

For informational purposes, the Exchange staff provides the Advisory Committees with the following benefit plan summaries included in the Certificate of Coverage that are relevant for each of the potential Essential Health Benefit benchmark plans.

Small Group Plans

- **Anthem BlueCare Health Maintenance Organization (HMO)**
- **Oxford PPO**
- **Aetna HMO**

Largest Non-Medicaid HMO

- **ConnectiCare HMO**

State Employee Health Benefit Plan

- **Anthem State Preferred Plan**
applies to both its Point-of-Service (POS) and Point-of-Enrollment (POE) plans
- **Oxford HMO**

Federal Employee Health Benefit Plan

- **Blue Cross and Blue Shield Service Benefit Plan**
applies to both the Standard Option and Basic Option
- **Government Employee Health Association, Inc. Benefit Plan**

**“SCHEDULE OF BENEFITS” from BlueCare Benefit Program—Certificate (2012)
for:**

Anthem BlueCross BlueShield Blue Care HMO

Date: February 22, 2012

SCHEDULE OF BENEFITS

BlueCare

SCHEDULE A

This schedule describes the benefits offered for Covered Services under this Subscriber agreement. For a more detailed explanation of benefits provided for in this Subscriber agreement, a member should refer to the proper Section. This Schedule is subject to all terms, conditions and limitations set forth in this Subscriber agreement.

SUMMARY

SUMMARY	PARTICIPATING OPTION
TYPE OF SERVICE AND BENEFIT MAXIMUM	MEMBER COST-SHARE
Office Visit Copayment	
Primary Care Physician	\$30 per visit
Participating Physician, Participating Provider	\$45 per visit
Person Responsible for Prior Authorization	Primary Care Physician Participating Physician Participating Provider
Lifetime Maximum Benefit	Unlimited
Human Organ and Tissue Transplant	Unlimited
Lifetime Maximum	

SUMMARY	PARTICIPATING OPTION
TYPE OF SERVICE AND BENEFIT MAXIMUM	MEMBER COST-SHARE
PREVENTIVE SERVICES	
Well Child Care	
7 exams from birth to 1 year of age 7 exams 1 to 5 years of age 1 exam every Calendar Year 5 to 22 years of age	No Copay
Adult Physical Exams	
1 exam per Calendar Year 22 years of age and older	\$0 per visit
Mammography	No Cost-Share
One baseline screening for female 35 through 39 years of age or more frequently if recommended by a physician One screening mammogram every Calendar Year for female 40 years of age and older or more frequently if recommended by a physician	
Immunizations and vaccinations (includes those needed for travel)	No Cost-Share
1 Vision Exam and Refraction every 2 Calendar Years	\$45 per visit

SUMMARY	PARTICIPATING OPTION
TYPE OF SERVICE AND BENEFIT MAXIMUM	MEMBER COST-SHARE
MEDICAL SERVICES	
<i>Surgical Services performed by a Surgeon or Physician (Specialist) in any setting other than an Office Visit</i>	Specialist Copay
<i>Non-Surgical Services of a Physician or Surgeon (Specialist) (other than a medical office visit). These services may include after care or attending medical care.</i>	No Cost-Share
Medical Office Visits	
<i>Primary Care Physician (Including surgical procedures done in the office. All services provided by your PCP take this Copay)</i>	\$30 per visit
<i>Participating Physician (Specialist) (including surgical procedures done in the office)</i>	\$45 per visit
Walk-In Center Services	\$30 per visit
Retail Health Clinic	\$30 per visit
Home Visits by Physicians	
Primary Care Physician	\$30 per visit
Participating Physician (Specialist)	\$45 per visit
Diagnostic X-ray and Imaging	
In a Radiologists office	Same as Specialist Office Visit Copayment
Outpatient Hospital	Same as Specialist Office Visit Copayment
High Cost Diagnostic Tests MRI, MRA, CTA, PET, SPECT or CAT scan	\$75 Maximum of \$375 per Calendar Year
Radiation Therapy	No Cost-Share
Laboratory Services <i>Independent Laboratory Services</i>	No Cost-Share
<i>All other places of service, including Outpatient Hospital Laboratory Services</i>	Same as Primary Care Office Visit Copayment
Allergy Testing and Treatment up to 80 visits every 3 Calendar Years (allergy extracts are covered)	
Primary Care Physician	\$30 per visit
Participating Physician	\$45 per visit

\$25 copay for allergy injections

SUMMARY	PARTICIPATING OPTION
TYPE OF SERVICE AND BENEFIT MAXIMUM	MEMBER COST-SHARE
Nutritional Counseling	No Cost-Share
HOSPITAL SERVICES	
All Inpatient Admissions	\$500 per day up to a \$2,000 per stay to a \$2,000 Calendar Year Maximum
	(waived if readmitted within 30 days for the same diagnosis)
Ancillary Services	No Cost-Share
Outpatient Surgery (Including colonoscopy)	\$500 per visit
Note: See Other Health Care Services section of this Schedule for Outpatient Surgery rendered in an ambulatory surgical center.	
OTHER HEALTH CARE SERVICES	
Skilled Nursing Facility up to 90 days per Calendar Year	Same as Hospital Inpatient Cost-Share
Outpatient Surgery In a licensed ambulatory surgical center (not located in a Hospital setting) (including colonoscopy)	\$ 100
Note: See the Hospital Services section of this Schedule for Outpatient Surgery rendered in a Hospital setting.	
Inpatient Rehabilitation Services up to 60 consecutive days per Calendar Year	No Cost-Share
<p>Home Health Care:</p> <p>(includes in Home Hospice (Care)</p> <p>Nursing and therapeutic services limited to 100 visits.</p> <p>Home health aide services limited to 80 visits.</p> <p>In the Home Hospice Medical Social Services under the direction of a Physician up to \$420</p>	Same as Primary Care Office Visit Copayment

Private Duty Nursing Limited to \$50,000 Per Calendar Year	Not Applicable
Infusion Therapy	No Cost-Share
Outpatient Rehabilitation Services	
Chiropractic Care up to 20 visits per Calendar Year. Physical, Occupational and Speech Therapy Care up to 30 visits per Calendar Year. Note: Any visit limits for Physical, Occupational and Speech Therapy will not apply to Autism Spectrum disorder services	\$45 per visit
Cardiac Rehabilitative Therapy	\$45 per visit
Autism Services: Behavioral Therapy All Autism Services are subject to the following maximums per Member: *Children up to age 9-\$50,000 *Children ages 9-13 \$35,000 *Children ages 13-15 \$25,000	No Cost-Share

SUMMARY	PARTICIPATING OPTION
TYPE OF SERVICE AND BENEFIT MAXIMUM	MEMBER COST-SHARE
<p>Durable Medical Equipment up to UNLIMITED per Calendar Year</p> <p>Diabetic equipment, drugs and supplies.</p> <p>Hearing Aid coverage available for dependent children age 12 years and under.</p>	50% Coinsurance
<p>Prosthetic Devices up to an Unlimited Maximum (Up to \$300 for each breast removed, not subject to the Member Cost-Share).</p>	50% Coinsurance
<p>Surgical Removal of any breast implant up to \$1,000 per Calendar Year</p>	No Cost-Share
<p>Wig Up to \$350 Maximum per Member per Calendar Year</p>	No Cost-Share
<p>Specialized Formula</p>	No Cost-Share
<p>Maternity/Family Planning</p> <p>Infertility Services</p> <p>Please see Maternity/Family Planning section of this document</p> <p>Office Visit</p> <p>Outpatient Hospital</p> <p>Inpatient Hospital</p> <p>NOTE: Infertility drugs (with infertility diagnosis). The maximum supply of a drug for which benefits will be provided when dispensed under any one prescription is 30 day supply or 100 unit dose, whichever is greater.</p> <p>NOTE: If this certificate has a Prescription Drug Rider, see rider for infertility drug coverage. Infertility drugs will not apply to the Prescription Drug Rider Maximum. In the absence of a prescription drug rider then the coverage stated in this Schedule of Benefits will apply.</p>	<p>Same as Office Visit Copay</p> <p>Same as Outpatient Hospital Cost-Share</p> <p>Same as Inpatient Hospital Cost-Share</p>
<p>Maternity</p>	Same as Office Visit Copay (first visit only)

SUMMARY	PARTICIPATING OPTION
TYPE OF SERVICE AND BENEFIT MAXIMUM	MEMBER COST-SHARE
Hospice Care (Inpatient)	No Cost-Share
Home Oxygen	No Cost-Share
Acupuncture	\$45 per visit
MEDICAL EMERGENCY/URGENT CARE SERVICES	
Emergency Room Treatment Copayment waived if the Member is admitted directly to the Hospital from the emergency room	\$150 per visit
Ambulance Services Land: Paid according to the Department of Public Health Ambulance Service Rate Schedule. Air: Paid according to the Department of Public Health Ambulance Service Rate Schedule. Cost-Share (waived if admitted)	No Cost-Share
Physician's Office Medical Emergency Visit	
Primary Care Physician	\$30 per visit
Participating Physician (Specialist)	\$45 per visit
Urgent Care Facility Visits	\$75 per visit
MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES	
OUTPATIENT	\$45 per visit
INPATIENT	Same as Hospital Inpatient Cost-Share

“COVERED SERVICES” and “MAXIMUMS AND LIMITATIONS” for:

Oxford Health Insurance (Direct, HSA Compatible)

Plan Effective Date: January 1, 2012

Oxford Health Insurance

HSA DIRECT
Sample Group

<u>COVERED SERVICES</u>	<u>IN-NETWORK</u>	<u>OUT-OF-NETWORK</u>
Primary and Preventive Care	<p>Primary Care:</p> <p>Covered 100% after Deductible.</p> <p>Some procedures require Precertification. Please see your Certificate.</p> <p>Preventive Care:</p> <p>No Charge for Preventive Care Visits</p> <p>Two well-woman examinations per Calendar Year, Pap tests and age appropriate mammograms are Covered. No Charge</p>	<p>Physician Office and Home Visits for Treatment of Illness or Injury:</p> <p>Primary Care is Covered subject to Deductible and 30% Coinsurance.</p> <p>Some procedures require Precertification. Please see your Certificate.</p> <p>Preventive Care:</p> <p>Preventive Care is Covered subject to Deductible and 30% Coinsurance.</p> <p>Two well-woman examinations per Calendar Year, Pap tests and age appropriate mammograms are Covered subject to Deductible and 30% Coinsurance.</p>
Inpatient Hospital Visit	<p>Covered 100% after Deductible.</p> <p>Precertification is required.</p>	<p>Covered subject to Deductible and 30% Coinsurance.</p> <p>Precertification is required.</p>
Diabetes Education and Self-Management	<p>Covered 100% after Deductible.</p>	<p>Covered subject to Deductible and 30% Coinsurance.</p>
Diabetic Supplies and Medications	<p>Covered 100% after Deductible.</p> <p>Precertification is required for the purchase of an insulin pump.</p>	<p>Covered subject to Deductible and 30% Coinsurance.</p> <p>Precertification is required for the purchase of an insulin pump.</p>

Please Note: Unless otherwise indicated, all benefit maximums and limitations are applied on a per Member, per Calendar Year basis.

