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

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

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POS UPFRONT PLAN DEDUCTIBLE — $500 INDIVIDUAL/$1,000 FAMILY – C *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)	No Member cost (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 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 – C *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

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POS UPFRONT PLAN DEDUCTIBLE — $750 INDIVIDUAL/$1,500 FAMILY — C

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**	$750 per Individual	$2,000 per Individual
■ **Family Plan Deductible**	$1,500 per Family	$4,000 per Family
■ **Individual Coinsurance Maximum** (does not include Plan Deductible)	Not Applicable	$3,000 per Individual
■ **Family Coinsurance Maximum**	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)	$750 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)	$1,500 per Family	$10,000 per Family
■ **Out-of-Network Reimbursement**	N/A	**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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POS UPFRONT PLAN DEDUCTIBLE — $750 INDIVIDUAL/$1,500 FAMILY – C *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)	No Member cost (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 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 — $750 INDIVIDUAL/$1,500 FAMILY – C *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

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

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	$3,000 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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POS UPFRONT PLAN DEDUCTIBLE — $1,000 INDIVIDUAL/$2,000 FAMILY – C *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)	No Member cost (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 – C *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

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

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	$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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POS UPFRONT PLAN DEDUCTIBLE — $1,000 INDIVIDUAL/$2,000 FAMILY – 50% – C *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)	No Member cost (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 – 50% – C *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

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POS UPFRONT PLAN DEDUCTIBLE — $1,500 INDIVIDUAL/$3,000 FAMILY — 20% — C

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**	$1,500 per Individual	$4,000 per Individual
■ **Family Plan Plan Deductible**	$3,000 per Family	$8,000 per Family
■ **Individual Coinsurance Maximum**(does not include Plan Deductible)	$2,000 per Individual	$6,000 per Individual
■ **Family Coinsurance Maximum**	$4,000 per Family	$12,000 per Family
■ **Individual Out-of-Pocket Maximum**(includes Plan Deductible and Coinsurance Maximum)	$3,500 per Individual	$10,000 per Individual
■ **Family Out-of-Pocket Maximum** (includes Plan Deductible and Coinsurance Maximum)	$7,000 per Family	$20,000 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)**	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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POS UPFRONT PLAN DEDUCTIBLE — $1,500 INDIVIDUAL/$3,000 FAMILY – 20% – C *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**	20% after Plan Deductible	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)	20% after Plan Deductible	50% after Plan Deductible
■ **Specialist Office Services** (includes services for illness, injury, sickness, follow-up care and consultations)	20% after Plan Deductible	50% after Plan Deductible
■ **Gynecological Preventive Exam Office Services** (one per contract year)	No Member cost (Plan Deductible Waived)	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% after Plan Deductible (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)	20% after Plan Deductible	50% after Plan Deductible
■ **Outpatient Rehabilitative Therapy** (up to 20 visits per contract year combined for physical, speech, and occupational therapy)	20% after Plan Deductible	50% after Plan Deductible

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POS UPFRONT PLAN DEDUCTIBLE — $1,500 INDIVIDUAL/$3,000 FAMILY – 20% – C *continued*

	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER COST
■ **Routine Vision Exam** (one per contract year)	20% (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

Rates displayed are quoted rates only. Plans and rates are subject to approval by the Connecticut Insurance Department. Final rates are subject to change based on medical history, federal and state regulations, and ConnectiCare's underwriting guidelines.

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

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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POS UPFRONT PLAN DEDUCTIBLE — $2,000 INDIVIDUAL/$4,000 FAMILY – C *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)	No Member cost (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 – C *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

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

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**	$2,500 per Individual	$5,000 per Individual
■ **Family Plan Deductible**	$5,000 per Family	$10,000 per Family
■ **Individual Coinsurance Maximum** (does not include Plan Deductible)	Not Applicable	$5,000 per Individual
■ **Family Coinsurance Maximum**	Not Applicable	$10,000 per Family
■ **Individual Out-of-Pocket Maximum** (In-network includes Plan Deductible only) (Out-of-network includes Plan Deductible and Coinsurance Maximum)	$2,500 per Individual	$10,000 per Individual
■ **Family Out-of-Pocket Maximum** (In-network includes Plan Deductible only) (Out-of-network includes Plan Deductible and Coinsurance Maximum)	$5,000 per Family	$20,000 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

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POS UPFRONT PLAN DEDUCTIBLE — $2,500 INDIVIDUAL/$5,000 FAMILY – C *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)	No Member cost (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 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 — $2,500 INDIVIDUAL/$5,000 FAMILY – C *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

