

## POS \$25/\$35 — HOSPITAL COPAYMENT \$500

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

	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER COST
<b>CALENDAR YEAR COST SHARE</b>		
■ <b>Individual Plan Deductible</b>	None	\$5,000
■ <b>Family Plan Deductible</b>	None	\$10,000
■ <b>Individual Out-of-Pocket Maximum</b> (includes Plan Deductible and Coinsurance)	None	\$10,000
■ <b>Family Out-of-Pocket Maximum</b> (includes Plan Deductible and Coinsurance)	None	\$20,000
■ <b>Out-of-Network Reimbursement</b>	None	Plan will reimburse up to the Maximum Allowable Amount
<b>DAILY HOSPITAL ROOM AND BOARD</b>		
■ <b>Hospitalization for Illness or Injury</b> (includes semi-private room and board; <b>excludes all maternity-related services</b> )	\$500 Copayment per day up to \$2,000 per year	30% after Plan Deductible
■ <b>Skilled Nursing and Rehabilitation Facilities</b> (up to 90 days)	No Member cost	30% after Plan Deductible
<b>MISCELLANEOUS HOSPITAL SERVICES</b>		
■ <b>Emergency Room</b> (Copayment waived if admitted)	\$150 Copayment per visit	\$150 Copayment per visit
■ <b>Walk-In/Urgent Care Centers</b>	\$50 Copayment per visit	\$50 Copayment per visit
<b>SURGICAL SERVICES</b>		
■ <b>Ambulatory Services (Outpatient)</b> (includes services performed in a Hospital or ambulatory facility)	\$500 Copayment per visit	30% after Plan Deductible
<b>ANESTHESIA SERVICES</b>		
■ <b>Anesthesia and oxygen services</b>	Included in Hospital Services	Included in Hospital Services

POS \$25/\$35 — HOSPITAL COPAYMENT \$500, CONT.

	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER COST
<b>IN-HOSPITAL MEDICAL SERVICES</b>		
■ <b>Inpatient medical services</b>	Included in Hospital Services	Included in Hospital Services
<b>OUT-OF-HOSPITAL CARE</b>		
■ <b>Primary Care Physician Office Services</b> (includes services for illness, injury, sickness, follow-up care and consultations)	\$25 Copayment per visit	30% after Plan Deductible
■ <b>Specialist Office Services</b> (includes services for illness, injury, sickness, follow-up care and consultations)	\$35 Copayment per visit	30% after Plan Deductible
■ <b>Gynecological Preventive Exam Office Services</b>	\$35 Copayment per visit	30% after Plan Deductible
■ <b>Maternity Care Office Services</b>	<b>Not a covered benefit</b>	<b>Not a covered benefit</b>
<b>OTHER BENEFITS</b>		
■ <b>Ambulance Services</b>	No Member cost	No Member cost after Plan Deductible
■ <b>Home Health Services</b> (up to 100 visits)	No Member cost	25%
■ <b>Laboratory Services</b> (includes services performed in a Hospital or laboratory facility)	No Member cost	30% after Plan Deductible
■ <b>Non-Advanced Radiology</b> (includes services performed in a Hospital or radiology facility)	\$10 Copayment per visit	30% after Plan Deductible
■ <b>Advanced Radiology</b> (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	30% after Plan Deductible
■ <b>Chiropractic Services</b> (up to 10 visits)	\$35 Copayment per visit	30% after Plan Deductible
■ <b>Outpatient Rehabilitative Therapy</b> (up to 20 visits combined for physical, speech, and occupational therapy)	\$35 Copayment per visit	30% after Plan Deductible
■ <b>Routine Vision Exam</b> (one per year)	\$35 Copayment	30% after Plan Deductible
■ <b>Disposable Medical Supplies</b> (up to \$300)	20%	30% after Plan Deductible
■ <b>Durable Medical Equipment Including Prosthetics</b> (up to \$1,500)	20%	30% after Plan Deductible
■ <b>Ostomy Supplies and Equipment</b> (up to \$1,000)	20%	30% after Plan Deductible
<b>LIFETIME MAXIMUM</b>	Unlimited	\$1,000,000

