Updates to the UniCare State Indemnity Plan/Basic Member Handbook

This Benefit Updates and Important Information booklet ("Benefit Update") contains important updates to your UniCare State Indemnity Plan/Basic coverage effective July 1, 2010. Please keep this Benefit Update—together with the Series 1 Member Handbook and the July 2009 and February 2010 Benefit Updates—in a convenient place for easy access when you need to check your health plan information.

This Benefit Update is also available on the Plan’s website: visit www.unicarestateplan.com > “Quick Links” > “Member Handbooks.” The updates in this Benefit Update will also be incorporated into the next printed version of your Member Handbook.

If you have any questions about these changes, please call UniCare Customer Service at (800) 442-9300, Monday through Thursday from 7:30 a.m. to 6:00 p.m. and Friday from 7:30 a.m. to 5:00 p.m. You can also e-mail us from our website: www.unicarestateplan.com (click on “Contact Us”). If you are deaf or hard of hearing and have a TDD machine, contact us on our TDD lines at (800) 322-9161 or (978) 474-5163. A UniCare customer service representative will be happy to help you.

CVS Caremark: New Pharmacy Benefit Manager

Beginning July 1, 2010, the Group Insurance Commission (GIC) has selected CVS Caremark as the new pharmacy benefit manager for UniCare State Indemnity Plan members. See pages 22-30 of this Benefit Update for information about your prescription drug benefits and changes, including the contact information for CVS Caremark.

The following changes are made to your Member Handbook to reflect this change:

A. The text, “Important Telephone Numbers” in the Table of Contents of your Member Handbook is deleted and replaced with the following:

**Important Telephone Numbers (toll free)**

**Medical Benefits**
UniCare State Indemnity Plan
(800) 442-9300
TDD: (800) 322-9161

**Pharmacy Benefits**
CVS Caremark
(877) 876-7214
TDD: (800) 238-0756

**Mental Health and Substance Abuse Benefits**
United Behavioral Health
(888) 610-9039
TDD: (800) 842-9489
B. The subsection, “Important Contact Information” in the “Important Plan Information” section on page 5 of your Member Handbook is deleted and replaced with the following:

**Important Contact Information**

If you have questions, please contact the following:

*For information about your medical benefits:*

**UniCare State Indemnity Plan/Basic**
P.O. Box 9016
Andover, MA 01810-0916
(800) 442-9300
TDD: (800) 322-9161
www.unicarestateplan.com

*For information about your prescription drug plan:*

**CVS Caremark**
(877) 876-7214 (toll free)
TDD: (800) 238-0756
www.caremark.com

*For information about your mental health and substance abuse benefits and Employee Assistance Program:*

**United Behavioral Health**
(888) 610-9039 (toll free)
TDD: (800) 842-9489
www.liveandworkwell.com
(access code: 10910)

C. All other references to “Express Scripts” in your Member Handbook, and in your July 2009 and February 2010 Benefit Updates, are now replaced with “CVS Caremark.”

**Calendar Year Deductible Carryover**

Any deductible amounts incurred for services rendered during the last three (3) months of a calendar year will apply toward the deductible requirement for the next year, provided that the member had continuous coverage under the Plan through the GIC at the time the charges in the prior year were incurred.

To reflect this change, the subsection, “Individual Calendar Year Deductible” on page 3 of your February 2010 Benefit Update has been deleted and replaced with the following:

**Individual Calendar Year Deductible**

The individual calendar year deductible is the amount you must pay before benefits for many services begin for that calendar year. In addition to meeting the individual calendar year deductible, you continue to be responsible for copays and coinsurance amounts, where applicable.

The calendar year deductible applies to most medical services you receive. Any deductible amounts incurred for services rendered during the last three (3) months of a calendar year will apply toward the deductible requirement for the next year, provided that the member had continuous coverage under the Plan through the GIC at the time the charges in the prior year were incurred.

**Example:** If you go to a provider for a medical problem in January, you will have to pay the applicable copay and then $250 of the Allowed Amount. If your provider charges less than $250, the balance of the deductible will be taken from your next service. If there are remaining charges after the deductible, then, depending on
which Basic Plan you have (CIC or without CIC), the Plan pays either 100% of the Allowed Amount, or 80% of the Allowed Amount and you will be responsible for the remaining 20%. Once you have paid the $250 calendar year deductible, you will not have to pay it again for the remainder of the calendar year for any services you receive.

The Plan determines the providers to whom you owe the deductible based on the order in which the claims are submitted. You will receive an Explanation of Benefits (EOB) that will indicate the provider(s) to whom you owe the deductible amounts for any services you receive.

The calendar year deductible applies to most medical services you receive. Check the Summary of Covered Services charts on pages 5-12 of your February 2010 Benefit Update to see the services to which the calendar year deductible applies.

**Physician Tiering**

The information on the Group Insurance Commission’s Clinical Performance Improvement (CPI) Initiative in the “Your Costs” section on page 10 of your Member Handbook and on page 4 of your July 2009 Benefit Update is deleted and replaced with the following:

**Physician Tiering**

To help you make more informed choices about your health care options and to control your premium costs, the Group Insurance Commission’s (GIC) Clinical Performance Improvement (CPI) Initiative includes a physician tiering program. Under this program, Massachusetts physicians are assigned to tiers based on an evaluation of various quality and/or cost-efficiency measures. Based on a comparison of their scores with their peers in the same specialties on these measures, individual physicians are assigned to one of three tiers, as described below.

For most specialties, physicians have been tiered based on both their quality and cost-efficiency scores. However, there are some specialties (excluding primary care) where sufficient quality measures are not readily available to develop an adequate evaluation of quality. Therefore, we have tiered some physicians on the basis of cost-efficiency scores only, as described below.

The names of the tiers have been assigned by the GIC for use uniformly across all of its participating health plans.

- **Tier 1*** (Excellent) – Tier 1 physicians are generally those who met or exceeded the quality assessment threshold, established for all physicians, and ranked at the highest level of cost-efficiency, as compared to their peers. Tier 1 is designed to acknowledge the high performance of these physicians in terms of both quality and cost-efficiency measures, as determined by the available data. (Some specialty physicians, for whom quality data was insufficient to allow for evaluation, were placed in Tier 1 solely on the basis of their rank at the highest level of cost-efficiency. These physicians are identified as such in the Provider Listing.)

- **Tier 2** (Good) – Tier 2 physicians are those who have met or exceeded the quality assessment threshold established for all physicians and have met the cost-efficiency threshold established by the Plan, but did not achieve scores as high as Tier 1 physicians.

- **Tier 3** (Standard) – Tier 3 physicians are those who did not meet the quality assessment threshold established for all physicians, or they did not meet the cost-efficiency threshold established by the Plan.

**Note:** For a variety of reasons, many physicians did not have sufficient data available during the data collection period to allow us to assess their quality and/or cost-efficiency. Some may lack sufficient data with regard to the quality measures and/or the cost-efficiency measures. In the Plan’s Provider Listing, these physicians are placed in the category of Not Tiered/Insufficient Data (NT/ID). You can see these physicians for a Tier 2 copay.

You will find detailed explanations about the assignment of doctors to tiers and about the methods used to determine the quality and cost-efficiency scores of the physicians at www.unicarestateplan.com > “Members” > “Forms and Documents.” You can also call the Andover Service Center at (800) 442-9300 to request materials.
The methodology used in this tiering process relies on nationally accepted approaches to evaluating both quality and cost-efficiency, and uses claims data submitted by health care providers themselves. The use of claims data has some limitations, and there are additional methods that you may wish to use in evaluating the quality and cost-efficiency of providers. In making decisions about choosing your providers, you should consider the potential limitations in the data as well as other factors that correlate with the quality of care that you receive, some of which may be subjective in nature, but which are important to you.

How to Find out Your Physician’s Tier Designation

To find out which tier your physician is in, log onto the Plan’s website: www.unicarestateplan.com > “Find a Provider” > “Physician Tier Listing.” You can also check the printed Provider Listing, or call the Andover Service Center at (800) 442-9300 for assistance.

Reasonable and Customary Charge

The term “Reasonable and Customary Charge” is no longer used. This change is reflected in your Member Handbook as follows:

A. The subsection, “Reasonable and Customary Charge” on page 8 of your Member Handbook is deleted.

B. The definition for “Reasonable and Customary Charge” in the “Plan Definitions” section on page 55 of your Member Handbook is deleted.

Reasonable and Customary Allowed Amount

The term “Reasonable and Customary Allowed Amount” is changed to “Allowed Amount.” This change is reflected in your Member Handbook as follows:

A. The subsection, “Reasonable and Customary Allowed Amount” in the “Your Costs” section on page 8 of your Member Handbook is deleted and replaced with the following:

   **Allowed Amount**
   The Allowed Amount is the amount UniCare determines to be within the range of payments most often made to similar providers for the same service or supply. These allowed amounts are expressed as maximum fees in fee schedules, maximum daily rates, flat amounts or discounts from charges.

   The Plan has established Allowed Amounts for most services from providers. This allowed amount may not be the same as the provider’s actual charge.

B. The title of the subsection, “Charges over the Reasonable and Customary Allowed Amount” in the “Your Costs” section on page 9 of your Member Handbook is changed to “Charges over the Allowed Amount.”

C. The term “Reasonable and Customary Allowed Amount” in the footnotes of the Summary of Covered Services charts in the “Benefit Highlights” section on pages 26-33 of your Member Handbook and on pages 5-12 of your February 2010 Benefit Update is changed to “Allowed Amount” wherever it appears.

D. The definition, “Reasonable and Customary Allowed Amount” in the “Plan Definitions” section on page 55 of your Member Handbook is deleted and replaced with the following:

   **“Allowed Amount”** – The Allowed Amount is the amount UniCare determines to be within the range of payments most often made to similar providers for the same service or supply. This allowed amount may not be the same as the provider’s actual charge. These allowed amounts are expressed as maximum fees in fee schedules, maximum daily rates, flat amounts or discounts from charges.
Managed Care Notification Requirements

Beginning July 1, 2010, there are changes to the Plan’s list of services, procedures and products for which you must notify the Plan. This notification within the specified time frame ensures that you or your dependent(s) obtain the maximum level of benefits allowed under the Plan.

The Managed Care Notification Requirements charts on pages 18-20 of your Member Handbook are deleted and replaced with the following charts to reflect these changes. The subsections, “Inpatient Hospitalizations,” “Durable Medical Equipment over $500” and “Manipulative Therapy” on pages 21 and 22 of your Member Handbook are also replaced to show changes to notification requirements for these products and services (see pages 11-12 of this Benefit Update).

