POS UPFRONT PLAN DEDUCTIBLE — $500 INDIVIDUAL/$1,000 FAMILY — A

Read Your Policy Carefully – This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. Upon enrollment, it is therefore important that you **READ YOUR POLICY CAREFULLY!**

Major Medical Expense Coverage – Policies of this category are designed to provide, to persons insured, coverage for major hospital, medical, and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services, and out-of-hospital care, subject to any deductibles, copayment provisions, or other limitations, which may be set forth in the policy.

	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER COST
CONTRACT YEAR COST SHARE		
■ **Individual Plan Deductible**	$500 per Individual	$2,000 per Individual
■ **Family Plan Deductible**	$1,000 per Family	$4,000 per Family
■ **Individual Coinsurance Maximum** (does not include Plan Deductible)	Not Applicable	$3,000 per Individual
■ **Family Coinsurance Maximum** (does not include Plan Deductible)	Not Applicable	$6,000 per Family
■ **Individual Out-of-Pocket Maximum** (In-network includes Plan Deductible only) (Out-of-network includes Plan Deductible and Coinsurance Maximum)	$500 per Individual	$5,000 per Individual
■ **Family Out-of-Pocket Maximum** (In-network includes Plan Deductible only) (Out-of-network includes Plan Deductible and Coinsurance Maximum)	$1,000 per Family	$10,000 per Family
■ **Out-of-Network Reimbursement**	None	**Plan will reimburse the coinsurance percentage of the Maximum Allowable Amount**
DAILY HOSPITAL ROOM AND BOARD		
■ **Hospitalization for Illness or Injury** (includes semi-private room and board; **excludes all maternity-related services)**	$500 Copayment per day up to $2,000 per contract year after Plan Deductible	50% after Plan Deductible
■ **Skilled Nursing and Rehabilitation Facilities** (up to 100 days per contract year)	No Member cost after Plan Deductible	50% after Plan Deductible

For help or questions call 1-866-508-0618

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POS UPFRONT PLAN DEDUCTIBLE — $500 INDIVIDUAL/$1,000 FAMILY *continued*

	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER COST
MISCELLANEOUS HOSPITAL SERVICES		
■ **Emergency Room**	$150 Copayment per visit after Plan Deductible	Same as In-network
■ **Walk-In/Urgent Care Centers**	$75 Copayment per visit after Plan Deductible	Same as In-network
SURGICAL SERVICES		
■ **Ambulatory Services (Outpatient)** (includes services performed in a Hospital or ambulatory facility)	$500 Copayment per visit after Plan Deductible	50% after Plan Deductible
ANESTHESIA SERVICES		
■ **Anesthesia and oxygen services**	Included in Hospital Services	Included in Hospital Services
IN-HOSPITAL MEDICAL SERVICES		
■ **Inpatient medical services**	Included in Hospital Services	Included in Hospital Services
OUT-OF-HOSPITAL CARE		
■ **Primary Care Provider Office Services** (includes services for illness, injury, sickness, follow-up care and consultations)	$30 Copayment per visit after Plan Deductible	50% after Plan Deductible
■ **Specialist Office Services** (includes services for illness, injury, sickness, follow-up care and consultations)	$45 Copayment per visit after Plan Deductible	50% after Plan Deductible
■ **Gynecological Preventive Exam Office Services** (one per contract year)	$45 Copayment per visit	50% after Plan Deductible
■ **Maternity Care Office Services**	Not a covered benefit	Not a covered benefit
OTHER BENEFITS		
■ **Ambulance Services**	No Member cost after Plan Deductible	Same as In-network
■ **Home Health Services** (up to 100 visits per contract year)	No Member cost (Plan Deductible Waived)	25% (Plan Deductible Waived)
■ **Laboratory Services** (includes services performed in a Hospital or laboratory facility)	No Member cost after Plan Deductible	50% after Plan Deductible
■ **Non-Advanced Radiology Services** (includes services performed in a Hospital or radiology facility)	$10 Copayment per visit after Plan Deductible	50% after Plan Deductible
■ **Advanced Radiology** (includes services for MRI, PET and CAT Scan, and Nuclear Cardiology performed in a Hospital or radiology facility)	$75 Copayment per visit up to 5 Copayments per year after Plan Deductible	50% after Plan Deductible
■ **Chiropractic Services** (up to 10 visits per contract year)	$45 Copayment per visit after Plan Deductible	50% after Plan Deductible
■ **Outpatient Rehabilitative Therapy** (up to 20 visits per contract year combined for physical, speech, and occupational therapy)	$45 Copayment per visit after Plan Deductible	50% after Plan Deductible

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POS UPFRONT PLAN DEDUCTIBLE — $500 INDIVIDUAL/$1,000 FAMILY *continued*

	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER COST
Routine Vision Exam (one per contract year)	$45 Copayment per visit	50% after Plan Deductible
Durable Medical Equipment and Supplies (includes services for Durable Medical Equipment including Prosthetics, Disposable Medical Supplies and Ostomy Supplies and Equipment up to $2,500 per contract year)	20% after Plan Deductible	50% after Plan Deductible
Lifetime Maximum	Unlimited	$1,000,000 per Member

PRESCRIPTION DRUG OPTIONS

Prescription drug coverage is optional under the Point of Service plans. If selected, In-network benefits are provided for covered prescription drugs purchased through participating retail pharmacies, or through our mail-order program. There is a three-tier benefit design for covered prescription drugs: tier one drugs have the lowest copayment level; tier two drugs have an intermediate copayment level; and tier three drugs have the highest copayment level.

In-Network Prescription Drug Options

Option I/II	Tier One	Tier Two	Tier Three	Benefit Limit
30-Day supply through participating retail pharmacies	$10 Copayment	50%	50%	$1,000 or $5,000
(Copay is 2X through mail-order)	$20 Copayment	50%	50%	

Option III	Tier One	Tier Two	Tier Three	Benefit Limit
30-Day supply through participating retail pharmacies	$15 Copayment	50% ($200 Deductible)	50% ($200 Deductible)	$100 Coins Max per Script
(Copay is 2X through mail-order)	$30 Copayment	50% ($200 Deductible)	50% ($200 Deductible)	$5,000 Benefit Maximum

The Benefit Limit is a combined in-network and out-of-network Benefit Limit up to which ConnectiCare will provide coverage in a contract year. The member is responsible for prescription drug costs that exceed the Benefit Limit.

Benefit Limits are per member per contract year limits.

Out-of-network pharmacy costs is a 50% member cost share.

For help or questions call 1-866-508-0618

POS UPFRONT PLAN DEDUCTIBLE — $2,000 INDIVIDUAL/$4,000 FAMILY — A

Read Your Policy Carefully – This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. Upon enrollment, it is therefore important that you **READ YOUR POLICY CAREFULLY!**

Major Medical Expense Coverage – Policies of this category are designed to provide, to persons insured, coverage for major hospital, medical, and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services, and out-of-hospital care, subject to any deductibles, copayment provisions, or other limitations, which may be set forth in the policy.