## POS \$30/\$45 — HOSPITAL DEDUCTIBLE \$2,000 INDIVIDUAL/\$4,000 FAMILY

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	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER COST
<b>BENEFIT DEDUCTIBLE</b>		
This benefit deductible is combined for Ambulatory Services (Outpatient) and Inpatient Services including mental health and alcohol and substance abuse		
■ <b>Individual Plan Deductible</b>	\$2,000	None
■ <b>Family Plan Deductible</b>	\$4,000	None
<b>CALENDAR YEAR COST SHARE</b>		
■ <b>Individual Plan Deductible</b>	None	\$5,000
■ <b>Family Plan Deductible</b>	None	\$10,000
■ <b>Individual Out-of-Pocket Maximum</b> (includes Plan Deductible and Coinsurance)	None	\$10,000
■ <b>Family Out-of-Pocket Maximum</b> (includes Plan Deductible and Coinsurance)	None	\$20,000
■ <b>Out-of-Network Reimbursement</b>	None	Plan will reimburse up to the Maximum Allowable Amount
<b>DAILY HOSPITAL ROOM AND BOARD</b>		
■ <b>Hospitalization for Illness or Injury</b> (includes semi-private room and board; <b>excludes all maternity-related services</b> )	\$2,000 per Individual, \$4,000 per Family	30% after Plan Deductible
■ <b>Skilled Nursing and Rehabilitation Facilities</b> (up to 90 days)	No Member cost	30% after Plan Deductible
<b>MISCELLANEOUS HOSPITAL SERVICES</b>		
■ <b>Emergency Room</b> (Copayment waived if admitted)	\$150 Copayment per visit	\$150 Copayment per visit
■ <b>Walk-In/Urgent Care Centers</b>	\$50 Copayment per visit	\$50 Copayment per visit
<b>SURGICAL SERVICES</b>		
■ <b>Ambulatory Services (Outpatient)</b> (includes services performed in a Hospital or ambulatory facility)	\$2,000 per Individual, \$4,000 per Family	30% after Plan Deductible

POS \$30/\$45 HOSPITAL DEDUCTIBLE — \$2,000 INDIVIDUAL/\$4,000 FAMILY, CONT.

	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER COST
<b>ANESTHESIA SERVICES</b>		
■ <b>Anesthesia and oxygen services</b>	Included in Hospital Services	Included in Hospital Services
<b>IN-HOSPITAL MEDICAL SERVICES</b>		
■ <b>Inpatient medical services</b>	Included in Hospital Services	Included in Hospital Services
<b>OUT-OF-HOSPITAL CARE</b>		
■ <b>Primary Care Physician Office Services</b> (includes services for illness, injury, sickness, follow-up care and consultations) (The Plan Deductible does not apply to some in-network preventive care services. Refer to Plan Deductible Information for details.)	\$30 Copayment per visit	30% after Plan Deductible
■ <b>Specialist Office Services</b> (includes services for illness, injury, sickness, follow-up care and consultations)	\$45 Copayment per visit	30% after Plan Deductible
■ <b>Gynecological Preventive Exam Office Services</b>	\$45 Copayment per visit	30% after Plan Deductible
■ <b>Maternity Care Office Services</b>	<b>Not a covered benefit</b>	<b>Not a covered benefit</b>
<b>OTHER BENEFITS</b>		
■ <b>Ambulance Services</b>	No Member cost	No Member cost after Plan Deductible
■ <b>Home Health Services</b> (up to 100 visits)	No Member cost	25%
■ <b>Laboratory Services</b> (includes services performed in a Hospital or laboratory facility)	No Member cost	30% after Plan Deductible
■ <b>Non-Advanced Radiology</b> (includes services performed in a Hospital or radiology facility)	\$10 Copayment per visit	30% after Plan Deductible
■ <b>Advanced Radiology</b> (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	30% after Plan Deductible
■ <b>Chiropractic Services</b> (up to 10 visits)	\$45 Copayment per visit	30% after Plan Deductible
■ <b>Outpatient Rehabilitative Therapy</b> (up to 20 visits combined for physical, speech, and occupational therapy)	\$45 Copayment per visit	30% after Plan Deductible
■ <b>Routine Vision Exam</b> (one per year)	\$45 Copayment	30% after Plan Deductible
■ <b>Disposable Medical Supplies</b> (up to \$300)	20%	30% after Plan Deductible
■ <b>Durable Medical Equipment Including Prosthetics</b> (up to \$1,500)	20%	30% after Plan Deductible
■ <b>Ostomy Supplies and Equipment</b> (up to \$1,000)	20%	30% after Plan Deductible
<b>LIFETIME MAXIMUM</b>	Unlimited	\$1,000,000