.managed care notification requirements†

<table>
<thead>
<tr>
<th>Treatment / Service</th>
<th>Notification Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>An Overnight Hospital Stay:</td>
<td></td>
</tr>
<tr>
<td>• Non-emergency Admission</td>
<td>At least 7 calendar days before the admission</td>
</tr>
<tr>
<td>• Emergency Admission</td>
<td>Within 24 hours (next business day)</td>
</tr>
<tr>
<td>• Maternity Admission</td>
<td>Within 24 hours (next business day)</td>
</tr>
<tr>
<td>Organ Transplants: Liver, Lung, Kidney, Heart, Bone Marrow, Simultaneous Kidney and Pancreas, All Other</td>
<td>At least 21 calendar days before transplant-related services begin</td>
</tr>
<tr>
<td>Durable Medical Equipment: (if the purchase price exceeds $500 or the expected rental charges will exceed $500 over the period of use) Exception: No notification is required for oxygen and oxygen equipment.</td>
<td>At least one business day before ordering the equipment</td>
</tr>
<tr>
<td>Home Health Care Provided By:</td>
<td></td>
</tr>
<tr>
<td>• Home Health Agencies</td>
<td>At least one business day before the services begin</td>
</tr>
<tr>
<td>• Visiting Nurse Associations</td>
<td></td>
</tr>
<tr>
<td>• Home Infusion Therapy Companies</td>
<td></td>
</tr>
<tr>
<td>• Private Duty Nurses</td>
<td></td>
</tr>
<tr>
<td>Manipulative Therapy for Children under Age 13 Provided By:</td>
<td></td>
</tr>
<tr>
<td>• Chiropractors</td>
<td>At least one business day before your first appointment date</td>
</tr>
<tr>
<td>• Medical and Osteopathic Physicians</td>
<td></td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>At least one business day before your first appointment date</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>At least one business day before your first appointment date</td>
</tr>
</tbody>
</table>

To obtain the maximum level of benefits, you must notify the Andover Service Center at (800) 442-9300.
† Claims submission does not constitute notification.

Managed Care Notification Requirements† (cont’d)
Note: Treatments and services that have been added to the following chart are indicated with the word “new.”

<table>
<thead>
<tr>
<th>Treatment / Service</th>
<th>Notification Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Selected Procedure Review: (Some of the procedures listed below may be performed in a doctor’s office.)</strong></td>
<td>At least seven (7) calendar days before the procedure for non-emergency procedures. If you are not sure whether the procedure is subject to these notification requirements, please call the Andover Service Center at (800) 442-9300.</td>
</tr>
<tr>
<td><strong>Procedure</strong></td>
<td><strong>Definition</strong></td>
</tr>
<tr>
<td><strong>Cardioverter-Defibrillator Implantation (NEW)</strong></td>
<td>Surgical implantation of a device to continuously monitor the heart rhythm to detect and correct abnormal heart rhythms</td>
</tr>
<tr>
<td><strong>Certain Drugs Administered by Infusion: (NEW)</strong></td>
<td><strong>Definition</strong></td>
</tr>
<tr>
<td>• Immune globulin</td>
<td>Administration of fluid via a vein or subcutaneous tissue</td>
</tr>
<tr>
<td>• Infliximab (Remicade)</td>
<td>An agent that is used for the treatment of inflammatory, autoimmune or other diseases</td>
</tr>
<tr>
<td></td>
<td>An agent used to treat certain inflammatory conditions such as arthritis, inflammatory bowel disease and other diseases</td>
</tr>
<tr>
<td><strong>Hyperbaric Oxygen Therapy (NEW)</strong></td>
<td>Administration of pure oxygen at higher than atmospheric pressure</td>
</tr>
<tr>
<td><strong>Knee Meniscal Transplant (NEW)</strong></td>
<td>Transplant of special cartilage in the knee to treat certain types of knee pain and problems</td>
</tr>
<tr>
<td><strong>Sinus Surgery, Including Endoscopy</strong></td>
<td>Any procedure by any method that opens, removes or treats the nasal sinuses, including the use of an endoscope</td>
</tr>
<tr>
<td><strong>Spinal Cord Stimulator and Neuromodulator Implantation (NEW)</strong></td>
<td>Implantation of a device that delivers electrical current directly to specific areas of the spinal cord with implanted electrodes, to treat pain or urinary incontinence</td>
</tr>
</tbody>
</table>

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### Managed Care Notification Requirements† (cont’d)

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<table>
<thead>
<tr>
<th>Procedure</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Upper Gastrointestinal Endoscopy</strong></td>
<td>Examination through a flexible telescopic tube (endoscope) of the upper gastrointestinal (UGI) area (that is, the esophagus, stomach, and duodenum) for diagnosis and/or treatment</td>
</tr>
<tr>
<td><strong>Surgical Treatments of the Back</strong></td>
<td>(including but not limited to the following procedures and any other spinal instrumentation not otherwise specified):</td>
</tr>
<tr>
<td>• Discectomy of the Lumbosacral Spine</td>
<td>Surgical procedure to remove a disc from the back</td>
</tr>
<tr>
<td>• Percutaneous and Endoscopic Discectomy and other minimally invasive procedures to treat back pain <strong>(NEW)</strong></td>
<td>Procedures on the spine using small incisions through the skin and probes, endoscopes or catheters to perform procedures</td>
</tr>
<tr>
<td>• Laminectomy/Laminotomy of the Lumbosacral Spine</td>
<td>Any surgical procedure removing portions of the vertebra to relieve pressure on the spinal cord or nerve roots in the lower back</td>
</tr>
<tr>
<td>• Spinal Fusion of the Lumbosacral Spine</td>
<td>Surgical procedures in which two or more of the vertebrae in the lower back are fused together</td>
</tr>
<tr>
<td>• Spinal Instrumentation of the Lumbosacral Spine</td>
<td>Any surgical procedure by any method to relieve pressure on the spinal cord or nerve roots in the lumbosacral spine (lower back)</td>
</tr>
<tr>
<td>• Vertebroplasty <strong>(NEW)</strong></td>
<td>Injection of material into the center of a collapsed spinal vertebra to repair fractures</td>
</tr>
<tr>
<td><strong>CT Scans – Computerized Axial Tomography:</strong></td>
<td>Special computerized x-ray of the abdomen or pelvis</td>
</tr>
<tr>
<td>• Abdomen and/or Pelvis</td>
<td>Special computerized x-ray of the neck</td>
</tr>
<tr>
<td>• Cervical Spine</td>
<td>Special computerized x-ray of the middle back</td>
</tr>
<tr>
<td>• Thoracic Spine</td>
<td></td>
</tr>
</tbody>
</table>
• Lumbosacral Spine
  Special computerized x-ray of the lower back

• Thoracic Cavity
  Special computerized x-ray of the chest and heart, and CT scan angiogram of the thoracic cavity

🎉 To obtain the maximum level of benefits, you must notify the Andover Service Center at (800) 442-9300.
† Claims submission does not constitute notification.

🎉 Managed Care Notification Requirements† (cont’d)
Note: Treatments and services that have been added to the following chart are indicated with the word “new.”

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>MRI – Magnetic Resonance Imaging:</td>
<td></td>
</tr>
<tr>
<td>• Abdomen and/or Pelvis</td>
<td>Imaging study of the abdomen or pelvis</td>
</tr>
<tr>
<td>• Breast (NEW)</td>
<td>Imaging study of the breast</td>
</tr>
<tr>
<td>• Knee</td>
<td>Imaging study of the knee</td>
</tr>
<tr>
<td>• Cervical Spine</td>
<td>Imaging study of the neck</td>
</tr>
<tr>
<td>• Thoracic Spine</td>
<td>Imaging study of the middle back</td>
</tr>
<tr>
<td>• Lumbosacral Spine</td>
<td>Imaging study of the lower back</td>
</tr>
<tr>
<td>• Thoracic Cavity</td>
<td>Imaging study of the chest</td>
</tr>
</tbody>
</table>

PET Scan of Any Part of the Body (NEW)
Specialized imaging to produce three-dimensional images of parts of the body

SPECT Scan of Any Part of the Body (NEW)
Specialized three-dimensional imaging of various tissues and organs

🎉 To obtain the maximum level of benefits, you must notify the Andover Service Center at (800) 442-9300.
† Claims submission does not constitute notification.

Utilization Management Program
Clarifications are made to the “Managed Care Program” section regarding the notification of your physician by a patient advocate or physician advisor. The “Utilization Management Program” subsection on pages 21-23 of the “Managed Care Program” section of your Member Handbook is deleted and replaced with the following to reflect these changes:

Utilization Management Program

Inpatient Hospitalizations

Initial Review: The Plan must review and determine the medical necessity of all inpatient hospital admissions.
You or someone on your behalf must initiate this process by calling the Andover Service Center at (800) 442-9300 at least seven (7) days in advance of a non-emergency admission, and within 24 hours or the next business day of an emergency or maternity admission.

The purpose of this process is to inform you whether the admission will be considered for benefits under the Plan prior to a non-emergency admission, or as soon as possible after an emergency admission. Calling the Andover Service Center minimizes your risk of incurring charges for non-covered services.

Upon notification to the Andover Service Center, a patient advocate may contact your physician and/or your physician’s representative to assist in determining the medical necessity and appropriateness of the treatment plan and setting.

You and your physician will each receive a written notice telling you if the Plan has confirmed the medical necessity and appropriateness of the admission. This notice will also specify the initial length of stay approved for the admission.

If the patient advocate is unable to confirm the medical necessity and appropriateness of the treatment, the inpatient hospital setting or the anticipated length of stay, a physician advisor will attempt to contact your physician before the Plan makes a final decision. The physician advisor will also be available to discuss the decision with your physician.

If the Plan determines that the admission is not medically necessary and appropriate, the patient advocate will promptly notify you, your physician and the hospital.

**Continued Stay Review:** Your physician may recommend that you stay in the hospital beyond the initial number of days that the Plan has approved. In this case, the Plan will determine whether a continued hospital stay is medically necessary and appropriate. You do not have to contact the Plan. During continued stay review, the patient advocate will work with the hospital staff to facilitate planning for care that may be required after your discharge.

If the patient advocate is unable to confirm that the continued hospitalization is medically necessary, a physician advisor will attempt to contact your physician before the Plan makes a final decision. The physician advisor will be available to discuss the decision with your physician. If the Plan determines that the continued stay is not medically necessary and appropriate, the patient advocate will promptly notify you, your physician and the hospital.

**Durable Medical Equipment over $500**
Any Durable Medical Equipment (DME)—other than oxygen and oxygen equipment—ordered by a physician that is expected to cost more than $500 is subject to Plan review. The $500 cost may be the result of either the purchase price or the total rental charges.

The Plan must be notified at least one (1) business day before the equipment is ordered from the equipment provider. Upon notification, a patient advocate may contact your health care provider to obtain clinical information that will be used to determine the medical appropriateness of the equipment. A patient advocate will notify you in writing regarding whether the Plan will authorize coverage for the equipment.

If you obtain equipment through a Preferred Vendor, the authorized item will be covered at 100% of the allowed amount after the calendar year deductible. Please note that if a covered item is not available through a Preferred Vendor, although it is authorized, it will only be covered at 80% of the allowed amount after the calendar year deductible.

**Home Health Care**
When a physician prescribes home health care services, the Plan must be notified at least one (1) business day before the services begin. Upon notification, a patient advocate may contact your health care provider to obtain clinical information that will be used to determine the medical appropriateness of the home health care services. A patient advocate will notify you in writing regarding whether the Plan will authorize coverage for the

Manipulative Therapy
Manipulative therapy refers to any hands-on treatment provided by a chiropractor or a medical or osteopathic physician. For children under age 13, the Plan must be notified at least one (1) business day before the services begin. Upon notification, a patient advocate may contact your health care provider to obtain clinical information that will be used to determine the medical appropriateness of the manipulative therapy services. Note: No prior notification is required for manipulative therapy services for adults and children age 13 and over.

Physical Therapy
When a physician prescribes physical therapy services for you or for your dependent(s), the Plan must be notified one (1) business day before the date of your first appointment. A patient advocate may contact your health care provider to obtain clinical information that will be used to determine the medical appropriateness of the physical therapy services.

Physical therapy must be ordered by a physician, and a copy of the order must be made available to the Plan upon request.