	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER COST
CONTRACT YEAR COST SHARE		
■ **Individual Plan Deductible**	$2,000 per Individual	$4,000 per Individual
■ **Family Plan Plan Deductible**	$4,000 per Family	$8,000 per Family
■ **Individual Coinsurance Maximum**(does not include Plan Deductible)	Not Applicable	$6,000 per Individual
■ **Family Coinsurance Maximum**	Not Applicable	$12,000 per Family
■ **Individual Out-of-Pocket Maximum** (In-network includes Benefit Deductible only) (Out-of-network includes Plan Deductible and Coinsurance Maximum)	$2,000 per Individual	$10,000 per Individual
■ **Family Out-of-Pocket Maximum** (In-network includes Benefit Deductible only) (Out-of-network includes Plan Deductible and Coinsurance Maximum)	$4,000 per Family	$20,000 per Family
■ **Out-of-Network Reimbursement**	Not Applicable	**Plan will reimburse the coinsurance percentage of the Maximum Allowable Amount**
DAILY HOSPITAL ROOM AND BOARD		
■ **Hospitalization for Illness or Injury** (includes semi-private room and board; **excludes all maternity-related services)**	$500 Copayment per day up to $2,000 per contract year after Plan Deductible	50% after Plan Deductible
■ **Skilled Nursing and Rehabilitation Facilities** (up to 100 days per contract year)	No Member cost after Plan Deductible	50% after Plan Deductible

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For help or questions call 1-866-508-0618

POS UPFRONT PLAN DEDUCTIBLE — $2,000 INDIVIDUAL/$4,000 FAMILY *continued*

	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER COST
MISCELLANEOUS HOSPITAL SERVICES		
■ **Emergency Room**	$150 Copayment per visit after Plan Deductible	Same as In-network
■ **Walk-In/Urgent Care Centers**	$75 Copayment per visit after Plan Deductible	Same as In-network
SURGICAL SERVICES		
■ **Ambulatory Services (Outpatient)** (includes services performed in a Hospital or ambulatory facility)	$500 Copayment per visit after Plan Deductible	50% after Plan Deductible
ANESTHESIA SERVICES		
■ **Anesthesia and oxygen services**	Included in Hospital Services	Included in Hospital Services
IN-HOSPITAL MEDICAL SERVICES		
■ **Inpatient medical services**	Included in Hospital Services	Included in Hospital Services
OUT-OF-HOSPITAL CARE		
■ **Primary Care Provider Office Services** (includes services for illness, injury, sickness, follow-up care and consultations)	$30 Copayment per visit after Plan Deductible	50% after Plan Deductible
■ **Specialist Office Services** (includes services for illness, injury, sickness, follow-up care and consultations)	$45 Copayment per visit after Plan Deductible	50% after Plan Deductible
■ **Gynecological Preventive Exam Office Services** (one per contract year)	$45 Copayment per visit (Plan Deductible Waived)	50% after Plan Deductible
■ **Maternity Care Office Services**	Not a covered benefit	Not a covered benefit
OTHER BENEFITS		
■ **Ambulance Services**	No Member cost	Same as In-network
■ **Home Health Services** (up to 100 visits per contract year)	No Member cost (Plan Deductible Waived)	25% (Plan Deductible Waived)
■ **Laboratory Services** (includes services performed in a Hospital or laboratory facility)	No Member cost after Plan Deductible	50% after Plan Deductible
■ **Non-Advanced Radiology Services** (includes services performed in a Hospital or radiology facility)	$10 Copayment per visit after Plan Deductible	50% after Plan Deductible
■ **Advanced Radiology** (includes services for MRI, PET and CAT Scan, and Nuclear Cardiology performed in a Hospital or radiology facility)	$75 Copayment per visit up to 5 Copayments per year after Plan Deductible	50% after Plan Deductible
■ **Chiropractic Services** (up to 10 visits per contract year)	$45 Copayment per visit after Plan Deductible	50% after Plan Deductible
■ **Outpatient Rehabilitative Therapy** (up to 20 visits per contract year combined for physical, speech, and occupational therapy)	$45 Copayment per visit after Plan Deductible	50% after Plan Deductible

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POS UPFRONT PLAN DEDUCTIBLE — $2,000 INDIVIDUAL/$4,000 FAMILY *continued*

	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER COST
Routine Vision Exam (one per contract year)	$45 Copayment per visit (Plan Deductible waived)	50% after Plan Deductible
Durable Medical Equipment and Supplies (includes services for Durable Medical Equipment including Prosthetics, Disposable Medical Supplies and Ostomy Supplies and Equipment up to $2,500 per contract year)	20% after Plan Deductible	50% after Plan Deductible
Lifetime Maximum	Unlimited	$1,000,000 per Member

PRESCRIPTION DRUG OPTIONS

Prescription drug coverage is optional under the Point of Service plans. If selected, In-network benefits are provided for covered prescription drugs purchased through participating retail pharmacies, or through our mail-order program. There is a three-tier benefit design for covered prescription drugs: tier one drugs have the lowest copayment level; tier two drugs have an intermediate copayment level; and tier three drugs have the highest copayment level.

In-Network Prescription Drug Options

Option I/II	Tier One	Tier Two	Tier Three	Benefit Limit
30-Day supply through participating retail pharmacies	$10 Copayment	50%	50%	$1,000 or $5,000
(Copay is 2X through mail-order)	$20 Copayment	50%	50%	

Option III	Tier One	Tier Two	Tier Three	Benefit Limit
30-Day supply through participating retail pharmacies	$15 Copayment	50% ($200 Deductible)	50% ($200 Deductible)	$100 Coins Max per Script
(Copay is 2X through mail-order)	$30 Copayment	50% ($200 Deductible)	50% ($200 Deductible)	$5,000 Benefit Maximum

The Benefit Limit is a combined in-network and out-of-network Benefit Limit up to which ConnectiCare will provide coverage in a contract year. The member is responsible for prescription drug costs that exceed the Benefit Limit.

Benefit Limits are per member per contract year limits.

Out-of-network pharmacy costs is a 50% member cost share.

For help or questions call 1-866-508-0618

POS UPFRONT PLAN DEDUCTIBLE — $1,000 INDIVIDUAL/$2,000 FAMILY — A

Read Your Policy Carefully – This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. Upon enrollment, it is therefore important that you **READ YOUR POLICY CAREFULLY!**

Major Medical Expense Coverage – Policies of this category are designed to provide, to persons insured, coverage for major hospital, medical, and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services, and out-of-hospital care, subject to any deductibles, copayment provisions, or other limitations, which may be set forth in the policy.