Oxford Health Insurance

<u>COVERED SERVICES</u>	<u>IN-NETWORK</u>	<u>OUT-OF-NETWORK</u>
Specialty Care		
Physician Office and Home Visits	Covered 100% after Deductible. Some procedures require Precertification. Please see your Certificate.	Covered subject to Deductible and 30% Coinsurance. Some procedures require Precertification. Please see your Certificate.
Inpatient Hospital Visit	Covered 100% after Deductible. Precertification is required.	Covered subject to Deductible and 30% Coinsurance. Precertification is required.
Naturopathic Care	Covered 100% after Deductible.	Covered subject to Deductible and 30% Coinsurance.
Obstetrical Services (Including prenatal and postnatal)	Covered 100% after Deductible. Some procedures require Precertification. Please see your Certificate.	Covered subject to Deductible and 30% Coinsurance. Some procedures require Precertification. Please see your Certificate.
Inpatient hospital services are Covered subject to the Inpatient facility Out-of-Pocket Expense.		
Elective Termination of Pregnancy	Covered 100% after Deductible.	Covered subject to Deductible and 30% Coinsurance.
Allergy Testing and Treatment	Covered 100% after Deductible.	Covered subject to Deductible and 30% Coinsurance.
Short Term Rehabilitation Services (Physical, Speech, and Occupational Therapy) Outpatient	Covered 100% after Deductible.	Covered subject to Deductible and 30% Coinsurance.
Short Term Rehabilitation Services (Physical, Speech, and Occupational Therapy) Inpatient	Covered 100% after Deductible. Precertification is required.	Covered subject to Deductible and 30% Coinsurance. Precertification is required.
Oral Surgery Inpatient	Covered 100% after Deductible. Precertification is required.	Covered subject to Deductible and 30% Coinsurance. Precertification is required.
Oral Surgery Outpatient	Covered 100% after Deductible. Precertification is required.	Covered subject to Deductible and 30% Coinsurance. Precertification is required.

Please Note: Unless otherwise indicated, all benefit maximums and limitations are applied on a per Member, per Calendar Year basis.

Oxford Health Insurance

COVERED SERVICES

IN-NETWORK

OUT-OF-NETWORK

Specialty Care (cont.)

Oral Surgery Office Visit	Covered 100% after Deductible.	Covered subject to Deductible and 30% Coinsurance.
Pediatric Preventive Dental (through age 11)	No Charge	No Charge
Laboratory Procedures	Covered 100% after Deductible.	Covered subject to Deductible and 30% Coinsurance.
Radiology Services and X-ray Examinations	Covered 100% after Deductible.	Covered subject to Deductible and 30% Coinsurance. Precertification is required for Ultrasound, PET scans, MRIs, and CAT Scans and Nuclear Medicine.
Diagnostic Mammography	Covered 100% after Deductible.	Covered subject to Deductible and 30% Coinsurance.
Prosthetic Devices	Surgery is Covered 100% after Deductible. Internal and External devices are Covered 100% after Deductible.	Surgery is Covered subject to Deductible and 30% Coinsurance. Internal and External devices are Covered subject to Deductible and 30% Coinsurance.
Durable Medical Equipment	Covered 100% after Deductible. Precertification is required on items that cost \$500 or more.	Covered subject to Deductible and 30% Coinsurance. Precertification is required on items that cost \$500 or more.
Hearing Aids	Covered 100% after Deductible.	Covered subject to Deductible and 30% Coinsurance.
Medical Supplies	Covered 100% after Deductible. Precertification is required.	Covered subject to Deductible and 30% Coinsurance. Precertification is required.

Please Note: Unless otherwise indicated, all benefit maximums and limitations are applied on a per Member, per Calendar Year basis.

Oxford Health Insurance

COVERED SERVICES	<u>In-Network</u>	<u>Out-of-Network</u>
Specialty Care (cont.)		
Transplants	Covered 100% after Deductible. Precertification is required.	Covered subject to Deductible and 30% Coinsurance. Precertification is required.
Home Health Care	Covered 100% after Deductible. Precertification is required.	Covered subject to 25% Coinsurance. Precertification is required.
Chiropractic Services	Covered 100% after Deductible.	Covered subject to Deductible and 30% Coinsurance.
Second Opinions	At your request, Covered 100% after Deductible. At Our request, No Charge.	Covered subject to Deductible and 30% Coinsurance.
Treatment of Infertility		
Inpatient Infertility Treatment	Covered 100% after Deductible. Precertification is required.	Covered subject to Deductible and 30% Coinsurance. Precertification is required.
Outpatient Infertility Treatment	Covered 100% after Deductible. Precertification is required.	Covered subject to Deductible and 30% Coinsurance. Precertification is required.
Infertility Treatment Office Visits	Covered 100% after Deductible. Precertification is required.	Covered subject to Deductible and 30% Coinsurance. Precertification is required.
Infertility Medications	Covered 100% after Deductible.	Covered subject to Deductible and 30% Coinsurance.

Please Note: Unless otherwise indicated, all benefit maximums and limitations are applied on a per Member, per Calendar Year basis.

Oxford Health Insurance

COVERED SERVICES	<u>In-Network</u>	<u>Out-of-Network</u>
Hospital and Other Facility Based Services		
Inpatient Hospital Services	Covered 100% after Deductible. Precertification is required.	Covered subject to Deductible and 30% Coinsurance. Precertification is required.
Outpatient Hospital Services and Ambulatory Surgical Center Services	Covered 100% after Deductible. Precertification is required.	Covered subject to Deductible and 30% Coinsurance. Precertification is required.
Skilled Nursing Facility Services	Covered 100% after Deductible. Precertification is required.	Covered subject to Deductible and 30% Coinsurance. Precertification is required.
Hospice Services		
Inpatient Hospice Services	Covered 100% after Deductible. Precertification is required.	Covered subject to Deductible and 30% Coinsurance. Precertification is required.
Outpatient Hospice Services	Covered 100% after Deductible. Precertification is required.	Covered subject to Deductible and 30% Coinsurance. Precertification is required.
Alcohol and Substance Abuse Services		
Inpatient Alcohol and Substance Abuse Rehabilitation	Covered 100% after Deductible. Precertification is required.	Covered subject to Deductible and 30% Coinsurance. Precertification is required.
Outpatient Alcohol and Substance Abuse Rehabilitation	Covered 100% after Deductible. Precertification is required.	Covered subject to Deductible and 30% Coinsurance. Precertification is required.
Alcohol and Substance Abuse Rehabilitation Office Visits	Covered 100% after Deductible. Precertification is required.	Covered subject to Deductible and 30% Coinsurance. Precertification is required.

Please Note: Unless otherwise indicated, all benefit maximums and limitations are applied on a per Member, per Calendar Year basis.

Oxford Health Insurance

COVERED SERVICES	<u>In-Network</u>	<u>Out-of-Network</u>
Hospital and Other Facility Based Services (cont.)		
Mental Health Services		
Inpatient Mental Health Services	Covered 100% after Deductible. Precertification is required.	Covered subject to Deductible and 30% Coinsurance. Precertification is required.
Outpatient Mental Health Services	Covered 100% after Deductible.	Covered subject to Deductible and 30% Coinsurance.
Mental Health Services Office Visits	Covered 100% after Deductible.	Covered subject to Deductible and 30% Coinsurance.
Medical Emergency and Urgent Care Services		
Emergency Room Services	Covered 100% after Deductible. Waived if the Member becomes confined in a hospital.	Covered 100% after Deductible. Waived if the Member becomes confined in a hospital. All Covered Emergency Room Services will be Covered as an In-Network benefit.
Urgent Care Facility Services	Covered 100% after Deductible. Precertification is required.	Covered subject to Deductible and 30% Coinsurance. Precertification is required.
Ambulance Services	Covered 100% after Deductible.	Covered 100% after Deductible. All Covered Ambulance Services will be Covered as an In-Network benefit.

Please Note: Unless otherwise indicated, all benefit maximums and limitations are applied on a per Member, per Calendar Year basis.

Oxford Health Insurance

<u>COVERED SERVICES</u>	<u>In-Network</u>	<u>Out-of-Network</u>
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Supplemental Coverage Information

Outpatient Prescription Drugs - Subject to the Plan Deductible.

Outpatient Prescription Drugs-Retail

Triple Tier

Tier 1- \$15 Copayment
 Tier 2- \$25 Copayment
 Tier 3- \$40 Copayment

Covered subject to Deductible and 30% Coinsurance.

Please Note: The above Copayments are applied to a 31-day supply of Prescription Drugs.

Outpatient Prescription Drugs- Mail Order

You will be responsible for two retail Copayments for a 90-day supply of Prescription Drugs.

Covered subject to Deductible and 30% Coinsurance per 90-day supply.

Please Note: Unless otherwise indicated, all benefit maximums and limitations are applied on a per Member, per Calendar Year basis.

Oxford Health Insurance

MAXIMUMS AND LIMITATIONS

Unless otherwise indicated, the following maximums and limitations apply to both the In-Network and Out-of-Network Benefits combined. All reimbursements for In-Network benefits are subject to the contracted rate.

All reimbursements for Out-of-Network benefits are subject to UCR. The Group has selected UCR reimbursements for Out-of-Network benefits at the 70th percentile of HIAA/Ingenix (when applicable). More information regarding Our UCR Policy and administration is available. You may request a copy of Our UCR Policy in the same manner as any Medical Policy. Please see your Member Handbook for information on how to obtain copies of Our Policies.

Out-of-Network Benefits	Unlimited.
Diabetic Supplies	Diabetic supplies will only be supplied in amounts consistent with the Member's treatment plan as developed by the Member's Physician. You are required to pay 2 applicable copayments for 90-day supply by mail order.
Naturopathic Care	Equipment, clothing, vitamins, supplements or other items and services that may be offered by the Naturopath are excluded from coverage.
Hearing Aids	We will pay a maximum benefit of \$1,500 per Member, per 12 month period.
Elective Termination of Pregnancy	We Cover one procedure per Member per Calendar Year. We pay a maximum benefit of \$350 per procedure.
Treatment of Infertility	This benefit is limited to Members under the age of 40 and is subject to a maximum benefit during the entire time the Member is continuously Covered under the Plan as follows: <ul style="list-style-type: none">▪ Ovulation inductions is limited to four cycles.▪ Intrauterine insemination is limited to three cycles.▪ In-vitro fertilization, GIFT, ZIFT and low tubal ovum transfer are subject to a combined limit of two cycles with not more than two embryo implantations per cycle.
Short Term Rehabilitation Therapy Services (Physical, Speech, and Occupational Therapy)	
Inpatient Rehabilitation	One consecutive 60 day period per condition, per lifetime.
Outpatient Rehabilitation	60 visits per condition, per lifetime.

Please Note: Unless otherwise indicated, all benefit maximums and limitations are applied on a per Member, per Calendar Year basis.

Oxford Health Insurance

MAXIMUMS AND LIMITATIONS (cont.)

Durable Medical Equipment	We will pay a maximum benefit of \$1,500 per Calendar Year.
Transplants	In-Network Coverage is available only at Network facilities specifically approved and designated by Us to perform these procedures.
Home Health Services	80 visits per Calendar Year.
Chiropractic Services	30 visits per Calendar Year.
Skilled Nursing Facility Services	30 days per Calendar Year.
Hospice Services	Unlimited
Bereavement Counseling for the Member's family	5 sessions either before or after the death of the Member.
Inpatient Alcoholism and Substance Abuse Rehabilitation	This benefit is provided to the same extent as other surgical/medical benefits covered under the Certificate.
Outpatient Alcoholism and Substance Abuse Rehabilitation	This benefit is provided to the same extent as other surgical/medical benefits covered under the Certificate.
Mental Health Services	
Inpatient Mental Health Services	This benefit is provided to the same extent as other surgical/medical benefits covered under the Certificate.
Outpatient Mental Health Services	This benefit is provided to the same extent as other surgical/medical benefits covered under the Certificate.
Supplemental Coverage Maximums and Limitations	
Vision Care	We will reimburse a Covered Member up to a maximum amount of up to \$50 for an annual eye examination and up to \$70 for hardware per 24 months per Calendar year. See Certificate for additional information.

Please Note: Unless otherwise indicated, all benefit maximums and limitations are applied on a per Member, per Calendar Year basis.