Occupational Therapy
When a physician prescribes occupational therapy services for you or for your dependent(s), the Plan must be notified one (1) business day before the date of your first appointment. A patient advocate may contact your health care provider to obtain clinical information that will be used to determine the medical appropriateness of the occupational therapy services.

Occupational therapy must be ordered by a physician, and a copy of the order must be made available to the Plan upon request.

Selected Procedures
Members scheduled on a non-emergency basis for one of the selected procedures listed on pages 8-10 of this Benefit Update must notify the Plan at least seven (7) calendar days before the scheduled date of the procedure. The Plan requires notification, whether the procedure is being done in a hospital on an inpatient or outpatient basis, in a freestanding facility or in a physician’s office.

If you are scheduled to have a procedure or special test done and you do not know the medical term for it, ask your physician to call the Andover Service Center at (800) 442-9300 to find out if prior notification is needed. Or check these notification requirements on our website: www.unicarestateplan.com > “Members” > “Notification Requirements” > “View notification requirements for non-Medicare members.” Upon notification, a patient advocate may contact your physician to obtain clinical information that will be used to determine the medical necessity of the planned procedure and the appropriateness of the setting in which it will be provided.

If the patient advocate is unable to confirm the medical necessity and appropriateness of the planned procedure, a physician advisor will attempt to contact your physician before the Plan makes a final decision. The physician advisor will also be available to discuss the decision with your physician.

Coverage for Clinical Trials for Cancer
Information about coverage for clinical trials has been updated. These changes are reflected in your Member Handbook as follows:

A. The subsection, “Coverage for Clinical Trials” on pages 43-44 in the “Description of Covered Services” section of your Member Handbook is deleted and replaced with the text below. In addition, this subsection is renamed, “Coverage for Clinical Trials for Cancer.”

Coverage for Clinical Trials for Cancer
Clinical trials are only covered for cancer treatment. The Plan does cover patient care services provided as part of a qualified clinical trial only for the treatment of any form of cancer. Coverage is subject to all pertinent provisions of the Plan, including use of participating providers, utilization review and provider payment
methods. In this context, patient care service means a health care item or service provided to an individual enrolled in a qualified clinical trial for cancer that is consistent with the patient’s diagnosis, consistent with the study protocol for the clinical trial and would otherwise be a covered benefit under the Plan. “Patient care service” does not include any of the following:

1. An investigational drug or device. However, a drug or device that has been approved for use in the qualified clinical trial will be a patient care service to the extent that the drug or device is not paid for by the manufacturer, distributor or provider of the drug or device, regardless of whether the Food and Drug Administration has approved the drug or device for use in treating the patient’s particular condition.

2. Non-health care services that a patient may be required to receive as a result of participation in the clinical trial.

3. Costs associated with managing the research of the clinical trial.

4. Costs that would not be covered for non-investigational treatments.

5. Any item, service or cost that is reimbursed or furnished by the sponsor of the clinical trial.

6. The costs of services that are inconsistent with widely accepted and established national or regional standards of care.

7. The costs of services that are provided primarily to meet the needs of the trial, including, but not limited to, tests, measurements and other services that are typically covered but are being provided at a greater frequency, intensity or duration.

8. Services or costs that are not covered under the Plan.

Coverage for qualified clinical trials shall be subject to all the other terms and conditions of the policy, including, but not limited to, requiring the use of participating providers, provisions related to utilization review and the applicable agreement between the provider and the carrier.

The following services for cancer treatment are covered under this benefit:

1. All services that are medically necessary for treatment of your condition, consistent with the study protocol of the clinical trial, and for which coverage is otherwise available under the Plan.

2. The allowed cost, as determined by the Plan, of an investigational drug or device that has been approved for use in the clinical trial for cancer treatment to the extent it is not paid for by its manufacturer, distributor, or provider.

B. The following definition is added to the “Plan Definitions” section on page 50 of your Member Handbook:

“Qualified Clinical Trials” – clinical trials that, according to state law, meet all of the following conditions:

1. The clinical trial is to treat cancer.

2. The clinical trial has been peer reviewed and approved by one of the following:
   – United States National Institutes of Health
   – A cooperative group or center of the National Institutes of Health
   – A qualified non-governmental research entity identified in guidelines issued by the National Institutes of Health for center support grants
   – The United States Food and Drug Administration pursuant to an investigational new drug exemption
   – The United States Departments of Defense or Veterans Affairs
– With respect to Phase II, III and IV clinical trials only, a qualified institutional review board

3. The facility and personnel conducting the clinical trial are capable of doing so by virtue of their experience and training and treat a sufficient volume of patients to maintain that experience.

4. With respect to Phase I clinical trials, the facility shall be an academic medical center or an affiliated facility and the clinicians conducting the trial shall have staff privileges at said academic medical center.

5. The patient meets the patient selection criteria enunciated in the study protocol for participation in the clinical trial.

6. The patient has provided informed consent for participation in the clinical trial in a manner that is consistent with current legal and ethical standards.

7. The available clinical or pre-clinical data provide a reasonable expectation that the patient’s participation in the clinical trial will provide a medical benefit that is commensurate with the risks of participation in the clinical trial.

8. The clinical trial does not unjustifiably duplicate existing studies.

9. The clinical trial must have a therapeutic intent and must, to some extent, assume the effect of the intervention on the patient.

Coverage for qualified clinical trials shall be subject to all the other terms and conditions of the policy, including, but not limited to, requiring the use of participating providers, provisions related to utilization review and the applicable agreement between the provider and the carrier.

C. The following exclusion is added to the “Exclusions” section on pages 45-47 of your Member Handbook:

Any clinical research trial other than a qualified clinical trial for the treatment of cancer (see the definition of a Qualified Clinical Trial on this page).

**Exclusions**

The following item is added to the “Exclusions” section on pages 45-47 of your Member Handbook:

Presbyopia-correcting intraocular lenses (IOLs) include, but are not limited to, accommodating and multifocal IOLs designed to restore a fuller range of near, intermediate and far distances as compared to monofocal IOLs. Examples include Crystalens®, ReZoom® and AcrySof® ReSTOR.

**Free or Low-Cost Health Coverage to Children and Families**

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some states have premium assistance programs that can help pay for coverage. These states use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums. For more information, see Appendix E, “Federal and State Mandates” on pages 36-41 of this Benefit Update.

**Extended Health Benefit Plan Eligibility for Dependent Students on a Medically Necessary Leave of Absence**

If your student dependent(s) has a serious illness or injury that causes him or her to leave school or stop going to college full time, his or her coverage will continue under Michelle’s Law.

Michelle’s Law ensures that full-time college students, who receive health insurance as dependents under a parent’s health plan, may take up to 12 months’ medical leave from college and remain covered under the UniCare State Indemnity Plan.

For more information, see Appendix E, “Federal and State Mandates” on pages 36-41 of this Benefit Update.
Group Health Continuation Coverage under COBRA Election Notice

The following replaces the information on pages 60-63 of your Member Handbook. Also, see the section “COBRA Subsidy and Special Extended Election Notice” on page 19 of this Benefit Update. This notice contains new, 2010-2011 information on your COBRA benefits.

Group Health Continuation under COBRA

This subsection contains important information about your rights to continue group health coverage at COBRA group rates if your group coverage otherwise would end due to certain life events. Please read it carefully.

You will receive a COBRA notice and application if the Group Insurance Commission (GIC) is informed that your current GIC coverage is ending due to (1) end of employment (2) reduction in hours of employment (3) death of employee/retiree (4) divorce or legal separation or (5) loss of dependent child status. This COBRA notice contains important information about your right to temporarily continue your health care coverage in the Group Insurance Commission’s (GIC’s) health plan through a federal law known as COBRA. If you elect to continue your coverage, COBRA coverage will begin on the first day of the month immediately after your current GIC coverage ends.

You must complete the GIC COBRA Election Form and return it to the GIC by no later than 60 days after your group coverage ends by sending it by mail to the Public Information Unit at the GIC at P.O. Box 8747, Boston, MA 02114 or by hand delivery to the GIC, 19 Staniford Street, 4th floor, Boston, MA 02114. If you do not submit a completed election form by this deadline, you will lose your right to elect COBRA coverage.

What is COBRA coverage?
COBRA is a federal law under which certain former employees, retirees, spouses, former spouses and dependent children have the right to temporarily continue their existing group health coverage at group rates when group coverage otherwise would end due to certain life events, called “Qualifying Events.” If you elect COBRA coverage, you are entitled to the same coverage being provided under the GIC’s plan to similarly situated employees or dependents. The GIC administers COBRA coverage.

This notice explains your COBRA rights and what you need to do to protect your right to receive it. If you have questions about COBRA coverage, contact the GIC’s Public Information Unit at (617) 727-2310, ext. 801 or write to the Unit at P.O. Box 8747, Boston, MA 02114. You may also contact the U.S. Department of Labor’s Employee Benefits Security Administration’s website at www.dol.gov/ebsa.

Who is eligible for COBRA coverage?
Each individual entitled to COBRA (known as a “Qualified Beneficiary”) has an independent right to elect the coverage, regardless of whether or not other eligible family members elect it. Qualified Beneficiaries may elect to continue their group coverage that otherwise would end due to the following life events:

If you are an employee of the Commonwealth of Massachusetts or municipality covered by the GIC’s health benefits program, you have the right to choose COBRA coverage if

• You lose your group health coverage because your hours of employment are reduced or
• Your employment ends for reasons other than gross misconduct.

If you are the spouse of an employee covered by the GIC’s health benefits program, you have the right to choose COBRA coverage for yourself if you lose GIC health coverage for any of the following reasons (known as “qualifying events”):

• Your spouse dies
• Your spouse’s employment with the Commonwealth or participating municipality ends for any reason other than gross misconduct or his/her hours of employment are reduced or
• You and your spouse legally separate or divorce
If you have dependent children who are covered by the GIC’s health benefits program, each child has the right to elect COBRA coverage if he or she loses GIC health coverage for any of the following reasons (known as “qualifying events”):

- The employee-parent dies
- The employee-parent’s employment is terminated (for reasons other than gross misconduct) or the parent’s hours or employment are reduced
- The parents legally separate or divorce or
- The dependent ceases to be a dependent child under GIC eligibility rules

How long does COBRA coverage last?
By law, COBRA coverage must begin on the day immediately after your group health coverage otherwise would end. If your group coverage ends due to employment termination or reduction in employment hours, COBRA coverage may last for up to 18 months. If it ends due to any other qualifying events listed above, you may maintain COBRA coverage for up to 36 months.

If you have COBRA coverage due to employment termination or reduction in hours, your family members’ COBRA coverage may be extended beyond the initial 18-month period up to a total of 36 months (as measured from the initial qualifying event) if a second qualifying event—the insured’s death or divorce—occurs during the 18 months of COBRA coverage. You must notify the GIC in writing within 60 days of the second qualifying event and before the 18-month COBRA period ends in order to extend the coverage. Your COBRA coverage may be extended to a total of 29 months (as measured from the initial qualifying event) if any qualified beneficiary in your family receiving COBRA coverage is disabled during the first 60 days of your 18-month COBRA coverage. You must provide the GIC with a copy of the Social Security Administration’s disability determination within 60 days after you receive it and before your initial 18-month COBRA period ends in order to extend the coverage.