	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER COST
CONTRACT YEAR COST SHARE		
■ **Individual Plan Deductible**	$1,000 per Individual	$2,000 per Individual
■ **Family Plan Plan Deductible**	$2,000 per Family	$6,000 per Family
■ **Individual Coinsurance Maximum**(does not include Plan Deductible)	Not Applicable	$4,000 per Individual
■ **Family Coinsurance Maximum**	Not Applicable	$8,000 per Family
■ **Individual Out-of-Pocket Maximum** (In-network includes Benefit Deductible only) (Out-of-network includes Plan Deductible and Coinsurance Maximum)	$1,000 per Individual	$7,000 per Individual
■ **Family Out-of-Pocket Maximum** (In-network includes Benefit Deductible only) (Out-of-network includes Plan Deductible and Coinsurance Maximum)	$2,000 per Family	$14,000 per Family
■ **Out-of-Network Reimbursement**	Not Applicable	**Plan will reimburse the coinsurance percentage of the Maximum Allowable Amount**
DAILY HOSPITAL ROOM AND BOARD		
■ **Hospitalization for Illness or Injury** (includes semi-private room and board; **excludes all maternity-related services)**	$500 Copayment per day up to $2,000 per contract year after Plan Deductible	50% after Plan Deductible
■ **Skilled Nursing and Rehabilitation Facilities** (up to 100 days per contract year)	No Member cost after Plan Deductible	50% after Plan Deductible

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For help or questions call 1-866-508-0618

POS UPFRONT PLAN DEDUCTIBLE — $1,000 INDIVIDUAL/$2,000 FAMILY *continued*

	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER COST
MISCELLANEOUS HOSPITAL SERVICES		
■ **Emergency Room**	$150 Copayment per visit after Plan Deductible	Same as In-network
■ **Walk-In/Urgent Care Centers**	$75 Copayment per visit after Plan Deductible	Same as In-network
SURGICAL SERVICES		
■ **Ambulatory Services (Outpatient)** (includes services performed in a Hospital or ambulatory facility)	$500 Copayment per visit after Plan Deductible	50% after Plan Deductible
ANESTHESIA SERVICES		
■ **Anesthesia and oxygen services**	Included in Hospital Services	Included in Hospital Services
IN-HOSPITAL MEDICAL SERVICES		
■ **Inpatient medical services**	Included in Hospital Services	Included in Hospital Services
OUT-OF-HOSPITAL CARE		
■ **Primary Care Provider Office Services** (includes services for illness, injury, sickness, follow-up care and consultations)	$30 Copayment per visit after Plan Deductible	50% after Plan Deductible
■ **Specialist Office Services** (includes services for illness, injury, sickness, follow-up care and consultations)	$45 Copayment per visit after Plan Deductible	50% after Plan Deductible
■ **Gynecological Preventive Exam Office Services** (one per contract year)	$45 Copayment per visit (Plan Deductible Waived)	50% after Plan Deductible
■ **Maternity Care Office Services**	Not a covered benefit	Not a covered benefit
OTHER BENEFITS		
■ **Ambulance Services**	No Member cost	Same as In-network
■ **Home Health Services** (up to 100 visits per contract year)	No Member cost (Plan Deductible Waived)	25% (Plan Deductible Waived)
■ **Laboratory Services** (includes services performed in a Hospital or laboratory facility)	No Member cost after Plan Deductible	50% after Plan Deductible
■ **Non-Advanced Radiology Services** (includes services performed in a Hospital or radiology facility)	$10 Copayment per visit after Plan Deductible	50% after Plan Deductible
■ **Advanced Radiology** (includes services for MRI, PET and CAT Scan, and Nuclear Cardiology performed in a Hospital or radiology facility)	$75 Copayment per visit up to 5 Copayments per year after Plan Deductible	50% after Plan Deductible
■ **Chiropractic Services** (up to 10 visits per contract year)	$45 Copayment per visit after Plan Deductible	50% after Plan Deductible
■ **Outpatient Rehabilitative Therapy** (up to 20 visits per contract year combined for physical, speech, and occupational therapy)	$45 Copayment per visit after Plan Deductible	50% after Plan Deductible

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POS UPFRONT PLAN DEDUCTIBLE — $1,000 INDIVIDUAL/$2,000 FAMILY *continued*

	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER COST
Routine Vision Exam (one per contract year)	$45 Copayment per visit (Plan Deductible waived)	50% after Plan Deductible
Durable Medical Equipment and Supplies (includes services for Durable Medical Equipment including Prosthetics, Disposable Medical Supplies and Ostomy Supplies and Equipment up to $2,500 per contract year)	20% after Plan Deductible	50% after Plan Deductible
Lifetime Maximum	Unlimited	$1,000,000 per Member

PRESCRIPTION DRUG OPTIONS

Prescription drug coverage is optional under the Point of Service plans. If selected, In-network benefits are provided for covered prescription drugs purchased through participating retail pharmacies, or through our mail-order program. There is a three-tier benefit design for covered prescription drugs: tier one drugs have the lowest copayment level; tier two drugs have an intermediate copayment level; and tier three drugs have the highest copayment level.

In-Network Prescription Drug Options

Option I/II	Tier One	Tier Two	Tier Three	Benefit Limit
30-Day supply through participating retail pharmacies	$10 Copayment	50%	50%	$1,000 or $5,000
(Copay is 2X through mail-order)	$20 Copayment	50%	50%	

Option III	Tier One	Tier Two	Tier Three	Benefit Limit
30-Day supply through participating retail pharmacies	$15 Copayment	50% ($200 Deductible)	50% ($200 Deductible)	$100 Coins Max per Script
(Copay is 2X through mail-order)	$30 Copayment	50% ($200 Deductible)	50% ($200 Deductible)	$5,000 Benefit Maximum

The Benefit Limit is a combined in-network and out-of-network Benefit Limit up to which ConnectiCare will provide coverage in a contract year. The member is responsible for prescription drug costs that exceed the Benefit Limit.

Benefit Limits are per member per contract year limits.

Out-of-network pharmacy costs is a 50% member cost share.

For help or questions call 1-866-508-0618

POS UPFRONT PLAN DEDUCTIBLE — $1,000 INDIVIDUAL/$2,000 FAMILY — 50% — A

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Major Medical Expense Coverage – Policies of this category are designed to provide, to persons insured, coverage for major hospital, medical, and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services, and out-of-hospital care, subject to any deductibles, copayment provisions, or other limitations, which may be set forth in the policy.