FAILURE TO PRECERTIFY

If you fail to obtain a required Precertification for an Out-of-Network benefit, you will be subject to a reduction in benefits. You must pay 50% of the scheduled benefit or \$500, whichever is less, for such service or supply when it has been determined the service or supply is medically necessary and is a covered benefit as outlined in your Certificate.

DEDUCTIBLE

The applicable Deductibles for this Plan are:

In-Network Individual: \$2,850 per contract year.

Out-of-Network Individual: \$2,850 per calendar year. Family (In-Network and Out-of-Network): A maximum of 2 times the Individual Deductible per calendar year.

The above Deductible amounts include Prescription Drug expenses. If you have a family contract the entire family Deductible must be satisfied before Coverage under this Plan is available. A family contract is a Plan that covers you and one or more Dependents.

OUT-OF-POCKET MAXIMUM

The maximum amount you must pay in any Contract Year for In-Network Covered Services including Deductible and Coinsurance is \$3,850 for an individual and 2 times the Individual Deductible per family. Remember, only Coinsurance and the amounts paid to meet your Deductible count toward the In-Network Out-of-Pocket Maximum. Note: amounts paid towards Prescription coverage DO NOT count towards this maximum.

The maximum amount you must pay in any Contract Year for Out-of-Network Covered Services including Deductible and Coinsurance is \$5,850 for an individual and 2 times the individual Deductible per family. Remember, only Coinsurance and the amounts paid to meet your Deductible count toward the Out-of-Network Out-of-Pocket Maximum. Amounts in excess of the UCR, and amounts paid for non-Covered Services, and any amounts paid as a penalty do not count toward the Out-of-Pocket Maximum.

Coinsurance and Deductible amounts paid for any Covered Service obtained under a Supplemental Rider (excluding State mandated offers), will not be applied toward the Out-of-Pocket Maximum. This includes Prescription coverage. Coinsurance paid for services and supplies for the treatment of infertility, and outpatient prescription drugs, will not be applied toward the Out-of-Pocket Maximum.

DEDUCTIBLE & COINSURANCE LIMITS

Any excess in the amount of payments will be refunded to the Member. Deductible, Coinsurance amounts paid for any Covered Service obtained under a Supplemental Rider (excluding State mandated offers, and Prescription Drugs) will not be applied toward the Out-of-Pocket Maximum Limits.

Please Note: Unless otherwise indicated, all benefit maximums and limitations are applied on a per Member, per Calendar Year basis.

Oxford Health Insurance

ELIGIBILITY LIMITS

The limiting age for Dependents (as defined in the Certificate) is 26.

EFFECTIVE DATES OF COVERAGE

Initial Enrollment (During the initial Group Open Enrollment Period). Coverage is effective on the effective date of the Agreement.

Newly Eligible Employee (Application within 31 days of becoming eligible). Coverage is effective as of the date the employee became eligible.

Newly Eligible Dependents (Application within 31 days of becoming eligible). Coverage is effective on the date the dependent became eligible. Coverage is effective at birth for newborns and newly born adopted children subject to the enrollment requirements as described in the Certificate.

Group Enrollment Period. Coverage will be effective on the renewal date of the Agreement.

IMPORTANT: This document is not a contract. It is only a summary of your coverage under this Plan. Please read your Certificate for a full description of your Covered Services, exclusions and other terms and conditions of coverage.

Please Note: Unless otherwise indicated, all benefit maximums and limitations are applied on a per Member, per Calendar Year basis.

“PLAN DESIGN AND BENEFITS” from Summary Booklet (2011) for:

Aetna Small Group QPOS (HAS Compatible)

Plan Effective Date: December 1, 2010

PLAN DESIGN AND BENEFITS - CT Open Access QPOS (OA QPOS) Hp-12/10 (HSA Compatible)

PLAN FEATURES	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Deductible (per plan year)	\$2,500 Individual \$5,000 Family	\$5,000 Individual \$10,000 Family
<p>Unless otherwise indicated, the Deductible must be met prior to benefits being payable. All covered expenses accumulate separately toward the participating and non-participating Deductible. The Individual Deductible can only be met when a member is enrolled for self only coverage with no dependent coverage. The Family Deductible can be met by a combination of family members or by any single individual within the family. Once the Family Deductible is met, all family members will be considered as having met their Deductible for the remainder of the plan year.</p>		
Member Coinsurance	0% after deductible	30% after deductible
Out-of-Pocket Maximum (per plan year, includes deductible)	\$3,500 Individual \$7,000 Family	\$8,000 Individual \$16,000 Family
<p>All covered expenses accumulate separately toward the participating and non-participating Out-of-Pocket Maximum. The Individual Out-of-Pocket Maximum can only be met when a member is enrolled for self only coverage with no dependent coverage. The Family Out-of-Pocket Maximum can be met by a combination of family members or by any single individual within the family. Once the Family Out-of-Pocket Maximum is met, all family members will be considered as having met their Out-of-Pocket Maximum for the remainder of the plan year. Only those out-of-pocket expenses resulting from the application of deductible, coinsurance percentage and copays, including prescription drug copays, (except any penalty amounts) may be used to satisfy the Out-of-Pocket Maximum.</p>		
Lifetime Maximum	Unlimited	Unlimited
Payment for services from a Non-Participating Provider*	Not Applicable	Professional: 110% of Medicare Facility: 140% of Medicare
Primary Care Physician Selection	Not Required	Not Applicable
<p>Precertification Requirement - certain non-participating provider services require precertification or benefits will be reduced. Refer to your plan documents for a complete list of services that require precertification.</p>		
Referral Requirement	None	None
PHYSICIAN SERVICES	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Primary Care Physician Visits	Office Hours: 0% after deductible After Office Hours/Home: 0% after deductible	30% after deductible
Specialist Office Visits	0% after deductible	30% after deductible
Maternity OB Visits	0% after deductible	30% after deductible
Allergy Treatment	Same as applicable participating provider office visit member cost sharing	30% after deductible
Allergy Testing	Same as applicable participating provider office visit member cost sharing	30% after deductible

PLAN DESIGN AND BENEFITS - CT Open Access QPOS (OA QPOS) Hp-12/10 (HSA Compatible)

PREVENTIVE CARE	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Routine Adult Physical Exams / Immunizations As recommended by physician	\$0 copay; deductible waived	Not Covered
Well Child Exams / Immunizations Ages birth-6 months: One exam every 2 months Ages 9-18 months: One exam every 3 months Ages 2-18 years: One exam per plan year Participating and Non-Participating combined	\$0 copay; deductible waived	30% after deductible
Routine Gynecological Exams One routine exam per plan year Participating and Non-Participating combined	\$0 copay; deductible waived	30% after deductible
Routine Mammograms One baseline mammogram for females age 35-39; and one annual mammogram for females age 40 and over Participating and Non-Participating combined	\$0 copay; deductible waived	30% after deductible
Routine Digital Rectal Exams / Prostate Specific Antigen Test One exam every 12 months for all males ages 50 and over and males under 50 who are symptomatic and/or whose biological father/brother has been diagnosed w/ prostate cancer Participating and Non-Participating combined	\$0 copay; deductible waived	30% after deductible
Routine (or Preventive) Colorectal Cancer Screening For all members age 50 and over. Sigmoidoscopy and Double Contrast Barium Enema (DCBE) - 1 every 5 years for all members age 50 and over Colonoscopy - 1 every 10 years for all members age 50 and over Fecal Occult Blood Testing (FOBT) - 1 every year for all members age 50 and over Participating and Non-Participating combined	\$0 copay; deductible waived	30% after deductible
Routine Eye Exams at Specialist One exam every 24 months Participating and Non-Participating combined	\$0 copay; deductible waived	Not Covered
Routine Hearing Screening at PCP	Covered as part of a routine physical exam	Covered as part of a routine physical exam

PLAN DESIGN AND BENEFITS - CT Open Access QPOS (OA QPOS) Hp-12/10 (HSA Compatible)

DIAGNOSTIC PROCEDURES	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Diagnostic Laboratory If performed as a part of a physician's office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing	0% after deductible	30% after deductible
Diagnostic X-ray except for Complex Imaging Services Outpatient hospital or other outpatient facility	0% after deductible	30% after deductible
Diagnostic X-ray for Complex Imaging Services Including, but not limited to, MRI, MRA, PET and CT Scans	0% after deductible	30% after deductible
EMERGENCY MEDICAL CARE	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Urgent Care Provider	0% after deductible	30% after deductible
Non-Urgent use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room	0% after deductible	Refer to participating provider benefit
Non-Emergency care in an Emergency Room	Not Covered	Not Covered
Emergency Ambulance	0% after deductible	Refer to participating provider benefit
Non-Emergency Ambulance	0% after deductible	30% after deductible
HOSPITAL CARE	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Inpatient Coverage Including maternity & transplants Coverage is provided at an IOE contracted facility only	0% after deductible	30% after deductible
Outpatient Surgery Provided in an outpatient hospital department	0% after deductible	30% after deductible
Outpatient Surgery Provided in a freestanding surgical facility	0% after deductible	30% after deductible
MENTAL HEALTH SERVICES	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Inpatient	0% after deductible	30% after deductible
Outpatient	0% after deductible	30% after deductible
ALCOHOL/DRUG ABUSE SERVICES	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Inpatient Detoxification	0% after deductible	30% after deductible
Outpatient Detoxification	0% after deductible	30% after deductible
Inpatient Rehabilitation	0% after deductible	30% after deductible
Outpatient Rehabilitation	0% after deductible	30% after deductible

PLAN DESIGN AND BENEFITS - CT Open Access QPOS (OA QPOS) Hp-12/10 (HSA Compatible)

OTHER SERVICES	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Skilled Nursing Facility Limited to 30 days per member per plan year Participating and Non-Participating combined	0% after deductible	30% after deductible
Home Health Care Limited to 80 visits per member per plan year; 1 visit equals a period of 4 hours or less Participating and Non-Participating combined	0% after deductible	25% after deductible
Inpatient Hospice Care	0% after deductible	30% after deductible
Outpatient Hospice Care	0% after deductible	30% after deductible
Private Duty Nursing	Not Covered	Not Covered
Outpatient Rehabilitation Therapy Includes speech, physical and occupational therapy Limited to 20 combined visits per plan year Participating and Non-Participating combined	0% after deductible	30% after deductible
Chiropractic Limited to 20 visits per member per plan year Participating and Non-Participating combined	0% after deductible	30% after deductible
Durable Medical Equipment	50% after deductible	50% after deductible
FAMILY PLANNING	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Infertility Treatment Coverage for only the diagnosis and surgical treatment of the underlying medical cause	Member cost sharing is based on the type of service performed and the place rendered	30% after deductible
Comprehensive Infertility Services For a covered person who is under age 40 and unable to conceive or produce conception, or sustain a successful pregnancy during a one year period. Coverage includes the following: • 3 courses of treatment for Artificial Insemination (AI) per lifetime • 4 courses of treatment of Ovulation Induction (OI) per lifetime	Member cost sharing is based on the type of service performed and the place rendered	30% after deductible
Advanced Reproductive Technology (ART) For a covered person who is under age 40 and unable to conceive or produce conception, or sustain a successful pregnancy during a one year period. Coverage includes the following: • 2 cycles with not more than 2 embryos per cycle of ART treatments (IVF, GIFT, ZIFT, low tubal ovum transfer) combined per lifetime	Member cost sharing is based on the type of service performed and the place rendered	30% after deductible

PLAN DESIGN AND BENEFITS - CT Open Access QPOS (OA QPOS) Hp-12/10 (HSA Compatible)

Voluntary Sterilization Including tubal ligation and vasectomy	Member cost sharing is based on the type of service performed and the place rendered	30% after deductible
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PLAN DESIGN AND BENEFITS - CT Open Access QPOS (OA QPOS) Hp-12/10 (HSA Compatible)

PHARMACY-PRESCRIPTION DRUG BENEFITS	PARTICIPATING PHARMACIES	NON-PARTICIPATING PHARMACIES
Prescription drug plan year deductible Must be satisfied before any prescription drug benefits are paid	Integrated with Medical Plan	Not Covered
Retail Up to a 30-day supply at participating pharmacies	After Integrated Medical/Pharmacy Deductible is met, \$10 copay for generic formulary drugs, \$25 copay for brand name formulary drugs, and \$40 for generic and brand name non-formulary drugs	Not Covered
Mail Order 31-90 day supply at participating pharmacies	After Integrated Medical/Pharmacy Deductible is met, \$20 copay for generic formulary drugs, \$50 copay for brand name formulary drugs, and \$80 for generic and brand name non-formulary drugs	Not Covered
Specialty CareRxSM Drugs	After Integrated Medical/Pharmacy Deductible is met, 20% for formulary and non-formulary drugs	Not Covered
Mandatory Generic (MG) - If the member or the physician requests brand when generic is available, the member pays the applicable copay or coinsurance plus the difference between the generic price and the brand price.		
Plan Includes: Contraceptive drugs and devices obtainable from pharmacy and diabetic supplies obtainable from a pharmacy.		
Precertification included and 90 day Transition of Care (TOC) for Precertification included.		

