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

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 *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)	20% after Plan Deductible	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 *continued*

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

ConnectiCare®

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Individual health plans the ConnectiCare way.

Prescription Drug Copayment Plan Benefit Summary

This is a brief summary of your prescription drug benefits. Refer to the appropriate ConnectiCare Insurance Company, Inc. Policy for more information. The Policy will prevail for all benefits, conditions, limitations and exclusions. It is important that you read your Policy. All Benefits described below are per Member per **Contract year**.

Prescription Drugs				
Covered prescription drugs through retail Participating Pharmacies or our mail order service. Generics are dispensed unless the Member pays the Generic Cost-Share plus the difference in price between the Generic Equivalent and the Brand Name Drug. Your Plan includes the following: Mandatory Drug Substitution, Generic Substitution Program, Tiered Cost-Share Program, and Voluntary Mail Order Program.				
	IN-NETWORK		OUT-OF-NETWORK	
Contract Year Benefit Deductible	$200 per Member $400 per Family Tier 1 drugs are exempt from this Benefit Deductible.		None	
Maximum Per Prescription	$100 Maximum Member Cost-Share per prescription. Applies to tiers 2 and 3.		None	
Prescription Drug Benefit Limit	$5,000 per Member The Prescription Drug 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.			
Out-of-Network Reimbursement	None		Plan will reimburse the coinsurance percentage of the Maximum Allowable Amount.	
RETAIL PHARMACY (up to a 30-day supply per prescription)	**MEMBER PAYS**	**PLAN PAYS**	**MEMBER PAYS**	**PLAN PAYS**
Tier 1 drugs	$15 Copayment per 30 day supply up to Benefit Limit, then no coverage	100% after Copayment up to Benefit Limit	50% Coinsurance up to Benefit Limit, then no coverage	50% Coinsurance up to Benefit Limit

RETAIL PHARMACY (up to a 30-day supply per prescription)	MEMBER PAYS	PLAN PAYS	MEMBER PAYS	PLAN PAYS
Tier 2 drugs	50% Coinsurance after Benefit Deductible up to Maximum Per Prescription up to Benefit Limit, then no coverage	50% Coinsurance after Benefit Deductible up to Maximum Per Prescription, then 100% up to Benefit Limit	50% Coinsurance up to Benefit Limit, then no coverage	50% Coinsurance up to Benefit Limit
Tier 3 drugs	50% Coinsurance after Benefit Deductible up to Maximum Per Prescription up to Benefit Limit, then no coverage	50% Coinsurance after Benefit Deductible up to Maximum Per Prescription, then 100% up to Benefit Limit	50% Coinsurance up to Benefit Limit, then no coverage	50% Coinsurance up to Benefit Limit
MAIL ORDER PHARMACY (up to a 90-day supply per prescription)	**MEMBER PAYS**	**PLAN PAYS**	**MEMBER PAYS**	**PLAN PAYS**
Tier 1 drugs	$30 Copayment per 90 day supply up to Benefit Limit, then no coverage	100% after Copayment up to Benefit Limit	Not a covered benefit	Not a covered benefit
Tier 2 drugs	50% Coinsurance after Benefit Deductible up to Maximum Per Prescription up to Benefit Limit, then no coverage	50% Coinsurance after Benefit Deductible up to Maximum Per Prescription, then 100% up to Benefit Limit	Not a covered benefit	Not a covered benefit
Tier 3 drugs	50% Coinsurance after Benefit Deductible up to Maximum Per Prescription up to Benefit Limit, then no coverage	50% Coinsurance after Benefit Deductible up to Maximum Per Prescription, then 100% up to Benefit Limit	Not a covered benefit	Not a covered benefit

Additional Information

- Under this program covered prescription drugs and supplies are put into categories (i.e., tiers) to designate how they are to be covered and the Members Cost-Share. The placement of a drug or supply into one of the tiers is determined by the ConnectiCare Pharmacy Services Department and approved by the ConnectiCare Pharmacy & Therapeutics Committee based on the drugs or supplies clinical effectiveness and cost, not on whether it is a Generic Drug Or Supply or Brand Name Drug Or Supply.
- Generic Drugs can reduce your out-of-pocket prescription costs. Generics have the same active ingredients as Brand Name Drugs, but usually cost much less. So, ask your doctor or pharmacist if a Generic alternative is available for your prescription. Also, remember to use a Participating Pharmacy. Most pharmacies in the United States participate in our network. To find one, visit our Web site at www.connecticare.com or call our Member Services Department at 1-800-251-7722.
- Certain prescription drugs and supplies require Pre-Authorization from us before they will be covered under the Prescription Drug Rider. You should visit our Web site at www.connecticare.com or call our Member Services Department at 1-800-251-7722 to find out if a prescription drug or supply requires Pre-Authorization.
- Always remember to carry your ConnectiCare ID Card.