COBRA coverage will end before the maximum coverage period ends if any of the following occurs:
- The COBRA cost is not paid in full when due (see section on paying for COBRA)
- You or another qualified beneficiary become covered under another group health plan that does not impose any pre-existing condition exclusion for the qualified beneficiary’s pre-existing covered condition covered by COBRA benefits
- You are no longer disabled as determined by the Social Security Administration (if your COBRA coverage was extended to 29 months due to disability)
- The Commonwealth of Massachusetts or your municipal employer no longer provides group health coverage to any of its employees or
- Any reason for which the GIC terminates a non-COBRA enrollee’s coverage (such as fraud)

The GIC will notify you in writing if your COBRA coverage is to be terminated before the maximum coverage period ends. The GIC reserves the right to terminate your COBRA coverage retroactively if you are subsequently found to have been ineligible for coverage.

How and when do I elect COBRA coverage?
Qualified beneficiaries must elect COBRA coverage within 60 days of the date that their group coverage otherwise would end or within 60 days of receiving a COBRA notice, whichever is later. A qualified beneficiary may change a prior rejection of COBRA election any time until that date. If you do not elect COBRA coverage within the 60-day election period, you will lose all rights to COBRA coverage.

There are several considerations when deciding whether to elect COBRA coverage. COBRA coverage can help you avoid incurring a coverage gap of more than 63 days, which under Federal law can cause you to lose your right to be exempt from pre-existing condition exclusions when you elect subsequent health plan
coverage. If you have COBRA coverage for the maximum period available to you, it provides you the right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions. You also have special enrollment rights under federal law, including the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a spouse’s plan) within 30 days after your COBRA coverage ends.

**How much does COBRA coverage cost?**
Under COBRA, you must pay 102% of the applicable cost of your COBRA coverage. If your COBRA coverage is extended to 29 months due to disability, your cost will increase to 150% of the applicable full cost rate for the additional 11 months of coverage.

The American Recovery and Reinvestment Act of 2009 (ARRA), as amended, reduces the COBRA premium in some cases. The premium reduction is available to certain individuals who experience a qualifying event that is an involuntary termination of employment during the period beginning with September 1, 2008 and ending with May 31, 2010. If you qualify for the premium reduction, you need only pay 35 percent of the COBRA premium otherwise due to the plan. This premium reduction is available for up to 15 months. If your COBRA continuation coverage lasts for more than 15 months, you will have to pay the full amount to continue your COBRA continuation coverage. See the “Summary of the COBRA Premium Reduction Provisions under ARRA” for more details, restrictions, and obligations as well as the form necessary to establish eligibility. This information is posted on the GIC’s website.

**How and when do I pay for COBRA coverage?**
If you elect COBRA coverage, you must make your first payment for COBRA coverage within 45 days after the date you elect it. If you do not make your first payment for COBRA coverage within the 45-day period, you will lose all COBRA coverage rights under the plan.

Your first payment must cover the cost of COBRA coverage from the time your coverage would have ended up to the time you make the first payment. Services cannot be covered until the GIC receives and processes this first payment, and you are responsible for making sure that the amount of your first payment is enough to cover this entire period.

After you make your first payment, you will be required to pay for COBRA coverage for each subsequent month of coverage. These periodic payments are due usually around the 15th of each month. The GIC will send monthly bills, specifying the due date for payment and the address to which payment is to be sent for COBRA coverage, but you are responsible for paying for the coverage even if you do not receive a monthly statement. Payments should be sent to the GIC’s address on the bill.

After the first payment, you will have a 30-day grace period beyond the due date on each monthly bill in which to make your monthly payment. Your COBRA coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. If you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to COBRA coverage.

**Can I elect other health coverage besides COBRA?**
Yes. You have the right to enroll, within 31 days after coverage ends, in an individual health insurance “conversion” policy with your current health plan without providing proof of insurability. Alternately, if you are a Massachusetts resident, you may purchase health insurance through the Commonwealth’s Health Connector Authority. The GIC has no involvement in conversion or Health Connector programs, and you pay premium to the plan sponsor for the coverage. The benefits provided under such a policy might not be identical to those provided through COBRA. You may exercise this right in lieu of electing COBRA coverage, or you may exercise this right after you have received the maximum COBRA coverage available to you.

**Your COBRA coverage responsibilities**
- You must inform the GIC of any address changes to preserve your COBRA rights.
• You must elect COBRA within 60 days from the date you receive a COBRA notice or you would lose group coverage due to one of the qualifying events described above. If you do not elect COBRA coverage within the 60-day limit, your group health benefits coverage will end and you will lose all rights to COBRA coverage.

• You must make the first payment for COBRA coverage within 45 days after you elect COBRA. If you do not make your first payment for the entire COBRA cost due within that 45-day period, you will lose all COBRA coverage rights.

• You must pay the subsequent monthly cost for COBRA coverage in full by the end of the 30-day grace period after the due date on the bill. If you do not make payment in full by the end of the 30-day grace period after the due date on the bill, your COBRA coverage will end.

• You must inform the GIC within 60 days of the later of either (1) the date of any of the following, or (2) the date on which coverage would be lost because of any of the following events:
  – The employee’s job terminates or his/her hours are reduced
  – The insured dies
  – The insured becomes legally separated or divorced
  – The insured or insured’s former spouse remarries
  – A covered child ceases to be a dependent under GIC eligibility rules
  – The Social Security Administration determines that the employee or a covered family member is disabled or
  – The Social Security Administration determines that the employee or a covered family member is no longer disabled.

If you do not inform the GIC of these events within the time period specified above, you will lose all rights to COBRA coverage. To notify the GIC of any of the above events within the 60 days for providing notice, send a letter to the Public Information Unit at Group Insurance Commission, P. O. Box 8747, Boston, MA 02114-8747.

COBRA Subsidy and Special Extended Election Notice
The following information has been added to the end of the subsection, “Group Health Continuation Coverage under COBRA” in the “General Provisions” section of your Member Handbook.

This notice contains important information about additional rights to continue your GIC health coverage and, for some people, at a temporarily reduced premium. **Please read the information contained in this notice very carefully.**

If you have lost coverage due to an involuntary termination some time between September 1, 2008 and December 31, 2009 and you are not eligible for Medicare or other group health plan coverage, you may be eligible for a temporary premium reduction in COBRA rates for up to nine months. Furthermore, if you lost coverage due to an involuntary termination some time between September 1, 2008 and February 17, 2009 AND either did not elect COBRA continuation coverage at that time or you elected COBRA but discontinued the coverage, you may be eligible for a second election opportunity.

The American Recovery and Reinvestment Act of 2009 (ARRA) reduces COBRA premium in some cases. Read this notice attached to help determine if you are eligible for COBRA at a temporarily reduced premium of 35% of the usual COBRA rate for up to nine months. If your COBRA continuation coverage lasts for more than nine months, you will have to pay the full amount to continue your COBRA continuation coverage. If you believe you meet the criteria for the COBRA premium reduction, contact the GIC for COBRA premium reduction rates and an application, and return it to the GIC with your completed COBRA election form. You do
not have to send payment with your application. If you elect COBRA and are eligible for the premium reduction, COBRA continuation coverage will begin on the date you lost your GIC-sponsored coverage, or retroactively on March 1, 2009 if you avail yourself of the Special Extended Election opportunity. The retroactive coverage is required by Federal law.

You must complete the GIC COBRA subsidy application forms and return to the GIC by no later than 60 days after you receive this notice by sending it by mail to the Public Information Unit at the GIC at P.O. Box 8747, Boston, MA 02114, or by hand delivery to the GIC, 19 Staniford Street, 4th floor, Boston, MA 02114. If you do not submit a completed election form by this deadline, you will lose your right to elect COBRA coverage. If you have any questions about this notice or your rights to COBRA continuation coverage, contact the GIC’s Public Information Unit at (617) 727-2310, ext. 1, or visit the GIC at 19 Staniford Street, 4th Floor, Boston, MA 02114.

**Important Information about Your COBRA Continuation Coverage Rights**

**Am I eligible for COBRA at reduced rates?**

If you lost group health coverage from September 1, 2008 through December 31, 2009 due to an involuntary termination of employment that occurred during that period and are not eligible for Medicare or other group health plan coverage, you are entitled to receive the premium reduction. Information about the amount of the premium reduction and how it affects your premium payments can be found below.

**How long will the premium reduction last?**

The premium reduction will last for up to nine months as long as you:

- Are eligible for continuation coverage at any time during the period from September 1, 2008 through December 31, 2009 and elect the coverage

- Have a continuation coverage election opportunity related to an involuntary termination of employment that occurred at some time from September 1, 2008 through December 31, 2009

- Are not eligible for Medicare, AND

- Are not eligible for coverage under any other group health plan, such as a plan sponsored by a successor employer or a spouse’s employer

**Am I eligible to elect COBRA continuation coverage at this time through the Special Extended Election?**

Only individuals who lost group health coverage from September 1, 2008 through February 16, 2009 due to an involuntary termination of employment that occurred during that period, and who did not elect COBRA continuation coverage during their first election period OR who elected but subsequently discontinued COBRA coverage (for reasons other than becoming eligible for another group health plan or Medicare), are entitled to elect coverage at this time. If you lost group health coverage for any other reason between these dates and did not elect COBRA continuation coverage when it was first offered, you are not entitled to this second election period.

**How long will continuation coverage last?**

Your coverage generally will begin on the first of the month after the month in which you were involuntarily terminated and can generally continue for up to 18 months from the date of your involuntary termination of employment. The duration of the premium reduction is determined separately and may not last for the entire length of your COBRA coverage.

Continuation coverage will be terminated before the end of the 18-month period if:

- Any required premium is not paid in full on time

- A qualified beneficiary becomes covered, after electing continuation coverage, under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary,
• A qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation coverage, or

• The employer ceases to provide any group health plan for its employees

Continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

**When and how must the first payment for COBRA continuation coverage be made?**
If you elect continuation coverage, you do not have to send any payment with the Election Form. However, you must make your first payment for continuation coverage not later than 45 days after the date of your election. (This is the date the Election Notice is post-marked, if mailed.) If you do not make your first payment for continuation coverage in full not later than 45 days after the date of your election, you will lose all continuation coverage rights under the Plan. You are responsible for making sure that the amount of your first payment is correct. You may contact the Public Information Unit, Group Insurance Commission, P.O. Box 8747, Boston, MA 02114-8747 (617) 727-2310, ext 1 to confirm the correct amount of your first payment.

**For More Information**
This notice does not fully describe continuation coverage or other rights under the Plan. More information about continuation coverage and your rights under the Plan is available in your summary plan description or from the Group Insurance Commission. If you have any questions concerning the information in this notice, your rights to coverage, or if you want a copy of the health plan handbook, you may contact the Public Information Unit, Group Insurance Commission, P.O. Box 8747, Boston, MA 02114-8747 (617) 727-2310, ext 1.

**Keep Your Plan Informed of Address Changes**
In order to protect your and your family’s rights, you should keep the Plan Administrator informed of any changes in your address and the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Group Insurance Commission.

**Coordination of Benefits (COB)**
The subsection, “Coordination of Benefits (COB)” in the “Your Claims” section on page 13 of your Member Handbook remains unchanged. However, we provide this annual reminder that if you have medical benefits under another health plan in addition to the UniCare State Indemnity Plan, you need to let us know by completing our “Other Health Insurance” form. This way, we can work with the other health plan to determine which plan has primary responsibility for providing coverage for each service.

This provision lets members with coverage under another plan use the coverage available to them under all health plans in which they are enrolled.

You must also complete the “Other Health Insurance” form if any of your family members covered under the UniCare State Indemnity Plan also have medical benefits under another health plan.

