthcare for the Emergency Admission of a Member to a Hospital, Skilled Nursing Facility, Substance Abuse Treatment Facility, Residential Treatment Facility or Hospice, when required under the terms of this Benefit Program.

BENEFIT ALLOWANCE: The benefit available for Covered Services rendered by a Provider. The Benefit Allowances are identified in the Schedule of Benefits and are incurred by a Member in a Benefit Period. Member is responsible for Provider's Charges in excess of the Benefit Allowance.

BENEFIT PERIOD: The period of time that we pay benefits for Covered Services. The Benefit Period is listed in the Schedule of Benefits. If your coverage ends earlier, the Benefit Period ends at the same time.

BENEFIT PROGRAM: The term Benefit Program means the program of health care benefits that is identified on the cover page of the Policy and described herein.

CALENDAR YEAR: The term Calendar Year means a period beginning 12:01 a.m. on January 1 and ending midnight on December 31 of the same year.

CLINICAL TRIAL: The term Clinical Trial means an organized, systematic, scientific study of therapies, tests or other clinical interventions for purposes of treatment or palliation or therapeutic intervention for the prevention of cancer or disabling or life-threatening chronic diseases in human beings.

A Clinical Trial must be conducted under the auspices of an independent peer-reviewed protocol that has been reviewed and approved by:

- One of the National Institutes of Health; or
- A National Cancer Institute affiliated cooperative group; or
- The federal Food and Drug Administration as part of an investigational new drug or device exemption; or
- The federal Department of Defense or Veterans Affairs.
- Qualified to receive Medicare coverage of its routine costs under the Medicare Clinical Trial Policy

established under the September 19, 2000, Medicare National Coverage Determination, as amended from time to time.

CASE MANAGEMENT: The term Case Management means the process of evaluating and arranging for Medically Necessary treatment for patients, identified through the use of one or more managed care programs.

CHRONIC CARE: The term Chronic Care means a condition that continues and/or recurs over a prolonged period of time. The condition is characterized by either a slow progressive loss of function or a static/stationary loss of function in which little or no measurable objective improvement is made despite therapeutic intervention.

COINSURANCE: The term Coinsurance means a fixed percentage of the Medicare reimbursement amount for Covered Services which the Member is required to pay as specified in the Schedule of Benefits.

CONCURRENT REVIEW: The term Concurrent Review means a process to monitor all Inpatient Admissions to determine its continued Medical Necessity, starting from the assignment of the initial Prior Authorization of days and continuing to the Member's discharge.

COST-SHARE: The term Cost-Share means the amount which the Member is required to pay for Covered Services. Where applicable, Cost-Shares can be in the form of Copayments, Coinsurance, and/or Deductibles.

COVERED SERVICE(S): The term Covered Service means services, supplies or treatment as described in this Policy. To be a Covered Service, the service, supply or treatment must be:

- Medically Necessary or otherwise specifically included as a benefit under this Policy;
- Within the scope of the license of the Provider performing the service;
- Rendered while coverage under this Policy is in force;
- Not Experimental or Investigational or otherwise excluded or limited by the Policy;
- Authorized in advance by United Healthcare if such preauthorization is required under the Policy.

CREDITABLE COVERAGE: The term Creditable Coverage means health coverage provided through an individual policy, a self-funded or fully insured group health plan offered by a public or private employer, Medicare, Medical Assistance, General Assistance Medical Care, the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), Federal Employees Health Benefit Plan (FEHBP), Medical Care Program of the Indian Health Service of a tribal organization, a state health benefit risk pool or a Peach Corp health plan.

CUSTODIAL CARE: The term Custodial Care means care primarily for the purpose of assisting the Member in the activities of daily living or in meeting personal rather than medical needs, and which is not specific treatment for an illness or injury. It is care which cannot be expected to substantially improve a medical condition and has minimal therapeutic value. Such care includes, but is not limited to:

assistance with walking, bathing, or dressing; transfer or positioning in bed; normally self-administered medicine; meal preparation; feeding by utensil, tube, or gastrostomy; oral hygiene; ordinary skin and nail care; catheter care; suctioning; using the toilet; enemas; and preparation of special diets and supervision over medical equipment or exercises; or over self-administration of oral medications not requiring constant attention of trained medical personnel.

Care can be custodial whether or not it is recommended or performed by a professional and whether or not it is performed in a facility (e.g. Hospital or Skilled Nursing Facility) or at home.

DATE OF PLACEMENT: The term Date of Placement means the assumption and retention by a person of legal obligation for total or partial support of a child in anticipation of adoption of the child.

DAY/NIGHT VISIT: The term Day/Night Visit means continuous treatment consisting of not less than 4 hours and not more than 12 hours in any 24 hour period when received in a General or Specialty Hospital or in a Substance Abuse Treatment Facility.

DEDUCTIBLE: The term Deductible means the fixed amount which the Member must pay for Covered Services in a Calendar Year.

- The individual and family Deductible amounts are shown in the Schedule of Benefits
- The family Deductible amount (2 Member) is met when each Member meets the individual Deductible amount as specified in the Schedule of Benefits.
- The family Deductible amount (3 or more Members) is met when one Member meets and the other family Members collectively meet the difference between the individual Deductible and family Deductible amounts, as specified in the Schedule of Benefits.

DEPENDENT: The term Dependent means a Subscriber's lawful spouse under a legally valid existing marriage and any children who meet the eligibility requirements set forth in the Eligibility Section.

DURABLE MEDICAL EQUIPMENT: The terms Durable Medical Equipment means equipment which:

- is designated for repeated use in the Medically Necessary Care, diagnosis or treatment of an illness or injury;
- improves the function of a malformed body part or prevents or retards further deterioration of the Member's medical condition; and
- is not useful in the absence of injury or illness.

EFFECTIVE DATE: The term Effective Date means the date a Subscriber and his or her Dependents, if any, are accepted by the Health Reinsurance Association and eligible to receive benefits for Covered Services under this Benefit Program.

ENROLLMENT DATE: The term Enrollment Date means the first day of coverage or, if there is a Waiting Period, the first day of the Waiting Period.

EXPERIMENTAL OR INVESTIGATIONAL: Medical, surgical, diagnostic, psychiatric, substance abuse or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time the Company makes a determination regarding coverage in a particular case are determined to be:

- This policy will cover a procedure, treatment or the use of any drug if the 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.
- Any covered person who has been diagnosed with a condition that creates a life expectancy in that person of less than two years and who has been denied an otherwise covered procedure, treatment or drug on the grounds that it is experimental may request an expedited appeal as provided in section 38a-226c and may appeal a denial thereof to the Insurance Commissioner in accordance with the procedures established in

section 38a-478n.

- For the purposes of conducting an appeal pursuant to section 38a-478n on the grounds that an otherwise covered procedure, treatment or drug is experimental, the basis of such an appeal shall be the medical efficacy of such procedure, treatment or drug. In conducting a review, we may consider whether the procedure, treatment or drug has been approved by the National Institute of Health or the American Medical Association,

- is listed in the United States Pharmacopoeia Drug Information Guide for Health Care Professionals (USP-DI), the American Medical Association Drug Evaluations (AMA-DE), or the American Society of Hospital Pharmacists' American Hospital Formulary Service Drug Information (AHFS-DI)

- is currently in a clinical trial of the federal Food and Drug Administration.

FREE STANDING MAGNETIC RESONANCE IMAGING FACILITY: The term Free Standing Magnetic Resonance Imaging Facility means a facility which has received certificate of need approval for its magnetic resonance equipment and its services from the State of Connecticut Commission on Hospitals and Health Care. Also, the facility must be accredited as an Ambulatory Health Care facility by the Joint Commission on Accreditation of Healthcare Organization (JCAHO). Also, the facility must be accredited as a Magnetic Resonance Imaging Facility by the American College of Radiology (ACR). The term Free-Standing Magnetic Resonance Imaging Facility does not include Physician's offices where the primary care is medical services.

HOSPICE: The term Hospice means a facility, organization or agency certified by Medicare that is primarily engaged in providing pain relief, symptom management and supportive services to terminally ill people and their families.

HOSPITAL: The term Hospital means an institution which provides 24 hour continuous services to confined patients and whose chief function is to provide diagnosis and therapeutic facilities for the surgical and medical diagnosis, treatment or care of injured or sick persons. A professional staff of licensed Physicians and surgeons must provide or supervise the services. The institution must provide General Hospital and major surgical facilities and services or specialty services. The following shall not be considered a Hospital:

- A convalescent or extended care unit within or affiliated with the Hospital;

- A non-Hospital based clinic;

- A nursing, rest or convalescent home, or extended care facility;

- An institution operated mainly for care of the aged;

- A health resort, spa or sanitarium; or

- Any facility not having appropriate state licensure and not accredited as a Hospital by the Joint Commission on the Accreditation of Health Care Organizations (JCAHO), except for a Hospital located outside the United States.

GENERAL HOSPITAL: The term General Hospital means a Hospital which is licensed as such by the State of Connecticut and has appropriate accreditation from the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). If out-of-state, a General Hospital must have equivalent licensure and accreditation.

SPECIALITY HOSPITAL: The term Specialty Hospital means a Hospital which is not a General Hospital but which is licensed by the State of Connecticut as a certain type of Specialty Hospital and has appropriate

accreditation from the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). If out-of-state, a Specialty Hospital must have equivalent licensure and accreditation.

MOBILE FIELD HOSPITAL: The term Mobile Field Hospital means a modular, transportable facility used intermittently, deployed at the discretion of the Governor, or the Governor's designee, for the purpose of training or in the event of a public health or other emergency for isolation care purposes or triage and treatment during a mass casualty event; or for providing surge capacity for a hospital during a mass casualty event or infrastructure failure and is licensed as such by the State of Connecticut.

IDENTIFICATION CARD: A card issued by United Healthcare to a Subscriber for identification purposes which must be shown by the Member to obtain Covered Services.

INPATIENT: The term Inpatient means a Member who occupies a bed in a Hospital or other 24 hour care facility, receives board as well as diagnosis, care or treatment and is counted as an Inpatient at the time of a Hospital or 24 hour care facility census.

INPATIENT FACILITY: The term Inpatient Facility means a facility other than a Hospital that provides board as well as diagnosis, care or treatment on a 24 hour basis to patients, such as, a Skilled Nursing Facility, Hospice, Substance Abuse Treatment Facility, Sub-acute Care Facility and Residential Treatment Facility.

MAINTENANCE CARE: The term Maintenance Care means treatment provided for the Member's continued well-being by preventing deterioration of the Member's chronic clinical condition; and maintenance of an achieved stationary status which is at a point where little or no measurable objective improvement in musculo-skeletal function can be effectuated despite therapy.

MEDICAL EMERGENCY: The term Medical Emergency means the onset of a serious illness or injury which requires emergency medical treatment or the onset of symptoms of sufficient severity that a Member reasonably believes that emergency medical treatment is needed.

MEDICALLY NECESSARY (MEDICALLY NECESSARY CARE, MEDICAL NECESSITY): The terms Medically Necessary (Medical Necessary Care, Medical Necessity) means health care 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:

- In accordance with generally accepted standards of medical practice;
- Clinically appropriate, in terms of type, frequency, extent, site and duration and considered effective for the patient's illness, injury or disease; and
- 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 of treatment of that patient's illness, injury or disease.

For the purpose of this subsection, "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: The term Medicare means Title XVIII of the Social Security Act of 1965, as amended.

MEMBER: The term Member means either a Subscriber or Dependent enrolled in this Benefit Program and eligible for benefits for Covered Services under this Benefit Program**.**

MEMBER'S COOPERATION: Each Member shall complete and submit to us such consents, releases, assignments and other documents as may be requested by us in order to obtain or assure reimbursement under Worker's Compensation or any other governmental program. Any Member who fails to cooperate will be responsible for any charge for services.

MENTAL HEALTH CARE: The term Mental Health Care means services provided to treat a mental disorder as defined in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders". Mental Health Care does not include (1) mental retardation, (2) learning disorders, (3) motor skills disorder, (4) communication disorders, (5) caffeine-related disorders, (6) relational problems, and (7) additional conditions that may be a focus of clinical attention, that are not otherwise defined as mental disorders in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders'.

OUTPATIENT: The term Outpatient means that the Member receives services in a Hospital emergency room, Physician's office, or ambulatory surgical facility and leaves in less than 24 hours.

OUT OF POCKET MAXIMUM: The term Out of Pocket Maximum means the amount which the Member is required to pay for Covered Services. Where applicable, Cost-Shares can be in the form of Copayments, Coinsurance, and/or Deductibles.

The out of pocket maximum will only apply to:

- Low Income insureds using service out of the state of Connecticut.

Any reduced or denied benefits paid by the Member do not apply toward the Out of Pocket Maximums shown in the Schedule of Benefits.

PARTIAL HOSPITALIZATION: The term Partial Hospitalization means continuous treatment in a General Hospital, Specialty Hospital or Residential Treatment Facility consisting of not less than 4 hours and not more than 12 hours in any 24 hour period.

PENALTY (PENALTIES): The term Penalty (Penalties) means that amount the Member must pay when he or she fails to obtain Prior Authorization; or for a Medical Emergency Admission which is not certified by United Healthcare within 2 business days.

PHYSICIAN or PROVIDER: The term Physician means any licensed doctor of medicine (M.D.), osteopathic Physician (D.O.), dentist (D.D.S./D.M.D.), podiatrist (Pod. D/D.S.C./D.P.M.), doctor of chiropractic (D.C.), naturopath (N.D.), optometrist (O.D.) or psychologist (Ph.D./Ed.D/PsyD.) who is licensed to practice in the state in which services are rendered.

Provider: The term Provider means any appropriately licensed or certified health care professional or facility providing health care services or supplies to Members.

Provider Charge: The charge for services or items as shown on the Provider's bill.

POLICY: The term Policy means this document, which describes the rights, benefits, terms, conditions and limitations of the coverage available to Subscribers and eligible Dependents, including the Schedule of Benefits, the membership application, health statement, rate page and any Riders and amendments thereto.

PRE-EXISTING CONDITION: A "Pre-Existing Condition" means a condition that was present before the effective date of coverage, for which any medical advice, diagnosis, care or treatment was recommended or received before such effective date. Routine follow-up care to determine whether a breast cancer has reoccurred in a person

who has been previously determined to be breast cancer free shall not be considered as medical advice, diagnosis, care or treatment for purposes of this section unless evidence of breast cancer is found during or as a result of such follow-up. Genetic information shall not be treated as a condition in the absence of a diagnosis of the condition related to such information.

This policy will not impose a waiting period for coverage of pre-existing conditions. Pre-existing conditions are covered immediately.

PRE-EXISTING CONDITION PERIOD: The term Pre-Existing Condition Period means a specified period of time immediately prior to the Enrollment Date.

