

HMO HOSPITAL DEDUCTIBLE — \$2,000 INDIVIDUAL/\$4,000 FAMILY

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.

	MEMBER COST:
<p>BENEFIT DEDUCTIBLE</p> <p>This benefit deductible is combined for Ambulatory Services (Outpatient) and Inpatient Services including mental health and alcohol and substance abuse</p>	\$2,000 per Individual/\$4,000 per Family
<p>DAILY HOSPITAL ROOM AND BOARD</p>	
<p>■ Hospitalization for Maternity, Illness or Injury (includes semi-private room and board)</p>	\$2,000 per Individual/\$4,000 per Family
<p>■ Skilled Nursing and Rehabilitation Facilities (up to 90 days)</p>	No Member cost
<p>MISCELLANEOUS HOSPITAL SERVICES</p>	
<p>■ Emergency Room (copayment waived if admitted)</p>	\$150 Copayment per visit
<p>■ Walk-In/Urgent Care Centers</p>	\$50 Copayment per visit
<p>SURGICAL SERVICES</p>	
<p>■ Ambulatory Services (Outpatient) (includes services performed in a Hospital or ambulatory facility, including colonoscopy)</p>	\$2,000 per Individual/\$4,000 per Family
<p>ANESTHESIA SERVICES</p>	
<p>■ Anesthesia and oxygen services</p>	Included in Hospital Services
<p>IN-HOSPITAL MEDICAL SERVICES</p>	
<p>■ Inpatient medical services</p>	Included in Hospital Services

HMO HOSPITAL DEDUCTIBLE — \$2,000 INDIVIDUAL/\$4,000 FAMILY, CONT.

	MEMBER COST:
OUT-OF-HOSPITAL CARE	
■ Primary Care Physician Office Services (includes services for preventive care, illness, injury, sickness, follow-up care and consultations)	\$25 Copayment per visit
■ Specialist Office Services (includes services for illness, injury, sickness, follow-up care and consultations)	\$35 Copayment per visit
■ Gynecological Preventive Exam Office Services	\$35 Copayment per visit
■ Maternity Care Office Services	\$35 Copayment per visit for initial visit only
OTHER BENEFITS	
■ Ambulance Services	No Member cost
■ Home Health Services (up to 100 visits)	No Member cost
■ Laboratory Services (includes services performed in a Hospital or laboratory facility)	No Member cost
■ Non-Advanced Radiology (includes services performed in a Hospital or radiology facility)	No Member cost
■ Advanced Radiology (includes services for MRI, PET and CAT Scan, and Nuclear Cardiology performed in a Hospital or radiology facility)	No Member cost
■ Chiropractic Services (up to 10 visits)	\$35 Copayment per visit
■ Outpatient Rehabilitative Therapy (up to 20 visits combined for physical, speech, and occupational therapy)	\$35 Copayment per visit
■ Routine Vision Exam (one per year)	\$35 Copayment
■ Disposable Medical Supplies (up to \$300)	20%
■ Durable Medical Equipment Including Prosthetics (up to \$1,500)	20%
■ Ostomy Supplies and Equipment (up to \$1,000)	20%
LIFETIME MAXIMUM	Unlimited

HMO UPFRONT PLAN DEDUCTIBLE — \$1,500 INDIVIDUAL/\$3,000 FAMILY

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	MEMBER COST:
CALENDAR YEAR COST SHARE	
■ Individual Plan Deductible	\$1,500
■ Family Plan Deductible	\$3,000
DAILY HOSPITAL ROOM AND BOARD	
■ Hospitalization for Maternity, Illness or Injury (includes semi-private room and board)	\$100 Copayment per day up to \$500 per calendar year after Plan Deductible
■ Skilled Nursing and Rehabilitation Facilities (up to 90 days)	No Member cost after Plan Deductible
MISCELLANEOUS HOSPITAL SERVICES	
■ Emergency Room (copayment waived if admitted)	\$150 Copayment per visit after Plan Deductible
■ Walk-In/Urgent Care Centers	\$50 Copayment per visit after Plan Deductible
SURGICAL SERVICES	
■ Ambulatory Services (Outpatient) (includes services performed in a Hospital or ambulatory facility)	\$100 Copayment per visit after Plan Deductible
ANESTHESIA SERVICES	
■ Anesthesia and oxygen services	Included in Hospital Services
IN-HOSPITAL MEDICAL SERVICES	
■ Inpatient medical services	Included in Hospital Services
OUT-OF-HOSPITAL CARE	
■ Primary Care Physician Office Services (includes services for illness, injury, sickness, follow-up care and consultations) (The Plan Deductible does not apply to some preventive care services. Refer to Plan Deductible Information for details.)	\$25 Copayment per visit after Plan Deductible

HMO UPFRONT PLAN DEDUCTIBLE— \$1,500 INDIVIDUAL/\$3,000 FAMILY, CONT.