* You may choose providers in our network (physicians and facilities) or may visit an out-of-network provider. Typically, you will pay substantially more money out of your own pocket if you choose to use an out-of-network doctor or hospital. The out-of-network provider will be paid based on Aetna's "recognized charge." This is not the same as the billed charge from the doctor.

Aetna pays a percentage of the recognized charge, as defined in your plan. The recognized charge for out-of-network hospitals, doctors and other out-of-network health care providers is a percentage (100 percent or above) of the rate that Medicare pays them.

You may have to pay the difference between the out-of-network provider's billed charge and Aetna's recognized charge, plus any coinsurance and deductibles due under the plan. Note that any amount the doctor or hospital bills you above Aetna's recognized charge does not count toward your deductible or out-of-pocket maximums.

PLAN DESIGN AND BENEFITS - CT Open Access QPOS (OA QPOS) Hp-12/10 (HSA Compatible)

This benefit applies when you *choose* to get care out of network. When you have no choice in the doctors you see (for example, an emergency room visit after a car accident), your deductible and coinsurance for the in-network level of benefits will be applied, and you should contact Aetna if your doctor asks you to pay more. Generally, you are not responsible for any outstanding balance billed by your doctors in an emergency situation.

What's Not Covered

This plan does not cover all health care expenses and includes exclusions and limitations. Members should refer to their plan documents to determine which health care services are covered and to what extent. The following is a partial list of services and supplies that are *generally not covered*. **However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased.**

- All medical or hospital services not specifically covered in, or which are limited or excluded by your plan documents, including costs of services before coverage begins and after coverage terminates.
- Cosmetic surgery.
- Custodial care.
- Dental care and x-rays.
- Donor egg retrieval.
- Experimental and investigational procedures (except for coverage for medically necessary routine patient care costs for Members participating in a cancer clinical trial).
- Home births.
- Immunizations for travel or work.
- Implantable drugs and certain injectable drugs.
- Nonmedically necessary services or supplies.
- Orthotics.
- Over-the-counter medications and supplies.
- Radial keratotomy or related procedures.
- Reversal of sterilization.
- Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies, counseling and prescription drugs.
- Special duty nursing.
- Therapy or rehabilitation other than those listed as covered in the plan documents.
- Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercises or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of existence of comorbid conditions.

PLAN DESIGN AND BENEFITS - CT Open Access QPOS (OA QPOS) Hp-12/10 (HSA Compatible)

This material is for informational purposes only and is not an offer or invitation to contract. An application must be completed to obtain coverage. Plan features and availability may vary by location and group size. Not all health services are covered. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features are subject to change. With the exception of Aetna Rx Home Delivery, Providers are independent contractors and are not agents of Aetna. Provider participation may change without notice. Aetna does not provide care or guarantee access to health services. If you are in a plan that requires the selection of a primary care physician and your primary care physician is part of an integrated delivery system or physician group, your primary care physician will generally refer you to specialists and hospitals that are affiliated with the delivery system or physician group.

If your plan covers outpatient prescription drugs, your plan may include a drug formulary (preferred drug list). A formulary is a list of prescription drugs generally covered under your prescription drug benefits plan on a preferred basis subject to applicable limitations and conditions. Your pharmacy benefit is generally not limited to the drugs listed on the formulary. The medications listed on the formulary are subject to change in accordance with applicable state law. For information regarding how medications are reviewed and selected for the formulary, formulary information, and information about other pharmacy programs such as precertification and step-therapy, please refer to Aetna's website at Aetna.com, or the Aetna Medication Formulary Guide. Aetna receives rebates from drug manufacturers that may be taken into account in determining Aetna's Preferred Drug List. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions. In addition, in circumstances where your prescription plan utilizes copayments or coinsurance calculated on a percentage basis or a deductible, use of formulary drugs may not necessarily result in lower costs for the member. Members should consult with their treating physicians regarding questions about specific medications. Refer to your plan documents or contact Member Services for information regarding the terms and limitations of coverage.

Aetna Rx Home Delivery refers to Aetna Rx Home Delivery, LLC, a subsidiary of Aetna, Inc., that is a licensed pharmacy providing mail-order pharmacy services. Aetna's negotiated charge with Aetna Rx Home Delivery may be higher than Aetna Rx Home Delivery's cost of purchasing drugs and providing mail-order pharmacy services.

In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.

"Aetna" is the brand name used for products and services provided by one or more of the Aetna group subsidiary companies.

For more information about Aetna plans, refer to www.aetna.com.

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“BENEFIT SUMMARY” for:

ConnectiCare HMO

Effective Date: 10/2011



HMO-OA-30/45-2500HospDed-CNT Open Access Contract Year Plan Benefit Summary

This is a brief summary of benefits. Refer to your Membership Agreement or consult with your benefits manager for more information. The Membership Agreement will prevail for all benefits, conditions, limitations and exclusions. All benefits described below are per Member per **Contract year**. All benefit limits/maximums are listed in the Plan pays column of this summary. A Referral from your Primary Care Provider is not required.

	IN-NETWORK	
Benefit Deductible	\$2,500 per Member \$5,000 per Family <i>(This Benefit Deductible is combined for ambulatory services (outpatient) and inpatient services)</i>	
Lifetime Maximum Benefit	Unlimited	
PREVENTIVE SERVICES (Refer to the "Prevention and Wellness" section of this summary for a complete list of services)	MEMBER PAYS	PLAN PAYS
Adult Physical Exam (one exam per year when provided by a PCP)	No Member cost	100%
Infant / Pediatric Physical Exam (frequency limits apply and the exam must be provided by a PCP)	No Member cost	100%
Gynecological Preventive Exam (one exam per year)	No Member cost	100%
Preventive Laboratory Services (Complete blood count and Urinalysis, one test per year)	No Member cost	100%
Baseline Routine Mammography (ages 35 - 40)	\$45 Copayment per visit	100% after Copayment
Annual Routine Mammography (over age 40)	No Member cost	100%
Annual Routine Vision Exam (one exam per year when provided by an Optometrist or Ophthalmologist)	\$45 Copayment per visit	100% after Copayment
OUTPATIENT SERVICES		
Primary Care Provider Office Services (includes services for illness, injury, sickness, follow-up care and consultations)	\$30 Copayment per visit	100% after Copayment
Specialist Office Services (includes services for illness, injury, sickness, follow-up care and consultations)	\$45 Copayment per visit	100% after Copayment

OUTPATIENT SERVICES		
Gynecological Office Services	\$45 Copayment per visit	100% after Copayment
Maternity Care Office Services	\$45 Copayment (for initial visit only)	100% after initial Copayment
Allergy Testing	Applicable office visit Copayment up to the benefit maximum; then no coverage	100% after Copayment up to \$315 every two years
Laboratory Services (includes services performed in a Hospital or laboratory facility)	No Member cost	100%
Non-Advanced Radiology (includes services performed in a Hospital or radiology facility)	\$45 Copayment per visit	100% after Copayment
Advanced Radiology (includes services for MRI, PET and CAT scan, and nuclear cardiology performed in a Hospital or radiology facility)	\$75 Copayment per visit up to five Copayments per year	100% after Copayment
Outpatient Rehabilitative Therapy (includes services combined for physical, speech, and occupational therapy)	\$45 Copayment per visit up to the visit maximum; then no coverage	100% after Copayment up to 40 visits per year
Chiropractic Services	\$45 Copayment per visit up to the visit maximum; then no coverage	100% after Copayment up to 20 visits per year
Home Health Services	No Member cost up to the visit maximum; then no coverage	100% up to 100 visits per year
Retail Clinic	\$30 Copayment per visit	100% after Copayment
EMERGENCY / URGENT CARE		
Walk-In/Urgent Care Centers	\$75 Copayment per visit	100% after Copayment
Emergency Room (Copayment waived if admitted)	\$150 Copayment per visit	100% after Copayment
Ambulance Services	No Member cost	100%
HOSPITAL SERVICES		
Inpatient Hospital Services, Including Room & Board	No Member cost after Benefit Deductible	100% after Benefit Deductible
Ambulatory Services (Outpatient) (includes services performed in a Hospital or ambulatory facility)	No Member cost after Benefit Deductible	100% after Benefit Deductible
Skilled Nursing and Rehabilitation Facilities	No Member cost after Benefit Deductible up to the visit maximum; then no coverage	100% after Benefit Deductible up to 90 days
MENTAL HEALTH SERVICES		
Inpatient Mental Health Services (including inpatient acute, residential and partial hospitalization programs)	No Member cost after Benefit Deductible	100% after Benefit Deductible

MENTAL HEALTH SERVICES		
Inpatient Alcohol and Substance Abuse Treatment (including inpatient acute, residential and partial hospitalization programs)	No Member cost after Benefit Deductible	100% after Benefit Deductible
Outpatient Mental Health, Alcohol and Substance Abuse Treatment (including office visits, professional services provided in the home and intensive outpatient treatment programs)	\$45 Copayment per visit	100% after Copayment
OTHER SERVICES		
Disposable Medical Supplies and Durable Medical Equipment Including Prosthetics	50%	50%
Diabetic Equipment and Supplies	20%	80%
PREVENTION AND WELLNESS		
<p>In-Network Prevention and wellness services as defined by the United States Preventive Service Task Force (USPSTF), listed below, are exempt from cost shares (deductible, copayment and coinsurance) under the Patient Protection and Affordable Care Act (PPACA). These services are identified by the specific coding your Provider submits to ConnectiCare. Service coding must match ConnectiCare's coding list to be exempt from all cost sharing.</p> <ul style="list-style-type: none"> • Routine Physical Exam and appropriate screening and counseling, one per year • Preventive Care and Screening for infants, children and adolescents supported by the Health Resources and Services Administration • Preventive Care and screenings for women supported by the Health Resources and Services Administration • Bone Density Screenings, age 60 or older, one every 23 months • Screening for colorectal cancer using fecal occult blood testing, sigmoidoscopy, or colonoscopy; age 50 or older, one per year • Routine Mammography Screening, age 40 or older, one per year • Immunizations recommended by the Advisory Committee on Immunization Practices of the CDC • Outpatient Laboratory Services, one per year <ul style="list-style-type: none"> ◦ Cervical Cancer and Cervical Dysplasia Screening - Pap Smear ◦ Lipid Cholesterol Screening for adults and children at risk ◦ Fasting Plasma Glucose or Hemoglobin A1c, age 18 or older for people at risk for diabetes ◦ Hematocrit and Hemoglobin, for children up to age 21 ◦ Lead screening, for children up to age 6 ◦ Tuberculin testing, for children up to age 21 ◦ Chlamydia, Syphilis and Gonorrhea screening for females all ages ◦ Human immunodeficiency virus screening - HIV testing, no limit ◦ Screening for phenylketonuria (PKU) in newborns, under 3 months of age ◦ Screening for sickle cell disease in newborns, under 3 months of age • Routine Vision Screening, up to age 21, one per year when services are rendered by a Primary Care Provider • Routine hearing screening up to age 21 when rendered by a Primary Care Provider • Developmental, Autism, and Psychosocial/behavioral assessments when rendered by a Primary Care Provider • Dietary counseling for adults with hyperlipidemia or obesity • Tobacco Cessation interventions • Screening for Hepatitis B, Iron Deficient Anemia, Rh (D) Blood Typing and Asymptomatic Bacteriuria in women who are pregnant • Screening for Abdominal Aortic Aneurysm in men age 65 - 75 who have ever smoked • BRCA counseling and genetic screening for women at risk 		

Important Information

- If you have questions regarding your Plan, visit our website at www.connecticare.com or call us at (860) 674-5757 or 1-800-251-7722.
- For mental health, alcohol, and substance abuse services call 1-888-946-4658 to obtain Pre-Authorization.
- We track benefits internally and do not provide Members with a regular update of benefits that have been used. Members should keep a record of benefits they use to determine when they reached their benefit limit. Members will be responsible for paying in full any services rendered after the limit is reached.
- If you are a Massachusetts resident, please refer to your *Amendatory Rider for Massachusetts Mandated Benefits* for additional details of your benefits.