	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER COST
CONTRACT YEAR COST SHARE		
■ **Individual Plan Deductible**	$1,000 per Individual	$5,000 per Individual
■ **Family Plan Plan Deductible**	$2,000 per Family	$10,000 per Family
■ **Individual Coinsurance Maximum**(does not include Plan Deductible)	$5,000 per Individual	$10,000 per Individual
■ **Family Coinsurance Maximum**	$10,000 per Family	$20,000 per Family
■ **Individual Out-of-Pocket Maximum**(includes Plan Deductible and Coinsurance Maximum)	$6,000 per Individual	$15,000 per Individual
■ **Family Out-of-Pocket Maximum** (includes Plan Deductible and Coinsurance Maximum)	$12,000 per Family	$30,000 per Family
■ **Out-of-Network Reimbursement**	None	**Plan will reimburse the coinsurance percentage of the Maximum Allowable Amount**
DAILY HOSPITAL ROOM AND BOARD		
■ **Hospitalization for Illness or Injury** (includes semi-private room and board; **excludes all maternity-related services)**	50% after Plan Deductible	50% after Plan Deductible
■ **Skilled Nursing and Rehabilitation Facilities** (up to 100 days per contract year)	50% after Plan Deductible	50% after Plan Deductible

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For help or questions call 1-866-508-0618

POS UPFRONT PLAN DEDUCTIBLE — $1,000 INDIVIDUAL/$2,000 FAMILY *continued*

	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER COST
MISCELLANEOUS HOSPITAL SERVICES		
■ **Emergency Room**	50% after Plan Deductible	Same as In-network
■ **Walk-In/Urgent Care Centers**	50% after Plan Deductible	Same as In-network
SURGICAL SERVICES		
■ **Ambulatory Services (Outpatient)** (includes services performed in a Hospital or ambulatory facility)	50% after Plan Deductible	50% after Plan Deductible
ANESTHESIA SERVICES		
■ **Anesthesia and oxygen services**	Included in Hospital Services	Included in Hospital Services
IN-HOSPITAL MEDICAL SERVICES		
■ **Inpatient medical services**	Included in Hospital Services	Included in Hospital Services
OUT-OF-HOSPITAL CARE		
■ **Primary Care Provider Office Services** (includes services for illness, injury, sickness, follow-up care and consultations)	50% after Plan Deductible	50% after Plan Deductible
■ **Specialist Office Services** (includes services for illness, injury, sickness, follow-up care and consultations)	50% after Plan Deductible	50% after Plan Deductible
■ **Gynecological Preventive Exam Office Services** (one per contract year)	50% (Plan Deductible waived)	50% after Plan Deductible
■ **Maternity Care Office Services**	Not a covered benefit	Not a covered benefit
OTHER BENEFITS		
■ **Ambulance Services**	50% after Plan Deductible	Same as In-network
■ **Home Health Services** (up to 100 visits per contract year)	25% (Plan Deductible Waived)	25% (Plan Deductible Waived)
■ **Laboratory Services** (includes services performed in a Hospital or laboratory facility)	50% after Plan Deductible	50% after Plan Deductible
■ **Non-Advanced Radiology Services** (includes services performed in a Hospital or radiology facility)	50% after Plan Deductible	50% after Plan Deductible
■ **Advanced Radiology** (includes services for MRI, PET and CAT Scan, and Nuclear Cardiology performed in a Hospital or radiology facility)	50% after Plan Deductible	50% after Plan Deductible
■ **Chiropractic Services** (up to 10 visits per contract year)	50% after Plan Deductible	50% after Plan Deductible
■ **Outpatient Rehabilitative Therapy** (up to 20 visits per contract year combined for physical, speech, and occupational therapy)	50% after Plan Deductible	50% after Plan Deductible

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POS UPFRONT PLAN DEDUCTIBLE — $1,000 INDIVIDUAL/$2,000 FAMILY *continued*

	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER COST
Routine Vision Exam (one per contract year)	50% (Plan Deductible waived)	50% after Plan Deductible
Durable Medical Equipment and Supplies (includes services for Durable Medical Equipment including Prosthetics, Disposable Medical Supplies and Ostomy Supplies and Equipment up to $2,500 per contract year)	50% after Plan Deductible	50% after Plan Deductible
Lifetime Maximum	Unlimited	$1,000,000 per Member

PRESCRIPTION DRUG OPTIONS

Prescription drug coverage is optional under the Point of Service plans. If selected, In-network benefits are provided for covered prescription drugs purchased through participating retail pharmacies, or through our mail-order program. There is a three-tier benefit design for covered prescription drugs: tier one drugs have the lowest copayment level; tier two drugs have an intermediate copayment level; and tier three drugs have the highest copayment level.

In-Network Prescription Drug Options

Option I	Tier One	Tier Two	Tier Three	Benefit Limit
30-Day supply through participating retail pharmacies	$15 Copayment	50% ($200 Deductible)	50% ($200 Deductible)	$100 Coins Max per Script
(Copay is 2X through mail-order)	$30 Copayment	50% ($200 Deductible)	50% ($200 Deductible)	$5,000 Benifit Maximum

The Benefit Limit is a combined in-network and out-of-network Benefit Limit up to which ConnectiCare will provide coverage in a contract year. The member is responsible for prescription drug costs that exceed the Benefit Limit.

Benefit Limits are per member per contract year limits.

Out-of-network pharmacy costs is a 50% member cost share.

For help or questions call 1-866-508-0618

POS UPFRONT PLAN DEDUCTIBLE — $2,500 INDIVIDUAL/$5,000 FAMILY — 50% — A

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	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER COST
CONTRACT YEAR COST SHARE		
■ **Individual Plan Deductible**	$2,500 per Individual	$5,000 per Individual
■ **Family Plan Plan Deductible**	$5,000 per Family	$10,000 per Family
■ **Individual Coinsurance Maximum**(does not include Plan Deductible)	$5,000 per Individual	$10,000 per Individual
■ **Family Coinsurance Maximum**	$10,000 per Family	$20,000 per Family
■ **Individual Out-of-Pocket Maximum**(includes Plan Deductible and Coinsurance Maximum)	$7,500 per Individual	$15,000 per Individual
■ **Family Out-of-Pocket Maximum** (includes Plan Deductible and Coinsurance Maximum)	$15,000 per Family	$30,000 per Family
■ **Out-of-Network Reimbursement**	None	**Plan will reimburse the coinsurance percentage of the Maximum Allowable Amount**
DAILY HOSPITAL ROOM AND BOARD		
■ **Hospitalization for Illness or Injury** (includes semi-private room and board; **excludes all maternity-related services)**	50% after Plan Deductible	50% after Plan Deductible
■ **Skilled Nursing and Rehabilitation Facilities** (up to 100 days per contract year)	50% after Plan Deductible	50% after Plan Deductible

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For help or questions call 1-866-508-0618