**Important:** You do not have to complete the “Other Health Insurance” form if you only have health plan coverage under the UniCare State Indemnity Plan. It is not necessary to tell us about coverage under:

• MassHealth

• Tricare, or

• Other types of coverage such as dental, vision or life insurance plans

• Medicare, if you are enrolled in our Medicare Extension Plan (OME)

**How to Get a Copy of the “Other Health Insurance” Form**

• **New Plan Members:** You’ll find a copy of this form in your welcome package.
• **Renewing Plan Members:** You can download this form from our website: [www.unicarestateplan.com](http://www.unicarestateplan.com) > “Members” > “Forms and Documents” > “Other Health Insurance Form.” Or call UniCare Customer Service at (800) 442-9300 to request the form.

**Need Help?**
If you’re not sure whether you need to complete the Other Health Insurance form, a customer service representative can help you. Please call UniCare Customer Service at (800) 442-9300.

**Online Plan Resources**

**Online Access to Medical Information and Plan Resources at [www.unicarestateplan.com](http://www.unicarestateplan.com)**
The Plan’s member discounts program is now referred to as “Special Offers” rather than HealthyExtensions. To reflect this change, the bulleted item regarding member discounts under “Online Access to Medical Information and Plan Resources at [www.unicarestateplan.com](http://www.unicarestateplan.com)” on page 3 of your Member Handbook is deleted and replaced with the following:

• Check out the Plan’s **discounts on health-related products and services** through its Special Offers program.

**Prescription Drug Plan**

*Administered by: CVS Caremark†*

CVS Caremark is the pharmacy benefit manager for your prescription drug benefit plan, effective July 1, 2010. The CVS Caremark pharmacy network includes major chain pharmacies nationwide, many independent pharmacies, a mail service pharmacy and a specialty drug pharmacy.

The following information replaces the section, “Prescription Drug Plan” on pages 65-74 of your Member Handbook, and on pages 18-26 of your July 2009 Benefit Update.

*The following benefit changes are effective July 1, 2010:*

• Prevacid OTC is covered at the Tier 1 copayment.
• Generic versions of Prevacid and Protonix are covered at the Tier 2 copayment.
• 90-day maintenance drug prescriptions may be filled at any CVS/pharmacy.

If you have any questions about your prescription drug benefits, contact CVS Caremark Customer Care toll-free at (877) 876-7214, TDD: (800) 238-0756.

**About Your Plan**

Prescription medications are covered by the plan only if they have been approved by the U.S. Food and Drug Administration (FDA). In addition, with the exception of the over-the-counter versions of omeprazole (omeprazole OTC), Prevacid (Prevacid OTC) and Prilosec (Prilosec OTC), medications are covered only if a prescription is required for their dispensing. Diabetic supplies and insulin are also covered by the plan.

The plan categorizes medications into six major categories:

**Generic Drugs**

Generic versions of brand medications contain the same active ingredients as their brand counterparts, thus offering the same clinical value. The FDA requires generic drugs to be just as strong, pure and stable as brand-name drugs. They must also be of the same quality and manufactured to the same rigorous standards. These requirements help to assure that generic drugs are as safe and effective as brand-name drugs.

**Maintenance Drug**

A maintenance drug is a medication taken on a regular basis for conditions such as asthma, diabetes, high-blood pressure or high-cholesterol.
Non-Preferred Brand-Name Drug
A non-preferred brand-name drug, or non-formulary drug, is a medication that usually has an alternative therapeutically-equivalent drug available on the formulary.

Preferred Brand-Name Drug
A preferred brand-name drug, also known as a formulary drug, is a medication that has been reviewed and approved by a group of physicians and pharmacists, and has been selected by CVS Caremark for formulary inclusion based on its proven clinical and cost-effectiveness.

Specialty Drugs
Specialty drugs are usually injectable and non-injectable biotech or biological drugs with one or more of several key characteristics, including:

- Potential for frequent dosing adjustments and intensive clinical monitoring to decrease the potential for drug toxicity and to increase the probability for beneficial treatment outcomes
- Need for intensive patient training and compliance assistance to facilitate therapeutic goals
- Limited or exclusive product availability and distribution
- Specialized product handling and/or administration requirements

Over-the-Counter (OTC) Drugs
Over-the-counter drugs are medications that do not require a prescription. Your plan does not provide benefits for OTC drugs, with the exception of omeprazole OTC, Prevacid OTC and Prilosec OTC (which are covered only if dispensed with a written prescription).

† CVS Caremark provides services through its operating company Caremark PhC, L.L.C. and affiliates.

Copayments
One of the ways your plan maintains coverage of quality, cost-effective medications is a multi-tier copayment pharmacy benefit: Tier 1 (most generic drugs), Tier 2 (mostly preferred brand-name drugs) or Tier 3 (non-preferred brand-name drugs). The following chart shows your copayment based on the type of prescription you fill and where you get it filled.

<table>
<thead>
<tr>
<th>Copayment for</th>
<th>Participating Retail Pharmacy up to 30-day supply</th>
<th>Mail Service or CVS/pharmacy up to 90-day supply</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Tier 1</strong></td>
<td></td>
<td></td>
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<tr>
<td><strong>Generic Drugs and</strong></td>
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<td></td>
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<tr>
<td>• Omeprazole OTC, Prevacid OTC, and Prilosec OTC (28-day supply – retail; 84-day supply – mail)*</td>
<td>$10</td>
<td>$20</td>
</tr>
<tr>
<td><strong>Tier 2</strong></td>
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<tr>
<td><strong>Preferred Brand-Name Drugs and</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Generic versions of Prevacid (lansoprazole) and Protonix (pantoprazole)</td>
<td>$25</td>
<td>$50</td>
</tr>
<tr>
<td><strong>Tier 3</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Non-Preferred Brand-Name Drugs and</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• COX-2 inhibitors (<em>pain and inflammation –</em></td>
<td>$50</td>
<td>$110</td>
</tr>
</tbody>
</table>
Copayment for Specialty Drugs – Two 30-day prescriptions allowed at any participating pharmacy; thereafter must be filled only through CVS Caremark Specialty Pharmacy

<table>
<thead>
<tr>
<th>Specialty Drugs: Tier 1</th>
<th>$10 up to a 30-day supply</th>
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</thead>
<tbody>
<tr>
<td>Specialty Drugs: Tier 2</td>
<td>$25 up to a 30-day supply</td>
</tr>
<tr>
<td>Specialty Drugs: Tier 3</td>
<td>$50 up to a 30-day supply</td>
</tr>
</tbody>
</table>

* Due to manufacturer packaging

How to Use the Plan
You will receive a benefit kit that includes a CVS Caremark Prescription ID card. Show this new ID card to your pharmacy so they can process your prescription drug benefits.

Register on www.caremark.com. As a registered user, you can check drug costs, order mail service refills, and review your prescription drug history. You can access this site 24 hours a day.

Filling Your Prescriptions
You may fill your prescriptions for non-specialty drugs at any participating retail pharmacy, or through the CVS Mail Service Pharmacy. Prescriptions for specialty drugs must be filled as described in the “CVS Caremark Specialty Pharmacy” subsection.

To obtain benefits at a retail pharmacy, you must fill your prescription at a participating pharmacy using your CVS Caremark Prescription ID card, with the exception of the limited circumstances detailed in the “Claim Forms” subsection.

Short-Term Medications – Up to 30 Days

Filling Your Prescriptions at a Participating Retail Pharmacy
The retail pharmacy is your most convenient option when you are filling a prescription for a short-term prescription that you need immediately (examples: antibiotics for strep throat or painkillers for an injury). Simply present your CVS Caremark Prescription ID card to your pharmacist, along with your written prescription, and pay the required copayment. Prescriptions filled at a non-participating retail pharmacy are not covered.

You can locate the nearest participating retail pharmacy anytime online after registering at www.caremark.com, or by calling toll-free at (877) 876-7214.

If you do not have your ID card, you can provide your pharmacist with the cardholder’s Social Security or GIC ID number, Bin number (610029), the group code (GICRX) and the RxPCN code (CRK). The pharmacist can also verify eligibility by contacting the CVS Caremark Pharmacy Help Desk toll-free at (800) 421-2342, TDD: (800) 238-0756.

Maintenance Medications – Up to 30 Days
After you fill two 30-day supplies of a maintenance medication at a retail pharmacy, you will be contacted by CVS Caremark to explain how you may convert your prescription to a 90-day supply to be filled either through
mail service or at a CVS/pharmacy. You will receive coverage for additional fills of the medication only if you convert your prescription to 90-days, or if you inform CVS Caremark that you prefer to continue to receive 30-day supplies at a retail pharmacy.

CVS Caremark will assist you in transitioning your maintenance prescription to either mail service or a CVS/pharmacy location.

**Maintenance Medications – Up to 90 Days**

**Filling 90-day Prescriptions Through CVS Caremark Mail Service Pharmacy or a CVS/pharmacy**

You have the choice and convenience of filling maintenance prescriptions for up to a 90-day supply at the mail service copayment, either through the CVS Caremark Mail Service Pharmacy or at a CVS/pharmacy.

**Mail service** is a convenient option for prescription drugs that you take on a regular basis for conditions such as asthma, diabetes, high-blood pressure, and high-cholesterol. Your prescriptions are filled and conveniently sent to you in a plain, weather-resistant pouch for privacy and protection. They are delivered directly to your home or to another location that you prefer.

**CVS/pharmacy** is another option for getting your 90-day maintenance medications for the same copayment amount as mail service. Prescriptions can be filled at one of over 7,000 CVS/pharmacy locations across the country.

**Convenient for You**

You get up to a 90-day supply of your maintenance medications—which means fewer refills and fewer visits to your pharmacy, as well as lower copayments. Once you begin using mail service, or the option of your local CVS/pharmacy, you can order refills online or by phone.

**Using Mail Service**

To begin using mail service for your prescriptions, just follow these three simple steps:

1. Ask your physician to write a prescription for up to a 90-day supply of your maintenance medication plus refills for up to one year, if appropriate. (Remember also to ask for a second prescription for an initial 30-day supply and take it to your local participating retail pharmacy.)

2. Complete a mail order form (contained in your Welcome Kit or found online after registering at www.caremark.com). Or call CVS Caremark Customer Care toll-free at (877) 876-7214 to request the form.

3. Put your prescription, payment and completed order form into the return envelope (provided with the order form) and mail it to CVS Caremark.

Please allow 10-14 business days for delivery from the time your order is placed. A pharmacist is available 24 hours a day to answer your questions about your medication.

If the CVS Caremark Mail Service Pharmacy is unable to fill a prescription because of a shortage of the medication, CVS Caremark will notify you of the delay in filling the prescription. You may then fill the prescription at a retail pharmacy, but the retail pharmacy copayment will apply.

**CVS Caremark Specialty Pharmacy**

CVS Caremark Specialty Pharmacy is a full-service specialty pharmacy that provides personalized care to each patient. You are allowed two fills of a specialty drug at any participating retail pharmacy. After these two fills, a specialty drug must be filled only at the CVS Caremark Specialty Pharmacy.

Specialty medications may be filled only at a maximum of 30-days supply. They are subject to a clinical review by CVS Caremark’s Specialty Guideline Management program to ensure the medications are being prescribed appropriately.

CVS Caremark Specialty Pharmacy offers a complete range of services and specialty drugs. Your specialty
drugs are quickly delivered to any approved location, at no additional charge. You have toll-free access to expert clinical staff who are available to answer all of your specialty drug questions. CVS Caremark Specialty Pharmacy will provide you with ongoing refill reminders before you run out of your medications.