“SCHEDULE OF BENEFITS” from State Preferred Summary Booklet (2011) for:

State of Connecticut Employees

Anthem BlueCross BlueShield State Preferred PPO

Plan Year: July 1, 2011 through June 30, 2012

Plan Administration: Self-Insured

SCHEDULE OF BENEFITS

STATE PREFERRED

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

COVERED SERVICE	IN-NETWORK SERVICES	OUT-OF-NETWORK SERVICES
Covered Person Annual Deductible	Not Applicable	\$300 individual \$600 two person \$900 family
Covered Person Coinsurance	Not Applicable	20%
Covered Person Coinsurance Limit	Not Applicable	\$2000 individual \$4000 family
Covered Person Cost-Share Maximum	Not Applicable	\$2300 individual \$4900 family
Lifetime Maximum	Unlimited	Unlimited
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 Calendar Year 6 through 21 years of age	No Copay	Deductible & Coinsurance
Adult Physical Examinations: 1 exam per Calendar Year 22 years of age and older	\$5 Office Visit Copay	Deductible & Coinsurance
Routine Gynecological Visit 1 visit per Calendar Year including pap smear	\$5 Office Visit Copay	Deductible & Coinsurance
Mammography One baseline screening for female 35 through 39 years of age One screening mammogram every Calendar Year for female 40 and older Note: or more frequently if recommended by the woman's Physician (M.D.)	No Copay	Deductible & Coinsurance
Immunizations and Vaccinations Includes those needed for travel	No Copay	Deductible & Coinsurance

Vision Exams 1 vision exam and refraction every Calendar Year Note: Out-of-Network: 1 vision exam per Covered Person every 2 Calendar Years	\$15 Copay	Deductible & 50% Coinsurance
Hearing Exams 1 hearing exam every Calendar Year	\$15 Copay	Deductible & Coinsurance
HOSPITAL SERVICES		
All Inpatient Admissions	No Copay	Deductible & Coinsurance
Specialty Hospital In-Network: Unlimited Out-of-Network: 60 days per Covered Person per Calendar Year	Same as Hospital Inpatient Cost-Share	Deductible & Coinsurance
Outpatient Surgery (Including colonoscopy)Note: See Other Provisions section also, for Outpatient Surgery rendered in an ambulatory surgical center	No Copay	Deductible & Coinsurance
DIAGNOSTIC SERVICES		
Diagnostic, Laboratory and X-ray Services	No Copay	Deductible & Coinsurance
High Cost Diagnostic Tests MRI, MRA, CAT, CTA, PET and SPECT scans	No Cost-Share	Deductible & Coinsurance

Allergy Office Visit/Testing	\$15 Copay	Deductible & Coinsurance
Allergy Injections Immunotherapy or other therapy treatments	No Copay	Deductible & Coinsurance
MEDICAL EMERGENCY / URGENT CARE SERVICES		
Emergency Room Treatment	No Copay	Paid as an In-Network Service
Urgent Care Services	No Copay	Paid as an In-Network Service
Ambulance Land & Air: Paid according to the Department of Public Health Ambulance Service Rate Schedule	No Copay	Paid as an In-Network Service
PHYSICIAN MEDICAL / SURGICAL SERVICES		
Medical Office Visit	\$15 Copay	Deductible & Coinsurance
Surgical Services Performed by a Surgeon or Physician (Specialist) in any setting other than an Office Visit	No Copay	Deductible & Coinsurance
Non-Surgical Services of a Physician or Surgeon (Other than a medical office visit) These services may include after care <i>or</i> attending medical care	No Copay	Deductible & Coinsurance

MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES		
Outpatient Treatment for Mental Health Care and Substance Abuse Care Up to 20 pass through visits allowed per Covered Person per Calendar Year. Prior authorization is required before the 21 st visit each Calendar Year	\$15 Copay	Deductible & Coinsurance
Inpatient Hospital Services In a Hospital or Residential Treatment Center for Mental Health Care Per Admission	Same as Hospital Inpatient Cost-Share	Deductible & Coinsurance
Inpatient Rehabilitation Treatment for Substance Abuse Care In a Hospital or Substance Abuse Treatment Facility Per Admission	Same as Hospital Inpatient Cost-Share	Deductible & Coinsurance
OTHER MEDICAL SERVICES		
Outpatient Surgery In a licensed ambulatory surgical center (Not located in a Hospital setting) (Including colonoscopy) Note: See the Hospital Services section also for Outpatient Surgery rendered in a Hospital setting	No Copay	Deductible & Coinsurance
Skilled Nursing Facility In-Network: Unlimited Out-of-Network: 60 days per Covered Person Per Calendar Year	Same as Hospital Inpatient Cost-Share	Deductible & Coinsurance
Private Duty Nursing Unlimited	Not Applicable	Deductible & Coinsurance
Human Organ and Tissue Transplant Services Unlimited Lifetime Maximum	No Copay	Deductible & Coinsurance

<p>Home Health Care (Including In-Home Hospice Care)</p> <p>Nursing and therapeutic services limited to 200 visits</p> <p>Home health aide services limited to 80 visits that are applicable to the 200 visit limit</p> <p>In the Home Hospice Medical Social Services under the direction of a Physician up to \$420</p> <p>*After a \$50 Deductible has been met, the Covered Person shall pay the applicable Coinsurance, plus amounts above the Maximum Allowed Amount. The Deductible for Home Health Care benefits accrues towards the Covered Person's annual Deductible.</p>	<p>No Copay</p>	<p>Deductible* & 20% Coinsurance</p>
<p>Infusion Therapy Unlimited</p>	<p>No Copay</p>	<p>Deductible & Coinsurance</p>
<p>Durable Medical Equipment and Prosthetic Devices Unlimited</p> <p>Hearing Aid Coverage Available for dependent children age 12 years and under with a maximum of \$1,000 within a two year period</p> <p>Diabetic equipment and supplies</p>	<p>No Cost-Share</p>	<p>Deductible & Coinsurance</p>
<p>Ostomy Related Services</p>	<p>No Copay</p>	<p>Deductible & Coinsurance</p>
<p>Wig Up to \$350 maximum per Covered Person per Calendar Year</p> <p>Note: if prescribed by a licensed oncologist for a patient who suffers hair loss as a result of chemotherapy.</p>	<p>No Copay</p>	<p>No Cost-Share</p>
<p>Specialized Formula</p>	<p>No Copay</p>	<p>Deductible & Coinsurance</p>
<p>Hospice Care (inpatient) In-Network: Unlimited</p> <p>Out-of-Network: 60 days per Covered Person per Calendar Year</p>	<p>No Copay</p>	<p>Deductible & Coinsurance</p>

“SCHEDULE OF BENEFITS” from Summary Plan Description (2011) for:

State of Connecticut Employees

Oxford HMO-Gatekeeper

Plan Year: July 1, 2011 through June 30, 2012

Plan Administration: Self-Insured

SCHEDULE OF BENEFITS

SUMMARY	PARTICIPATING OPTION
TYPE OF SERVICE & BENEFIT MAXIMUMS	COVERED PERSON COST SHARE
Office Visit	\$10 per visit
Primary	\$10 per visit
Participating Provider	\$10 per visit
Prior Authorization	Primary Care Participating Physician Participating Provider
Lifetime Benefit Maximum	Unlimited
Human Organ & Transplant Lifetime Maximum	Unlimited
PREVENTIVE SERVICES	
Well Care Child	
6 exams from birth to 1 year of age 6 exams 1-5 years of age 1 exam every Calendar Year 6 through 21 years of age	No Cost-Share
Adult Physical Exam	
1 exam per calendar year	\$5 per visit
1 routine gynecological exam including pap smear	\$5 per visit
Mammography 1 baseline screening females ages 35-39 or more frequently if physician recommended	No Cost-Share
Immunizations and Vaccinations (including for travel)	No Cost-Share
1 routine vision exam per calendar year	\$15 per visit
1 routine hearing exam (as part of routine physical)	\$15 per visit
Walk In Center Services	\$10 per visit
MEDICAL SERVICES	
Primary Physician office visits (Including surgical procedures provided in office)	\$10 per visit
Specialist Office Visit (Including surgical procedures provided in office)	\$10 per visit
SURGICAL SERVICES	
Provided by surgeon in any non-office	No Cost-Share

setting	
Non-Surgical Services (Other than medical visits) These services may include after care or attending medical care	No Cost-Share
Home visits by physician	
Primary Care	\$10 per visit
Participating Physician	\$10 per visit
Diagnostic X-ray and Imaging	
In Radiologist office	No Cost-Share
Stand-alone outpatient	No Cost-Share
High Cost Diagnostics: MRI, MRA, CAT, CTA, PET, and SPECT scans	No Cost-Share
Radiation Therapy	No Cost-Share
Laboratory Services	No Cost-Share
Allergy Testing	
Primary Care	\$10 per visit
Participating Physician	\$10 per visit
Allergy Injection	No Cost-Share
Immunotherapy and other treatments	
Infertility Services	
Please see family/maternity section	
Office Visit	\$10 per visit
Outpatient hospital	Same as Outpatient Cost Share
Inpatient hospital	Same as Outpatient Cost Share
Maternity	\$5 Office Visit Copay Only on first visit
Nutritional I Counseling	
3 visits per member, calendar year	No Cost-Share
HOSPITAL SERVICES	
All Inpatient Admissions	No Cost-Share
Ancillary Services	No Cost-Share
Outpatient Services (Including Colonoscopy) See other provisions section for Outpatient	No Cost-Share

Services rendered in Ambulatory Surgical Center	
OTHER HEALTH CARE SERVICES	
Outpatient Surgery	No Cost-Share
Skilled Nursing Facility (Unlimited)	No Cost-Share
Private Duty Nursing (Unlimited)	No Cost-Share
Inpatient Rehabilitation	No Cost-Share
Home Health Care (Including hospice) Nursing and Therapeutic Services Limited to 200 Visits	No Cost-Share
Home Aid services limited to 80 that are applicable to the 200 visit limit	
In Home Hospice Medical Social Services under the direction of Physician up to \$420	No Cost-Share
Infusion Therapy (Unlimited)	No Cost-Share
OUTPATIENT REHABILITATION SERVICES:	
Physical, Occupational and Chiropractic Care (Unlimited)	No Cost-Share
Speech Therapy Covered only for treatment resulting from autism, stroke, tumor removal, injury or congenital anomalies of the or pharynx (Unlimited)	No Cost-Share
Autism Services: Behavioral Therapy	No Cost-Share
Outpatient Rehabilitation Physical, occupational, and speech therapy	No Cost-Share