POS UPFRONT PLAN DEDUCTIBLE — $2,500 INDIVIDUAL/$5,000 FAMILY *continued*

	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER COST
MISCELLANEOUS HOSPITAL SERVICES		
■ **Emergency Room**	50% after Plan Deductible	Same as In-network
■ **Walk-In/Urgent Care Centers**	50% after Plan Deductible	Same as In-network
SURGICAL SERVICES		
■ **Ambulatory Services (Outpatient)** (includes services performed in a Hospital or ambulatory facility)	50% after Plan Deductible	50% after Plan Deductible
ANESTHESIA SERVICES		
■ **Anesthesia and oxygen services**	Included in Hospital Services	Included in Hospital Services
IN-HOSPITAL MEDICAL SERVICES		
■ **Inpatient medical services**	Included in Hospital Services	Included in Hospital Services
OUT-OF-HOSPITAL CARE		
■ **Primary Care Provider Office Services** (includes services for illness, injury, sickness, follow-up care and consultations)	50% after Plan Deductible	50% after Plan Deductible
■ **Specialist Office Services** (includes services for illness, injury, sickness, follow-up care and consultations)	50% after Plan Deductible	50% after Plan Deductible
■ **Gynecological Preventive Exam Office Services** (one per contract year)	50% (Plan Deductible waived)	50% after Plan Deductible
■ **Maternity Care Office Services**	Not a covered benefit	Not a covered benefit
OTHER BENEFITS		
■ **Ambulance Services**	50% after Plan Deductible	Same as In-network
■ **Home Health Services** (up to 100 visits per contract year)	25% (Plan Deductible Waived)	25% (Plan Deductible Waived)
■ **Laboratory Services** (includes services performed in a Hospital or laboratory facility)	50% after Plan Deductible	50% after Plan Deductible
■ **Non-Advanced Radiology Services** (includes services performed in a Hospital or radiology facility)	50% after Plan Deductible	50% after Plan Deductible
■ **Advanced Radiology** (includes services for MRI, PET and CAT Scan, and Nuclear Cardiology performed in a Hospital or radiology facility)	50% after Plan Deductible	50% after Plan Deductible
■ **Chiropractic Services** (up to 10 visits per contract year)	50% after Plan Deductible	50% after Plan Deductible
■ **Outpatient Rehabilitative Therapy** (up to 20 visits per contract year combined for physical, speech, and occupational therapy)	50% after Plan Deductible	50% after Plan Deductible

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POS UPFRONT PLAN DEDUCTIBLE — $2,500 INDIVIDUAL/$5,000 FAMILY *continued*

	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER COST
Routine Vision Exam (one per contract year)	50% (Plan Deductible waived)	50% after Plan Deductible
Durable Medical Equipment and Supplies (includes services for Durable Medical Equipment including Prosthetics, Disposable Medical Supplies and Ostomy Supplies and Equipment up to $2,500 per contract year)	50% after Plan Deductible	50% after Plan Deductible
Lifetime Maximum	Unlimited	$1,000,000 per Member

PRESCRIPTION DRUG OPTIONS

Prescription drug coverage is optional under the Point of Service plans. If selected, In-network benefits are provided for covered prescription drugs purchased through participating retail pharmacies, or through our mail-order program. There is a three-tier benefit design for covered prescription drugs: tier one drugs have the lowest copayment level; tier two drugs have an intermediate copayment level; and tier three drugs have the highest copayment level.

In-Network Prescription Drug Options

Option I	Tier One	Tier Two	Tier Three	Benefit Limit
30-Day supply through participating retail pharmacies	$15 Copayment	50% ($200 Deductible)	50% ($200 Deductible)	$100 Coins Max per Script
(Copay is 2X through mail-order)	$30 Copayment	50% ($200 Deductible)	50% ($200 Deductible)	$5,000 Benifit Maximum

The Benefit Limit is a combined in-network and out-of-network Benefit Limit up to which ConnectiCare will provide coverage in a contract year. The member is responsible for prescription drug costs that exceed the Benefit Limit.

Benefit Limits are per member per contract year limits.

Out-of-network pharmacy costs is a 50% member cost share.

For help or questions call 1-866-508-0618

POS UPFRONT PLAN DEDUCTIBLE — $5,000 INDIVIDUAL/$10,000 FAMILY — 50% — A

Read Your Policy Carefully – This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. Upon enrollment, it is therefore important that you **READ YOUR POLICY CAREFULLY!**

Major Medical Expense Coverage – Policies of this category are designed to provide, to persons insured, coverage for major hospital, medical, and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services, and out-of-hospital care, subject to any deductibles, copayment provisions, or other limitations, which may be set forth in the policy.

	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER COST
CONTRACT YEAR COST SHARE		
■ **Individual Plan Deductible**	$5,000 per Individual	$10,000 per Individual
■ **Family Plan Plan Deductible**	$2,000 per Family	$20,000 per Family
■ **Individual Coinsurance Maximum**(does not include Plan Deductible)	$10,000 per Individual	$10,000 per Individual
■ **Family Coinsurance Maximum**	$20,000 per Family	$20,000 per Family
■ **Individual Out-of-Pocket Maximum**(includes Plan Deductible and Coinsurance Maximum)	$15,000 per Individual	$20,000 per Individual
■ **Family Out-of-Pocket Maximum** (includes Plan Deductible and Coinsurance Maximum)	$30,000 per Family	$40,000 per Family
■ **Out-of-Network Reimbursement**	None	**Plan will reimburse the coinsurance percentage of the Maximum Allowable Amount**
DAILY HOSPITAL ROOM AND BOARD		
■ **Hospitalization for Illness or Injury** (includes semi-private room and board; **excludes all maternity-related services)**	50% after Plan Deductible	50% after Plan Deductible
■ **Skilled Nursing and Rehabilitation Facilities** (up to 100 days per contract year)	50% after Plan Deductible	50% after Plan Deductible

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For help or questions call 1-866-508-0618

POS UPFRONT PLAN DEDUCTIBLE — $5,000 INDIVIDUAL/$10,000 FAMILY *continued*

	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER COST
MISCELLANEOUS HOSPITAL SERVICES		
■ **Emergency Room**	50% after Plan Deductible	Same as In-network
■ **Walk-In/Urgent Care Centers**	50% after Plan Deductible	Same as In-network
SURGICAL SERVICES		
■ **Ambulatory Services (Outpatient)** (includes services performed in a Hospital or ambulatory facility)	50% after Plan Deductible	50% after Plan Deductible
ANESTHESIA SERVICES		
■ **Anesthesia and oxygen services**	Included in Hospital Services	Included in Hospital Services
IN-HOSPITAL MEDICAL SERVICES		
■ **Inpatient medical services**	Included in Hospital Services	Included in Hospital Services
OUT-OF-HOSPITAL CARE		
■ **Primary Care Provider Office Services** (includes services for illness, injury, sickness, follow-up care and consultations)	50% after Plan Deductible	50% after Plan Deductible
■ **Specialist Office Services** (includes services for illness, injury, sickness, follow-up care and consultations)	50% after Plan Deductible	50% after Plan Deductible
■ **Gynecological Preventive Exam Office Services** (one per contract year)	50% (Plan Deductible waived)	50% after Plan Deductible
■ **Maternity Care Office Services**	Not a covered benefit	Not a covered benefit
OTHER BENEFITS		
■ **Ambulance Services**	50% after Plan Deductible	Same as In-network
■ **Home Health Services** (up to 100 visits per contract year)	25% (Plan Deductible Waived)	25% (Plan Deductible Waived)
■ **Laboratory Services** (includes services performed in a Hospital or laboratory facility)	50% after Plan Deductible	50% after Plan Deductible
■ **Non-Advanced Radiology Services** (includes services performed in a Hospital or radiology facility)	50% after Plan Deductible	50% after Plan Deductible
■ **Advanced Radiology** (includes services for MRI, PET and CAT Scan, and Nuclear Cardiology performed in a Hospital or radiology facility)	50% after Plan Deductible	50% after Plan Deductible
■ **Chiropractic Services** (up to 10 visits per contract year)	50% after Plan Deductible	50% after Plan Deductible
■ **Outpatient Rehabilitative Therapy** (up to 20 visits per contract year combined for physical, speech, and occupational therapy)	50% after Plan Deductible	50% after Plan Deductible