To begin receiving your specialty drugs through CVS Caremark Specialty Pharmacy, call toll-free at (800) 237-2767.

**CVS Caremark Specialty Pharmacy Services**

- **Patient Counseling** – Convenient access to pharmacists and nurses who are specialty medication experts
- **Patient Education** – Educational materials
- **Convenient Delivery** – Coordinated delivery to your home, your doctor’s office, a CVS/pharmacy or other approved location
- **Refill Reminders** – Ongoing refill reminders from CVS Caremark Specialty Pharmacy
- **Language Assistance** – Language interpreting services are provided for non-English speaking patients

CVS Caremark Specialty Pharmacy serves a wide range of patient populations, including those with hemophilia, hepatitis, HIV/AIDS, cancer, multiple sclerosis and rheumatoid arthritis.

**Claim Forms**

Retail purchases out of the country, or purchases at a participating retail pharmacy without the use of your CVS Caremark Prescription ID card, are covered as follows:

<table>
<thead>
<tr>
<th>Type of Claim</th>
<th>Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claims for prescriptions for plan members who reside in a nursing home or live or travel outside the U.S. or Puerto Rico.*</td>
<td>Claims will be reimbursed at the full cost submitted less the applicable copayment.</td>
</tr>
<tr>
<td>Claims for purchases at a participating (in-network) pharmacy without a CVS Caremark Prescription ID card.</td>
<td>Claims incurred within 30 days of the member’s eligibility effective date will be covered at full cost, less the applicable copayment. -or- Claims incurred more than 30 days after the member’s eligibility effective date will be reimbursed at a discounted cost, less the applicable copayment.</td>
</tr>
</tbody>
</table>
Other Plan Provisions

Brand-Name Drugs with Exact Generic Equivalents
The plan encourages the use of generic drugs. There are some brand-name drugs, such as Ambien and Fosamax, for which exact generic equivalents are available. If you fill a prescription for a brand-name medication for which there is an exact generic equivalent, the standard brand copayment will not apply. Instead, you will be responsible for the full difference in price between the brand-name drug and the generic drug, plus the generic copayment.

Prescription Drugs with OTC Equivalents or Alternatives
Some prescription drugs have OTC equivalent products available. These OTC products have strengths, active chemical ingredients, routes of administration and dosage forms identical to the prescription drug products. Your plan does not provide benefits for prescription drugs with OTC equivalents.

Some prescription drugs also have OTC product alternatives available. These OTC products, though not identical, are very similar to the prescription drugs. For example, OTC alternatives to Clarinex, a prescription drug, are the OTC products Claritin and Zyrtec. Your plan does not provide benefits for prescription drugs when OTC alternatives are available.

Prior Authorization
Some drugs in your plan require prior authorization. If a drug that you take requires prior authorization, your physician will need to contact CVS Caremark to see if the prescription meets the plan’s conditions for coverage. If you are prescribed a drug that requires prior authorization, your physician should call (800) 626-3046.

Current examples of drugs requiring Prior Authorization*

<table>
<thead>
<tr>
<th>Actiq</th>
<th>Humira</th>
<th>Raptiva</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amevive</td>
<td>Hyalgan</td>
<td>Rebib</td>
</tr>
<tr>
<td>Aralast</td>
<td>Immune Globulin Products</td>
<td>Regranex</td>
</tr>
<tr>
<td>Aranesp</td>
<td>Kineret</td>
<td>Remicade</td>
</tr>
<tr>
<td>Amevive</td>
<td>Lamisil</td>
<td>Revatio</td>
</tr>
<tr>
<td>Avonex</td>
<td>Myobloc</td>
<td>Somavert</td>
</tr>
<tr>
<td>Betaseron</td>
<td>Neulasta</td>
<td>Sporanox</td>
</tr>
<tr>
<td>Botox</td>
<td>Neupogen</td>
<td>Supartz</td>
</tr>
<tr>
<td>Byetta</td>
<td>Nutritional Supplements</td>
<td>Synvisc</td>
</tr>
<tr>
<td>Cerezyme</td>
<td>Orencia</td>
<td>Tazorac</td>
</tr>
<tr>
<td>Copaxone</td>
<td>Orthovisc</td>
<td>Tysabri</td>
</tr>
<tr>
<td>Enbrel</td>
<td>Pegasys</td>
<td>Vfend</td>
</tr>
<tr>
<td>Epogen</td>
<td>Peg-Intron</td>
<td>Victoza</td>
</tr>
<tr>
<td>Euflexxa</td>
<td>Fabrazyme</td>
<td>Weight Loss</td>
</tr>
</tbody>
</table>

* Claims for medications filled outside the United States and Puerto Rico are covered only if the medications have U.S. equivalents.
Fentora  
Forteo  
Growth Promoting Agents  
Penlac  
Privigen  
Procrit  
Prolastin  
as Xenical and Merida  
Xolair  
Zemaira

*This list is subject to change during the year. Call CVS Caremark toll-free at (877) 876-7214 to check if your drugs are included in the program.

**Quantity Dispensing Limits**
To promote member safety and appropriate and cost-effective use of medications, your prescription plan includes a drug quantity management program. This means that for certain prescription drugs, there are limits on the quantity of the drug that you may receive at one time.

Quantity per dispensing limits are based on the following:

- The manufacturer’s recommended dosage and duration of therapy
- Common usage for episodic or intermittent treatment
- FDA-approved recommendations and/or clinical studies
- As otherwise determined by your plan

Examples of drugs with quantity limits currently include Flonase, Imitrex, Levitra, and Viagra.*

**Step Therapy**
In some cases, your plan requires the use of less expensive first-line prescription drugs before the plan will pay for more expensive second-line prescription drugs. First-line prescription drugs are safe and effective medications used for the treatment of medical conditions or diseases. Your prior claims history, if you are a continuing member of the plan, will show whether first-line prescription drugs have been purchased within the previous 180 days, allowing the second-line medication to be approved without delay.

If you have not had a medication filled within the previous 180 days while a member of this plan, a first-line prescription drug must be used and the Step Therapy requirements will apply to your prescription.

In certain situations, a member may be granted an authorization for a second-line prescription drug without the prior use of a first-line prescription drug if specific medical criteria have been met.

Unless you meet certain medical criteria or have a prior history of use of the first-line prescription drug, your pharmacist will receive a message that the prescription will not be covered. The message will list alternative, first-line drugs that could be used. You or your pharmacist will then need to contact your physician to have your prescription changed, or you will have to pay the full cost of the prescription. If you are using mail service, CVS Caremark will notify you of a delay in filling your prescription and will contact your physician about switching to a first-line prescription drug. If your physician does not respond within two business days, CVS Caremark will not fill your prescription and will return it to you.
## Current examples of prescription drugs requiring Step Therapy*

<table>
<thead>
<tr>
<th>Category</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADD/ADHD</td>
<td>Strattera, Intuniv</td>
</tr>
<tr>
<td>Allergies &amp; Asthma</td>
<td>Accolate, Beconase AQ, Omnaris, Nasacort AQ, Nasonex, Rhinocort Aqua,</td>
</tr>
<tr>
<td></td>
<td>Singulair, Veramyst, Xopenex Nebulizer Solution, Zyflo/CR</td>
</tr>
<tr>
<td>Antidepressants</td>
<td>Cymbalta, Effexor XR, Lexapro, Luvox CR, Pexeva, Pristiq, Sarafem,</td>
</tr>
<tr>
<td></td>
<td>Savella, venlafaxine extended-release</td>
</tr>
<tr>
<td>Benign Prostatic Hypertrophy (BPH)</td>
<td>Avodart</td>
</tr>
<tr>
<td>Antipsychotic</td>
<td>Symbyax</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Actos, Actoplus Met, Avandia, Avandamet, Avandaryl, Duetact</td>
</tr>
<tr>
<td>High-Blood Pressure</td>
<td>Atacand/HCT, Avapro, Avalide, Azor, Benicar/HCT, Bystolic, Coreg CR,</td>
</tr>
<tr>
<td></td>
<td>Diovan/HCT, Exforge/HCT, Innopran XL, Micardis/HCT, Teveten/HCT,</td>
</tr>
<tr>
<td></td>
<td>Twynsta</td>
</tr>
<tr>
<td>High-Cholesterol</td>
<td>Advicor, Altoprev, Caduet, Crestor, Lescol/XL, Lipitor, Livalo, Simcor,</td>
</tr>
<tr>
<td></td>
<td>Vytorin, Zetia</td>
</tr>
<tr>
<td>Incontinence</td>
<td>Detrol, Detrol LA, Enablex, Gelnique, Oxytrol, Sanctura/XR, Toviaz,</td>
</tr>
<tr>
<td></td>
<td>VESIcare</td>
</tr>
</tbody>
</table>
## Current examples of prescription drugs requiring Step Therapy*

<table>
<thead>
<tr>
<th>Category</th>
<th>Drugs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insomnia</td>
<td>Ambien CR, Edluar, Lunesta, Rozerem, Zolpimist</td>
</tr>
<tr>
<td>Neuropathy</td>
<td>Lyrica</td>
</tr>
<tr>
<td>Osteoporosis</td>
<td>Actonel, Actonel Plus Calcium, Boniva, Fosamax Plus D, Fosamax Solution, Skelid</td>
</tr>
<tr>
<td>Pain/Arthritis</td>
<td>Arthrotec, Cambia, Celebrex, Flector, Pennsaid, Voltaren gel, Zipsor</td>
</tr>
<tr>
<td>Stomach Ulcers</td>
<td>Aciphex, Dexilant, Lansoprazole, Nexium, pantoprazole, Protonix, Zegerid, Protonix packets, Prilosec packets, Prevacid Solutab</td>
</tr>
<tr>
<td>Topical Dermatitis</td>
<td>Elidel, Protopic</td>
</tr>
</tbody>
</table>

* This list is subject to change during the year. Call CVS Caremark toll-free at (877) 876-7214 to check if your drugs are included in the program.

## Drug Utilization Review Program

Each prescription drug purchased through this plan is subject to utilization review. This process evaluates the prescribed drug to determine if any of the following conditions exist:

- Adverse drug-to-drug interaction with another drug purchased through the plan;
- Duplicate prescriptions;
- Inappropriate dosage and quantity; or
- Too early refill of a prescription.

If any of the above conditions exist, medical necessity must be determined before the prescription drug can be filled.

## Exclusions

Benefits exclude:

- Smoking cessation programs or medications
• Dental preparations
• Over-the-counter drugs, vitamins or minerals (with the exception of diabetic supplies and OTC versions of omeprazole, Prevacid or Prilosec)
• Non-sedating antihistamines
• Homeopathic drugs
• Prescription products for cosmetic purposes such as photo-aged skin products and skin depigmentation products
• Medications in unit dose packaging
• Impotence medications for members under the age of 18
• Allergens
• Hair growth agents
• Special medical formulas or food products, except as required by state law

*This list is subject to change during the year.

Definitions

**Brand-Name Drug** – The brand name is the trade name under which the product is advertised and sold, and is protected by patents so that it can only be produced by one manufacturer for 17 years. Once a patent expires, other companies may manufacture a generic equivalent, providing they follow stringent FDA regulations for safety.

**Copayment** – A copayment is the amount that members pay for covered prescriptions. If the plan’s contracted cost for a medication is less than the applicable copayment, the member pays only the lesser amount.