All Autism Services are subject to the following maximums per covered person: Children up to age 9: \$50,000 per calendar year Ages 9-13: \$35,000 per calendar year Ages 13-15: \$25,000 per calendar year	
Cardiac Rehabilitation	No Cost-Share
Durable Medical Equipment	No Cost-Share
Hearing Aid Coverage for dependent children age 12 and under maximum of \$1,000 within two year period	No Cost-Share
Prosthetic Devices	No Cost-Share
Surgical Removal of any breast implant	
Wig Up to \$350 maximum per calendar year Note: if prescribed by a licensed oncologist for a patient who suffers hair loss as a result of chemotherapy	No Cost-Share
Hospice Care Unlimited Inpatient	No Cost-Share
Home Oxygen	No Cost-Share
Specialized Formula	No Cost-Share
MEDICAL EMERGENCY/URGENT CARE SERVICES	
Emergency Room Treatment	No Cost-Share
Ambulance Services Land & Air: Paid according to the Department of Public Health Ambulance Service Rate Schedule	No Cost-Share
Physician's Office Medical Emergency Visit:	\$10 per visit \$10 per visit

Primary Care Participating Physician	\$10 per visit
Urgent Care Facilities Visits	No Cost-Share
MENTAL HEALTH SUBSTANCE ABUSE SERVICES	
Outpatient Up to 20 pass through visits allowed per calendar year, Prior Authorization is required before the 21 st visit each calendar year	\$10 per visit
Inpatient	No Cost-Share

**“SECTION 5: BENEFITS” and “SUMMARY OF BENEFITS” from Benefit Plan
(2012) for:**

Federal Employee Health Benefit Plan

**Blue Cross Blue Shield Service Benefit PPO Plan
A Fee-for-Service Plan (Standard and Basic Option)**

Plan Effective Date: 2012

Section 5. Benefits

See pages 9-10 for how our benefits changed this year. Page 144 and page 145 are a benefits summary of each option. Make sure that you review the benefits that are available under the option in which you are enrolled.

Standard and Basic Option Overview	30
Section 5(a). Medical services and supplies provided by physicians and other health care professionals.....	31
Diagnostic and treatment services.....	32
Lab, X-ray and other diagnostic tests.....	33
Preventive care, adult.....	34
Preventive care, children.....	37
Maternity care	39
Family Planning	40
Infertility services	41
Allergy care.....	41
Treatment therapies.....	42
Physical therapy, occupational therapy, speech therapy, and cognitive therapy.....	43
Hearing services (testing, treatment, and supplies).....	44
Vision services (testing, treatment, and supplies).....	44
Foot care.....	45
Orthopedic and prosthetic devices	46
Durable medical equipment (DME).....	47
Medical supplies	48
Home health services	49
Chiropractic.....	49
Manipulative treatment	50
Alternative treatments	50
Educational classes and programs.....	51
Section 5(b). Surgical and anesthesia services provided by physicians and other health care professionals.....	52
Surgical procedures.....	53
Reconstructive surgery.....	55
Oral and maxillofacial surgery.....	56
Organ/tissue transplants	57
Anesthesia	65
Section 5(c). Services provided by a hospital or other facility, and ambulance services	66
Inpatient hospital.....	67
Outpatient hospital or ambulatory surgical center	69
Extended care benefits/Skilled nursing care facility benefits	73
Hospice care.....	73
Ambulance	76
Section 5(d). Emergency services/accidents	77
Accidental injury.....	78
Medical emergency	79
Ambulance	80
Section 5(e). Mental health and substance abuse benefits	81
Professional services	81
Inpatient hospital or other covered facility	82
Outpatient hospital or other covered facility.....	83
Not covered.....	83
Section 5(f). Prescription drug benefits	84

Covered medications and supplies.....	88
Section 5(g). Dental benefits.....	97
Accidental injury benefit.....	97
Dental benefits.....	101
Section 5(h). Special features.....	104
Flexible benefits option.....	104
Blue Health Connection.....	106
Blue Health Assessment.....	105
Diabetes Management Incentive Program.....	105
MyBlue Customer eService.....	108
National Provider Directory.....	108
Care Management Programs.....	108
Services for the deaf and hearing impaired.....	106
Web accessibility for the visually impaired.....	106
Travel benefit/services overseas.....	107
Healthy Families Programs.....	108
WalkingWorks® Wellness Program.....	108
Section 5(i). Services, drugs, and supplies provided overseas.....	108
Non-FEHB benefits available to Plan members.....	110
Summary of benefits for the Blue Cross and Blue Shield Service Benefit Plan Standard Option – 2012.....	145
Summary of benefits for the Blue Cross and Blue Shield Service Benefit Plan Basic Option – 2012.....	147

Standard and Basic Option Overview

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

The Standard and Basic Option Section 5 is divided into subsections. Please read *Important things you should keep in mind* at the beginning of the subsections. Also read the *General exclusions* in Section 6; they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about Standard and Basic Option benefits, contact us at the customer service telephone number on the back of your Service Benefit Plan ID card or at our Web site at www.fepblue.org.

Each option offers unique features.

- **Standard Option** When you have Standard Option, you can use both Preferred and Non-preferred providers. However, your out-of-pocket expenses are lower when you use Preferred providers and Preferred providers will submit claims to us on your behalf. Standard Option has a calendar year deductible for some services and a \$20 copayment for office visits to primary care providers (\$30 for specialists). Standard Option also features a Preferred retail pharmacy program, a Preferred mail service drug program, and a Preferred specialty drug pharmacy program.
- **Basic Option** Basic Option does not have a calendar year deductible. Most services are subject to copayments (\$25 for primary care providers and \$35 for specialists). Members do not need to have referrals to see specialists. You must use Preferred providers for your care to be eligible for benefits, except in certain circumstances, such as emergency care. Preferred providers will submit claims to us on your behalf. Basic Option also offers a Preferred retail pharmacy program and a Preferred specialty drug pharmacy program.

Summary of benefits for the Blue Cross and Blue Shield Service Benefit Plan Standard Option – 2012

Do not rely on this chart alone. All benefits are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.

If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.

Below, an asterisk (*) means the item is subject to the \$350 per person (\$700 per family) calendar year deductible. If you use a Non-PPO physician or other health care professional, you generally pay any difference between our allowance and the billed amount, in addition to any share of our allowance shown below.

Standard Option Benefits	You pay	Page
Medical services provided by physicians:		
<ul style="list-style-type: none"> • Diagnostic and treatment services provided in the office 	PPO: Nothing for preventive care; 15%* of our allowance; \$20 per office visit for primary care physicians and other health care professionals; \$30 per office visit for specialists Non-PPO: 35%* of our allowance	31-32
Services provided by a hospital:		
<ul style="list-style-type: none"> • Inpatient 	PPO: \$250 per admission Non-PPO: \$350 per admission, plus 35% of our allowance	69-71
<ul style="list-style-type: none"> • Outpatient 	PPO: 15%* of our allowance Non-PPO: 35%* of our allowance	72-75
Emergency benefits:		
<ul style="list-style-type: none"> • Accidental injury 	PPO: Nothing for outpatient hospital and physician services within 72 hours; regular benefits thereafter Non-PPO: Any difference between the Plan allowance and billed amount for outpatient hospital and physician services within 72 hours; regular benefits thereafter Ambulance transport services: Nothing	81-82
<ul style="list-style-type: none"> • Medical emergency 	PPO and Non-PPO: 15%* of our allowance for emergency room care; Regular benefits for physician and hospital care* provided in settings other than the emergency room Ambulance transport services: \$100 per day for ground ambulance (no deductible); \$150 per day for air or sea ambulance (no deductible)	81, 83-84
Mental health and substance abuse treatment	PPO: Regular cost-sharing, such as \$20 office visit copay; \$250 per inpatient admission Non-PPO: Regular cost-sharing, such as 35%* of our allowance for office visits; \$350 per inpatient admission, plus 35% of our allowance	85-87
Prescription drugs	Retail Pharmacy Program:	88-99

	<ul style="list-style-type: none"> • PPO: 20% of our allowance generic (15% if you have Medicare)/30% of our allowance preferred brand-name/45% of our allowance non-preferred brand-name/30% of our allowance specialty; up to a 90-day supply • Non-PPO: 45% of our allowance (AWP); up to a 90-day supply <p>Mail Service Prescription Drug Program:</p> <ul style="list-style-type: none"> • \$15 generic (\$10 if you have Medicare)/\$70 preferred brand-name/\$95 non-preferred brand-name per prescription; up to a 90-day supply <p>Specialty Drug Pharmacy Program:</p> <p>\$80 per prescription; up to a 90-day supply</p>	
Dental care	Scheduled allowances for diagnostic and preventive services, fillings, and extractions; regular benefits for dental services required due to accidental injury and covered oral and maxillofacial surgery	57, 100-104
Special features:	Special features: Flexible benefits option; Blue Health Connection; Blue Health Assessment; Diabetes Management Incentive Program; MyBlue Customer eService; national provider directory; care management programs; travel benefit/ services overseas; Healthy Families Programs; and <i>Walking Works®</i> Wellness Program	106-108
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum)	Nothing after \$5,000 (PPO) or \$7,000 (PPO/Non-PPO) per contract per year; some costs do not count toward this protection	23-24

Summary of benefits for the Blue Cross and Blue Shield Service Benefit Plan Basic Option – 2012

Do not rely on this chart alone. All benefits are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.

If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.

Basic Option does not provide benefits when you use Non-preferred providers. For a list of the exceptions to this requirement, see page 14. There is no deductible for Basic Option.

Basic Option Benefits	You pay	Page
Medical services provided by physicians:		
<ul style="list-style-type: none"> • Diagnostic and treatment services provided in the office 	PPO: Nothing for preventive care; \$25 per office visit for primary care physicians and other health care professionals; \$35 per office visit for specialists Non-PPO: You pay all charges	31-21
Services provided by a hospital:		
<ul style="list-style-type: none"> • Inpatient 	PPO: \$150 per day up to \$750 per admission Non-PPO: You pay all charges	69-71
<ul style="list-style-type: none"> • Outpatient 	PPO: \$75 per day per facility Non-PPO: You pay all charges	72-75
Emergency benefits:		
<ul style="list-style-type: none"> • Accidental injury 	PPO: \$125 copayment for emergency room care; \$50 copayment for urgent care Non-PPO: \$125 copayment for emergency room care Ambulance transport services: \$100 per day for ground ambulance; \$150 per day for air or sea ambulance	81-82
<ul style="list-style-type: none"> • Medical emergency 	Same as for accidental injury	81, 83-84
Mental health and substance abuse treatment		
	PPO: Regular cost-sharing, such as \$25 office visit copayment; \$150 per day up to \$750 per inpatient admission Non-PPO: You pay all charges	85-87
Prescription drugs:		
	Retail Pharmacy Program: <ul style="list-style-type: none"> • PPO: \$10 generic/\$40 preferred brand-name per prescription/50% coinsurance (\$50 minimum) for non-preferred brand-name drugs/ \$50 specialty. 34-day maximum supply on initial prescription; up to 90 days for refills with 3 copayments • Non-PPO: You pay all charges 	88-99

	Specialty Drug Pharmacy Program: \$40 per prescription. 34-day maximum supply on initial prescription; up to 90 days for refills with 3 copayments	
Dental care	PPO: \$25 copayment per evaluation (exam, cleaning, and X-rays); most services limited to 2 per year; sealants for children up to age 16; \$25 copayment for dental services required due to accidental injury; regular benefits for covered oral and maxillofacial surgery Non-PPO: You pay all charges	57, 100-101, 105
Special features:	Special features: Flexible benefits option; Blue Health Connection; Blue Health Assessment; Diabetes Management Incentive Program; MyBlue Customer eService; national provider directory; care management programs; travel benefit/services overseas; Healthy Families Programs; and <i>WalkingWorks</i> ® Wellness Program	106-108
Protection against catastrophic costs (out-of-pocket maximum):	Nothing after \$5,000 (PPO) per contract per year; some costs do not count toward this protection	23-24

“SECTION 3: HOW YOU GET CARE” and “SUMMARY OF BENEFITS” from Benefit Plan (2012) for:

Government Employee Health Association, Inc. PPO Plan (High and Standard Option)

Plan Effective Date: 2012

Section 3. How you get care

Identification cards

We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider, or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation (for annuitants), or your electronic enrollment system (such as Employee Express) confirmation letter.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at (800) 821-6136 or write to us at GEHA, P. O. Box 4665, Independence, MO 64051-4665. You may also request replacement cards through our Web site: www.geha.com.