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POS UPFRONT PLAN DEDUCTIBLE — $2,500 INDIVIDUAL/$5,000 FAMILY — 20% — C

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**	$2,500 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)	$2,000 per Individual	$5,000 per Individual
■ **Family Coinsurance Maximum**	$4,000 per Family	$10,000 per Family
■ **Individual Out-of-Pocket Maximum** (In-network includes Plan Deductible only) (Out-of-network includes Plan Deductible and Coinsurance Maximum)	$4,500 per Individual	$10,000 per Individual
■ **Family Out-of-Pocket Maximum** (In-network includes Plan Deductible only) (Out-of-network includes Plan Deductible and Coinsurance Maximum)	$9,000 per Family	$20,000 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)**	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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POS UPFRONT PLAN DEDUCTIBLE — $2,500 INDIVIDUAL/$5,000 FAMILY — 20% — C *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**	20% after Plan Deductible	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)	20% after Plan Deductible	50% after Plan Deductible
■ **Specialist Office Services** (includes services for illness, injury, sickness, follow-up care and consultations)	20% after Plan Deductible	50% after Plan Deductible
■ **Gynecological Preventive Exam Office Services** (one per contract year)	No Member cost (Plan Deductible Waived)	50% after Plan Deductible
■ **Maternity Care Office Services**	Not a covered benefit	Not a covered benefit
OTHER BENEFITS		
■ **Ambulance Services**	20% after Plan Deductible	50% after Plan Deductible
■ **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)	20% after Plan Deductible	50% after Plan Deductible
■ **Outpatient Rehabilitative Therapy** (up to 20 visits per contract year combined for physical, speech, and occupational therapy)	20% after Plan Deductible	50% after Plan Deductible

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POS UPFRONT PLAN DEDUCTIBLE — $2,500 INDIVIDUAL/$5,000 FAMILY — 20% — C *continued*

	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER COST
■ **Routine Vision Exam** (one per contract year)	20% (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

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

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**	$2,500 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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POS UPFRONT PLAN DEDUCTIBLE — $2,500 INDIVIDUAL/$5,000 FAMILY – 50% – C *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)	No Member cost (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 – 50% – C *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

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POS COPAY AND DEDUCTIBLE — $5,000 INDIVIDUAL/$10,000 FAMILY — 20% – C

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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POS COPAY AND DEDUCTIBLE — $5,000 INDIVIDUAL/$10,000 FAMILY – 20% – C *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)	No Member cost	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 COPAY AND DEDUCTIBLE — $5,000 INDIVIDUAL/$10,000 FAMILY – 20% – C *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.

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

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	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)	$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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POS UPFRONT PLAN DEDUCTIBLE — $5,000 INDIVIDUAL/$10,000 FAMILY – 50% – C *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)	No Member cost (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 – 50% – C *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

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POS UPFRONT PLAN DEDUCTIBLE — $10,000 COMBINED — C

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
CONTACT YEAR COST SHARE	**MEMBER COST**	
■ **Individual Plan Deductible**	$10,000 per Individual	
■ **Family Plan Deductible**	$20,000 per Family	
■ **Individual Coinsurance Maximum**	$10,000 per Individual	
■ **Family Coinsurance Maximum** (does not include Plan Deductible)	$20,000 per Family	
■ **Individual Out-of-Pocket Maximum** (In-network includes Plan Deductible only) (Out-of-network includes Plan Deductible and Coinsurance Maximum)	$20,000 per Individual	
■ **Family Out-of-Pocket Maximum** (In-network includes Plan Deductible only) (Out-of-network includes Plan Deductible and Coinsurance Maximum)	$40,000 per Family	
■ **Out-of-Network Reimbursement**	**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)**	No Member cost 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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POS UPFRONT PLAN DEDUCTIBLE — $10,000 COMBINED — C *continued*