PRE-EXISTING CONDITION LIMITATION PERIOD: The term Pre-Existing Condition Limitation Period means a period of time during which no benefits will be provided for a Pre-Existing Condition.

PREMIUM: The term Premium means the amount charged by the Health Reinsurance Association to provide benefits for Covered Services under this Benefit Program.

PRIOR AUTHORIZATION (PRIOR AUTHORIZED): The term Prior Authorization means that prior approval has been obtained from United Healthcare, which enables a Member to receive benefits for certain Covered Services.

PROOF: The term Proof means any information that may be required by the Health Reinsurance Association in order to satisfactorily determine a Member's eligibility or compliance with any provision of this Benefit Program.

PROSTHETIC DEVICE: The term Prosthetic Device means any device which replaces all or part of a body organ (including contiguous tissues), or replaces all or part of the function of a permanently inoperative, absent, or malfunctioning part of the body.

RESIDENTIAL TREATMENT FACILITY: The term Residential Treatment Facility means a treatment center which provides residential care and treatment for emotionally disturbed individuals, is licensed by the Department of Children and Families (DCF), and is accredited by the Council on Accreditation or The Joint Commission on the Accreditation of Health Care Organizations as a Residential Treatment Facility.

ROUTINE PATIENT CARE COSTS: The term Routine Patient Care Costs means costs for Medically Necessary health care services that are incurred as a result of treatment rendered to a Member for purposes of a Clinical Trial that would otherwise be covered if such services were not rendered in conjunction with a Clinical Trial. Such services shall include those rendered by a Physician, diagnostic or laboratory tests, hospitalization or other services provided to the Member during the course of treatment in Clinical Trial and Coverage for Routine Patient Care Costs incurred for off-label drug prescriptions in accordance with Connecticut Law.

Routine Patient Care Costs shall not include:

- the cost of an investigational new drug or device that has not been approved for market for any indication by the federal Food and Drug Administration;
- the cost of a non health care service that an insured person may be required to receive as a result of the treatment being provided for the purposes of the Clinical Trial;
- facility, ancillary, professional services and drug costs that are paid for by grants or funding for the Clinical Trial;

- costs of services that are inconsistent with widely accepted and established regional or national standards of care for a particular diagnosis, or are performed specifically to meet the requirements of the Clinical Trial;

- costs that would not be covered under this Benefit Program for non-investigational treatments, including items excluded from coverage under the Benefit Program; and

- transportation, lodging, food or any other expenses associated with travel to or from a facility providing the Clinical Trial, for the insured person or any family member or companion.

Low Income Plan Insured Members:

Hospitalization includes treatment at an out of state facility if such treatment is not available in Connecticut and not eligible for reimbursement by the sponsors of such clinical trial. Treatment at an out of state hospital shall be made available by the out of state hospital and Health Reinsurance Association at no greater cost to the member than if such treatment was available in Connecticut.

The Health Reinsurance Association may require that any routine tests or services required under the clinical trial protocol be performed by providers or institutions within Connecticut.

SKILLED NURSING FACILITY: The term Skilled Nursing Facility means any institution that:

- accepts and charges for patients on an Inpatient basis;

- is primarily engaged in providing skilled nursing care, rehabilitative and related services to patients requiring medical and skilled nursing care;

- is under the supervision of a licensed Physician;

- provides 24 hour a day nursing service under the supervision of a registered nurse; and

- is not a place primarily for the treatment of nervous-mental disorders, pulmonary tuberculosis, a place of rest, Custodial Care or acute Inpatient level of care.

SPECIALIZED FORMULA: The term Specialized Formula means a nutritional formula for children up to age twelve that is exempt from the general requirements for nutritional labeling under the statutory and regulatory guidelines of the Federal Food and Drug Administration and is intended for use solely under medical supervision in the dietary management of specific diseases.

SUBCONTRACTOR: The term Subcontractor means an entity with whom the Health Reinsurance Association may subcontract particular services to such as organizations or entities that have specialized expertise in certain areas. This may include but is not limited to prescription drugs and mental health/behavioral health and substance abuse services. Such subcontracted organizations or entities may make benefit determinations and/or perform administrative, claims paying, or customer service duties on the Health Reinsurance Association's behalf.

SUBSCRIBER: The term Subscriber means a person who is eligible for Covered Services, has enrolled in this Benefit Program and for whom the Health Reinsurance Association has accepted the appropriate Premium.

SUBSTANCE ABUSE CARE: The term Substance Abuse Care means services to treat alcoholism or drug dependency.

SUBSTANCE ABUSE TREATMENT FACILITY: The term Substance Abuse Treatment Facility means a facility which is established primarily to provide 24 hour Inpatient treatment of substance abuse and licensed for

such care by the State of Connecticut Department of Public Health and Addiction Services.

URGENT CARE: "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 the life or health of the covered person or the ability of the covered person to regain maximum function, or
- In the opinion of a health care professional with knowledge of the covered person's medical condition, would subject the covered person 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 a covered person from requiring an inpatient setting.

URGENT CARE FACILITY: The term Urgent Care Facility means a Provider from whom Urgent Care services may be obtained.

WAITING PERIOD: The term Waiting Period means the period of time which must pass before the first day of coverage under the Benefit Program.

INTRODUCTION

"You" or "your" refers to the Subscriber or the Dependent of the Subscriber who is named on the Identification (ID) Card. The Dependent Member is a covered Dependent of the Subscriber. "We," "us," and "our" refer to the Health Reinsurance Association ("HRA"). Other terms are defined in the "Definitions" section of the Policy.

SPECIAL HEALTH CARE PORTABILITY PLAN

This Policy describes your Health Reinsurance Association Individual (Special Health Care) health care coverage. The Policy explains the benefits, exclusions, limitations, terms and conditions of membership and services and the guidelines which must be adhered to in order for you to obtain benefits for Covered Services. This Policy replaces and supersedes any Policy, contract, policy or program of the same or similar coverage that the Health Reinsurance Association may have issued to you prior to the issue date of this Policy. Amendments to this Policy may occur, as approved by the State of Connecticut Insurance Department. The Effective Date of such changes shall be designated by the Health Reinsurance Association, and notification to the Subscribers will be provided by the Health Reinsurance Association.

This Benefit Program provides benefits for services throughout the state of Connecticut. The selection of a primary care Physician (PCP) is not required. However, this is a managed care program which requires that you observe all guidelines and procedures for obtaining Covered Services.

Please see the Schedule of Benefits for the applicable Cost-Shares and/or Penalties. In addition to listing the Cost-Shares that are your responsibility, this Schedule of Benefits also contains benefit maximums for specific types of coverage.

The Member is entitled to the Covered Services described in the Benefits Section of the Policy. The Covered

Services therein are subject to the terms; conditions; and limitations of the Policy.

CUSTOMER SERVICE

Member Services is available to explain policies and procedures and answer questions regarding the availability of benefits.

For information and assistance, a Member may call or write United Healthcare. The telephone number for Member Services is printed on the Member's Identification Card. The address of United Healthcare is:

United Healthcare
P.O. Box 740800
Atlanta, GA, 30375-0800

Toll free customer service office telephone number 1-800-634-5500

Monday through Friday - 7:00 a.m. to 7:00 p.m. CST

ELIGIBILITY

The enrollment application and any other forms or statements as requested by the Health Reinsurance Association must be received and accepted by the Health Reinsurance Association before the applicant shall be considered for membership under the Benefit Program. If additional information is requested and is not received by the Health Reinsurance Association within 60 days of the request, the applicant may be asked to reapply. The applicant's right to coverage is subject to the condition that all information provided to the Health Reinsurance Association is true, correct and complete to the best of the applicant's knowledge and belief. The Subscriber is responsible for providing the Health Reinsurance Association with immediate notification of all name, address or phone number changes.

This Policy was issued based on information you gave us on your application. If you know of any misstatement on your application, or if you omitted any medical information about any person covered by the Policy, you should advise us immediately about the mistake. Otherwise, you Policy may not be a valid contract with us.

To become eligible for membership as a Subscriber under this Benefit Program, the applicant must:

- Be a resident of the State of Connecticut;
- Be under age 65;
- Submit Proof satisfactory to the Health Reinsurance Association
- Agree to pay for the cost of Premium that the Health Reinsurance Association requires; and
- Reveal any coordination of benefits arrangements or other health benefit arrangements for the applicant or Dependents as they become effective.

- Provide documentation that the applicant's household income is less than 300% of the Federal Poverty Level (FPL) if you are applying for the Special Health Care Low Income plan.

The following requirements must be satisfied to guarantee renewability:

- Eligibility criteria continues to be met except that the member or dependents may be over age 65 and reside outside of Connecticut.

- There are no fraudulent or material misrepresentations on the application or under the terms of this coverage, subject to the incontestability provision;

- Membership has not been terminated by the Health Reinsurance Association under the terms of this Policy; and

- Membership has not been rescinded by the Health Reinsurance Association.

- Provide documentation, as requested by the Health Reinsurance Association annually, that the applicant's household income is less than 300% of the Federal Poverty Level (FPL) if you are applying for the Special Health Care Low Income plan.

ELIGIBLE DEPENDENTS

Dependents are eligible to apply for coverage under the Benefit Program if they meet the eligibility criteria stated below.

The following are eligible for membership as Dependents under the Benefit Program:

- Spouse: The lawful spouse of the Subscriber under a legally valid, existing marriage and who is deemed eligible under the Benefit Program.

- Dependent Child Under Age 26 The Dependent child under age 26 of the Subscriber or spouse, including a step-child of either, a child legally placed for adoption, a legally adopted child, a child for whom the Subscriber has been appointed a legal guardian, the Dependent child under age 26 of the Subscriber or spouse for whom the Subscriber has been designated as the responsible party under a Qualified Medical Child Support Order (QMCSO).

- Qualified Medical Child Support Orders. A Dependent child may become eligible for benefits for Covered Services as a consequence of a domestic relations order issued by a state court to a divorced parent who is a Subscriber. Enrollment may be required even in circumstances in which the child was not previously enrolled in the Benefit Program and might not otherwise be eligible for coverage.

The Dependent is not eligible if he becomes covered under a group health plan through the Dependents own employment.

The word "child" means the Subscriber's natural child, stepchild, adopted child or other child. "Child" also includes the Subscriber's mentally or physically handicapped child if the disability began before age 26, and as a result of the disability, the child is unable to support himself or herself.

Newborn Dependent Child Benefits for Covered Services under the Benefit Program shall be provided for a newborn of the Subscriber from the moment of birth up to and including 61 (sixty one) days immediately following birth. With respect to coverage after 61 (sixty one) days following birth, a newborn of a Subscriber may become an enrolled Dependent under the Benefit Program when a completed application is submitted by the Subscriber and

accepted by the Health Reinsurance Association. The application must be submitted to the Health Reinsurance Association within 61 (sixty one) days following the date of birth or 31 (thirty one) days following the Date of Placement for adoption and the Health Reinsurance Association eligibility requirements must be met as specified in this Section.

A Newborn of Enrolled Dependent Child. A newborn of an enrolled Dependent child is eligible for benefits for Covered Services only from the moment of birth up to and including 61 (sixty one) days immediately following birth, but is not eligible for enrollment beyond this 61 (sixty one) day period under the Benefit Program until and unless the Subscriber is appointed by a court as legal guardian and can offer Proof of such legal guardianship.

Benefits for Covered Services for a newborn shall consist of Covered Services for injury or sickness including Medically Necessary Care and treatment of medically diagnosed congenital defects and birth abnormalities subject to the terms, conditions, exclusions and limitations of this Policy**.**

A mentally or physically incapacitated child's coverage will not end due to age. It will continue as long as Dependents coverage under this Plan continues and the child continues to meet the following conditions:

- The child is incapacitated.
- The child is not capable of self-support.
- The child depends mainly on the Participant for support.

The Participant must give the Company proof that the child meets these conditions when requested. The Company will not ask for proof more than once a year.

Proof acceptable to the Health Reinsurance Association of such incapacity and dependency must be received within 31 days of the date upon which the child's coverage would have terminated in the absence of such incapacity. The disability must be certified at the time of enrollment by a Physician and then no more than annually thereafter.

EFFECTIVE DATE OF COVERAGE

Applications from newly eligible persons and newly eligible Dependents may be submitted in advance of the initial date of eligibility, however benefits for Covered Services shall not be available prior to the initial date of eligibility.

Applications for new Members received and accepted by the Health Reinsurance Association on or before the end of the month will be effective the first of the following month.

Eligibility for coverage and the Effective Date for any Member will be decided by the Health Reinsurance Association after you return your application for Coverage and it is approved.

Effective Dates for membership enrollees may be deferred if all required data is not received, or is incomplete.

New spouses and new step-children are initially eligible the first of the month following the date of the marriage of the new spouse to the Subscriber.

Newborn children of the Subscriber, lawful spouse or covered dependent are initially eligible as of the moment of birth.

Newly adopted children and children placed for adoption are initially eligible as of the Date of Placement for adoption. This policy will cover a child placed for adoption on the same basis as other dependents. Newly adopted children and children placed for adoption are covered for the first 31 (thirty-one) day period following the date the

child was legally placed for adoption. A completed application and required premium must be provided to the Health Reinsurance Association before the expiration of the thirty-one-day period following the date the child was legally placed for adoption.

Dependent children for whom the Subscriber has been appointed by the court of law as the responsible party under a Qualified Medical Child Support Order are initially eligible as of the date the court order is in effect.

Dependent children for whom the Subscriber or lawful spouse has been appointed by the court of law as the legal guardian are initially eligible as of the date the court order is in effect.

CHANGES AFFECTING ELIGIBILITY

The Health Reinsurance Association must be immediately notified in writing of any change that may impact a Member's eligibility under the Benefit Program. These changes include, but are not limited to:

- The marriage of the Subscriber or an enrolled Dependent child;
- The divorce of the Subscriber;
- The birth of a child of a Member;
- A Dependent child attains the maximum age limit for coverage under the Benefit Program or becomes covered under a group health plan through the dependents own employment
- Loss of eligibility for other reasons specified in the Policy.

PRE-EXISTING CONDITION EXCLUSION PROVISION

This Benefit Program will provide coverage for services that are determined to be related to Pre-Existing Conditions. To maintain continuous Creditable Coverage you must not have a break in coverage of more than 120 consecutive days (or 150 consecutive days when coverage was terminated due to involuntary loss of coverage).

"Preexisting conditions provision" means a policy provision which limits or excludes benefits relating to a condition based on the fact that the condition was present before the effective date of coverage, for which any medical advice, diagnosis, care or treatment was recommended or received before such effective date. Routine follow-up care to determine whether a breast cancer has reoccurred in a person who has been previously determined to be breast cancer free shall not be considered as medical advice, diagnosis, care or treatment for purposes of this section unless evidence of breast cancer is found during or as a result of such follow-up. Genetic information will not be treated as a condition in the absence of a diagnosis of the condition related to such information. Pregnancy is not considered a preexisting condition.