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POS UPFRONT PLAN DEDUCTIBLE — $5,000 INDIVIDUAL/$10,000 FAMILY *continued*

	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER COST
Routine Vision Exam (one per contract year)	50% (Plan Deductible waived)	50% after Plan Deductible
Durable Medical Equipment and Supplies (includes services for Durable Medical Equipment including Prosthetics, Disposable Medical Supplies and Ostomy Supplies and Equipment up to $2,500 per contract year)	50% after Plan Deductible	50% after Plan Deductible
Lifetime Maximum	Unlimited	$1,000,000 per Member

PRESCRIPTION DRUG OPTIONS

Prescription drug coverage is optional under the Point of Service plans. If selected, In-network benefits are provided for covered prescription drugs purchased through participating retail pharmacies, or through our mail-order program. There is a three-tier benefit design for covered prescription drugs: tier one drugs have the lowest copayment level; tier two drugs have an intermediate copayment level; and tier three drugs have the highest copayment level.

In-Network Prescription Drug Options

Option I	Tier One	Tier Two	Tier Three	Benefit Limit
30-Day supply through participating retail pharmacies	$15 Copayment	50% ($200 Deductible)	50% ($200 Deductible)	$100 Coins Max per Script
(Copay is 2X through mail-order)	$30 Copayment	50% ($200 Deductible)	50% ($200 Deductible)	$5,000 Benifit Maximum

The Benefit Limit is a combined in-network and out-of-network Benefit Limit up to which ConnectiCare will provide coverage in a contract year. The member is responsible for prescription drug costs that exceed the Benefit Limit.

Benefit Limits are per member per contract year limits.

Out-of-network pharmacy costs is a 50% member cost share.

For help or questions call 1-866-508-0618

POS UPFRONT PLAN DEDUCTIBLE — $5,000 INDIVIDUAL/$10,000 FAMILY — A

Read Your Policy Carefully – This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. Upon enrollment, it is therefore important that you **READ YOUR POLICY CAREFULLY!**

Major Medical Expense Coverage – Policies of this category are designed to provide, to persons insured, coverage for major hospital, medical, and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services, and out-of-hospital care, subject to any deductibles, copayment provisions, or other limitations, which may be set forth in the policy.

	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER COST
CONTRACT YEAR COST SHARE		
■ **Individual Plan Deductible**	$5,000 per Individual	$10,000 per Individual
■ **Family Plan Plan Deductible**	$10,000 per Family	$20,000 per Family
■ **Individual Coinsurance Maximum**(does not include Plan Deductible)	$5,000 per Individual	$2,500 per Individual
■ **Family Coinsurance Maximum**	$10,000 per Family	$5,000 per Family
■ **Individual Out-of-Pocket Maximum** (includes Plan Deductible and Coinsurance Maximum)	$10,000 per Individual	$12,500 per Individual
■ **Family Out-of-Pocket Maximum** (includes Plan Deductible and Coinsurance Maximum)	$20,000 per Family	$25,000 per Family
■ **Out-of-Network Reimbursement**	Not Applicable	**Plan will reimburse the coinsurance percentage of the Maximum Allowable Amount**
DAILY HOSPITAL ROOM AND BOARD		
■ **Hospitalization for Illness or Injury** (includes semi-private room and board; **excludes all maternity-related services)**	20% after Plan Deductible	50% after Plan Deductible
■ **Skilled Nursing and Rehabilitation Facilities** (up to 100 days per contract year)	20% after Plan Deductible	50% after Plan Deductible

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For help or questions call 1-866-508-0618

POS UPFRONT PLAN DEDUCTIBLE — $5,000 INDIVIDUAL/$10,000 FAMILY *continued*

	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER COST
MISCELLANEOUS HOSPITAL SERVICES		
■ **Emergency Room**	20% after Plan Deductible	Same as In-network
■ **Walk-In/Urgent Care Centers**	$50 Copayment per visit	Same as In-network
SURGICAL SERVICES		
■ **Ambulatory Services (Outpatient)** (includes services performed in a Hospital or ambulatory facility)	20% after Plan Deductible	50% after Plan Deductible
ANESTHESIA SERVICES		
■ **Anesthesia and oxygen services**	Included in Hospital Services	Included in Hospital Services
IN-HOSPITAL MEDICAL SERVICES		
■ **Inpatient medical services**	Included in Hospital Services	Included in Hospital Services
OUT-OF-HOSPITAL CARE		
■ **Primary Care Provider Office Services** (includes services for illness, injury, sickness, follow-up care and consultations)	$30 Copayment per visit	50% after Plan Deductible
■ **Specialist Office Services** (includes services for illness, injury, sickness, follow-up care and consultations)	$45 Copayment per visit	50% after Plan Deductible
■ **Gynecological Preventive Exam Office Services** (one per contract year)	$45 Copayment per visit	50% after Plan Deductible
■ **Maternity Care Office Services**	Not a covered benefit	Not a covered benefit
OTHER BENEFITS		
■ **Ambulance Services**	20% after Plan Deductible	Same as In-network
■ **Home Health Services** (up to 100 visits per contract year)	20% (Plan Deductible Waived)	25% (Plan Deductible Waived)
■ **Laboratory Services** (includes services performed in a Hospital or laboratory facility)	20% after Plan Deductible	50% after Plan Deductible
■ **Non-Advanced Radiology Services** (includes services performed in a Hospital or radiology facility)	20% after Plan Deductible	50% after Plan Deductible
■ **Advanced Radiology** (includes services for MRI, PET and CAT Scan, and Nuclear Cardiology performed in a Hospital or radiology facility)	20% after Plan Deductible	50% after Plan Deductible
■ **Chiropractic Services** (up to 10 visits per contract year)	$45 Copayment per visit	50% after Plan Deductible
■ **Outpatient Rehabilitative Therapy** (up to 20 visits per contract year combined for physical, speech, and occupational therapy)	$45 Copayment per visit	50% after Plan Deductible

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POS UPFRONT PLAN DEDUCTIBLE — $5,000 INDIVIDUAL/$10,000 FAMILY *continued*

	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER COST
Routine Vision Exam (one per contract year)	$45 Copayment per visit	50% after Plan Deductible
Durable Medical Equipment and Supplies (includes services for Durable Medical Equipment including Prosthetics, Disposable Medical Supplies and Ostomy Supplies and Equipment up to $2,500 per contract year)	20% after Plan Deductible	50% after Plan Deductible
Lifetime Maximum	Not Applicable	$1,000,000 per Member

PRESCRIPTION DRUG OPTIONS

Prescription drug coverage is optional under the Point of Service plans. If selected, In-network benefits are provided for covered prescription drugs purchased through participating retail pharmacies, or through our mail-order program. There is a three-tier benefit design for covered prescription drugs: tier one drugs have the lowest copayment level; tier two drugs have an intermediate copayment level; and tier three drugs have the highest copayment level.