	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER COST
MISCELLANEOUS HOSPITAL SERVICES		
■ **Emergency Room**	No Member cost after Plan Deductible	Same as In-network
■ **Walk-In/Urgent Care Centers**	No Member cost after Plan Deductible	Same as In-network
SURGICAL SERVICES		
■ **Ambulatory Services (Outpatient)** (includes services performed in a Hospital or ambulatory facility)	No Member cost 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)	No Member cost after Plan Deductible	50% after Plan Deductible
■ **Specialist Office Services** (includes services for illness, injury, sickness, follow-up care and consultations)	No Member cost after Plan Deductible	50% after Plan Deductible
■ **Gynecological Preventive Exam Office Services** (one per contract year)	No Member cost (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 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)	No Member cost 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)	No Member cost after Plan Deductible	50% after Plan Deductible
■ **Chiropractic Services** (up to 10 visits per contract year)	No Member cost after Plan Deductible	50% after Plan Deductible
■ **Outpatient Rehabilitative Therapy** (up to 20 visits per contract year combined for physical, speech, and occupational therapy)	No Member cost after Plan Deductible	50% after Plan Deductible

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

	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER COST
■ **Routine Vision Exam** (one per contract year)	No Member cost (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)	No Member cost 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

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IN-NETWORK SERVICES NOT SUBJECT TO COST SHARE

In-Network Prevention and wellness services as defined by the United States Preventive Service Task Force (listed below) are exempt from all member cost shares (deductible, copayment and coinsurance) under the Patient Protection and Affordable Care Act (PPACA). These services are identified by the specific coding your Provider submits to ConnectiCare. Service coding must match ConnectiCare's coding list to be exempt from all cost sharing.

- Routine Physical Exam and appropriate screening and counseling, one per year
- Bone Density Screenings, age 60 or older, one every 23 months
- Screening for colorectal cancer using fecal occult blood testing, sigmoidoscopy, or colonoscopy, age 50 or older, one per contract year
- Routine Mammography Screening, age 40 or older, one per contract year
- Immunizations for children: Diphtheria, Hemophilus Influenza B, Hepatitis A, Hepatitis B, Influenza, Measles, Meningitis, Mumps, Pertussis, Pneumococcus, Polio, Rotavirus, Rubella, Tetanus and Varicella (chickenpox)
- Immunizations for adults: Diphtheria, Hemophilus Influenza B, Hepatitis A, Hepatitis B, Herpes Zoster, Influenza, Measles, Meningitis, Mumps, Pertussis, Pneumococcus, Polio, Rubella, Tetanus and Varicella (chickenpox)
- Outpatient laboratory services, one per contract year:
  - Cervical Cancer and Cervical Dysplasia Screening – Pap smear
  - Lipid Cholesterol Screening for adults and children at risk
  - Fasting Plasma Glucose or Hemoglobin A1c, age 18 and older for people at risk for diabetes
  - Hematocrit and Hemoglobin, for children up to age 21.
  - Lead screening, for children up to age 6
  - Tuberculin testing, for children up to age 21
  - Chlamydia, Syphilis and Gonorrhea screening for females all ages
  - Human immunodeficiency virus screening – HIV testing (no limit)
  - Screening for phenylketonuria (PKU) in newborns, under 3 months of age
  - Screening for sickle cell disease in newborns, under 3 months of age
- Routine Vision Screening, up to age 21, one per year when services are rendered by a Primary Care Provider
- Routine hearing screening up to age 21 when rendered by a Primary Care Provider
- Developmental, Autism, and Psychosocial/ behavioral assessments when rendered by a primary care provider.
- Dietary counseling for adults with hyperlipidemia or obesity
- Tobacco Cessation interventions
- Screening for Hepatitis B, Iron Deficient Anemia, Rh (D) Blood Typing and Asymptomatic Bacteriuria in women who are pregnant.
- Screening for Abdominal Aortic Aneurysm in men age 65 – 75 who have ever smoked
- BRCA counseling and genetic screening for women at risk

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" or "Genetic Testing" subsections 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.

33. Peak flow meters are excluded.
    However, peak flow meters may be covered if:
    - The Member is enrolled in our asthma health management program,
    - Is being actively case managed, and
    - The use of the peak flow meter is approved by us.