The Pre-Existing Condition exclusion does not apply to individuals eighteen (18) years and younger.

CERTIFICATE OF CREDITABLE COVERAGE

Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), a Certificate of Creditable Coverage must be presented by any individual and his or her Dependent(s) who seek to obtain coverage under this Policy. The information included on this Certificate of Creditable Coverage should include the names of any Members who terminated from the prior health benefit Plan, the date of coverage and the type of coverage provided under that Plan. The Certificate of Creditable Coverage will provide the Health Reinsurance Association with

information regarding previous coverage to assist it in determining eligibility for the Policy.

MANAGED BENEFITS – Managed Care Guidelines

Subject to the terms and conditions of the Policy, a Member is eligible for benefits for Covered Services for Medically Necessary Care when prescribed or ordered by a Physician and when in accordance with the provisions of this Managed Benefits Section.

"Medically necessary" or "medical necessity" means health care 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:

- In accordance with generally accepted standards of medical practice;
- Clinically appropriate, in terms of type, frequency, extent, site and duration and considered effective for the patient's illness, injury or disease; and
- 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.

"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.

A Member's right to benefits for Covered Services provided under this Policy is subject to certain policies or guidelines and limitations, including, but not limited to: the Health Reinsurance Association Medical Policy; Prior Authorization; Concurrent Review; and Case Management. A description of each of these provisions is described in the Managed Care Guidelines that explains its purpose; requirements; and effects on benefits. Failure to follow the Managed Care Guidelines for obtaining Covered Services will result in a reduction or denial of benefits.

NOTICE: Prior Authorization does NOT guarantee coverage for or the payment of the service or procedure reviewed. The Member should contact his/her Physician and/or United Healthcare to be sure that Prior Authorization has been obtained.

Reversal or Rescinded Preauthorization or Precertification

A Member will be notified at least three business days prior to the scheduled date of an admission, service, procedure or extension of stay that a preauthorization or precertification has been reversed or rescinded on the basis of medical necessity, fraud or lack of coverage.

If an admission, service, procedure or extension of stay has taken place in reliance on a preauthorization or precertification, the service, procedure or extension of stay will not be revered or rescinded.

Unless reversed or rescinded, a preauthorization or precertification will be effective for sixty days from the date of issuance.

The Member should consult his/her Physician concerning courses of treatment and care. Notwithstanding any benefit determination, the Member and the Member's Physician must determine what care and/or treatment is received.

Questions regarding Managed Care Guidelines or to determine which services require Prior Authorization can be

addressed by calling the telephone number on the back of the Member's Identification Card.

YOUR RESPONSIBILITIES WHEN OBTAINING HEALTH CARE - PRIOR AUTHORIZATION

Prior Authorization of certain services is required so that we can review the service to verify that it is Medically Necessary and that the treatment provided is the proper level of care. It is the Member's responsibility to notify the Physician or Provider that Prior Authorization is required for the services listed below. Prior Authorization may be obtained by contacting United Healthcare at the telephone number located on the back of the Member's Identification Card.

Prior Authorization must be obtained prior to the initial treatment for the non-Hospital based services listed below.

With Prior Authorization, we guarantee payment for services that we approve in advance if the services are otherwise covered under the Policy, if the Coinsurance/ Deductible requirements are satisfied, and you are covered on the date you receive care. Benefits for Covered Services are subject to the terms, conditions and limitations of the Policy. The Prior Authorization will indicate a period for approval. Any service not performed in the specified time frame will need to be re-authorized.

Non-Medically Necessary treatment or services, for which the necessary Prior Authorization has not been obtained from United Healthcare will not be considered services eligible for reimbursement under this Policy. The Member and Physician or Provider will receive written notification regarding the approval or denial of Prior Authorization.

Covered Services Requiring Prior Authorization For Non-Hospital Based Services

Whenever a Member obtains any of the following services Prior Authorization must be obtained from United Healthcare:

- Certain Prosthetic Devices and Durable Medical Equipment. Please see the Covered Service Section for additional information.
- Human Organ and Tissue Transplants
- Mental Health Care and Substance Abuse Care. Only the following situations require Prior Authorization:
    - Inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility);
    - Intensive Outpatient Treatment programs;
    - Outpatient electro-convulsive treatment;
    - Psychological testing;
    - Extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management.
- MRI, MRA, CT, CTA, PET, SPECT, Nuclear Cardiology, MRS, CT/PET, ECHO Cardiology
- Specialized Formula
- Infertility Services

- Physical Therapy
- Occupational Therapy

Prior Authorization For Hospital Based Services

Prior Authorization For Hospital Admissions/Inpatient Facility Admissions or Admission to a Partial Hospitalization or Day/Night Program.

When a Member is scheduled for an Admission to a Hospital, Skilled Nursing Facility or Hospice, the Member or the Member's representative must obtain Prior Authorization from United Healthcare unless the Admission is due to a Medical Emergency. It is the Member's responsibility to notify the Physician or Provider that Prior Authorization is required for an Inpatient Admission. Note: For guidelines regarding an Admission due to a Medical Emergency, please refer to the Medical Emergency Services Section.

Elective Admissions

For Elective Admissions, the Member or Member's representative must call United Healthcare for Prior Authorization at the number located on the back of the Member's Identification Card when the Admission is scheduled. This call must be made no later than one business day prior to the Elective Admission day.

Medical Emergency Admissions

This Benefit Program shall provide benefits for Medical Emergency Admissions if the care is determined to be for a Medical Emergency. The Member or the Member's representative must notify United Healthcare within 2 business days of an Inpatient Admission due to a Medical Emergency.

Concurrent Review

The availability of benefits for Inpatient Covered Services will be subject to Concurrent Review. Based on the results of the Concurrent Review, United Healthcare will determine that:

- There will be additional Inpatient days Prior Authorized; or
- There will be a change in the services, supplies, treatment or setting; or
- There will be no additional Inpatient days Authorized as of a specific date.
- Penalties For Not Obtaining Prior Authorization

If the appropriate Prior Authorization is not obtained for Elective Admissions, benefits will be reduced, as shown on the Schedule of Benefits.

No benefits will be payable under the Benefit Program, for Physician Inpatient medical care visits or Hospital room and board charges if you fail to obtain the Prior Authorization from United Healthcare and United Healthcare determines the Admission is not Medically Necessary for an Inpatient setting. Further, if you elect to be admitted after a determination by United Healthcare that Inpatient days cannot be Prior Authorized there will be no payment for benefits.

Case Management

United Healthcare may, at its discretion, provide benefits supplemental to those Covered Services provided under this Benefit Program as a part of Case Management.

Case Management is a program tailored to the Member. United Healthcare's case managers work collaboratively with the Member, the Member's family and Providers to coordinate the Member's health care benefits. United Healthcare will make its decisions regarding Case Management on a case-by-case basis.

Member Appeal Process

If United Healthcare denies, reduces or terminates benefits at any time during the review process, the Member, Member's representative, Hospital, Skilled Nursing Facility, Substance Abuse Treatment Facility, Residential Treatment Facility, Hospice or other Inpatient Facility or Physician may request an Appeal review. Please refer to the Member Appeal Process Section for further information regarding this process.

COVERED SERVICES

A Covered Service is incurred on the date the service, supply or treatment was provided to you.

GENERAL PROVISIONS

Conformity with State Law

Any provision of this Policy which is in conflict with the laws of the state in which it is issued is hereby amended to conform to the minimum requirements of such laws.

Policies and Procedures

The Plan may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of this Policy with which a Member shall comply.

Waiver

No agent or other person, except an authorized officer of the Health Reinsurance Association, has authority to waive any conditions or restrictions of this Policy, to extend the time for making a payment to the Plan, or to bind the Plan by making any promise or representation or by giving or receiving any information.

Plan's Sole Discretion

The Plan or anyone acting on Our behalf, may, at its sole discretion, cover services and supplies not specifically covered by the Policy. This applies if it is determined 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.

This Section lists Covered Services and the benefits we pay. This Benefit Program shall provide benefits for the Covered Services described in this section and subject to the Managed Benefits Section of this Policy. The Member is responsible for the applicable Deductible and Coinsurance. Failure to comply with the guidelines outlined in the Managed Benefits Section of the Policy will result in Penalties or denial of benefits. Please refer to the Schedule of

Benefits for specific Cost-Shares.

The following conditions apply to the description of Covered Services referenced in this section;

- All Covered Services and Benefits are subject to the conditions, exclusions, limitations, terms and provisions of this Policy, including any attachments and riders.

- The Health Reinsurance Association cannot prohibit Providers outside of Connecticut from billing you for the difference in the amount paid and the amount the provider charges.

- Benefits for Covered Services may be payable subject to an approved treatment plan created under the terms of the Policy

- Payment for Covered Services will be limited by any applicable Copayment, Deductible or annual or lifetime payment limit in the Policy, including the Schedule of Benefits.

- The fact that a Provider may prescribe, order, recommend or approve a service, treatment or supply does not make it Medically Necessary or a Covered Service and does not guarantee payment.

- United Healthcare bases its decisions about referrals, Prior Authorization, Medical Necessity, experimental services and new technology on medical policy developed by United Healthcare.

- United Healthcare may also consider published peer-review medical literature, opinions of experts and the recommendations of nationally recognized public and private organizations which review the medical effectiveness of health care services and technology.

AMBULANCE/MEDICALLY NECESSARY TRANSPORTATION SERVICES

Transportation by professional ambulance, by land or air, to and from a medical facility.

These services must be given within the United States.

This policy shall cover medical transportation services whenever any person covered by the policy is transported, when medically necessary, by ambulance to a hospital.

Plan will not pay more than the maximum allowable rate established by the Department of Public Health in accordance with section 19a-177.

Covered Services do not include:

- Transportation for Elective Hospital Admissions.

- Transportation solely for the convenience of the Member.

Please refer to the Exclusions and Limitations Section of this Policy for other services not covered under this Benefit Program.

BONE MARROW TESTING

This policy will provide coverage for human leukocyte antigen testing, also referred to as histocompatibility locus antigen testing, for A, B and DR antigens for utilization in bone marrow transplantation.

This policy will not impose a coinsurance, copayment, deductible or other out-of-pocket expense for the testing in excess of twenty per cent of the cost for the testing per year.

The policy will require that testing be performed in a facility:

- accredited by the American Society for Histocompatibility and Immunogenetics, or its successor, and
- certified under the Clinical Laboratory Improvement Act of 1967, 42 USC Section 263a, as amended from time to time

Individuals at the time of the testing must complete and sign an informed consent form that also authorizes the results of the test to be used for participation in the National Marrow Donor Program.

The coverage is limited to a lifetime maximum benefit of one testing.

DIAGNOSTIC SERVICES

This Policy Covers:

- Diagnostic x-ray or imaging studies
- Magnetic Resonance Imaging (MRI)
- Laboratory and pathology tests
- Electronic diagnostic medical procedures
- Outpatient polysomnography
- Laboratory and diagnostic tests, including PSA tests
- CAT Scan
- Colorectal cancer screening, including, but not limited to: An annual fecal occult blood test; and Colonoscopy, flexible sigmoidoscopy or radiologic imaging. Any additional colonoscopy ordered in a policy year by a physician for an insured will not be subject to any coinsurance, copayment, deductible or other out-of-pocket expense. The policy will not impose a deductible for a procedure that a physician initially undertakes as a screening colonoscopy or a screening sigmoidoscopy.

*Outpatient Surgical Cost-Shares apply. Please refer to the Schedule of Benefits for the appropriate Cost-Shares. Outpatient polysomnograms are covered for the diagnosis of sleep apnea or narcolepsy, when provided in a facility accredited by the Association of Sleep Disorders Centers Clinical Sleep Society Covered Services Prior Approval Required: MRI, MRA, CT, CTA, PET, SPECT, Nuclear Cardiology, MRS, CT/PET, ECHO Cardiology
Covered Services do not include:

Please refer to the Exclusions and Limitations Section of this Policy for other services not covered under this Benefit Program.

DURABLE MEDICAL EQUIPMENT, PROSTHETIC DEVICES, SUPPLIES & APPLIANCES

Please Note: Durable Medical equipment over $1,000 requires prior authorization. Contact Customer Service before any such equipment is obtained.

This Policy Covers:

- Durable Medical Equipment which improves the function of a malformed body part, or prevents or retards further deterioration of the Member's medical condition.
- Prosthetic Devices, when prescribed, whether surgically implanted or worn as an anatomic supplement and subject to the following:
    - Repair, replacement, fitting, and adjustments are covered when made necessary by normal wear and tear or by body growth or change. In cases of a tumor of the oral cavity, non-dental Prosthetic Devices, including maxillo-facial Prosthetic Devices used to replace anatomic structures removed during treatment of head or neck tumors, and additional Appliances essential for the support of such Prosthetic Devices.
- Appliances such as a leg, arm, back or neck brace or artificial legs, arms or eyes or any prosthesis with supports, including replacement if a Member's physical condition changes.
- Diabetic equipment and supplies.
- Ostomy bags, catheters and supplies required for their use, and any other Medically Necessary ostomy related appliances including; but not limited to: collection devices; irrigation equipment and supplies; and skin barriers and protectors.
- External breast prosthesis following mastectomy for malignancy or other disease of breast tissue. Prior authorization is not applicable to prostheses pursuant to the Women's Health and Cancer Rights Act of 1998.
- Hypodermic needles or syringes prescribed by a licensed practitioner for the purpose of administering medications for medical conditions provided such medications are covered under this Policy.
- Hearing aid coverage available for children twelve years of age or younger. Wigs if prescribed by a licensed oncologist for a patient who suffers hair loss as a result of chemotherapy**.**

Please refer to the Schedule of Benefits for the appropriate Cost-Shares.

Prior Authorization is required. Please refer to the Managed Benefits Section of this Policy for information on how to obtain Prior Authorization.

Covered Services do not include:

Dental devices, household and personal comfort items, eyeglasses, hearing aids (except for children twelve years of age or younger), orthopedic shoes or other supportive or corrective devices for the feet; or any other item not specifically defined in the definition of Appliances.

Repair and replacement of Prosthetic Devices and Appliances made necessary because of loss or damage caused by misuse or mistreatment.

Please refer to the Exclusions and Limitations Section of this Policy for other services not covered under this Benefit Program.

GENDER DYSHORIA

This policy will not discrimination against an individual because of the individual's gender identity or expression is prohibited.

Medically necessary services related to gender dysphoria will not be handled differently from medically necessary services for other medical and behavioral health conditions.

These services will be subject to medical necessity determinations on a case by case basis with respect to an insured's request for transgender services. However, if a request is denied on the basis the services are not medically necessary, the insured has the right to an independent review. Please refer to the Member Appeal Process Section for further information regarding this process.