	MEMBER COST:
OUT-OF-HOSPITAL CARE, CONT.	
<ul style="list-style-type: none"> ■ Specialist Office Services (includes services for illness, injury, sickness, follow-up care and consultations) 	\$35 Copayment per visit after Plan Deductible
<ul style="list-style-type: none"> ■ Gynecological Preventive Exam Office Services 	\$35 Copayment per visit
<ul style="list-style-type: none"> ■ Maternity Care Office Services 	\$35 Copayment per visit for initial visit only after Plan Deductible
OTHER BENEFITS	
<ul style="list-style-type: none"> ■ Ambulance Services 	No Member cost after Plan Deductible
<ul style="list-style-type: none"> ■ Home Health Services (up to 100 visits) 	No Member cost
<ul style="list-style-type: none"> ■ Laboratory Services (includes services performed in a Hospital or laboratory facility) 	No Member cost after Plan Deductible
<ul style="list-style-type: none"> ■ Non-Advanced Radiology (includes services performed in a Hospital or radiology facility) 	No Member cost after Plan Deductible
<ul style="list-style-type: none"> ■ 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
<ul style="list-style-type: none"> ■ Chiropractic Services (up to 10 visits) 	\$35 Copayment per visit after Plan Deductible
<ul style="list-style-type: none"> ■ Outpatient Rehabilitative Therapy (up to 20 visits combined for physical, speech, and occupational therapy) 	\$35 Copayment per visit after Plan Deductible
<ul style="list-style-type: none"> ■ Routine Vision Exam (one per year) 	\$35 Copayment
<ul style="list-style-type: none"> ■ Disposable Medical Supplies (up to \$300) 	20% after Plan Deductible
<ul style="list-style-type: none"> ■ Durable Medical Equipment Including Prosthetics (up to \$1,500) 	20% after Plan Deductible
<ul style="list-style-type: none"> ■ Ostomy Supplies and Equipment (up to \$1,000) 	20% after Plan Deductible
LIFETIME MAXIMUM	Unlimited

HMO UPFRONT PLAN DEDUCTIBLE — \$2,500 INDIVIDUAL/\$5,000 FAMILY

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

MEMBER COST:

CALENDAR YEAR COST SHARE

■ Individual Plan Deductible	\$2,500
■ Family Plan Deductible	\$5,000

DAILY HOSPITAL ROOM AND BOARD

■ Hospitalization for Maternity, Illness or Injury (includes semi-private room and board)	\$100 Copayment per day up to \$500 per calendar year after Plan Deductible
■ Skilled Nursing and Rehabilitation Facilities (up to 90 days)	No Member cost after Plan Deductible

MISCELLANEOUS HOSPITAL SERVICES

■ Emergency Room (copayment waived if admitted)	\$150 Copayment per visit after Plan Deductible
■ Walk-In/Urgent Care Centers	\$50 Copayment per visit after Plan Deductible

SURGICAL SERVICES

■ Ambulatory Services (Outpatient) (includes services performed in a Hospital or ambulatory facility)	\$100 Copayment per visit after Plan Deductible
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ANESTHESIA SERVICES

■ Anesthesia and oxygen services	Included in Hospital Services
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IN-HOSPITAL MEDICAL SERVICES

■ Inpatient medical services	Included in Hospital Services
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OUT-OF-HOSPITAL CARE

■ Primary Care Physician Office Services (includes services for illness, injury, sickness, follow-up care and consultations) (The Plan Deductible does not apply to some preventive care services. Refer to Plan Deductible Information for details.)	\$25 Copayment per visit after Plan Deductible
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HMO UPFRONT PLAN DEDUCTIBLE— \$2,500 INDIVIDUAL/\$5,000 FAMILY, CONT.

OUT-OF-HOSPITAL CARE, CONT.

■ Specialist Office Services (includes services for illness, injury, sickness, follow-up care and consultations)	\$35 Copayment per visit after Plan Deductible
■ Gynecological Preventive Exam Office Services	\$35 Copayment per visit
■ Maternity Care Office Services	\$35 Copayment per visit for initial visit only after Plan Deductible

OTHER BENEFITS

■ Ambulance Services	No Member cost after Plan Deductible
■ Home Health Services (up to 100 visits)	No Member cost
■ Laboratory Services (includes services performed in a Hospital or laboratory facility)	No Member cost after Plan Deductible
■ Non-Advanced Radiology (includes services performed in a Hospital or radiology facility)	No Member cost 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
■ Chiropractic Services (up to 10 visits)	\$35 Copayment per visit after Plan Deductible
■ Outpatient Rehabilitative Therapy (up to 20 visits combined for physical, speech, and occupational therapy)	\$35 Copayment per visit after Plan Deductible
■ Routine Vision Exam (one per year)	\$35 copayment
■ Disposable Medical Supplies (up to \$300)	20% after Plan Deductible
■ Durable Medical Equipment Including Prosthetics (up to \$1,500)	20% after Plan Deductible
■ Ostomy Supplies and Equipment (up to \$1,000)	20% after Plan Deductible

LIFETIME MAXIMUM	Unlimited
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PRESCRIPTION DRUG OPTIONS

Benefits for prescription drugs are provided 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 Member cost share level; tier two drugs have an intermediate member cost share level; and tier three drugs have the highest Member cost share level.

In-Network Prescription Drug Options

Option I	Tier One	Tier Two	Tier Three	Benefit Limit
30-Day supply through participating retail pharmacies	\$10	\$20	\$35	\$1,000 \$2,000 \$3,000
90-Day supply through participating Mail Order Vendor	\$20	\$40	\$70	

Option II	Tier One	Tier Two	Tier Three	Benefit Limit
30-Day supply through participating retail pharmacies	\$15	\$25	\$40	\$1,000 \$2,000 \$3,000
90-Day supply through participating Mail Order Vendor	\$30	\$50	\$80	

In-Network Prescription Drug Option for HMO 30/45 Hospital Copayment — \$500 with Radiology Copay Plan Only

Option I	Tier One	Tier Two	Tier Three	Benefit Limit
30-Day supply through participating retail pharmacies	\$20	50%	50%	\$3,000
90-Day supply through participating Mail Order Vendor	\$40	50%	50%	

The Benefit Limit is the limit to which ConnectiCare will provide coverage in a calendar year. The Member is responsible for prescription drug costs that exceed the Benefit Limit.

Benefit Limits are per Member per calendar year limits.