    When those conditions are met, peak flow meters may be provided as part of an asthma health management program value-added service or as a benefit.
34. Personal convenience or comfort items of any kind.
35. Physical therapy, occupational therapy, speech therapy or chiropractic therapy that is long term or maintenance in nature.
36. Private room accommodations and private duty nursing in a facility.
37. Routine foot care and treatment, unless Medically Necessary for neuro-circulatory conditions.
38. Routine physical exams and immunizations at an Urgent Care Center.
39. Sensory and auditory integration therapy, unless covered under the "Autism Services" and "Birth To Three Program (Early Intervention Services)" subsections of the "Benefits" section.
40. Services and supplies exceeding the applicable benefit maximums.
41. Services and supplies not specifically included in this Policy, except as otherwise described in one of our supplemental coverage Riders, if applicable.
42. Services or supplies rendered by a physician or provider to himself or herself, or rendered to his or her family members, such as parents, grandparents, spouse, children, step-children, grandchildren or siblings.
43. Services rendered at Hospital-based clinics are excluded unless the Hospital clinics are contracted with us for specific services.
44. Services (e.g., physical examinations, blood tests), supplies, vaccinations/immunizations and medications, including prophylactic, required by or received at a wilderness camp or a boarding school.
45. Services (e.g., physical examinations, blood tests), supplies, vaccinations/immunizations and medications, including prophylactic, required by third parties or obtained for foreign or domestic travel (e.g., employment, school, camp, licensing, insurance, travel and pursuant to a court order).
46. Sex change services.
47. Smoking cessation products are excluded, except to treat nicotine addiction. When that occurs, the product must be obtained with a prescription and Pre-Authorized.

    In addition, we may also cover smoking cessation products if:
    - The Member is enrolled in one of our health management programs,
    - The Member is being actively case managed, and
    - The use of the smoking cessation product is approved by us.

    When those conditions are met, smoking cessation products may be provided as part of a health management program value-added service or as a benefit.
48. Speech therapy for stuttering, lisp correction, or any speech impediment not related to illness or injury, except as required by applicable law.
49. Temporomandibular joint (TMJ) dysfunction or temporomandibular disease (TMD) syndrome: any non-surgical treatment, including but not limited to appliances, behavior modification, physiotherapy, and prosthodontic therapy.
50. Third party coverage, such as other primary insurance, workers' compensation and Medicare will not be duplicated.
51. Transportation, accommodation costs, and other non-medical expenses related to Health Services (whether they are recommended by a physician or not), except as otherwise described in the "Benefits" section.
52. Treatment of snoring in the absence of sleep apnea.
53. Vision services including:
    - Eyeglasses and contact lenses, unless the contact lenses are the only mechanism available to restore visual function for a Member who has no visual function or unless this Plan includes our Vision Care Rider and the Rider includes these terms.
    - Eye surgeries and procedures primarily for the purpose of correcting refractive defects of the eyes,
    - Vision and hearing examinations, except as set forth in the "Eye Care" and "Hearing Screenings" subsections of the "Benefits' section, and
    - Vision therapy and vision training.
54. War related treatment or supplies, whether the war is declared or undeclared.
55. Web visits, e-visits, and other on-line consultations, health evaluations using internet resources, as well as telephone consultations.
56. Weight loss/control treatment, programs, clinics, medications, and surgical treatment for morbid obesity.
57. Wigs, hair prosthetics, scalp hair prosthetics and cranial prosthetics, except for a wig as prescribed by an oncologist when the wig is required in connection with hair loss suffered as a result of chemotherapy or radiation therapy, as described in the "Durable Medical Supplies (DME), Including Prosthetics" subsection of the "Benefits" section.

IMPORTANT INFORMATION

Eligibility

To become eligible for benefits under this Benefit Program, the applicant must:

- Be a resident of the State of Connecticut
- Between 19 and 65 years of age

Please Note: Dependents under 19 years of age must enroll within 31 days of a qualifying event. No exceptions. Examples of a qualifying event include:

- birth of a natural child
- adopting a child
- adding step-children
- losing previous health care coverage

Spouses and dependents age 19 and over can apply anytime and are subject to medical underwriting.

Special Exemption: For these individuals with policies issued March 1, 2010 or prior, ConnectiCare will allow the policy holders to add a dependent, regardless of age, anytime, and we will medically underwrite each case and accept or deny the dependent.

Renewal Provision

The Policy will automatically renew each time you send us premium payment. Payment must be made on or before the due date or by the end of the calendar month the premium is due. Your policy will remain in force during this time. We can refuse to renew your policy only when we refuse to renew all individual plans in this State. Nonrenewal will not affect an existing claim.

Premium Rates

The amount, time and manner of payment of premium shall be determined by ConnectiCare and shall be subject to the approval of the State of Connecticut Insurance Department.

In the event of any change in premium, the subscriber will be given notice at least 30 days prior to such change. Payment of the premium by the subscriber shall serve as notice of the subscriber's acceptance of the change.

If you have questions regarding this plan, please contact your insurance agent or call us at (860) 674-3575 or 1-800-282-4722.

(860) 647-7353 or 1-866-508-0618

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

This plan is issued on an individual basis and is regulated as an individual health insurance plan.