Where you get covered care

You can get care from any “covered provider” or “covered facility”. How much we pay – and you pay – depends on the type of covered provider or facility you use and who bills for the covered services. If you use our preferred providers, you will pay less.

• Covered providers

We consider the following to be covered providers when they perform services within the scope of their license or certification:

A licensed doctor of medicine (M.D.) or a licensed doctor of osteopathy (D.O.). Other covered providers include a chiropractor, nurse midwife, nurse anesthetist, audiologist, dentist, optometrist, licensed clinical social worker, licensed clinical psychologist, licensed professional counselor, licensed marriage and family therapist, podiatrist, speech, physical and occupational therapist, nurse practitioner/clinical specialist, nursing school administered clinic, physician assistant, registered nurse first assistants, certified surgical assistants, Christian Science practitioner and a dietician with state licensure or statutory certification.

The term “doctor” includes all of these providers when the services are performed within the scope of their license or certification. The term “primary care physician” includes family or general practitioners, pediatricians, obstetricians/gynecologists and medical internists, and mental health/substance abuse providers.

Medically underserved areas. Note: We cover any licensed medical practitioner for any covered service performed within the scope of that license in the states OPM determines are “medically underserved”. For 2012, the states are: Alabama, Alaska, Arizona, Idaho, Illinois, Kentucky, Louisiana, Mississippi, Missouri, Montana, New Mexico, North Dakota, Oklahoma, South Dakota, and Wyoming.

• Covered facilities

Covered facilities include:

- Freestanding ambulatory facility
 - (1) A facility which is licensed by the state as an ambulatory surgery center or has Medicare certification as an ambulatory surgical center, has permanent facilities and equipment for the primary purpose of performing surgical and/or renal dialysis procedures on an outpatient basis; provides treatment by or under the supervision of doctors and nursing services whenever the patient is in the facility; does not provide inpatient accommodations; and is not, other than incidentally, a facility used as an office or clinic for the private practice of a doctor or other professional.
 - (2) Ambulatory Surgical Facilities in the state of California do not require a license if they are physician owned. To be covered these facilities must be accredited by one of the following: AAAHC (Accreditation Association for Ambulatory Health Care), AAAASF (American Association for Accreditation for Ambulatory Surgery Facilities), IMQ (Institute for Medical Quality) or JCAHO (Joint Commission on Accreditation of Healthcare Organizations).
- Christian Science nursing organization/facilities that are accredited by The Commission for Accreditation of Christian Science Nursing Organization/Facilities Inc.

- Hospice
 - A facility which meets all of the following:
 - (1) Primarily provides inpatient hospice care to terminally ill persons;
 - (2) Is certified by Medicare as such, or is licensed or accredited as such by the jurisdiction it is in;
 - (3) Is supervised by a staff of M.D.'s or D.O.'s, at least one of whom must be on call at all times;
 - (4) Provides 24 hour a day nursing services under the direction of an R.N. and has a full-time administrator; and
 - (5) Provides an ongoing quality assurance program.
- Skilled Nursing Facility licensed by the state or Medicare certified if the state does not license these facilities. See limitations on page 52.
- Hospital
 - (1) An institution which is accredited as a hospital under the Hospital Accreditation Program of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO); or
 - (2) A medical institution which is operated pursuant to law, under the supervision of a staff of doctors, and with 24 hour a day nursing service, and which is primarily engaged in providing general inpatient acute care and treatment of sick and injured persons through medical, diagnostic, and major surgical facilities, all of which facilities must be provided on its premises or have such arrangements by contract or agreement; or
 - (3) An institution which is operated pursuant to law, under the supervision of a staff of doctors and with 24 hour a day nursing service and which provides services on the premises for the diagnosis, treatment, and care of persons with mental/substance abuse disorders and has for each patient a written treatment plan which must include diagnostic assessment of the patient and a description of the treatment to be rendered and provides for follow-up assessments by or under the direction of the supervising doctor.

The term hospital does not include a convalescent home or skilled nursing facility, or any institution or part thereof which: a) is used principally as a convalescent facility, nursing facility, or facility for the aged; b) furnishes primarily domiciliary or custodial care, including training in the routines of daily living; or c) is operating as a school.

- **Transitional care**

Specialty care: If you have a chronic or disabling condition and

- lose access to your specialist because we drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB plan, or
- lose access to your PPO specialist because we terminate our contract with your specialist for reasons other than for cause,

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

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

- **If you are hospitalized when your enrollment begins**

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at (800) 821-6136. If you are new to the FEHB Program, we will reimburse you for your covered services while you are in the hospital beginning on the effective date of your coverage.

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

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

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

You need prior Plan approval for certain services

• Inpatient hospital admission (including Skilled Nursing Facility, Long Term Acute Care or Rehabilitation Facility)

The pre-service claim approval processes for inpatient hospital admissions (called precertification) and for other services, are detailed in this Section. A **pre-service claim** is any claim, in whole or in part, that requires approval from us in advance of obtaining medical care or services. In other words, a pre-service claim for benefits (1) requires precertification, prior approval or a referral and (2) will result in a reduction of benefits if you do not obtain precertification, prior approval or a referral.

Precertification is the process by which – prior to your inpatient hospital admission – we evaluate the medical necessity of your proposed stay and the number of days required to treat your condition. Unless we are misled by the information given to us, we won't change our decision on medical necessity.

In most cases, your physician or hospital will take care of requesting precertification. Because you are still responsible for ensuring that your care is precertified, you should always ask your physician or hospital whether they have contacted us.

Warning:

We will reduce our benefits for the inpatient hospital stay, Long Term Acute Care stay or Rehabilitation Facility stay by \$500 if no one contacts us for precertification. If the stay is not medically necessary, we will only pay for any covered medical services and supplies that are otherwise payable on an outpatient basis.

We will reduce our benefits for the Skilled Nursing Facility stay if no one contacts us for precertification. If the stay is not medically necessary we will not pay any benefits.

Exceptions:

You do not need precertification in these cases:

- You are admitted to a hospital outside the United States
- You have another group health insurance policy that is the primary payor for the hospital stay
- Medicare Part A is the primary payor for the hospital stay

Note: If you exhaust your Medicare hospital benefits and do not want to use your Medicare lifetime reserve days, then we will become the primary payor and you **do** need precertification.

How to precertify an admission to a hospital, Skilled Nursing Facility, Long Term Acute Care or Rehabilitation Facility

First, you, your representative, your physician or your hospital must call InforMed (Medical Management Service – IMMS) before admission or services requiring prior authorization are rendered. The toll-free number is (800) 242-1025. For admissions to Skilled Nursing Facilities, Long Term Acute Care Facilities, or Rehabilitation Facilities please call OrthoNet to precertify at (877) 304-4419. For all admissions except mental health/substance abuse in the state of Georgia, call Coventry Health Care of Georgia. The toll-free number is (800) 470-2004. For all admissions except mental health/substance abuse in the states of North Carolina and South Carolina, call WellPath. The toll-free number is (800) 708-9355. For all admissions except mental health/substance abuse in the state of Pennsylvania, call HealthAmerica Pennsylvania. The toll-free number is (800) 755-1135. (For mental health/substance abuse precertification, call InforMed toll-free at (800) 242-1025.) See Section 5(e) *Mental health and substance abuse benefits*.

Next, provide the following information:

- enrollee's name and plan identification number;
- patient's name, birth date, and phone number;
- reason for hospitalization, proposed treatment, or surgery;
- name and phone number of admitting doctor;
- name of hospital or facility; and
- number of planned days of confinement.

We will then tell the doctor and/or hospital the number of approved inpatient days and we will send written confirmation of our decision to you, your doctor, and the hospital.

• **Non-urgent care claims**

For non-urgent care claims, we will tell the physician and/or hospital the number of approved inpatient days, or the care that we approve for other services that must have prior authorization. We will make our decision within 15 days of receipt of the pre-service claim.

If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you of the need for an extension of time before the end of the original 15 day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

• **Urgent care claims**

If you have an **urgent care claim** (i.e., when waiting for the regular time limit for your medical care or treatment could seriously jeopardize your life, health, or ability to regain maximum function, or in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without this care or treatment), we will expedite our review and notify you of our decision within 72 hours. If you request that we review your claim as an urgent care claim, we will review the documentation you provide and decide whether it is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

If you fail to provide sufficient information, we will contact you within 24 hours after we receive the claim to provide notice of the specific information we need to complete our review of the claim. We will allow you up to 48 hours from the receipt of this notice to provide the necessary information. We will make our decision on the claim within 48 hours of (1) the time we received the additional information or (2) the end of the time frame, whichever is earlier.

We may provide our decision orally within these time frames, but we will follow up with written or electronic notification within three days of oral notification.

• **Emergency inpatient admission**

If you have an emergency admission due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you, your representative, the physician, or the hospital must telephone us within two business days following the day of the emergency admission, even if you have been discharged from the hospital. If you do not telephone the Plan within two business days, penalties may apply - see *Warning* under *Inpatient hospital admission* earlier in this Section and *If your hospital stay needs to be extended* below.

• **Maternity care**

You do not need precertification of a maternity admission for a routine delivery. However, if your medical condition requires you to stay more than 48 hours after a vaginal delivery or 96 hours after a cesarean section, then your physician or the hospital must contact us for precertification of additional days. Further, if your baby stays after you are discharged, then your physician or the hospital must contact us for precertification of additional days for your baby.

NICU cases

Confinements of infants in the neonatal care unit at any level must be reported to GEHA. GEHA in collaboration with Alere, will review NICU cases, and assign a level of care based on the infant's acuity and consistent with TIOP (March of Dimes report Toward Improving the Outcome of Pregnancy), the 2004 AAP (American Academy of Pediatrics) statement regarding hospital levels of care and NUBC (National Uniform Billing Committee). The facility is notified of the assigned level of care at the time the case is first reviewed and when a change occurs. If the facility bills for a higher level of care than is approved, you will be responsible for the difference between the higher level of care charge and the lower approved level of care charge.

• If your hospital stay needs to be extended

If your hospital stay - including for maternity care - needs to be extended, you, your representative, your doctor or the hospital must ask us to approve the additional days. If you remain in the hospital beyond the number of days we approved and did not get the additional days precertified, then

- For the part of the admission that was medically necessary, we will pay inpatient benefits, but,
- For the part of the admission that was not medically necessary, we will pay only medical services and supplies otherwise payable on an outpatient basis and will not pay inpatient benefits.