HOME HEALTH CARE

This Policy Covers:

Benefit Period:

- After an Admission – commencing within 7 days after discharge from the Hospital.
- In lieu of an Admission
- Terminal Illness – upon diagnosis by a Physician Skilled nursing care by a Registered Nurse (R.N.) or a Licensed Practical Nurse (L.P.N.) under the supervision of a R.N. when the services of a R.N. are not available. Skilled, progressive and rehabilitative services of a licensed physical therapist.
- A maximum of eighty (80) visits are covered per calendar year.

Other Covered Services

- Occupational, speech and respiratory therapy;
- Medical and surgical supplies and prescribed Durable Medical Equipment;
- Prescription Drugs dispensed from a retail Pharmacy;
- Oxygen and its administration;

- Home health aide services consisting primarily of patient care of a medical or therapeutic nature;
- Laboratory services;
- Dietary services;
- Transportation to and from a Hospital for treatment, re-admission or discharge by the most safe and cost-effective means available.

Notes:

Please refer to the Schedule of Benefits for the appropriate Cost-Shares.

The Member must be essentially confined at home and home health care services must be rendered for treatment of the same illness or injury for which the Member was hospitalized. (This does not apply if the individual is diagnosed with 6 months or less to live.) Every four hours of Covered Services rendered by a home health aide will be charged as one visit.

Please refer to the Private Duty Nursing Section of the Benefit Chart for covered private duty nursing services.

Covered Services do not include:

- Meals, personal comfort items and housekeeping services.
- Nursing services provided in the home by a relative, even if a registered nurse or a licensed practical nurse.

Please refer to the Exclusions and Limitations Section of this Policy for other services not covered under this Benefit Program.

HOSPICE SERVICES

This Policy Covers:

- Inpatient Hospice services in a Hospice, Hospice unit in a Hospital or Skilled Nursing Facility.
- Part-time intermittent nursing care by a registered nurse or licensed practical nurse and services of a home health aide for patient care up to 8 hours.
- Psychological and dietary counseling.
- Consultation or Case Management services by a Physician.
- Physical and/or occupational therapy.
- Medical supplies, drugs and medicines prescribed by a Physician.
- Medical social services under the direction of a Physician up to $200.
- Hospice services in the home from a home health care agency.
- Part-time or intermittent services of a home health aide for patient care up to 8 hours per day.

- Bereavement counseling.

Please refer to the Schedule of Benefits for the appropriate Cost-Shares.

Physician must certify that patient is terminally ill with 6 months or less to live. Prior Authorization is required. Please refer to the Managed Benefits Section of this Policy for information on how to obtain Prior Authorization. The Hospital Inpatient/Inpatient Facility Coinsurance amount is not subject to Out of Pocket Maximums.

Please refer to the Exclusions and Limitations Section of this Policy for other services not covered under this Benefit Program.

HOSPITAL SERVICES

This Policy Covers:

Inpatient Hospital Services:

Room and board for a semi-private Hospital room. If a private room is used, this Benefit Program shall only provide benefits for Covered Services up to the cost of the semi-private room rate, unless United Healthcare determines that a private room is Medically Necessary.

Following a mastectomy, benefits for Covered Services will be provided as follows:

- At least 48 hours after a mastectomy or lymph node dissection unless otherwise agreed upon by the Member and Physician.

- Inpatient and Outpatient Hospital services and supplies;

- Use of an operating, delivery and treatment room, and equipment (including intensive care); Prescribed drugs; Administration of blood and blood processing; Anesthesia, anesthesia supplies and services; Medical and surgical dressing, supplies, casts and splints; Diagnostic services; Rehabilitative and restorative physical therapy and occupational therapy and speech therapy for treatment expected to result in the reasonable improvement of a Member's condition; Radiation therapy; Chemotherapy for treatment of cancer; Laboratory tests; X-ray or imaging studies;

- Outpatient surgery in a licensed ambulatory surgical center; Pre-admission testing.

- Tests and studies required in connection with a scheduled Admission for surgery; Services for hemodialysis or peritoneal dialysis for chronic renal disease, including equipment, training and medical supplies until the Member is covered by the Medicare End Stage Renal Disease program;

- Services associated with accidental consumption or ingestion of a controlled drug or other substance.

- Outpatient Surgical Cost-Shares apply to colonoscopies performed on an Outpatient basis. Please refer to the Schedule of Benefits for the appropriate Cost-Shares. Any additional colonoscopy ordered in a policy year by a physician for an insured will not be subject to any coinsurance, copayment, deductible or other out-of-pocket expense.

    - The policy will not impose a deductible for a procedure that a physician initially undertakes as a screening colonoscopy or a screening sigmoidoscopy.

If a Member is admitted as an Inpatient as a result of Outpatient surgery, the Member must notify United Healthcare within 2 business days of the Admission. Please refer to the Benefits Section of this Policy for information on how to notify us of your Admission.

Pre-Admission testing must be rendered to a Member as an Outpatient prior to the scheduled Admission and not repeated upon Admission for surgery. The Member will be responsible for the charges for Pre-Admission testing if the Member cancels or postpones the scheduled Admission.

Inpatient and Outpatient Hospital Dental Services - Anesthesia, nursing and related hospital charges for Inpatient dental services; Outpatient Hospital dental services; or one day dental services are covered if deemed Medically Necessary by the treating dentist or oral surgeon and the patient's primary care Physician in accordance with Prior Authorization requirements and (1) the patient has been determined by a licensed dentist in conjunction with a licensed primary care Physician to have a dental condition of sufficient complexity that it requires Inpatient services; Outpatient Hospital dental services; or one day dental services, or (2) the patient has a developmental disability, as determined by a licensed primary care Physician, that places him or her at serious risk.

Covered Services do not include:

Private duty nursing services during an Inpatient Hospital Admission.

Please refer to the Exclusions and Limitations Section of this Policy for other services not covered under this Benefit Program.

HUMAN ORGAN AND TISSUE TRANSPLANT SERVICES

This Policy Covers:

- When Prior Authorized, the Policy shall provide the benefits specified in this Section for directly related services of the following:
  - Heart Lung Heart-lung Pancreas Liver (adult or child)
  - Kidney Bone marrow Peripheral Stem Cell procedures when performed in conjunction with the administration of high dose chemotherapy
- In addition, this Benefit Program shall provide the benefits specified in this Section without Prior Authorization for the following services provided in connection with human organ and tissue transplant services:
  - Blood transfusion, Cornea transplant, Bone and cartilage grafting, Skin grafting
  - Hospital Covered Services with Prior Authorization from United Healthcare.
  - Room and board for a semi-private room. If a private room is used, this Benefit Program will only provide benefits for Covered Services up to the cost of the semi-private room rate unless United Healthcare determines that a private room is Medically Necessary.
  - Services and supplies furnished by the Hospital.
  - Care provided in a special care unit which concentrates all facilities, equipment, and supportive services necessary to provide an intensive level of care for critically ill patients.
  - Use of operating and treatment rooms.
  - Diagnostic services, which includes a referral for evaluation.
  - Rehabilitative and restorative physical therapy services.
  - Hospital supplies:
  - Prescribed drugs;
  - Whole blood, administration of blood, and blood processing;
  - Anesthesia, anesthesia supplies and services;
  - Medical and surgical dressings and supplies.
    Surgical Covered Services in connection with covered human organ and tissue transplants with

Prior Authorization from United Healthcare.

- Surgery, including diagnostic services directly associated with a surgery (separate payment will not be made for pre-operative and post-operative services, or for more than one surgical procedure performed at one operative session);
- Services of a Physician who actively assists the operating surgeon in the performance of such surgery;
- Administration of anesthesia ordered by the attending Physician and rendered by a Physician or other Provider other than the surgeon or assistant at surgery.
- Medical Covered Services in connection with covered human organ and tissue transplants with Prior Authorization from United Healthcare.
- Inpatient medical care visits.
- Intensive medical care rendered to a Member whose condition requires a Physician's constant attendance and treatment for a prolonged period of time.
- Medical care rendered concurrently with surgery during the Hospital stay by a Physician other than the operating surgeon for treatment of a medical condition separate from the condition for which the surgery was performed.
- Medical care by two or more Physicians rendered concurrently during the Hospital stay when the nature or severity of the Member's condition requires the skills of separate Physicians.
- Consultation services rendered by another Physician at the request of the attending Physician, other than staff consultations which are required by Hospital rules and regulations.
- Home, office and other Outpatient medical care visits for examination and treatment of the Member.
- Diagnostic services, which includes a referral for evaluation.
- Rehabilitative and restorative therapy services;
- Services provided in a Skilled Nursing Facility, with Prior Authorization from United Healthcare, which are neither custodial in nature nor for the convenience of the Member or the Physician, and only until the Member has reached the maximum level of recovery possible for the particular condition and no longer requires skilled nursing care or definitive treatment other than routine supportive care.
- Home health care Covered Services to a homebound Member when prescribed by the Member's attending Physician in lieu of hospitalization and arranged prior to discharge from the Hospital.
- Medically Necessary immunosuppressant drugs prescribed in connection with covered human organ and tissue transplants and which, under Federal law, may only be dispensed by written prescription and which are approved for general use by the Food and Drug Administration.
- Transportation costs incurred for travel to and from the site of surgery for Covered Services for a transplant recipient and one other individual accompanying the patient, or if the transplant recipient is a minor child, transportation costs for two other individuals accompanying the patient.
- Reasonable and necessary lodging and meal expenses, not to exceed $50 total per day ($100 total if two companions are accompanying a minor child), are payable for the individual accompanying the patient.
- Lodging for the Member while receiving Medically Necessary post-operative Outpatient care at the Hospital.
- Benefits for the following services when provided in connection with covered human organ and tissue transplants:
- Transportation of the surgical harvesting team and donor organ or tissue; and
- Evaluation and surgical removal of the donor organ or tissue and related supplies
- If a human organ or tissue transplant is provided from a donor to a transplant recipient, the following apply:
- When both the recipient and the donor are Members, each is entitled to the Covered Services specified in this Section.

- When only the recipient is a Member, both the donor and the recipient are entitled to the Covered Services specified in this Section:
  - The donor benefits are limited to only those not provided or available to the donor from any other source. This includes, but is not limited to, other insurance coverage, grants, foundations, government programs, etc.;

- Benefits provided to the donor will be charged against the recipient Member's coverage under the Policy.

When the recipient is uninsured and the donor is a Member, this Benefit Program will only provide benefits related to the procurement of the organ up to the maximum stated in this Subsection.

No benefits will be provided for procurement of a donor organ or organ tissue which is not used in a transplant procedure which is a Covered Service, unless the transplant is cancelled due to the Member's medical condition or death and the organ cannot be transplanted to another person. No benefits will be provided for procurement of a donor organ or organ tissue which has been sold rather than donated.

Notes:

This Benefit Program shall provide benefits for human organ and tissue transplant services only with authorization from United Healthcare. The Hospital must be designated and approved by United Healthcare to perform specific Covered Services provided under this Section. It should be noted that not every designated Hospital performs each of the specified Covered Services. In addition, the Member must follow all provisions in this Benefit Program.

Prior Authorization is required for all Covered Services provided under this Section. Please refer to the Managed Care Section of this Policy for information on how to obtain Prior Authorization.

Failure to obtain prior authorization for a covered service will be subject to a penalty of the lesser of two hundred dollars ($200) or fifty percent (50%) of the charge. If the human organ and tissue transplant services are not medically necessary, the human organ and tissue transplant services are not covered.

The term “donor” means a person who furnishes organ tissue for transplantation in a histo-compatible recipient. Only those organ and tissue transplants and directly related procedures specified in this Section are Covered Services under this Benefit Program.

Benefits will only be provided for Covered Services and supplies furnished to the transplant recipient during the period beginning five days before the day on which a transplant procedure which is a Covered Service is performed, and ends 365 days post operatively.

When a Member obtains human organ and tissue transplant Covered Services from a Hospital or facility that is not designated and approved by United Healthcare, he or she shall be responsible for all applicable Cost-Shares as well as amounts that exceed the Medicare Reimbursement Amount. These expenditures will not accumulate toward the Out of Pocket Maximum.

Covered Services do not include:

- Benefits for services if the Member is not a suitable candidate as determined by the Hospital designated and approved by United Healthcare to provide such services.

- Benefits for services for donor searches or tissue matching, or personal living expenses related to donor searches or tissue matching, for the recipient or donor, or their respective family or friends.

- Any human organ and tissue transplant service that is determined to be Experimental or Investigational is not a Covered Service.

- Benefits for transportation and lodging for the transplant recipient and companion(s), when the human organ or tissue transplant is provided in a Hospital or other facility not designated and approved by United Healthcare.

MEDICAL EMERGENCY

This Policy Covers:

Ambulance services when the Member's condition at the time of the treatment is confirmed to have been a Medical Emergency. Medical Emergency services provided at a Hospital's emergency room. Medical Emergency services provided by a Physician.

Please refer to the Schedule of Benefits for any applicable Cost-Shares.

This Benefit Program shall only provide benefits for Medical Emergency services if the care is determined to be for a Medical Emergency. All Admissions resulting from a Medical Emergency must be approved by United Healthcare within 2 business days of the diagnosis, care or treatment of the Medical Emergency.

Emergency room services are covered only if it is determined that the presenting symptoms, as coded by the provider and recorded by the hospital on the UB92 form or its successor, or the final diagnosis, whichever reasonably indicates an emergency medical condition, shall be the basis for reimbursement or coverage, provided such symptoms reasonably indicated an emergency medical condition.

For the purposes of this policy, in accordance with the National Committee for Quality Assurance, an emergency medical condition is a condition such that a prudent lay-person, acting reasonably, would have believed that emergency medical treatment is needed.

Claims for services rendered to the Member shall be subject to review by United Healthcare. Based on United Healthcare's review, the Member may be liable for Cost-Shares, or the full cost of all services rendered if United Healthcare determines that the services provided were not for a Medical Emergency. Medical Emergency Covered Services are limited to the treatment rendered during the initial visit only.

All services deemed by United Healthcare to be Medical Emergencies are eligible for benefits as if rendered by Participating Physicians, Participating Providers or Participating Hospitals benefits as specified in the Schedule of Benefits and Benefit Chart. This policy provides benefits for isolation care and emergency services provided by the state's mobile field hospital. The reimbursement rates paid will be equal to the rates paid under the Medicaid program, as determined by the Department of Social Services.

In addition, Emergency Care includes immediate Mental Disorder Treatment when the lack of the treatment could reasonably be expected to result in the patient harming him or her and/or other persons.

Covered Services do not include:

Please refer to the Exclusions and Limitations Section of this Policy for other services not covered under this Benefit Program.

MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

This Policy Covers:

- Outpatient treatment for Mental Health Care and Substance Abuse Care.
- Inpatient Hospital Services in a Hospital or Residential Treatment Center Facility for Mental Health Care Inpatient rehabilitation treatment for Substance Abuse Care in a Hospital or Substance Abuse Treatment.
- Facility Partial Hospitalization sessions and Day/Night Visits.

- Treatment for Mental Health and Substance Abuse is covered as any other illness.

- Please refer to the Schedule of Benefits for the appropriate Cost-Shares.

- Prior Authorization is required. Please refer to the Managed Benefits Section for how to obtain Prior Authorization.

Outpatient care for mental illness includes services rendered in the following locations: a non-profit community mental health center, a non-profit licensed adult mental health center, a non-profit licensed adult psychiatric clinic operated by an accredited Hospital or in a Residential Treatment Facility when provided by or under the supervision of a Physician practicing as a psychiatrist, licensed psychologist, Certified Independent Social Worker, Certified Marriage and Family Therapist or a Licensed or Certified Alcohol and Drug Counselor; or appropriately licensed professional counselor.

Outpatient care for mental illness includes services by a person with a master's degree in social work when such person renders service in a child guidance clinic or in a Residential Treatment Facility under the supervision of a Physician practicing as a psychiatrist, licensed psychologist, Certified Independent Social Worker, Certified Marriage and Family Therapist or a Licensed or Certified Alcohol and Drug Counselor or appropriately licensed professional counselor.

Benefits for confinement in a Residential Treatment Facility shall be provided only in the following situations:

- The insured has a serious mental illness or nervous condition that substantially impairs the person's thoughts, perception of reality, emotional process, or judgment or grossly impairs the behavior of the insured, and, upon assessment of the insured by a physician, psychiatrist, psychologist or clinical social worker, cannot appropriately, safely or effectively be treated in an acute care, partial hospitalization, intensive outpatient or outpatient setting;

- An individual Treatment Plan must be prescribed by a Physician with certain specific attainable goals and objectives appropriate to both the patient and the treatment modality of the program.

Benefits for expenses of emergency medical care arising from accidental ingestion or consumption of a controlled drug, shall be provided in the following manner:

- In the case of benefits based upon confinement as an inpatient in a hospital, whether or not operated by the state, the period of confinement for which benefits shall be payable shall be at least thirty days in any calendar year.

- For covered expenses incurred by the insured while other than an inpatient in a hospital, benefits shall be available for such expenses during any calendar year up to a maximum of five hundred dollars. For purposes of this section, the term "covered expenses" means the reasonable charges for treatment deemed necessary under generally accepted medical standards.

Covered Services do not include:

Please refer to the Exclusions and Limitations Section of this Policy for other services not covered under this Benefit Program.

ORAL SURGERY

This Policy Covers:

For office based services see Physician Medical/ Surgical Section.

For Hospital based services see Hospital Service Section.

The following are Covered Services:

- An initial visit for the prompt immediate repair of trauma due to an accident or injury, to the jaw, natural teeth, cheeks lips, tongue and/or the roof of the mouth. Benefits available for services provided during the initial visit, include but are not limited to the following:
    - Evaluation;
    - Radiology to evaluate extent of injury;
    - Treatment of the wound; tooth fracture or evulsion.
- No additional benefits will be provided for any services rendered after the initial visit, including but not limited to: follow-up care, replacement of sound natural teeth, crowns, bridges, and prosthetic devices.
- Oral surgical services for treatment of lesions, tumors and cysts on or in the mouth. Oral surgery services for treatment related to tumors of the oral cavity, treatment of fractures of the jaw and/or facial bones, and dislocation of the jaw.
- Please refer to the Schedule of Benefits for the appropriate Cost-Shares. The Hospital Inpatient/Inpatient Facility Coinsurance amount is not subject to Out of Pocket Maximums.

Covered Services Not Included:

- In the case of injury to the oral cavity, non-covered Prosthetic Devices include, but are not limited to, plates, bridges, dentures or caps/crowns.
- Injury to teeth or soft tissue as a result of chewing or biting shall not be considered an accidental injury.

Please refer to the Exclusions and Limitations Section of this Policy for other services not covered under this Benefit Program.

OTHER PROVISIONS

This Policy Covers:

- Coverage for medically necessary early intervention services provided as part of an individualized family service plan. Coverage for such services provided by qualified personnel for a child from birth until the child's third birthday, and a maximum benefit of six thousand four hundred dollars per child per year and an aggregate benefit of nineteen thousand two hundred dollars per child over the total three-year period. No payment made under this section shall be applied by the Health Reinsurance Association against or result in a loss of benefits due to any maximum lifetime or annual limits specified in the policy, or adversely affect the availability of health insurance to the child, the child's parent or the child's family members insured under the policy, or be a reason for the Health Reinsurance Association to rescind or cancel such policy.
- Coverage for physical therapy, speech therapy and occupational therapy services for the treatment of autism spectrum disorders, as set forth in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders".

- Blood derivatives when purchased through a blood derivative supplier.
- Blood lead screenings and clinically indicated risk assessments when ordered by a Primary Care Physician.
- Blood and blood plasma.
- Amino acid modified preparations and low protein modified food products for the treatment of inherited metabolic diseases.
- Coverage for Specialized Formulas when such Specialized Formulas are Medically Necessary for the treatment of a disease or condition and are administered under the direction of a Physician.
    - "Low protein modified food product" means:
        - a product formulated to have less than one gram of protein per serving and intended for the dietary treatment of an inherited metabolic disease under the direction of a physician.
    - "Amino acid modified preparation" means:
        - a product intended for the dietary treatment of an inherited metabolic disease under the direction of a physician.
    - "Specialized formula" means:
        - a nutritional formula for children up to age twelve that is exempt from the general requirements for nutritional labeling under the statutory and regulatory guidelines of the federal Food and Drug Administration and is intended for use solely under medical supervision in the dietary management of specific diseases.
    - This policy provides coverage for amino acid modified preparations and low protein modified food products for the treatment of inherited metabolic diseases, including cystic fibrous, if the amino acid modified preparations or low protein modified food products are prescribed for the therapeutic treatment of inherited metabolic diseases and are administered under the direction of a physician.
    - This policy provides coverage for specialized formulas when such specialized formulas are medically necessary for the treatment of a disease or condition and are administered under the direction of a physician.
    - This policy provides coverage for such preparations, food products and formulas on the same basis as outpatient prescription drugs.

      Prior Authorization is required for the purchase of Specialized Formula. Please refer to the Managed Benefits Section of this Policy for information on how to obtain Prior Authorization.
- Speech Therapy for Children Under Age 3.
    - Services of a licensed speech therapist for treatment given to a child under age 3 whose speech is impaired due to one of the following conditions:
        - Infantile autism.

- Developmental delay or cerebral palsy.
- Hearing impairment.
- Major congenital anomalies that affect speech such as, but not limited to, cleft lip and cleft palate.

- This policy provides coverage of a minimum of forty-eight hours of inpatient care for a mother and her newborn infant following a vaginal delivery and a minimum of ninety-six hours of inpatient care for a mother and her newborn infant following a caesarean delivery. The time periods shall commence at the time of delivery.
  - Any decision to shorten the length of inpatient stay shall be made by the attending health care providers after conferring with the mother.
  - If a mother and newborn are discharged prior to the inpatient length of stay provided above, coverage shall be provided for a follow-up visit within forty-eight hours of discharge and an additional follow-up visit within seven days of discharge. Follow-up services shall include, but not be limited to, physical assessment of the newborn, parent education, assistance and training in breast or bottle feeding, assessment of the home support system and the performance of any medically necessary and appropriate clinical tests. Services shall be consistent with protocols and guidelines developed by attending providers or by national pediatric, obstetric and nursing professional organizations for these services and shall be provided by qualified health care personnel trained in postpartum maternal and newborn pediatric care.
- Medically Necessary Pain Management medication and procedures when ordered by a pain management specialist.

  Pain management services must be ordered by a pain management specialist and will include all means medically necessary to make a diagnosis and develop a treatment plan including the use of necessary medications and procedures.

  A pain management specialist means a physician who is credentialed by the American Academy of Pain Management or who is a board-certified:
  - Anesthesiologist,
  - Neurologist,
  - Oncologist,
  - Radiation oncologist with additional training in pain management, or
  - Physiatrist.
- Coverage for wound-care supplies that are Medically Necessary for the treatment of epidermolysis bullosa and are administered under the direction of a Physician.
- Hearing aids for children twelve years of age or younger. Such hearing aids shall be considered durable medical equipment under the policy.
- Infertility services paid in accordance with Connecticut General Statute. 38a-509. Prior Authorization is

required.

- Member is eligible to receive benefits until the day of their 40th birthday.
- Ovulation induction coverage is limited to a lifetime max of 4 cycles;
- Intrauterine insemination is limited to a lifetime max of 3 cycles;
- In-vitro, GIFT, ZIFT and low tubal ovum transfer is limited to a maximum of two cycles

  combined with not more than two embryo implantations per cycle-with each fertilization or

  transfer counting as one cycle; costs incurred for an insured for egg/sperm retrieval for use in a surrogate transplant will be covered.

  - Members must disclose if they had services under another carrier that were covered by that carrier.

- Infertility drugs (with infertility diagnosis).
- Care related to a complication of pregnancy. A complication of pregnancy is a condition that is distinct from pregnancy but is adversely affected by pregnancy. Examples of such conditions include: acute nephritis, nephrosis, cardiac decompensation, missed abortion and conditions of comparable severity. It also includes conditions such as non-elective cesarean section, ectopic pregnancy, hyperemesis gravidarum and spontaneous abortion occurring when a viable birth is not possible.
- Routine Patient Care Costs in connection with Clinical Trial. A clinical trial for the prevention of cancer or disabling or life-threatening chronic diseases in human beings is eligible for coverage only if it involves a therapeutic intervention and is a clinical trial.
- A Clinical Trial must be conducted under the auspices of an independent peer-reviewed protocol that has been reviewed and approved by:
  - One of the National Institutes of Health; or
  - A National Cancer Institute affiliated cooperative group; or
  - The federal Food and Drug Administration as part of an investigational new drug or device exemption; or
  - The federal Department of Defense or Veterans Affairs.
  - Qualified to receive Medicare coverage of its routine costs under the Medicare Clinical Trial Policy established under the September 19, 2000, Medicare National Coverage Determination, as amended from time to time.
- Outpatient diabetes self-management training is covered if prescribed by a licensed health care professional and performed by a certified, licensed or registered health care professional trained in diabetes care and operating within the scope of their licensure. Benefits are provided for 10 hours of initial training, 4 hours of additional training because of changes in the individual's condition and four hours of training required by new developments in the treatment of diabetes.

- Any person who has been diagnosed with a condition that creates a life expectancy in that person of less than two years and who has been denied an otherwise covered procedure, treatment or drug on the grounds that it is experimental may request an expedited appeal and may appeal a denial to the Insurance Commissioner. For the purposes of conducting an appeal on the grounds that an otherwise covered procedure, treatment or drug is experimental, the basis of such an appeal shall be the medical efficacy of such procedure, treatment or drug.

- Coverage is provided for up to 30 days of intravenous antibiotic therapy, or 60 days of oral antibiotic therapy, or both, for the treatment of Lyme Disease. Further treatment is covered if recommended by a board-certified rheumatologist, infectious disease specialist or neurologist.

- Coverage is provided, without prior authorization, for children diagnosed with cancer on or after January 1, 2000, for neuropsychological testing ordered by a licensed physician, to assess the extent of any cognitive or developmental delays in such child due to chemotherapy or radiation treatment.

- Coverage is provided for health care services rendered to treat any injury sustained by any person when such injury is alleged to have occurred or occurs under circumstances in which:

    - such person has an elevated blood alcohol content, or

    - such person has sustained such injury while under the influence of intoxicating liquor or any drug or both.

        - For the purposes of this section, "elevated blood alcohol content" means a ratio of alcohol in the blood of such person that is eight-hundredths of one per cent or more of alcohol, by weight.

- Coverage is provided for mammographic examinations to any woman covered under the policy which are at least equal to the following minimum requirements:

    - a baseline mammogram for any woman who is thirty-five to thirty-nine years of age, inclusive; and

    - a mammogram every year for any woman who is forty years of age or older or more frequently if recommended by a physician.

- Coverage is also provided for comprehensive ultrasound screening of an entire breast or breasts 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 if 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 a woman's physician or advanced practice registered nurse.

- Magnetic resonance imaging of an entire breast or breasts in accordance with guidelines established by the American Cancer Society.

- The treatment of prostate cancer, provided such treatment is medically necessary and in accordance with guidelines established by the National Comprehensive Cancer Network, the American Cancer Society or the American Society of Clinical Oncology.

PHYSICIAN MEDICAL/SURGICAL SERVICES

This Policy Covers:

- Medical services for the treatment of an illness or injury.

- Medical office visits, specialist consultations, injections and home visits by a Physician. Chiropractic services, evaluation and treatment and Allergy testing.

- Inpatient Hospital/Inpatient Facility visits during a covered Admission.

- Acute Psychiatric Care while an Inpatient at a Hospital or Inpatient Facility. 1 session per Inpatient day

- Inpatient consultations by other than the attending Physician. (2 per 30 day period)

Surgical Procedures:

If more than one surgical procedure is performed during the same operation, we will calculate the allowable charge for all of the services combined by adding:

- The allowable charge for the service with the highest allowable charge; plus a reduced percentage of what the allowable charge would have been for each of the additional surgical services if these services had been performed alone.

For breast implants which were surgically implanted as a result of a mastectomy, benefits for Covered Services for the Medically Necessary removal of such implants due to a medical complication of a mastectomy will be covered the same as any other illness or injury. As to all other breast implants, benefits for Covered Services for the Medically Necessary removal of any breast implant without regard to the reason for implantation will be provided for up to $1,000 per Member per Calendar Year.

Surgical Assistant Services.

In accordance with C.G.S. Section 38a 490c, coverage for Medically Necessary orthodontic processes and appliances for the treatment of craniofacial disorders for individuals eighteen years of age or younger if such processes and appliances are prescribed by a craniofacial team recognized by the American Cleft Palate-Craniofacial Association.

Please refer to the Schedule of Benefits for the appropriate Cost-Shares.

United Healthcare will pay for the services of only one Physician in a given specialty if the surgery reasonably could be expected to be performed by one Physician.

Services of surgical assistants are payable as a surgery benefit based on approved surgical assistant procedures when a Hospital or ambulatory surgical facility does not provide surgical assistants through a residential or surgical assistant program.