**Diabetic Supplies** – Diabetic supplies include needles, syringes, test strips, lancets and blood glucose monitors.

**FDA** – The U.S. Food and Drug Administration.

**Formulary** – A formulary is a list of recommended prescription medications that is created, reviewed and continually updated by a team of physicians and pharmacists. The CVS Caremark formulary contains a wide range of generic and preferred brand name products that have been approved by the FDA. The formulary applies to medications that are dispensed in either the retail pharmacy or mail service settings. The formulary is developed and maintained by CVS Caremark. Formulary designations may change as new clinical information becomes available.

**Generic Drugs** – Generic versions of brand medications contain the same active ingredients as their brand counterparts, thus offering the same clinical value. The FDA requires generic drugs to be just as strong, pure and stable as brand name drugs. They must also be of the same quality and manufactured to the same rigorous standards. These requirements assure that generic drugs are as safe and effective as brand-name drugs.

**Maintenance Drug** – A maintenance drug is a medication taken on a regular basis for conditions such as asthma, diabetes, high-blood pressure or high-cholesterol.

**Non-Preferred Brand-Name Drug** – A non-preferred brand-name drug, or non-formulary drug, is a medication that has been reviewed by CVS Caremark, which determined that an alternative drug that is clinically equivalent and more cost-effective may be available.

**Over-the-Counter (OTC) Drugs** – Over-the-counter drugs are medications that do not require a prescription.
Your plan does not provide benefits for OTC drugs, with the exception of omeprazole OTC, Prevacid OTC and Prilosec OTC (which are covered if dispensed with a written prescription).

**Participating Pharmacy** – A participating pharmacy is a pharmacy in the CVS Caremark nationwide network. All major pharmacy chains and most independently-owned pharmacies participate.

**Preferred Brand-Name Drug** – A preferred brand name drug, also known as a formulary drug, is a medication that has been reviewed and approved by a group of physicians and pharmacists, and has been selected by CVS Caremark for formulary inclusion based on its proven clinical and cost-effectiveness.

**Prescription Drug** – A prescription drug is any medical substance, the label of which under the Federal Food, Drug, and Cosmetic Act, must bear the legend: “Caution Federal Law prohibits dispensing without a prescription.” The term prescription drug also includes insulin and diabetic supplies.

**Prior Authorization** – Prior authorization means determination of medical necessity. It is required before prescriptions for certain drugs will be paid by the plan.

**Special Medical Formulas or Food Products** – Special medical formulas or food products means nonprescription enteral formulas for home use for which a physician has issued a written order and which are medically necessary for the treatment of malabsorption caused by Crohn’s disease, ulcerative colitis, gastroesophageal reflux, gastrointestinal motility, chronic intestinal pseudo-obstruction, and inherited diseases of amino acids and organic acids. These products may require prior authorization to determine medical necessity.

For inherited diseases of amino acids and organic acids, food products modified to be low protein are covered up to $5,000 per calendar year per member.

To access the benefit for special medical formulas or food products, call the Group Insurance Commission at (617) 727-2310, extension 1.

**Specialty Drugs** – Specialty drugs are usually injectable and non-injectable biotech or biological drugs with one or more of several key characteristics, including:

- Requirement for frequent dosing adjustments and intensive clinical monitoring to decrease the potential for drug toxicity and to increase the probability for beneficial treatment outcomes
- Need for intensive patient training and compliance assistance to facilitate therapeutic goals
- Limited or exclusive product availability and distribution
- Specialized product handling and/or administration requirements

**Other Plan Information**

**Claims Inquiry**
If you believe a claim was incorrectly denied or you have questions about a prescription, call CVS Caremark Customer Care toll-free at (877) 876-7214. TDD: (800) 238-0756.

**Health and Prescription Information**
Health and prescription information about members is used by CVS Caremark to administer benefits. As part of the administration, CVS Caremark may report health and prescription information to the administrator or sponsor of the benefit plan. CVS Caremark also uses that information and prescription data gathered from claims nationwide for reporting and analysis without identifying individual members.

**Appendix A: GIC Notices**

**Notice of Group Insurance Commission (GIC) Privacy Practices**
Effective February 17, 2010
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

By law, the GIC must protect the privacy of your personal health information. The GIC retains this type of information because you receive health benefits from the Group Insurance Commission. Under federal law, your health information (known as “protected health information” or “PHI”) includes what health plan you are enrolled in and the type of health plan coverage you have. This notice explains your rights and our legal duties and privacy practices.

The GIC will abide by the terms of this notice. Should our information practices materially change, the GIC reserves the right to change the terms of this notice, and must abide by the terms of the notice currently in effect. Any new notice provisions will affect all protected health information we already maintain, as well as protected health information that we may receive in the future. We will mail revised notices to the address you have supplied, and will post the updated notice on our website at www.mass.gov/gic.

**Required and Permitted Uses and Disclosures**

We use and disclose protected health information (“PHI”) in a number of ways to carry out our responsibilities. The following describes the types of uses and disclosures of PHI that federal law requires or permits the GIC to make without your authorization:

**Payment activities** – The GIC may use and share PHI for plan payment activities, such as paying administrative fees for health care, paying health care claims, and determining eligibility for health benefits.

**Health Care Operations** – The GIC may use and share PHI to operate its programs that include evaluating the quality of health care services you receive, arranging for legal and auditing services (including fraud and abuse detection); and performing analyses to reduce health care costs and improve plan performance.

To Provide You Information on Health-Related Programs or Products: Such information may include alternative medical treatments or programs or health-related products and services, subject to limits imposed by law as of February 17, 2010.

**Other Permitted Uses and Disclosures** – The GIC may use and share PHI as follows:

- To resolve complaints or inquiries made on your behalf (such as appeals).
- To enable business associates that perform functions on our behalf or provide services if the information is necessary for such functions or services. Our business associates are required, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract. As of February 17, 2010, our business associates also will be directly subject to federal privacy laws.
- For data breach notification purposes. We may use your contact information to provide legally-required notices of unauthorized acquisition, access or disclosure of your health information
- To verify agency and plan performance (such as audits)
- To communicate with you about your GIC-sponsored benefits (such as your annual benefits statement)
- For judicial and administrative proceedings (such as in response to a court order)
- For research studies that meet all privacy requirements, and
- To tell you about new or changed benefits and services or health care choices

**Required Disclosures** – The GIC must use and share your PHI when requested by you or someone who has the legal right to act for you (your Personal Representative); when requested by the United States Department of Health and Human Services to make sure your privacy is being protected, and when otherwise required by law.
Organizations that Assist Us – In connection with payment and health care operations, we may share your PHI with our third party “Business Associates” that perform activities on our behalf, for example, our Indemnity Plan administrator. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we have asked of them. These business associates will be contractually bound to safeguard the privacy of your PHI.

Except as described above, the GIC will not use or disclose your PHI without your written authorization. You may give us written authorization to use or disclose your PHI to anyone for any purpose. You may revoke your authorization so long as you do so in writing; however, the GIC will not be able to get back your health information we have already used or shared based on your permission.

Your Rights
You have the right to:

• Ask to see and get a copy of your PHI that the GIC maintains. You must ask for this in writing. Under certain circumstances, we may deny your request. If the GIC did not create the information you seek, we will refer you to the source (e.g., your health plan administrator). The GIC may charge you to cover certain costs, such as copying and postage.

• Ask the GIC to amend your PHI if you believe that it is wrong or incomplete and the GIC agrees. You must ask for this in writing, along with a reason for your request. If the GIC denies your request to amend your PHI, you may file a written statement of disagreement to be included with your information for any future disclosures.

• Get a listing of those with whom the GIC shares your PHI. You must ask for this in writing. The list will not include health information that was: (1) collected prior to April 14, 2003; (2) given to you or your personal representative; (3) disclosed with your specific permission; (4) disclosed to pay for your health care treatment, payment or operations; or (5) part of a limited data set for research.

• Ask the GIC to restrict certain uses and disclosures of your PHI to carry out payment and health care operations; and disclosures to family members or friends. You must ask for this in writing. Please note that the GIC will consider the request, but we are not required to agree to it and in certain cases, federal law does not permit a restriction.

• Ask the GIC to communicate with you using reasonable alternative means or at an alternative address, if contacting you at the address we have on file for you could endanger you. You must tell us in writing that you are in danger, and where to send communications.

• Receive a separate paper copy of this notice upon request (an electronic version of this notice is on our website at www.mass.gov/gic.)

If you believe that your privacy rights may have been violated, you have the right to file a complaint with the GIC or the federal government. GIC complaints should be directed to: GIC Privacy Officer, P.O. Box 8747, Boston, MA 02114. Filing a complaint or exercising your rights will not affect your GIC benefits. To file a complaint with the federal government, you may contact the United States Secretary of Health and Human Services. To exercise any of the individual rights described in this notice, or if you need help understanding this notice, please call (617) 727-2310, extension 1 or TTY for the deaf and hard of hearing at (617) 227-8583.

Your Prescription Drug Coverage and Medicare

Important Notice from the Group Insurance Commission (GIC) about Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the Plan and about your options under Medicare’s prescription drug
coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

FOR MOST PEOPLE, THE DRUG COVERAGE THAT YOU CURRENTLY HAVE THROUGH YOUR GIC HEALTH PLAN IS A BETTER VALUE THAN THE MEDICARE DRUG PLANS, SO YOU DON'T NEED TO PAY FOR ADDITIONAL DRUG COVERAGE.

There are two important things you need to know about your current coverage and Medicare’s prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. The GIC has determined that the prescription drug coverage offered by your Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year thereafter from November 15th through December 31st.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage if You Decide to Join a Medicare Drug Plan?
• You can continue to receive prescription drug coverage through your GIC health plan rather than joining a Medicare drug plan. Most GIC members do not need to do anything and should not enroll in a Medicare drug plan.

• Your GIC drug coverage is part of your GIC health insurance which pays for your health expenses as well as your prescription drugs.

• If you elect Medicare drug coverage, you will have to pay for the entire Medicare drug coverage premium.

• If you should enroll in a Medicare drug plan while you are also enrolled in Fallon Senior Plan or Tufts Health Plan Medicare Preferred, you will lose your GIC-sponsored health plan coverage under current Medicare rules.

• If you have limited income and assets, the Social Security Administration offers help paying for Medicare prescription drug coverage. Help is available on-line at www.socialsecurity.gov, or by phone at (800) 772-1213 (TTY: (800) 325-0778).

• If you do decide to join a Medicare drug plan and drop your current GIC health coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with a GIC Medicare plan and don’t join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For More Information about This Notice or Your Current Prescription Drug Coverage …
Contact the GIC at (617) 727-2310 ext. 1. NOTE: You'll get this notice each year before the next period that you can join a Medicare drug plan, and if this coverage through the GIC changes, you will receive another notice. You also may request a copy of this notice at any time.

For More Information about Your Options under Medicare Prescription Drug Coverage …
More detailed information about Medicare plans that offer prescription drug coverage is in the “Medicare & You” handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov.
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the “Medicare & You” handbook for their telephone number) for personalized help.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Appendix B: Disclosure When Plan Meets Minimum Standards

This health plan meets the Minimum Creditable Coverage standards and will satisfy the individual mandate that you have health insurance. Please see additional information below.

MASSACHUSETTS REQUIREMENT TO PURCHASE HEALTH INSURANCE:
As of January 1, 2008, the Massachusetts Health Care Reform Law requires that Massachusetts residents, eighteen (18) years of age and older, must have health coverage that meets the Minimum
Creditable Coverage standards set by the Commonwealth Health Insurance Connector, unless waived from the health insurance requirement based on affordability or individual hardship. For more information call the Connector at 1-877-MA-ENROLL or visit the Connector website (www.mahealthconnector.org).

