

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

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

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

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

continued on next page

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

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

continued on next page

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

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

PRESCRIPTION DRUG OPTIONS

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

In-Network Prescription Drug Options

Option I	Tier One	Tier Two	Tier Three	Benefit Limit
30-Day supply through participating retail pharmacies	\$10 Copayment	50%	50%	\$1,000
90-Day supply through participating Mail Order Vendor	\$20 Copayment	50%	50%	

Option II	Tier One	Tier Two	Tier Three	Benefit Limit
30-Day supply through participating retail pharmacies	\$10 Copayment	50%	50%	\$5,000
90-Day supply through participating Mail Order Vendor	\$20 Copayment	50%	50%	

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.

PLAN DEDUCTIBLE INFORMATION

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

- Bone Density screenings, age 50 or older, **one every 23 months**
- Colorectal cancer screenings, fecal occult blood test, sigmoidoscopy or colonoscopy (including an associated biopsy performed during a colonoscopy), age 50 or older, **one per contract year**
- Gynecological preventive exam, **one per contract year**
- Immunizations for:
 - Children* - Chickenpox, Diphtheria, Hemophilus Influenza B, Hepatitis A, Hepatitis B, Influenza, Measles, Meningitis, Mumps, Pertussis, Pneumococcus, Polio, Rotavirus, Rubella, and Tetanus
 - Adults* - Chickenpox, Diphtheria, Hemophilus Influenza B, Hepatitis A, Hepatitis B, Herpes Zoster, Influenza, Measles, Meningitis, Mumps, Pertussis, Pneumococcus, Polio, Rubella and Tetanus
- Mammography screenings for:
 - One routine screening between the ages of 35 and 40, then**
 - One routine screening per contract year at age 40 or older**
- Newborn well baby visits
- Outpatient laboratory services (**one per contract year**) associated with preventive exams *limited to*:
 - Blood count
 - Cervical cancer screening - Pap tests
 - Chlamydia and Gonorrhea screening
 - Cholesterol screening
 - Fasting plasma glucose
 - Hematocrit or hemoglobin
 - Human Papillomavirus
 - Lead screening
 - Tuberculin Test
 - Urinalysis
 - Venipuncture
- Preventive exams for adult (**one per contract year**) and pediatric exams as coded by the most current edition American Medical Association's Current Procedural Terminology Coding Manual, including an electrocardiogram
- Prostate cancer screening and associated laboratory tests, age 50 and older, **one per contract year**
- Routine vision exam, **one per contract year**

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