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

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	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER COST
<b>CALENDAR YEAR COST SHARE</b>		
■ <b>Individual Plan Deductible</b>	\$500	\$1,500
■ <b>Family Plan Deductible</b>	\$1,000	\$3,000
■ <b>Individual Out-of-Pocket Maximum</b> (includes Plan Deductible and Coinsurance)	None	\$3,000
■ <b>Family Out-of-Pocket Maximum</b> (includes Plan Deductible and Coinsurance)	None	\$6,000
■ <b>Out-of-Network Reimbursement</b>	None	Plan will reimburse up to the Maximum Allowable Amount
<b>DAILY HOSPITAL ROOM AND BOARD</b>		
■ <b>Hospitalization for Illness or Injury</b> (includes semi-private room and board; <b>excludes all maternity-related services</b> )	\$500 Copayment per admission after Plan Deductible	30% after Plan Deductible
■ <b>Skilled Nursing and Rehabilitation Facilities</b> (up to 90 days)	No Member cost after Plan Deductible	30% after Plan Deductible
<b>MISCELLANEOUS HOSPITAL SERVICES</b>		
■ <b>Emergency Room</b> (Copayment waived if admitted)	\$150 Copayment per visit after Plan Deductible	\$150 Copayment per visit after Plan Deductible
■ <b>Walk-In/Urgent Care Centers</b>	\$50 Copayment per visit after Plan Deductible	\$50 Copayment per visit after Plan Deductible
<b>SURGICAL SERVICES</b>		
■ <b>Ambulatory Services (Outpatient)</b> (includes services performed in a Hospital or ambulatory facility)	\$250 Copayment per visit after Plan Deductible	30% after Plan Deductible
<b>ANESTHESIA SERVICES</b>		
■ <b>Anesthesia and oxygen services</b>	Included in Hospital Services	Included in Hospital Services