This health plan meets the Minimum Creditable Coverage standards that became effective July 1, 2008 as part of the Massachusetts Health Care Reform Law. If you are covered under this plan, you will satisfy the statutory requirement that you have health insurance meeting these standards.

THIS DISCLOSURE IS FOR THE MINIMUM CREDITABLE COVERAGE STANDARDS THAT ARE EFFECTIVE JANUARY 1, 2010. BECAUSE THESE STANDARDS MAY CHANGE, REVIEW YOUR HEALTH PLAN MATERIALS EACH YEAR TO DETERMINE WHETHER YOUR HEALTH PLAN MEETS THE LATEST STANDARDS.

If you have questions about this notice, you may contact the Division of Insurance by calling (617) 521-7794 or visiting its website at www.mass.gov/doi.

Appendix E: Federal and State Mandates

Medicaid and the Children’s Health Insurance Program (CHIP)

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer’s health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer’s plan. This is called a “special enrollment” opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance.

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of February 16, 2010. You should contact your State for further information on eligibility.

### ALABAMA – Medicaid

Website: http://www.medicaid.alabama.gov
Phone: 1-800-362-1504

### ALASKA – Medicaid

Website: http://health.hss.state.ak.us/dpa/programs/me
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<th>State</th>
<th>Program</th>
<th>Website</th>
<th>Phone</th>
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</table>
| Alaska        | Medicaid | Phone (Outside of Anchorage): 1-888-318-8890  
                |         | Phone (Anchorage): 907-269-6529        |             |
| Arizona       | CHIP    | Website: [http://www.azahcccs.gov/applicants/default.aspx](http://www.azahcccs.gov/applicants/default.aspx)  
                |         | Phone: 602-417-5422                    |             |
| Arkansas      | CHIP    | Website: [http://www.arkidsfirst.com/](http://www.arkidsfirst.com/)  
                |         | Phone: 1-888-474-8275                  |             |
| California    | Medicaid | Website: [http://www.dhcs.ca.gov/services/Pages/TPLD_CAU_cont.aspx](http://www.dhcs.ca.gov/services/Pages/TPLD_CAU_cont.aspx)  
                |         | Phone: 1-866-298-8443                  |             |
| Colorado      | Medicaid and CHIP | Medicaid Website: [http://www.colorado.gov/](http://www.colorado.gov/)  
                                      |             | Medicaid Phone: 1-800-866-3513         |             |
                                      |         | CHIP Website: [http://www.CHPplus.org](http://www.CHPplus.org)  
                                      |             | CHIP Phone: 303-866-3243                |             |
| Florida       | Medicaid | Website: [http://www.fdhc.state.fl.us/Medicaid/index.shtml](http://www.fdhc.state.fl.us/Medicaid/index.shtml)  
                |         | Phone: 1-866-762-2237                  |             |
| Georgia       | Medicaid | Website: [http://www.dhcs.ca.gov/services/Pages/TPLD_CAU_cont.aspx](http://www.dhcs.ca.gov/services/Pages/TPLD_CAU_cont.aspx)  
<pre><code>            |         | Phone: 1-866-298-8443                  |             |
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<td>INDIANA</td>
<td><a href="http://www.in.gov/fssa/2408.htm">http://www.in.gov/fssa/2408.htm</a></td>
<td>1-877-438-4479</td>
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<td>IOWA</td>
<td><a href="http://www.dhs.state.ia.us/hipp/">www.dhs.state.ia.us/hipp/</a></td>
<td>1-888-346-9562</td>
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<td>KANSAS</td>
<td><a href="https://www.khpa.ks.gov">https://www.khpa.ks.gov</a></td>
<td>785-296-3981</td>
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<td>KENTUCKY</td>
<td><a href="http://chfs.ky.gov/dms/default.htm">http://chfs.ky.gov/dms/default.htm</a></td>
<td>1-800-635-2570</td>
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<td>LOUISIANA</td>
<td><a href="http://www.dhh.louisiana.gov/offices/?ID=92">www.dhh.louisiana.gov/offices/?ID=92</a></td>
<td>1-888-342-0555</td>
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<td>MAINE</td>
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<td>MASSACHUSETTS</td>
<td>Medicaid &amp; CHIP Website: <a href="http://www.mass.gov/MassHealth">http://www.mass.gov/MassHealth</a></td>
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<td>Medicaid &amp; CHIP Phone: 1-800-462-1120</td>
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<td>MINNESOTA</td>
<td>Website: <a href="http://www.dhs.state.mn.us/">http://www.dhs.state.mn.us/</a> Click on Health Care, then Medical Assistance</td>
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<td>Phone: 800-657-3739</td>
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<td>MISSOURI</td>
<td>Website: <a href="http://www.dss.mo.gov/mhd/index.htm">http://www.dss.mo.gov/mhd/index.htm</a></td>
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<td>Phone: 573-751-6944</td>
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<td>MONTANA</td>
<td>Website: <a href="http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml">http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml</a></td>
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<td>Phone: 1-800-694-3084</td>
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<td>NEBRASKA</td>
<td>Website: <a href="http://www.dhhs.ne.gov/med/medindex.htm">http://www.dhhs.ne.gov/med/medindex.htm</a></td>
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<td>Phone: 1-877-255-3092</td>
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<td>NEVADA</td>
<td>Medicaid Website: <a href="http://dwss.nv.gov/">http://dwss.nv.gov/</a></td>
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<td>Medicaid Phone: 1-800-992-0900</td>
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<td>CHIP Website: <a href="http://www.nevadacheckup.nv.org/">http://www.nevadacheckup.nv.org/</a></td>
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<td>NEW HAMPSHIRE</td>
<td>Medicaid</td>
<td><a href="http://www.dhhs.state.nh.us/DHHS/MEDICAID">http://www.dhhs.state.nh.us/DHHS/MEDICAID</a></td>
<td>1-800-852-3345 x 5254</td>
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<td><a href="http://www.state.nj.us/humanservices/dmahs/clients/medicaid/">http://www.state.nj.us/humanservices/dmahs/clients/medicaid/</a></td>
<td>CHIP Phone: 1-800-701-0710</td>
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<td><a href="http://www.hsd.state.nm.us/mad/index.html">http://www.hsd.state.nm.us/mad/index.html</a></td>
<td>CHIP Phone: 1-888-997-2583</td>
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<td><a href="http://www.nyhealth.gov/health_care/medicaid/">http://www.nyhealth.gov/health_care/medicaid/</a></td>
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<td>OKLAHOMA</td>
<td>Website: <a href="http://www.insureoklahoma.org">http://www.insureoklahoma.org</a>  Phone: 1-888-365-3742</td>
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<td>PENNSYLVANIA</td>
<td>Website: <a href="http://www.dpw.state.pa.us/partnersproviders/medicalassistance/doingbusiness/003670053.htm">http://www.dpw.state.pa.us/partnersproviders/medicalassistance/doingbusiness/003670053.htm</a>  Phone: 1-800-644-7730</td>
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<td>RHODE ISLAND</td>
<td>Website: <a href="http://www.dhs.ri.gov">www.dhs.ri.gov</a>  Phone: 401-462-5300</td>
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<td>SOUTH CAROLINA</td>
<td>Website: <a href="http://www.scdhhs.gov">http://www.scdhhs.gov</a>  Phone: 1-888-549-0820</td>
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<td>TEXAS</td>
<td>Website: <a href="http://www.texas.gov">http://www.texas.gov</a>  Phone: 1-800-755-2604</td>
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<td>UTAH – Medicaid</td>
<td><a href="https://www.gethipptexas.com/">Website</a></td>
<td>1-800-440-0493</td>
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<td><a href="http://health.utah.gov/medicaid/">Website</a></td>
<td>1-866-435-7414</td>
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<td>VERMONT – Medicaid</td>
<td><a href="http://ovha.vermont.gov/">Website</a></td>
<td>1-800-250-8427</td>
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<td>VIRGINIA – Medicaid and CHIP</td>
<td>Medicaid <a href="http://www.famis.org/">Website</a></td>
<td>1-800-432-5924</td>
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<td>CHIP <a href="http://www.famis.org/">Website</a></td>
<td>1-866-873-2647</td>
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<td>WASHINGTON – Medicaid</td>
<td><a href="http://ihrsa/sites/DCS/COB/default.aspx">Website</a></td>
<td>1-800-562-6136</td>
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<td>WEST VIRGINIA – Medicaid</td>
<td><a href="http://www.wvrecovery.com/hipp.htm">Website</a></td>
<td>304-342-1604</td>
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<td>WISCONSIN – Medicaid</td>
<td><a href="http://dhs.wisconsin.gov/medicaid/publications/p-10095.htm">Website</a></td>
<td>1-800-362-3002</td>
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<td>WYOMING – Medicaid</td>
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Coverage for Reconstructive Breast Surgery

Item number 3, “Reconstructive Breast Surgery” in the “Surgical Services” subsection in the “Description of Covered Services” section on page 35 of your Member Handbook remains unchanged. However, federal law requires us to re-issue this information to our members every year. Therefore, the following information replicates the information in your Member Handbook.

3. Reconstructive breast surgery:
   
   (a) All stages of breast reconstruction following a mastectomy
   
   (b) Reconstruction of the other breast to produce a symmetrical appearance after mastectomy
   
   (c) Prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas

Benefits for reconstructive breast surgery will be payable on the same basis as any other illness or injury under the Plan, including the application of appropriate deductibles and coinsurance amounts.

Several states have enacted similar laws requiring coverage for treatment related to mastectomy. If the law of your state is applicable and is more generous than the federal law, your benefits will be paid in accordance with your state’s law.

Minimum Maternity Confinement Benefits

The subsection, “Minimum Maternity Confinement Benefits” in the “Managed Care Program” section on page 22 of your Member Handbook remains unchanged. However, we are legally required to re-send this information to our members every year. Therefore, the following information replicates the information in your Member Handbook.

Minimum Maternity Confinement Benefits

Coverage is provided for inpatient hospital services for a mother and newborn child for a minimum of:

1. 48 hours following an uncomplicated vaginal delivery, and

2. 96 hours following an uncomplicated caesarean section

Any decision to shorten the minimum confinement period will be made by the attending physician in consultation with the mother. If a shortened confinement is elected, coverage will include one home visit for post-delivery care.
Home post-delivery care is defined as health care provided to a woman at her residence by a physician, registered nurse or certified nurse midwife. The health care services provided must include, at a minimum:

1. Parent education
2. Assistance and training in breast or bottle feeding, and
3. Performance of necessary and appropriate clinical tests

Any subsequent home visits must be clinically necessary and provided by a licensed health care provider.

You must notify the Plan within 24 hours—one (1) business day—of being admitted to the hospital. Please call a patient advocate at the UniCare Customer Service Department if you have questions.

**Michelle’s Law**

Michelle’s Law extends group health benefit plan eligibility for dependent students on a medically necessary leave of absence. The law protects dependent students from losing coverage if a serious illness or injury causes them to leave school or stop going full time.

To continue coverage under Michelle’s Law, the following conditions must be met:

1. The child qualifies as a dependent under the plan
2. The child is enrolled in the health plan as a full-time student at a college or like place of higher learning
3. The child is enrolled before the first day that the medically necessary leave is needed

In addition, the child’s leave of absence must:

1. Start while the child is suffering from a serious illness or injury
2. Be medically necessary, as certified by the child’s treating physician
3. Cause the child to lose student status under the terms of the plan