• Other services

Some surgeries and procedures require a referral, precertification, or prior authorization. You need to call us at (800) 821-6136 before receiving treatment for care such as:

- ACI (Autologous Cultured Chondrocytes), also called Genzyme tissue repair (or Carticel) for knee cartilage damage
- Abdominoplasty/ diastasis recti repair/ panniculectomy
- Botox injections
- Breast reconstruction except immediate reconstruction for diagnosis of cancer
- Certain prescription drugs
- Chronic dialysis provided at a dialysis unit, outpatient hospital facility or in the home
- Coma stimulation
- Cosmetic procedures including: blepharoplasty or any other type of eyelid surgery, browlift, liposuction, and scar revision
- Epidural injections
- Experimental/ investigation surgery or treatment
- FACET injections
- Genetic testing
- Growth hormone therapy (GHT)
- Gynecomastia-cosmetic (see mammoplasty)
- Injectable drugs for arthritis, psoriasis or hepatitis
- Injectable hematopoietic drugs (drugs for anemia, low white blood count)
- Inpatient hospital mental health and substance abuse benefits, inpatient care at residential treatment centers and outpatient intensive day treatment
- Intrathecal pump insertion for pain management (morphine pump, baclofen pump)
- Left ventricular assistive device (LVAD)
- Mammoplasty, reduction (unilateral/ bilateral)
- Mastectomy performed prophylactically
- Morbid obesity surgeries

- Multilevel artificial disc replacement
- Multilevel spinal surgeries
- Non-Surgical outpatient cancer treatment, including chemotherapy and radiation
- Organ and tissue transplant procedures
- Orthognathic surgery (jaw), including TMJ
- Physical, occupational and speech therapy
- Psychological testing
- Rhinoplasty-no prior approval for septoplasty
- Spinal fusion
- Surgical correction of congenital anomalies
- Surgical treatment of hyperhidrosis (benefits will not be approved unless alternative therapies such as botox injections or topical aluminum chloride and pharmacotherapy have been unsuccessful)
- Sympathectomy by thoracoscopy or laproscopy
- Transplants, except kidney or cornea
- UPPP Uvulopalatopharyngoplasty
- Other surgeries, as identified by the Plan

• **Radiology/Imaging procedures precertification**

Radiology precertification is the process by which prior to scheduling specific imaging procedures we evaluate the medical necessity of your proposed procedure to ensure the appropriate procedure is being requested for your condition. In most cases your physician will take care of precertification. Because you are still responsible for ensuring that we are asked to precertify your procedure, you should ask your doctor to contact us.

The following outpatient radiology services need to be precertified:

- CT - Computerized Axial Tomography
- MRI - Magnetic Resonance Imaging
- MRA - Magnetic Resonance Angiography
- NC - Nuclear Cardiac Imaging Studies
- PET - Positron Emission Tomography

How to precertify a radiology/imaging procedure:

For outpatient CT, MRI, MRA, NC and PET studies, you, your representative or your doctor must call MedSolutions before scheduling the procedure. The toll free number is (866) 879-8317. For the state of Georgia, call Coventry Health Care of Georgia. The toll-free number is (800) 470-2004. For the states of North Carolina and South Carolina, call WellPath. The toll-free number is (800) 708-9355. For the state of Pennsylvania, call Health America Pennsylvania. The toll-free number is (800) 755-1135. Provide the following information: patient's name, plan identification number, and birth date, requested procedure and clinical support for request, name and telephone number of ordering provider, and name of requested imaging facility.

Exceptions:

You do not need precertification in these cases:

- You have another health insurance policy that is the primary payor including Medicare Part A & B or Part B only
- The procedure is performed outside the United States
- You are an inpatient in a hospital
- The procedure is performed as an emergency

Warning:

We will reduce our benefits for these procedures by \$100 if no one contacts us for precertification. If the procedure is not medically necessary, we will not pay any benefits.

• If your treatment needs to be extended

If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, then we will make a decision within 24 hours after we receive the claim.

If you disagree with our pre-service claims decision

If you have a **pre-service claim** and you do not agree with our decision regarding precertification of an inpatient admission or prior approval of other services, you may request a review in accord with the procedures detailed below.

If you have already received the service, supply, or treatment, then you have a **post-service claim** and must follow the entire disputed claims process detailed in Section 8.

• To reconsider a non-urgent care claim

Within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

In the case of a pre-service claim and subject to a request for additional information, we have 30 days from the date we receive your written request for reconsideration to

1. Precertify your hospital stay, or, if applicable, arrange for the health care provider to give you the care or grant your request for prior approval for a service, drug, or supply; or
2. Ask you or your provider for more information.

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

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

3. Write to you and maintain our denial.

• To reconsider a urgent care claim

In the case of an appeal of a pre-service urgent care claim, within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

Subject to a request for additional information, we will notify you of our decision within 72 hours after receipt of your reconsideration request. We will hasten the review process, which allows oral or written requests for appeals and the exchange of information by telephone, electronic mail, facsimile, or other expeditious methods.

• To file an appeal with OPM

After we reconsider your **pre-service claim**, if you do not agree with our decision, you may ask OPM to review it by following Step 3 of the disputed claims process detailed in Section 8 of this brochure.

Summary of benefits for the High Option of the Government Employees Health Association, Inc. 2012

Do not rely on this chart alone. All benefits are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.

If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.

Below, an asterisk (*) means the item is subject to the \$350 calendar year deductible. And, after we pay, you generally pay any difference between our allowance and the billed amount if you use a Non-PPO physician or other health care professional.

High Option Benefits	You pay	Page
Medical services provided by physicians:		
<ul style="list-style-type: none"> Diagnostic and treatment services provided in the office 	PPO: \$20 copay per covered office visit and 10%* of other covered professional services including X-ray and lab Non-PPO: 25%* of covered professional services	25-48
Services provided by a hospital:		
<ul style="list-style-type: none"> Inpatient 	PPO: Nothing for room and board, 10% of other hospital charges, inpatient \$100 per admission deductible applies Non PPO: Nothing for room and board, 25% of other hospital charges, inpatient \$300 per admission deductible applies	49-51
<ul style="list-style-type: none"> Outpatient 	PPO: 10%* of other hospital charges Non PPO: 25%* of other hospital charges	51-52
Emergency benefits:		
<ul style="list-style-type: none"> Accidental injury 	Nothing up to Plan allowance of covered charges incurred within 72 hours of an accident.	55
<ul style="list-style-type: none"> Medical emergency 	Regular benefits*	56
Mental health and substance abuse treatment:	Regular cost-sharing*	57-59
Prescription drugs:		
<ul style="list-style-type: none"> Retail pharmacy 	Network pharmacy: Member pays lesser of \$5 or pharmacy's usual and customary cost for generic drugs/25% single-source brand name drugs for up to a maximum of \$150 for up to a 30-day supply/\$5 plus the difference in the cost of the generic drug and the brand name drug for multi-source brand name for up to a 30-day supply for the initial fill and first refill. For subsequent refills, you pay the greater of 50% or the amount described above.	64-65 & 67-68

Retail pharmacy - continued on next page

**Summary of benefits for the High Option of the
Government Employees Health Association, Inc. 2012 (continued)**

High Option Benefits	You pay	Page
<ul style="list-style-type: none"> Retail pharmacy - <i>continued</i> 	<p>Non-network pharmacy: Member pays lesser of \$5 or pharmacy's usual and customary cost for generic drugs/25% single-source brand name drugs for up to a maximum of \$150 for up to a 30-day supply/\$5 plus the difference in the cost of the generic drug and the brand name drug for multi-source brand name drugs for up to a 30-day supply for the initial fill and first refill. For subsequent refills you pay the greater of 50% or the amount described above and any difference between our allowance and the cost of the drug.</p> <p>Copayments and coinsurance go toward a \$4,000 annual prescription out-of-pocket except for the difference between the cost of the generic and brand multi-source drugs and the 50% coinsurance after the first two fills and the 70% coinsurance for non-preferred sleep aid drugs.</p>	64-65 & 67-68
<ul style="list-style-type: none"> Mail Order 	<p>Member pays lesser of \$15 or the cost of the drug for generic drugs/25% single-source brand name drugs for up to a maximum of \$350 for up to a 90-day supply/\$15 plus the difference in the cost of the generic drug and the brand name drug for multi-source brand name for up to a 90-day supply.</p> <p>Copayments and coinsurance go toward a \$4,000 annual prescription out-of-pocket except for the difference between the cost of the generic and brand multi-source drugs and the 70% coinsurance for non-preferred sleep aid drugs.</p>	66, 69
Dental care:	Charges in excess of the scheduled amounts for diagnostic and preventive service, restorations, and extractions	70
Special features:	Flexible benefits options, online customer and claims services, Services for deaf and hearing impaired, High risk pregnancies, Lab Card Program, Health Advice Line, Health Assessment and Personal Health Record.	71-72
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum):	<p>Nothing after \$4,000 per year for PPO providers</p> <p>Nothing after \$6,000 per year for Non-PPO providers</p> <p>Some costs do not count toward this protection.</p>	18-19

Summary of benefits for the Standard Option of the Government Employees Health Association, Inc. 2012

Do not rely on this chart alone. All benefits are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.

If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.

Below, an asterisk (*) means the item is subject to the \$350 calendar year deductible. And, after we pay, you generally pay any difference between our allowance and the billed amount if you use a Non-PPO physician or other health care professional.

Standard Option Benefits	You pay	Page
Medical services provided by physicians:		
<ul style="list-style-type: none"> Diagnostic and treatment services provided in the office 	PPO: \$10 copay primary care physician; \$25 copay specialist for covered office visits and 15%* of other covered professional services including X-ray and lab Non-PPO: 35%* of covered professional services	25-48
Services provided by a hospital:		
<ul style="list-style-type: none"> Inpatient 	PPO: 15%* of covered hospital charges Non PPO: 35%* of covered hospital charges	49-51
<ul style="list-style-type: none"> Outpatient 	PPO: 15%* of covered hospital charges Non PPO: 35%* of covered hospital charges	51-52
Emergency benefits:		
<ul style="list-style-type: none"> Accidental injury 	Nothing up to Plan allowance of covered charges incurred within 72 hours of an accident.	55
<ul style="list-style-type: none"> Medical emergency 	Regular benefits*	56
Mental health and substance abuse treatment:		
	Regular cost-sharing*	57-59
Prescription drugs:		
<ul style="list-style-type: none"> Retail pharmacy 	Network pharmacy: Member pays lesser of \$5 or pharmacy's usual and customary cost for generic drugs/50% brand name for up to a maximum of \$200 for up to a 30-day supply. Non-network pharmacy: Member pays lesser of \$5 or pharmacy's usual and customary cost for generic drugs/50% brand name for up to a maximum of \$200 for up to a 30-day supply and any difference between our allowance and the cost of the drug. Copayments and coinsurance for prescription drugs go toward a \$6,000 annual prescription out-of-pocket limit (for Self Only or Self and Family enrollment) except for the 70% coinsurance for non-preferred sleep aid drugs.	64-65 & 67-68

**Summary of benefits for the Standard Option of the
Government Employees Health Association, Inc. 2012 (continued)**

Standard Option Benefits	You pay	Page
<ul style="list-style-type: none"> • Mail Order 	<p>Member pays lesser of \$15 or the cost of the drug for generic drugs/50% brand name for up to a maximum of \$500 for up to a 90-day supply.</p> <p>Copayments and coinsurance for prescription drugs go toward a \$6,000 annual prescription out-of-pocket limit (for Self Only or Self and Family enrollment) except for the 70% coinsurance for non-preferred sleep aid drugs.</p>	66, 69
Dental care:	50% up to Plan allowance for diagnostic and preventive services and charges in excess of the scheduled amounts for restorations and extractions.	70
Special features:	Flexible benefits options, online customer and claims services, Services for deaf and hearing impaired, High risk pregnancies, Lab Card Program, Health Advice Line, Health Assessment and Personal Health Record.	71-72
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum):	<p>Nothing after \$5,000 per year for PPO providers</p> <p>Nothing after \$7,000 per year for Non-PPO providers</p> <p>Some costs do not count toward this protection.</p>	18-19