In-Network Prescription Drug Options

Option I/II	Tier One	Tier Two	Tier Three	Benefit Limit
30-Day supply through participating retail pharmacies	$10 Copayment	50%	50%	$1,000 or $5,000
(Copay is 2X through mail-order)	$20 Copayment	50%	50%	

Option III	Tier One	Tier Two	Tier Three	Benefit Limit
30-Day supply through participating retail pharmacies	$15 Copayment	50% ($200 Deductible)	50% ($200 Deductible)	$100 Coins Max per Script
(Copay is 2X through mail-order)	$30 Copayment	50% ($200 Deductible)	50% ($200 Deductible)	$5,000 Benefit Maximum

The Benefit Limit is a combined in-network and out-of-network Benefit Limit up to which ConnectiCare will provide coverage in a contract year. The member is responsible for prescription drug costs that exceed the Benefit Limit.

Benefit Limits are per member per contract year limits.

Out-of-network pharmacy costs is a 50% member cost share.

For help or questions call 1-866-508-0618

POS UPFRONT PLAN DEDUCTIBLE — $10,000 COMBINED — B *continued*

	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER COST
Routine Vision Exam (one per contract year)	No Member cost after Plan Deductible	50% after Plan Deductible
Durable Medical Equipment and Supplies (includes services for Durable Medical Equipment including Prosthetics, Disposable Medical Supplies and Ostomy Supplies and Equipment up to $2,500 per contract year)	No Member cost (Plan Deductible Waived)	50% after Plan Deductible
Lifetime Maximum	Unlimited	$1,000,000 per Member

PRESCRIPTION DRUG OPTIONS

Prescription drug coverage is optional under the Point of Service plans. If selected, In-network benefits are provided for covered prescription drugs purchased through participating retail pharmacies, or through our mail-order program. There is a three-tier benefit design for covered prescription drugs: tier one drugs have the lowest copayment level; tier two drugs have an intermediate copayment level; and tier three drugs have the highest copayment level.

In-Network Prescription Drug Options

Option I/II	Tier One	Tier Two	Tier Three	Benefit Limit
30-Day supply through participating retail pharmacies	$10 Copayment	50%	50%	$1,000 or $5,000
(Copay is 2X through mail-order)	$20 Copayment	50%	50%	

Option III	Tier One	Tier Two	Tier Three	Benefit Limit
30-Day supply through participating retail pharmacies	$15 Copayment	50% ($200 Deductible)	50% ($200 Deductible)	$100 Coins Max per Script
(Copay is 2X through mail-order)	$30 Copayment	50% ($200 Deductible)	50% ($200 Deductible)	$5,000 Benefit Maximum

The Benefit Limit is a combined in-network and out-of-network Benefit Limit up to which ConnectiCare will provide coverage in a contract year. The member is responsible for prescription drug costs that exceed the Benefit Limit.

Benefit Limits are per member per contract year limits.

Out-of-network pharmacy costs is a 50% member cost share.

For help or questions call 1-866-508-0618

PLAN DEDUCTIBLE INFORMATION

The Plan Deductible **does not** apply to the following covered health services when they are rendered by a Participating Provider. Please note that the limitation provisions detailed below only show you when those services do not apply to the Plan Deductible for the identified in-network services.

- Bone Density screenings, age 50 or older, **one every 23 months**
- Colorectal cancer screenings, fecal occult blood test, sigmoidoscopy or colonoscopy (including an associated biopsy performed during a colonoscopy), age 50 or older, **one per contract year**
- Gynecological preventive exam, **one per contract year**
- Immunizations for:

  Children - Chickenpox, Diphtheria, Hemophilus Influenza B, Hepatitis A, Hepatitis B, Influenza, Measles, Meningitis, Mumps, Pertussis, Pneumococcus, Polio, Rotavirus, Rubella, and Tetanus

  Adults - Chickenpox, Diphtheria, Hemophilus Influenza B, Hepatitis A, Hepatitis B, Herpes Zoster, Influenza, Measles, Meningitis, Mumps, Pertusis, Pneumococcus, Polio, Rubella and Tetanus
- Mammography screenings for:

  One routine screening between the ages of 35 and 40, then
  One routine screening per contract year at age 40 or older
- Newborn well baby visits
- Outpatient laboratory services **(one per contract year)** associated with preventive exams *limited* to:
  - Blood count
  - Cervical cancer screening - Pap tests
  - Chlamydia and Gonorrhea screening
  - Cholesterol screening
  - Fasting plasma glucose
  - Hematocrit or hemoglobin
  - Human Papillomavirus
  - Lead screening
  - Tuberculin Test
  - Urinalysis
  - Venipuncture
- Preventive exams for adult **(one per contract year)** and pediatric exams as coded by the most current edition American Medical Association's Current Procedural Terminology Coding Manual, including an electrocardiogram
- Prostate cancer screening and associated laboratory tests, age 50 and older, **one per contract year**
- Routine vision exam, **one per contract year**

For help or questions call 1-866-508-0618

EXCLUSIONS AND LIMITATIONS

The following is a list of services, supplies, etc., that are excluded under the policy unless otherwise noted.