In addition to the Exclusions and Limitations stated elsewhere in this Policy, the following limitations apply:

- Reconstructive surgeries, procedures and services: Benefits are available for Medically Necessary reconstructive surgeries, procedures and services only if at least one of the following criteria is met. Reconstructive surgeries, procedures and services must be:

    - Medically Necessary due to accidental injury; or

    - Medically Necessary for reconstruction or restoration of a functional part of the body

following a covered surgical procedure for disease or injury; or

- Medically Necessary to restore or improve a bodily function; or

- Medically Necessary to correct a birth defect for covered dependent children who have functional physical deficits due to a birth defect. Corrective surgery for children who do not have functional physical deficits due to a birth defect is not covered under any portion of this Policy; or

- Medically Necessary due to a mastectomy in accordance with the Women's Health and Cancer Rights Act of 1998.

Reconstructive surgeries, procedures and services that do not meet at least one of the above criteria are not covered under any portion of this Benefit Program.

Breast Reconstruction Surgery Benefits and the Women's Health and Cancer Rights Act of 1998

If you are receiving covered benefits for a mastectomy, you should know that the Women's Health and Cancer Right's Act of 1998 provides for:

- Reconstruction of the breast(s) on which a covered mastectomy has been performed;

- Surgery and reconstruction of the other breast to produce a symmetrical appearance;

- Prostheses and treatment of physical complications related to all stages of a covered mastectomy, including lymphedema (swelling). Prior authorization is not applicable to such prostheses.

The manner in which services are provided is between you and your physician. Coverage is subject to all of the terms and conditions stated in this Policy, including any applicable deductible, copayment and coinsurance. You may be entitled to additional benefits mandated by state law.

Please refer to the Exclusions and Limitations Section of this Policy for other services not covered under this Benefit Program.

PREVENTIVE SERVICES

This Policy Covers:

Please refer to the Schedule of Benefits for the appropriate Cost-Shares.

Coverage for hearing examinations includes screening to determine the Medical Necessity for hearing correction when performed by a Physician certified as an otolaryngologist or a legally qualified audiologist holding a Certificate of Clinical Competence in Audiology from the American Speech and Hearing Association in the absence of any applicable licensing requirements.

Covered Services do not include:

Please refer to the Exclusions and Limitations Section of this Policy for other services not covered under this Benefit Program.

PRIVATE DUTY NURSING

This Policy Covers:

Private Duty Nursing Services. Limited to $20,000 per Calendar Year

Notes:

Please refer to the Schedule of Benefits for the appropriate Cost-Shares.

Covered Services do not include:

- Private duty nursing care services for the convenience of the Member or while the Member is an Inpatient in a Hospital or Skilled Nursing Facility.
- Care primarily to provide room and board (with or without routine nursing care), training in personal hygiene, and other forms of self-care.

Please refer to the Exclusions and Limitations Section of this Policy for other services not covered under this Benefit Program.

SKILLED NURSING FACILITIES

This Policy Covers:

Coverage includes:

- Skilled nursing care;
- Rehabilitative and related services; and
- Semiprivate room and board.

Notes:

Please refer to the Schedule of Benefits for the appropriate Cost-Shares.

Prior Authorization is required. Please refer to the Managed Benefits Section of this Policy for how to obtain Prior Authorization. The Hospital Inpatient/Inpatient Facility Coinsurance amount is not subject to Cost-Share Maximums.

Covered Services do not include:

Please refer to the Exclusions and Limitations Section of this Policy for other services not covered under this Benefit Program.

Room and board charges exceeding the Skilled Nursing Facility's most common semi-private rate shall be excluded.

THERAPY SERVICES

This Policy Covers:

- Outpatient Rehabilitation

- Outpatient physical, occupational, speech and chiropractic therapy; Outpatient cardiac rehabilitation therapy;

- **Other Therapy Services**

  - Radiation Therapy Chemotherapy for the treatment of cancer; Electroshock Therapy; Kidney Dialysis in a Hospital or free-standing dialysis center;

  - Infusion Therapy – Benefit will be provided for Outpatient Hospital or home Infusion Therapy regimens under the following conditions:

  - A plan of care for such services is prescribed in writing by a Physician (M.D.);

  - Infusion Therapy is limited to:

    - Chemotherapy (including gamma globulin);

    - intravenous antibiotic therapy;

    - total parenteral nutrition;

    - enteral therapy when nutrients are only available by a Physician's prescription;

    - intravenous pain management;

Covered Services will include supplies, solutions, and pharmaceuticals.

Notes:

Please refer to the Schedule of Benefits for the appropriate Cost-Shares.

Speech therapy is a Covered Service when prescribed by a Physician (M.D.) and provided by a licensed speech pathologist.

Covered Services do not include:

Please refer to the Exclusions and Limitations Section of this Policy for other services not covered under this Benefit Program.

EXCLUSIONS AND LIMITATIONS

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

Please remember, this plan does not cover any service or supply not specifically listed as a Covered Service in this Policy. The following list of exclusions is not a complete list of all services, supplies, conditions or situations that are not Covered Services. If a service is not covered, then all services performed in conjunction with that service are not covered. United Healthcare determines if services or supplies are Medically Necessary however, a Member may utilize all applicable Member Appeal procedures as well as the option of legal action.

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

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

Benefits for services which are not:

- specifically described in the Policy.
- rendered or ordered by a Physician
- within the scope of the Physician's, Provider's or Hospital's licensure; and
- Medically Necessary Care for the proper diagnosis and treatment of the Member.
- Benefits may be reduced or denied if subject to the Managed Benefits – Managed Care Guidelines. Any reduced or denied benefits paid by the Member do not apply toward the Out of Pocket Maximums shown in the Schedule of Benefits.
- Benefits for services rendered before the Member's Effective Date under this Benefit Program.
- Benefits for services rendered after the person's Benefit Program has been rescinded, suspended, cancelled, interrupted or terminated. Any person obtaining services after his or her Benefit Program is rescinded, suspended, cancelled, interrupted or terminated for any reason will be solely responsible for payment of such services.
- Care for conditions which are required by State or Local law to be treated in a public facility.
- Services and care in a Veteran's Hospital or any Federal Hospital, except as may be otherwise required by law.
- Services covered in whole or in part by public or private grants.
- Services required by third parties, including but not limited to: school, employment, summer camp and premarital physicals and related tests.
- Studies related to pregnancy except for significant medical reasons.
- Simplified or self-administered tests and multiphasic screening.
- Cosmetic Surgeries, procedures and services performed primarily to improve appearance and not otherwise determined by United Healthcare to meet the coverage criteria for reconstructive surgeries, procedures and services as set forth in this Policy.
- Dental diagnosis, care, treatment, x-rays, or Appliances, for any of the diseases or lesions of the oral cavity, its contents or contiguous structures, the extraction of teeth, the correction of malpositions of the teeth and jaw, or for pain, deformity, deficiency, injury or physical condition of teeth, unless otherwise provided for in this Policy.
- Surgical and non-surgical examination, diagnosis, including invasive (internal) and non-invasive (external) procedures and tests, and all services related to diagnosis and treatment, both medical and surgical, of temporomandibular joint dysfunction or syndrome also called myofascial pain dysfunction or craniomandibular pain syndrome. This exclusion includes but is not limited to the following: contrast and

non-contrast imaging, arthroscopic and open surgical procedures, physical therapy, and appliance therapy such as occlusal Appliances (splints) or adjustments.

- Routine foot care in the absence of systemic or vascular disease affecting the foot, including hygienic care, treatment of corns or calluses, services performed in conjunction with fitting of supportive or comfort devices for the foot or other foot care.

- Services for Custodial Care, Chronic Care and/or Maintenance Care. Including without limitation, Methadone and Suboxone maintenance or any other similar maintenance therapy program and its related testing, supplies, visits and treatment.

- Prenatal medical conferences with a pediatrician regarding an unborn child unless the visit is the result of a medical referral.

- Charges for the Member's room and board when the Member has a leave of absence from the Hospital, Substance Abuse Treatment Facility or other Inpatient Facility.

- Drugs or medications, legend and over-the-counter, prescribed for use as an Outpatient, except as otherwise stated herein.

- Sperm collection and preservation, all services related to surrogate parenting arrangements and preparatory treatment. (Costs incurred for an insured for egg/sperm retrieval for use in a surrogate transplant will be covered.)

- Reversal of Voluntary Sterilization. We do not provide benefits for services to reverse voluntarily induced sterility.

- Vaccines other than routine immunizations or those needed for travel.

- Services, medical supplies or supplies not specifically listed as Covered Services. These include but are not limited to educational therapy, marital counseling, sex therapy, weight control programs, nutritional programs and exercise programs.

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

- Experimental or Investigational treatment, procedure, facility, equipment, drugs, devices or supplies. Any services associated with or as follow-up to any of the above is not a Covered Service.

- Any treatment, procedure, facility, equipment, drug, device or supply which requires Federal or other governmental agency approval not granted at the time services are rendered. Any service associated with, or as follow-up to, any of the above is not a Covered Service.

- Any services by a Physician or Provider to himself or herself or for services rendered to his or her parent, spouse, children, grandchildren or any other immediate family Member or relation which the Member is not legally required to pay.

- Wigs, except as noted in the Covered Services Section.

- Inpatient services which can be properly rendered as Outpatient services.

- Disease contracted or injuries resulting from war.

- Charges after the Provider's or Hospital's regular discharge hour on the day indicated for the Member's discharge by his/her Physician.

- Supervisory care by a Physician for a Member who is mentally or physically disabled and who is not under specific medical, surgical or psychiatric treatment to reduce the disability to the extent necessary to enable the patient to live outside an institution providing medical care; or when despite such treatment, there is no reasonable likelihood that the disability will be so reduced.

- Travel, whether or not recommended by a Physician.

- Pulmonary function tests which are delivered in other than a Physician's office or health care facility do not meet the definition of a covered diagnostic laboratory test.

- Services or procedures rendered without regard for specific clinical indications, routinely for groups or individuals or which are performed solely for research purposes.

- Services or procedures which have become obsolete or are no longer medically justified as determined by appropriate medical specialties.

- Radiation therapy as a treatment for acne vulgaris.

- Services rendered by a Physician in the employ of a Home (e.g. Skilled Nursing Facility) do not qualify as Home & Office Care.

The following is a list of procedures which are not covered:

- Allogeneic or Syngeneic Bone Marrow Transplant or other forms of stem cell rescue and stem cell infusion (with or without high dose chemotherapy and/or radiation) are those with a donor other than the patient.

  They are not covered except in the following cases:

  - When at least five out of six histocompatibility complex antigens match between the patient and the donor.

  - The mixed leukocyte culture is non-reactive.

  - One of the following conditions is being treated:

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

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

- Autologous Bone Marrow Transplantation or other forms of stem cell rescue and stem cell infusion (in which the patient is the donor) with high dose chemotherapy or radiation are not covered except for the following:

    - Non-Hodgkin's lymphoma, high grade, first or subsequent remission. No morphological evidence of bone marrow involvement should be evident. Hodgkin's disease as defined above with an absence of bone marrow involvement.

    - Acute nonlymphocytic leukemia in second remission, in which no HLA matched donor exists or an allogeneic transplant is inappropriate.

    - Acute lymphocytic leukemia in second remission, in which no HLA matched donor exists or an allogeneic transplant is inappropriate.

    - Retinoblastoma, adjuvant setting after successful induction (consolidation).

    - Neuroblastoma, adjuvant setting after successful induction (consolidation).

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

- Surrogacy. Costs associated with surrogate parenting or gestational carriers are not covered. Services or supplies provided to a person not covered under the Policy in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple). (Costs incurred for an insured for egg/sperm retrieval for use in a surrogate transplant will be covered.)

- Weight loss programs. Weight loss programs whether or not they are pursued under medical or Physician supervision, unless specifically listed as covered in this Policy. This exclusion includes, but is not limited to, commercial weight loss programs.

- Nutritional and/or dietary supplements, except as provided in this Policy or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either a written Prescription or dispensing by a licensed Pharmacist.

- Health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a Physician.

RIGHT OF RECOVERY

To the extent permissible by law, United Healthcare shall have a right of recovery against third parties for benefits for Covered Services provided under the terms of this Benefit Program, where the Member has a right of recovery against third parties for the cost of Covered Services. Acceptance of Covered Services will constitute consent by the Member to United Healthcare's right of recovery. The Member agrees to take all further action to execute and deliver such additional instruments and to take such other action as United Healthcare shall require to implement this provision. United Healthcare will have the right to bring suit against such third party in the name of the Member and in its own name as subrogee. The Member shall do nothing to prejudice the rights given to United Healthcare by this provision without its consent.

If a Member received payment from a third party by suit or settlement for the cost of Covered Services, such Member is obligated to reimburse United Healthcare less United Healthcare's pro rata share of the reasonable attorney's fees and cost the Member sustained in obtaining the recovery.

Workers Compensation

This policy provides coverage for a bodily injury caused by an accident arising out of and in the course of employment to a covered individual who is:

- A sole proprietor or business partner who is not covered by the provisions of chapter 568 or who accepts the provisions of chapter 568 pursuant to subdivision (10) of section 31-275; or

- An employee of a corporation and who is a corporate officer, regardless of any election by such individual to be excluded from coverage.

The payment of benefits are subject to the policy provisions which apply to a claim not resulting from bodily injury caused by an accident arising out of and in the course of employment.

Whenever any such covered individual who receives benefits for any such injury under this policy has a right of recovery or reimbursement against any person or organization, any carrier that has paid such benefits to or for the individual shall be subrogated to all such rights of recovery or reimbursement to the extent of its payment. The association shall also have a lien on the proceeds of any award or approval of any compromise made by a workers' compensation commissioner pursuant to the individual's workers' compensation claim.

To the extent permissible by law, the Health Reinsurance Association shall be entitled to the following:

- To charge the entity obligated under such law for the dollar value of those benefits to which the Member is entitled.

- To charge the Member for such dollar value, to the extent that the Member has been paid for the Covered Services.

- To reduce any sum owing to the Member by the amount that the Member has received payment.

- To place a lien on any sum owing to the Member for the amount United Healthcare has paid for Covered Services rendered to the Member, in the event that there is a disputed and/or controverted claim between the Member's employer and the designated Workers' Compensation insurer as to whether or not the Member is entitled to receive Workers' Compensation benefits payments.

- To recover any such sum owing as described above, in the event that the disputed and/or controverted claim is resolved by monetary settlement to the full extent of such settlement.

- If a Member is entitled to benefits under Workers' Compensation, employer's liability or occupational disease law, it is necessary to follow all of the guidelines in the Managed Benefits Section in order for this Benefit Program to continue to provide benefits for Covered Services when the Workers' Compensation benefits are exhausted.

Automobile Insurance

To the extent permissible by law, benefits shall not be provided by this Benefit Program for Covered Services paid,

payable or required to be provided as basic reparations benefits under any no-fault or other automobile insurance policy.

United Healthcare shall be entitled:

- To charge the insurer obligated under such law for the dollar value of those benefits to which a Member is entitled;

- To charge the Member for such dollar value, to the extent that the Member has received payment from any and all sources, including but not limited to, first party payment.