1. Abdominoplasty, lipectomy and panniculectomy.
2. All assistive communication devices.
3. Any treatment for which there is Insufficient Evidence Of Therapeutic Value for the use for which it is being prescribed is not covered.
4. Any treatment or services related to the provision of a non-covered benefit, including educational and administrative services related to the use or administration of a non-covered benefit, as well as evaluations and medical complications resulting from receiving services that are not covered ("Related Services"), unless **BOTH** of these conditions are met:
   - The Related Services are Medically Necessary acute inpatient care services needed by the Member to treat complications resulting from the non-covered benefit when such complications are life threatening at the time the Related Services are rendered, as determined by us, and
   - The Related Services would be a Health Service if non-covered benefit were covered by the Plan.
5. Attorney fees.
6. Benefits for services rendered before the Member's Effective Date under this Plan and after the Plan has been rescinded, suspended, canceled, or interrupted or terminated.
7. Blood donation expenses incurred by the Member's relatives or friends for their blood donated for use by the Member. Also, whole blood, blood plasma, and other blood derivatives and donor services, which are provided by the Red Cross and cord blood retrieval and storage.
8. Cardiac rehabilitation for Phase III, unless the Member meets the criteria for enrollment into our HeartCare health management program, is being actively case managed and the rehabilitation is approved by us. Phase III Cardiac Rehabilitation may be covered as part of a health management program value-added service or benefit. Phase IV cardiac rehabilitation is always excluded.
9. Care, treatment, services or supplies to the extent the Member has obtained benefits under any applicable law, government program, public or private grant, or for which there would be no charge to the Member in the absence of this Plan, except where benefits are obtained in a Veteran's Home or Hospital for a non service connected disability or as required by applicable law. However, care treatment or services that are otherwise Medically Necessary and provided in a Veteran's Hospital are covered.
10. Conditions with the following diagnoses:
    - Caffeine-related disorders,
    - Communication disorders,
    - Learning disorders,
    - Mental retardation,
    - Motor skills disorders,
    - Relational disorders,
    - Sexual deviation, and
    - Other conditions that may be a focus of clinical attention not defined as mental disorders in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders".
11. Cosmetic Treatments and procedures, including, but not limited to:
    - Any medical or Hospital services related to Cosmetic Treatments or procedures,
    - Benign nevus or any benign skin lesion removal (except when the nevus or skin lesion causes significant impairment of physical or mechanical function),
    - Benign seborrhic keratosis,
    - Blepharoplasty, unless the upper eye lid obstructs the pupil, and blepharoplasty would result in significant improvement of the upper field of vision,
    - Breast augmentation, (except or as described in the "Reconstructive Surgery" and "Durable Medical Equipment (DME) Including Prosthetics" subsections of the "Benefits" section of this Policy or as otherwise required by applicable law),
    - Dermabrasion,
    - Excision of loose or redundant skin and/or fat after the Member has had a substantial weight loss,
    - Liposuction,
    - Otoplasty,
    - Reduction mammoplasty for Members under 18, (except or as described in the "Reconstructive Surgery" and "Durable Medical Equipment (DME) Including Prosthetics" subsections of the "Benefits" section of this Policy or as otherwise required by applicable law);
    - Scar revision following surgery or injury (except when the scar causes significant impairment of physical or mechanical function,
    - Septoplasty, septorhinoplasty, and rhinoplasty, unless necessary to alleviate a significant nasal obstruction,
    - Skin tag removal,
    - Spider vein removal (including sclerotherapy),
    - Tattoo removal,
    - Treatment of craniofacial disorders, except as otherwise described in the "Craniofacial Disorders" subsection of the "Benefits" section, and
    - Vascular birthmark removal (except when the vascular birthmark causes significant impairment of physical or mechanical function).
12. Custodial Care, convalescent care, domiciliary care, and rest home care. Also care provided by home health aides that is not patient care of a medical or therapeutic nature or care provided by non-licensed professionals.

13. Dental services, including but not limited to the following are excluded, except as otherwise provided in your Benefit Summary:
    - Anesthesia, except as otherwise required by State law,
    - Bite appliances or night guards,
    - Bone grafts,
    - Correction of congenital malformation, including genial, mandibular or maxillary osteotomies, and vestibuloplasty,
    - Correction of oral malocclusion,
    - Crowns,
    - Dental implants,
    - Prosthetic devices, except as otherwise provided herein,
    - Repair, restoration or re-implantation of teeth following an injury, and
    - Tooth extractions, including impacted teeth

NOTE: some Plan options cover limited dental care as described in the "Dental Care" provisions of the "Additional Services" subsection of the "Benefits" section of this Policy.

You will know dental care is part of your Plan, if your Benefit Summary includes Dental Care provisions and corresponding Cost-Share amounts.

NOT ALL PLAN OPTIONS HAVE DENTAL CARE BENEFITS.

14. Education services, including testing, training, rehabilitative for educational purposes and screening and treatment associated with learning disabilities, unless covered under the "Autism Services" or "Birth To Three Program (Early Interventional Services)" subsections of the "Benefits" section.
15. Experimental Or Investigational treatment.
16. Family planning services, including but not limited to:
    - Contraceptive drugs and devices, except to the extent applicable insurance law requires coverage for these items. When they are covered, they are covered under our ***Prescription Drug Rider***. If you do not have our ***Prescription Drug Rider*** as part of this Plan, there is no coverage for contraceptive drugs and devices,
    - Home births (except that care related to complications of home births shall be covered),
    - Infertility services not specifically covered under the "Infertility Services" subsection of the "Benefits" section and our ***Prescription Drug Rider*** (if your Plan has this supplemental coverage), are excluded, including but not limited to the following:
        - Cryopreservation (freezing) or banking of eggs, embryos, or sperm.
        - Genetic analysis and testing, except as described in the "Infertility Services" or "Genetic Testing" subsections of the "Benefits" section.
        - Medications for sexual dysfunction.
        - Recruitment, selection and screening and any other expenses of donors (donors of eggs, embryos and sperm).
        - Reversal of surgical sterilization.
        - Surrogacy and all charges associated with surrogacy.
    - Labor doulas and labor coaches are excluded.
17. Foot orthotics, except if the member is diabetic.
18. Health club membership and exercise equipment.
19. Hearing aids, except as otherwise described in the "Durable Medical Equipment (DME), Including Prosthetics" subsection of the "Benefits" section.
20. Hypnosis (except as an integral part of psychotherapy), biofeedback (except when ordered by a physician to treat urinary incontinence), acupuncture, and certain holistic practices.
21. Infant formulas, food supplements, nutritional supplements and enteral nutritional therapy, except as provided in the "Nutritional Supplements And Food Products" subsection of the "Benefits" section of this Policy or our ***Prescription Drug Rider***, if applicable.
22. Massage, except when part of a prescribed physical or occupational therapy program if that program is a covered benefit.
23. Maternity care and treatment (pre-natal and post-natal) including home births are excluded, except that care related to complications of pregnancy is covered.
24. Medical supplies or equipment that are not considered to be durable medical equipment or disposable medical supplies or that are not on our covered list of such equipment or supplies.
25. Neuropsychological and neurobehavioral testing, except when it is performed by an appropriately licensed neurologist, psychologist, or psychiatrist and when it is performed to assess the extent of any cognitive or developmental delays due to chemotherapy or radiation treatment in a child diagnosed with cancer.
26. New Treatments for which we have not yet made a coverage policy.
27. Non-durable equipment such as orthopedic or prosthetic shoes and prophylactic anti-embolism stockings, (such as jobst stockings except when the Member has a history of deep vein thrombosis and varicose veins).
28. Non-Emergency land ambulance/medical transport services to and from a physician's office for routine care.
29. Non-Medically Necessary services or supplies.
30. Non-medical supportive counseling services (individual or group) for alcohol or substance abuse (e.g., Alcoholics Anonymous).
31. Overnight or day camps focused on illness or disability.
32. Over-the-counter (OTC) items of any kind, including but not limited to home testing or other kits and products, except as provided throughout the "Benefits" section.