- To reduce any sum owing to the Member by the amount that the Member has received payment from any and all sources, including but not limited to, first party payment.

- A Member who fails to secure no-fault insurance required by applicable law shall be deemed to be his or her own insurer and United Healthcare shall reduce his or her benefits for Covered Services by the amount of basic reparations benefits or other benefits provided for injury if such a no-fault policy had been obtained.

- If a Member is entitled to benefits under a no-fault or other automobile insurance policy, benefits for Covered Services will only be provided when a Member follows all of the guidelines stated in the Managed Benefits Section of the Policy. It is necessary to follow all the guidelines in the Managed Benefits Section in order for United Healthcare to continue to provide benefits for Covered Services when the no-fault or other automobile insurance policy benefits are exhausted.

TERMINATION

This Section describes how coverage for a Member can be cancelled, rescinded, suspended or not renewed.

Termination of the Member

The Member's enrollment in the Benefit Program shall terminate:

- The last day of the month that required charges are paid for your coverage if we do not receive payment when due by the end of the grace period.

- The day following the Subscriber's death. When a Subscriber dies, the surviving spouse of the deceased Subscriber, if covered under the policy, shall become the Subscriber. If the surviving spouse was not covered under the policy, the Dependents shall be terminated the first of the month following the Subscriber's death.

- The first day of the month following the loss of eligibility due to:

    - He or she no longer meets the eligibility requirements of the Benefit Program as defined in the Eligibility Section of this Policy;

    - The Dependent child's enrollment in the Benefit Program shall terminate on the policy anniversary date on or after whichever of the following occurs first, the date on which the Dependent child;

    - Becomes covered under a group health plan through the dependent's own employment; or

    - Attains the age as specified in the Eligibility Section of this Policy.

Following the Effective Date of the Policy the Health Reinsurance Association may rescind, cancel or limit the Benefit Program; if the Member has submitted false information to the Health Reinsurance Association, or omitted information during the application process concerning eligibility, insurability or health status, and such information was material to the underwriting and enrollment of the application at the time submitted and the acceptance by the Health Reinsurance Association of that application for coverage.

United Healthcare may also initiate and conduct a review on a post claim basis to obtain information when the information sought is:

- in relation to a medical condition not disclosed on the application, or
- when the information on the claim or the facts and circumstances of the medical treatment for which a claim is submitted clearly indicate the response, or responses to the questions on the application, or the information provided on the application might be suspect in any way.

The Health Reinsurance Association must obtain prior approval from the Insurance Department to rescind, cancel or limit the Policy.

The Benefit Program may not be rescinded, cancelled or limited more than 2 years after the effective date of the Policy based on information received in the application process.

When a Member ceases to be a Subscriber or Dependent, or the required contribution, if any, is not paid, the Member's coverage will terminate at the end of the last day for which payment was made;

- Termination of an enrolled Dependent's Coverage will occur on the first day of the month following the occurrence of Divorce or legal separation of the spouse;
- Other enrolled Dependent's criteria are no longer met by the spouse or enrolled Dependents as defined in the Eligibility Section.;
- Enrollment in the Benefit Program shall be terminated on the day after the death of an enrolled Dependent.

Termination of the Benefit Program

Either You or We may cancel this Benefit Program by giving written notice to the other party. If We cancel this Benefit Program, written notice shall also be provided to Your Eligible Dependents under this Benefit Program.

This Benefit Program will be terminated, for Your non-payment of the Premiums when due or for Your failure to perform any obligation required by this Benefit Program.

Grace Period

This Benefit Program has a grace period of one calendar month. This means that if a payment is not made on or before the date it is due, it may be paid during the grace period. During the grace period, the Benefit Plan will stay in force unless prior to the date payment is due You give timely written notice to Us that the Policy is to be cancelled.

If you do not make payment during the grace period, the Benefit Program will be cancelled, at Our option, on the last day that payment is made in full for the policy.

Reinstatement

This Benefit Program will be reinstated if the request for reinstatement is received within 30 days of the cancellation date and all outstanding Premiums are paid in full. This Benefit Program may be reinstated once.

Consent

No event of termination, expiration, non-renewal, or cancellation of the Benefit Program shall affect the rights and obligations of the parties arising out of any transactions occurring prior to the Effective Date of any such event. The Member hereby acknowledges that the termination, expiration, non-renewal, or cancellation of the contract will automatically result in the termination of the Benefit Program.

Rescission of the Benefit Program by the Health Reinsurance Association will cause the Benefit Program and any other contracts or agreements between the Health Reinsurance Association and the Member to be null and void.

Certificates of Creditable Coverage

Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), a certificate of creditable coverage must be issued to a Subscriber and his or her covered Dependents who terminate from this Benefit Program. The information included on the certificate of creditable coverage will include the names of any Members terminating, the date coverage under this Benefit Program ended, and the type of coverage provided under this Benefit Program. This certificate of creditable coverage will provide a subsequent insurer or group plan with information regarding previous coverage to assist it in determining any pre-existing condition exclusion period or affiliation period. This certificate of creditable coverage should be presented by the Subscriber to his or her next employer group and/or when applying for subsequent health insurance. In addition, a terminated Member may request an additional copy of the Certificate of Creditable Coverage by contacting the Health Reinsurance Association.

CLAIMS PROVISIONS

United Healthcare and the Health Reinsurance Association reserves the right to review any submitted claims for services and has complete discretion to interpret and apply the terms of the Benefit Program and to determine which services are eligible for reimbursement.

Physician, Providers and Hospitals

When you receive Covered Services from a Physician, Provider or Hospital, the Physician or Provider shall file the claim with United Healthcare. Any payment due under this Benefit Program shall be made directly to the Physician, Provider or Hospital.

If further review of a claim is requested the Member should first contact Member Services. If resolution is not met, the Member should follow the guidelines set forth in the Member Appeal Process Section of this Policy.

Payment For Covered Services

Payment by United Healthcare for Covered Services shall be made directly to the Physician, Provider or Hospital

In order to be considered for payment, claims submitted by a Member for payment for Covered Services provided Physicians, Providers and Hospitals must be received by United Healthcare within 15 months from the date the Covered Services were performed. Claims for Covered Services more than 15 months after the date the services were performed shall not be covered or paid. Claims for Covered Services must be submitted to:

United Healthcare

PO. Box740800
Atlanta, GA. 30374-0800

United Healthcare will not routinely issue a benefit payment of less than $1.00 except upon written request from the Member.

Claims for benefits filed in a paper format for Covered Services provided to a Member will be processed within sixty (60) days of the date the claim is received by United Healthcare except that when there is a deficiency in the information needed for processing a claim, as determined in accordance with section 38a-477. The insurer will send written notice to the claimant or health care provider, as the case may be, of all alleged deficiencies in information needed for processing a claim not later than thirty days (30) after the insurer receives a claim for payment or reimbursement under the contract, and pay claims for payment or reimbursement under the contract not later than thirty days (30) after the insurer receives the information requested.

Claims filed in an electronic format for benefits for Covered Services provided to a Member will be processed within twenty (20) days of the date the claim is received by United Healthcare except that when there is a deficiency in the information needed for processing a claim, as determined in accordance with section 38a-477. The insurer will notify the claimant or health care provider, as the case may be, of all alleged deficiencies in information needed for processing a claim not later than ten days (10) after the insurer receives a claim for payment or reimbursement under the contract, and pay claims for payment or reimbursement under the contract not later than ten days (10) after the insurer receives the information requested.

If the time to process a health claim is extended because the Member has not submitted requested information, the time period requirements for claim processing will be tolled from the date the notice of requested information is sent to the Member until the date United Healthcare receives the Member's response. United Healthcare will make a claim decision within fifteen (15) days after receipt of the requested information. Members should submit the requested information within forty-five (45) days of receipt of the request.

Claim Overpayments

When United Healthcare has made payments for Covered Services either in error or in excess of the maximum amount of payment necessary to satisfy the provisions of this Benefit Program, United Healthcare has the right to recover these payments from one or more of the following as may be appropriate. United Healthcare will not attempt to recover from any Member or Provider overpayments not made to or held by such Member or Provider. Overpayments may be recovered from:

- Any person to or for whom such payments were made;
- Enrollment in the Benefit Program shall be terminated on the day after the death of an enrolled Dependent.
- Any insurance companies; or
- Any other organizations.

United Healthcare's right to recover may include subtracting from future benefits payments the amount United Healthcare has paid in error or in excess. The Subscriber personally and on behalf of his or her Dependents will, upon request, execute and deliver such documents as may be required and do whatever is necessary to secure United Healthcare's right to recover any erroneous or excess payments.

Claim Denials

If benefits are denied, in whole or in part, United Healthcare will send the Member a written notice within the established time periods described in the section Payment for Covered Services. The Member or the Member's duly authorized representative may appeal the denial as described in the Member Appeal Process section below. The adverse determination notice will include the reason(s) for the denial, reference to the Plan provisions(s) on which the denial is based, whether additional information is needed to process the claim and why the information is needed, the claim appeal procedures and time limits.

If the denial involves a utilization review determination, the notice will also specify:

- whether an internal rule, guideline, protocol or other criterion was relied upon in making the claim decision and that this information is available to the Member upon request and at no charge;

- that an explanation of the scientific or clinical judgment for a decision based on Medical Necessity, Experimental or Investigational treatment or a similar limitation is available to the Member upon request and at no charge.

PREMIUMS

The amount, time and manner of payment of Premiums shall be determined by the Health Reinsurance Association and shall be subject to the approval of the State of Connecticut Insurance Department.

All Premiums shall be due and payable in full and in advance for the period in which this Benefit Program provides benefits.

Failure of the Subscriber to remit agreed upon contributions shall void the eligibility of the Subscriber and his or her Dependents to receive benefits covered under this Benefit Program. In such cases, the Subscriber will become financially responsible for any services rendered as of the last day payment has been received by the Health Reinsurance Association.

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 of contributions shall serve as notice of the Subscriber's acceptance of the change.

The Health Reinsurance Association shall not routinely issue a Premium refund in amounts of less than one dollar.

The Health Reinsurance Association may apply refunds and credits for the following reason:

- The Subscriber has prepaid beyond the cancellation date.

Overpayments.

In no event will a refund or credit be made for more than a period of 12 months from the date of the qualifying event.

MEMBER APPEAL PROCESS

Questions may be posed about the Member's health benefit plan. Since questions often can be handled informally, these questions may be addressed by contacting Member Service/Customer Service, utilizing the telephone number provided on the back of the Member's Identification Card. In addition, information about the following Appeal process may be obtained by contacting Member Service/Customer Service.

The Appeal process is available to the Member, the Member's duly authorized representative, the Provider of record, or the Provider of record's duly authorized representative.

You may ask for and get copies of all documents including the actual benefit provision, guideline, protocol or other similar criterion on which this decision was based. If you prefer, any other person you choose may ask for this information. United Healthcare will send this information within five business days after receiving your request. United Health care will send this information within one calendar day after receiving your request about a final adverse coverage decision for:

- An admission, availability of care, continued stay, or health care service for which you received emergency services but haven't been discharged from a facility; or

- A denial of coverage based on a decision that the recommended or requested health care service or treatment is experimental or investigational and your treating provider certifies in writing that this care service or treatment would be significantly less effective if not promptly initiated.

United Healthcare will communicate this information to you by telephone, facsimile, electronic means or any other expeditious method available.

If you don't agree with United Healthcare's coverage decision, you have the right to ask for an appeal review.

You must ask for an appeal review within 180 calendar days from the date you get the letter. You, your provider, or any other person you choose, may ask for an appeal review on your behalf. A person of your choice may also help you during the appeal review process. You need to let United Healthcare know, in writing, if you want someone to represent or help you.

Whether or not you use the appeal review rights available to you, you may contact the Consumer Affairs Division of the Connecticut Insurance Department or the Connecticut Office of the Health Care Advocate at any time. You may also benefit from free assistance with filing an appeal review.

Consumer Affairs Division of the Connecticut Insurance Department
Address: P.O. Box 816
Hartford, CT 06142-0816

Phone: (toll-free) 800-203-3447

Email: cid.ca@ct.gov

Connecticut Office of the Health Care Advocate
Address: P.O. Box 1543
Hartford, CT 06144

Phone: (toll-free) 866-466-4446

Email: Healthcare.advocate@ct.gov

An expedited appeal review is available if you have not had services and the time frame of a standard appeal review would:

- Seriously jeopardize (harm) your life or health; or

- Jeopardize your ability to regain maximum function.

An expedited appeal review is also available for:

- Substance use disorder or co-occurring mental health disorder; or
- Inpatient services, partial hospitalization, residential treatment, or intensive outpatient services needed to keep a covered person from requiring an inpatient setting in connection with a mental health disorder.

You, your doctor or any person you choose, may ask for an expedited appeal review in writing or by phone. In your request, please let United Healthcare know that you are asking for an expedited appeal review. Include any additional information you have that supports the request.

Send a written request to:

United Healthcare
P.O. Box 740800
Atlanta, GA. 30374-0800

By phone: Call customer service at the phone number on your member ID card.

United Healthcare will let you know their decision within 72 hours of receiving a request for an expedited appeal review.

However, United Healthcare will let you know their decision within 24 hours of receiving an expedited appeal review, unless you, or the person you choose to act on your behalf to help you, fails to give United Healthcare information needed to make a coverage decision, for:

- Substance use disorder or co-occurring mental health disorder; or
- Inpatient services, partial hospitalization, residential treatment, or intensive outpatient services needed to keep a covered person from requiring an inpatient setting in connection with a mental health disorder.

United Healthcare will communicate this information to you by telephone, facsimile, electronic means or any other expeditious method available.

You, your doctor or any person you choose may ask for an expedited external review with the Connecticut Insurance Department instead of, or at the same time as, asking for an expedited appeal review with United Healthcare if:

- You have a medical condition for which the time period for completing an expedited internal review would seriously jeopardize your health or your ability to regain maximum function;
- The decision concerns an admission, availability of care, continued stay or health care services for which you received emergency services but have not been discharged; or
- Coverage is denied because the service or treatment is experimental or investigational and your treating physician certifies in writing that the service or treatment would be significantly less effective if not promptly started and you have also filed a request for an expedited internal review.

Your request must be sent in writing to the Connecticut Insurance Department.

Send a written request to:

Connecticut Insurance Department
Attention External Review
P.O. Box 816
Hartford, CT 06142-0816.

If you prefer, the request can be sent by overnight mail to 153 Market Street, 7th Floor, Hartford, CT 06103. An External Review Guide and application are available on the Department's web site, www.ct.gov/cid.

If you ask for an expedited external review with the Connecticut Insurance Department at the same time as an expedited appeal review with United Healthcare, the Independent Review Organization (IRO) assigned to your review by the Insurance Commissioner will decide if you must finish the expedited internal review with United Healthcare before moving forward with the expedited external review.

You may ask for a standard appeal review (an appeal review that is not expedited) for a coverage decision you don't agree with. You can also ask for a standard appeal review for a rescission (ending or canceling) of coverage. Your request must be in writing. In your request, please let us know that you are asking for an appeal review. Include any additional information you have to support your request.

Send a written request to:

United Healthcare
P.O. Box 740800
Atlanta, GA. 30374-0800

Unless your health benefit plan documents state otherwise, United Healthcare will respond to an appeal review request for a medical necessity decision within 30 calendar days from the date they get the request. United Healthcare will respond to an appeal review request not based on medical necessity within 20 business days from the date they get the request. The response will be in writing.

If your appeal review is based on medical necessity, the appropriate clinical peer will review it. A clinical peer is a doctor or other health care professional who holds a non-restricted license in a state of the United States and in the same or similar specialty as typically manages the medical condition, procedure or treatment under review. For a substance use or mental health disorder, the clinical peer will have additional qualifications as specified in Connecticut Insurance Department Bulletin HC-92. This Bulletin can be found at www.ct.gov/cid. All relevant information given to United Healthcare by you or on your behalf will be reviewed regardless of whether it was considered at the time the initial decision was made. If your appeal review involves a substance use or mental health disorder, United Healthcare will also use the criteria defined in Bulletin HC-92 to review your request.

If your appeal review is not based on medical necessity, United Healthcare will send it for appropriate administrative review. United Healthcare may reach out to any providers who may have additional information to support your appeal review. The reviewers won't have been involved in the initial decision. They also won't be a subordinate (in a lower position) of the person who made the initial decision.

Before issuing a decision on an appeal review of an adverse coverage decision based on medical necessity, United Healthcare will give you, free of charge, any new or additional evidence relied upon or scientific or clinical rationale. United Healthcare will give you this information in advance of the appeal review resolution date. This will allow you a reasonable amount of time to respond before that date.

If we deny your appeal review, you, or any person you choose, must send a request for an external review to the State of Connecticut Insurance Department within 120 days from the date you get our response to your appeal review.

If United Healthcare doesn't respond to a first level appeal review involving medical necessity within the required time-frame, you can ask for an external review without having to exhaust your appeal review rights with United Healthcare.

Plan Information Practices Notice

The purpose of this information practices notice is to provide a notice to Members regarding the Plan's standards for the collection, use and disclosure of information gathered in connection with the Plan's business activities.

The Plan may collect personal information about a Member from persons or entities other than the Member. The Plan may disclose Member information to persons or entities outside of the Plan without Member authorization in certain circumstances. A Member has a right of access and correction with respect to all personal information collected by the Plan. A more detailed notice will be furnished to you upon request.

Notice

Any notice given by the Health Reinsurance Association to a Subscriber shall be sufficient if mailed to the Subscriber at his or her address as it appears on the records of the Health Reinsurance Association. Notice given to the Health Reinsurance Association must be sent to the Health Reinsurance Association's address as shown in this Policy. United Healthcare, or a Member, may by written notice, indicate a new address for giving notice.

Miscellaneous Provisions

Entire Contract

This Policy, including the endorsements and the attached papers, if any, make up the entire contract of coverage.

We have discretionary authority to determine your eligibility for benefits and to construe the provisions of this Policy.

The membership application, health statement and rate page are incorporated by reference herein.

A Member shall complete and submit to the Health Reinsurance Association such applications or other forms or statements as the Health Reinsurance Association may reasonably request. A Member warrants that all information contained therein shall be true, correct, and complete to the best of the Member's knowledge and belief and the Member accepts that all right to benefits under this Benefit Program are conditional upon said warranties. No statement by the Member in his or her application shall void this contract or be used in any legal proceeding unless such application or an exact copy thereof is included in or attached to the Policy.

Lifetime Maximum Benefit Limit

- Your lifetime maximum benefit under the Health Reinsurance Association is $1,500,000.

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.

The Health Reinsurance Association as the Insurance Issuer

The Health Reinsurance Association does not furnish Covered Services. The Health Reinsurance Association makes payment of 75% of the Medicare reimbursement amount for Covered Services received by Members. The Health Reinsurance Association is not liable for any act or omission of any Physician, Provider or Hospital. The Health Reinsurance Association has no responsibility for a Physician's, Provider's or Hospital's failure or refusal to render Covered Services to a Member.

The Health Reinsurance Association's sole obligation is to provide the benefits described in the Policy.

No action at law based upon or arising out of the Physician-patient, Provider-patient or Hospital-patient relationship may be maintained against the Health Reinsurance Association.

Disclosure

The Member hereby expressly acknowledges its understanding that the Policy constitutes a contract solely between the Member and the Health Reinsurance Association. The Member further acknowledges and agrees that he or she has not entered in this Policy based upon representations by any person other than the Health Reinsurance Association and that no person, entity or organization other than the Health Reinsurance Association shall be held accountable or liable to the Member for any of the Health Reinsurance Association's obligations to the Member created under the Policy. This paragraph shall not create any additional obligations whatsoever on the part of the Health Reinsurance Association other than those obligations created under other provisions of the Policy.

Authority for Discretionary Decisions

The Health Reinsurance Association, or anyone acting on its behalf, shall determine the administration of benefits and eligibility for participation in such a manner that has a rational relationship to the terms set forth herein. However, the Health Reinsurance Association, or anyone acting on its behalf, has complete discretion to determine the administration of the Member's benefits. The Health Reinsurance Association's determination shall be final and conclusive and may include, without limitation, determination of whether the services, care, treatment, or supplies are Medically Necessary, Investigational/Experimental-Investigative and whether surgery is cosmetic. However, a Member may utilize all applicable Member Appeal procedures as well as the option of legal action.

The Health Reinsurance Association, or anyone acting on Our behalf, shall have all the powers necessary or appropriate to enable it to carry out its duties in connection with the operation and administration of the Policy. This includes, without limitation, the power to construe the Contract, to determine all questions arising under the Policy and to make, establish and amend the rules, regulations and procedures with regard to the interpretation and administration of the provisions of this Policy. However, these powers shall be exercised in such a manner that has reasonable relationship to the provisions of the Policy and applicable state or federal laws. A specific limitation or exclusion will override more general benefit language.

Release of Records

By your application, you have agreed to allow all Providers to give us needed information about the care they provide to you to the extent permitted by law.

Clerical Errors

Clerical errors made in connection with the Benefit Program, whether by the Health Reinsurance Association, or the Member will not terminate coverage that would otherwise have been effective; or continue coverage that

would otherwise have ceased or should not have been in effect.

Assigning Coverage

A Member may not assign this Benefit Program or any of the Member's rights, benefits or obligations under this Benefit Program to any other person or entity except with the prior written consent of the Health Reinsurance Association, which consent may be conditioned by or withheld by the Health Reinsurance Association in its sole discretion. Any attempted assignment by a Member in violation of this provision shall not impose any obligation upon the Health Reinsurance Association to honor or give effect to such assignment and shall constitute grounds for cancellation of this Benefit Program, effective as of the date to which Premiums have been paid.

Notwithstanding the terms of any provision regarding the payment of benefits payable for a Covered Service, a Member may assign the benefits to a dentist or oral surgeon, who performs such services, in accordance with the Connecticut Law concerning Assignment of Benefits to a Dentist or Oral Surgeon.

Notice of Claim

The Health Reinsurance Association will not be liable under the Policy unless proper notice is furnished to United Healthcare that Covered Services have been rendered to a Member. Written notice must be given within 60 days after completion of the Covered Services. The notice must include the data necessary for United Healthcare to determine benefits. An expense will be considered incurred on the date the service or supply was received.

Failure to give notice to United Healthcare 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 United Healthcare be required to accept notice more than 15 months after Covered Services are received.

Claim Forms

United Healthcare, upon receipt of a notice of claim, shall furnish to the Member such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within fifteen 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.

Legal Actions

No action at law or in equity shall be brought to recover on this policy prior to the expiration of sixty days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

Identification Cards

United Healthcare will provide the Subscriber with Identification Cards.

Changes to the Contract

This Benefit Program shall remain in effect unless amended, terminated, rescinded, suspended or cancelled as described herein. The Health Reinsurance Association may amend the Policy with approval from the State of Connecticut Department of Insurance. The Effective Date of such changes shall be designated by the Health Reinsurance Association, and notification to Subscribers will be provided by the Health Reinsurance Association.

The Health Reinsurance Association and United Healthcare have the right to develop medical and managed care policies and procedures and to amend such policies and procedures from time to time. The Effective Date of such changes shall be designated by the Health Reinsurance Association.

Time Periods

When the time of day is important for benefits or determining when coverage starts and ends, a day begins at 12:01 a.m. and ends at 12:00 p.m. eastern standard time.

PLAN DESCRIPTION INFORMATION

Provider Reimbursement

Special Health Care Low Income Plan

- After the annual deductible is met, this plan pays 75% of the Medicare reimbursement amount. If you are using Connecticut Doctors and Hospitals, this amount must be accepted as paid in full. The Connecticut providers may not bill you for any difference once the annual deductible is met.

- If you use Doctors and Hospital outside of Connecticut, the plan pays 75% of the Medicare reimbursement amount. Doctors and Hospitals outside of Connecticut may bill you for any difference above what the plan pays.

Institutional Providers

Institutional Providers include, but are not limited to: general Hospitals, rehabilitation Hospitals, ambulatory surgery centers, and behavioral health facilities.

- After the annual deductible is met, this plan pays 75% of the Medicare reimbursement amount. If you are using Connecticut Doctors and Hospitals, this amount must be accepted as paid in full. The Connecticut providers may not bill you for any difference once the annual deductible is met.

- If you use Doctors and Hospital outside of Connecticut, the plan pays 75% of the Medicare reimbursement amount. Doctors and Hospitals outside of Connecticut may bill you for any difference above what the plan pays.

MANAGED PRESCRIPTION DRUG

Please note: Outpatient Prescription Drugs are only covered if they are prescribed for the treatment of:

- Pain Management

- Lyme Disease

- Diabetes.

- Oral Chemotherapy.

- Infertility, if the member meets the criteria for treatment as described in this policy.

All other outpatient prescription Drugs are not covered.

DOMESTIC PARTNER COVERAGE

Definition;

- The definition of Domestic Partnership for this Policy shall be two individuals, of the same sex or opposite sex, that have been each others sole domestic partner for 12 months or more; are mentally competent; at least 18 years old; who are not related in any way (including by blood or adoption) that would prohibit marriage under state law; not married to or separated from anyone else; and are financially interdependent.

Eligible Individuals;

- All Individuals that meet the eligibility requirements for Individual coverage of the Health Reinsurance Association may request Domestic Partner coverage.

Domestic Partner Eligibility Criteria

Domestic Partner eligibility between two persons of the same sex or opposite sex exist when all the requirements identified below are satisfied.

Domestic Partners must meet all of the criteria below:

- Each party is the sole Domestic Partner of the other.
- Each party is at least eighteen (18) years of age.
- Both parties currently share a common legal residence and have shared said residence for at least 12 months prior to application for Domestic Partner coverage.
- Domestic Partners must be jointly responsible for basic living expenses.
- Both parties are in a relationship of mutual support, caring, and commitment and intend to remain in such a relationship in the indefinite future.
- Neither party is married to another person.
- Neither party is related to the other by adoption or blood to a degree of closeness that would bar marriage in the state in which they reside, except for those states that legally recognizes Domestic Partners as a legal valid marriage.

Domestic Partners must have in effect and provide proof of any one of the following:

- Designation of Domestic Partner as beneficiary for life insurance and retirement contract; or
- Designation of Domestic Partner as primary beneficiary in the (Covered Person's) will; or,

Documentation by one Partner designating the other partner as his/her agent for:

- Personal relationship issues, or
- Health care decisions, or

- Health Care agent.

- Neither party has filed a Termination of Domestic Partnership within the preceding 12 months.

Eligibility

Dependent children including a step-child, a child legally placed for adoption, a legally adopted child, a child for whom the Subscriber has been appointed a legal guardian, of the Covered Person and/or Partner are eligible for benefits for covered services if the following requirements are satisfied:

- Child Under Age 26 The Dependent child under age 26 of the Subscriber or spouse, including a step-child of either, a child legally placed for adoption, a legally adopted child, a child for whom the Subscriber has been appointed a legal guardian, the Dependent child under age 26 of the Subscriber or spouse for whom the Subscriber has been designated as the responsible party under a Qualified Medical Child Support Order (QMCSO).

- The Dependent is not eligible if he becomes covered under a group health plan through the Dependents own employment.

- The word "child" means the Subscriber's natural child, stepchild, adopted child or other child. "Child" also includes the Subscriber's mentally or physically handicapped child if the disability began before age 26, and as a result of the disability, the child is unable to support himself or herself. The Health Reinsurance Association may, after a period of two years has elapsed following the child's attainment of the limiting age of 26, require periodic proof of the child's continuing incapacity and dependency but in no case more frequently than once every year.

- In the case of a newborn infant of the Covered Person and/or Partner or enrolled dependent, such child shall be eligible for benefits for covered services from birth through age 61 (sixty one) days under the policy of their parents(s), subject to any applicable managed care or managed benefits provisions of this Policy. An infant age 62 (sixty two) days or over is eligible for benefits for covered services as a dependent child and may be added to the parents policy.

- In the case of children placed for adoption of the Covered Person and/or Partner or enrolled dependent, such child shall be eligible for benefits for covered services for 31 (thirty one) days under the policy of their parents(s), subject to any applicable managed care or managed benefits provisions of this Policy. Following the Date of Placement for adoption, a child is eligible for benefits for covered services as a dependent child and may be added to the parents policy 32 (thirty two) days following the Date of Placement for adoption.

In the case of a disabled dependent child of the Covered Person and/or Partner, where "disabled" means that the child is incapable of sustaining employment by reason of physical or mental handicap, the disabled child may continue as dependent beyond the age limit set forth in this Policy provided:

- proof of disability is submitted and accepted by the Health Reinsurance Association. Note: the Health Reinsurance Association may require proof of disability annually.

- the child became disabled prior to the age limit for a dependent child set forth in the Policy under which the child was eligible for benefits for Covered Services.

Effective Date of Coverage

Coverage for Domestic Partners and eligible dependents of the Domestic Partner will be as follows:

- Upon the Individual's initial enrollment, provided all Domestic Partnership eligibility requirements are satisfied and approved by the Health Reinsurance Association.

- An Individual may enroll a Partner provided all Domestic Partnership eligibility requirements are satisfied and approved by the Health Reinsurance Association. The Effective Date of coverage will be in accordance with any applicable waiting period in place by the Health Reinsurance Association.

Termination

If the Domestic Partnership status changes such that the Partner is no longer eligible for coverage, the Covered Person must complete and file a Termination of Domestic Partnership form within 30 days of the change of such status.