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

	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER COST
<b>IN-HOSPITAL MEDICAL SERVICES</b>		
■ <b>Inpatient medical services</b>	Included in Hospital Services	Included in Hospital Services
<b>OUT-OF-HOSPITAL CARE</b>		
■ <b>Primary Care Physician Office Services</b> (includes services for illness, injury, sickness, follow-up care and consultations) (The Plan Deductible does not apply to some in-network preventive care services. Refer to Plan Deductible Information for details.)	\$25 Copayment per visit after Plan Deductible	30% after Plan Deductible
■ <b>Specialist Office Services</b> (includes services for illness, injury, sickness, follow-up care and consultations)	\$35 Copayment per visit after Plan Deductible	30% after Plan Deductible
■ <b>Gynecological Preventive Exam Office Services</b>	\$35 Copayment per visit	30% after Plan Deductible
■ <b>Maternity Care Office Services</b>	<b>Not a covered benefit</b>	<b>Not a covered benefit</b>
<b>OTHER BENEFITS</b>		
■ <b>Ambulance Services</b>	No Member cost after Plan Deductible	No Member cost after Plan Deductible
■ <b>Home Health Services</b> (up to 100 visits)	No Member cost	25%
■ <b>Laboratory Services</b> (includes services performed in a Hospital or laboratory facility)	No Member cost after Plan Deductible	30% after Plan Deductible
■ <b>Non-Advanced Radiology</b> (includes services performed in a Hospital or radiology facility)	No Member cost after Plan Deductible	30% after Plan Deductible
■ <b>Advanced Radiology</b> (includes services for MRI, PET and CAT Scan, and Nuclear Cardiology performed in a Hospital or radiology facility)	No Member cost after Plan Deductible	30% after Plan Deductible
■ <b>Chiropractic Services</b> (up to 10 visits)	\$35 Copayment per visit after Plan Deductible	30% after Plan Deductible
■ <b>Outpatient Rehabilitative Therapy</b> (up to 20 visits combined for physical, speech, and occupational therapy)	\$35 Copayment per visit after Plan Deductible	30% after Plan Deductible
■ <b>Routine Vision Exam</b> (one per year)	\$35 Copayment	30% after Plan Deductible
■ <b>Disposable Medical Supplies</b> (up to \$300)	20% after Plan Deductible	30% after Plan Deductible
■ <b>Durable Medical Equipment Including Prosthetics</b> (up to \$1,500)	20% after Plan Deductible	30% after Plan Deductible
■ <b>Ostomy Supplies and Equipment</b> (up to \$1,000)	20% after Plan Deductible	30% after Plan Deductible
<b>LIFETIME MAXIMUM</b>	Unlimited	\$1,000,000

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

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	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER COST
<b>CALENDAR YEAR COST SHARE</b>		
■ <b>Individual Plan Deductible</b>	\$1,000	\$2,000
■ <b>Family Plan Deductible</b>	\$2,000	\$4,000
■ <b>Individual Out-of-Pocket Maximum</b> (includes Plan Deductible and Coinsurance)	None	\$5,000
■ <b>Family Out-of-Pocket Maximum</b> (includes Plan Deductible and Coinsurance)	None	\$10,000
■ <b>Out-of-Network Reimbursement</b>	None	Plan will reimburse up to the Maximum Allowable Amount
<b>DAILY HOSPITAL ROOM AND BOARD</b>		
■ <b>Hospitalization for Illness or Injury</b> (includes semi-private room and board; <b>excludes all maternity-related services</b> )	\$500 Copayment per admission after Plan Deductible	30% after Plan Deductible
■ <b>Skilled Nursing and Rehabilitation Facilities</b> (up to 90 days)	No Member cost after Plan Deductible	30% after Plan Deductible
<b>MISCELLANEOUS HOSPITAL SERVICES</b>		
■ <b>Emergency Room</b> (Copayment waived if admitted)	\$150 Copayment per visit after Plan Deductible	\$150 Copayment per visit after Plan Deductible
■ <b>Walk-In/Urgent Care Centers</b>	\$50 Copayment per visit after Plan Deductible	\$50 Copayment per visit after Plan Deductible
<b>SURGICAL SERVICES</b>		
■ <b>Ambulatory Services (Outpatient)</b> (includes services performed in a Hospital or ambulatory facility)	\$250 Copayment per visit after Plan Deductible	30% after Plan Deductible
<b>ANESTHESIA SERVICES</b>		
■ <b>Anesthesia and oxygen services</b>	Included in Hospital Services	Included in Hospital Services

**POS UPFRONT PLAN DEDUCTIBLE— \$1,000 INDIVIDUAL/\$2,000 FAMILY, CONT.**

	<b>IN-NETWORK MEMBER COST</b>	<b>OUT-OF-NETWORK MEMBER COST</b>
<b>IN-HOSPITAL MEDICAL SERVICES</b>		
■ <b>Inpatient medical services</b>	Included in Hospital Services	Included in Hospital Services
<b>OUT-OF-HOSPITAL CARE</b>		
■ <b>Primary Care Physician Office Services</b> (includes services for illness, injury, sickness, follow-up care and consultations) (The Plan Deductible does not apply to some in-network preventive care services. Refer to Plan Deductible Information for details.)	\$25 Copayment per visit after Plan Deductible	30% after Plan Deductible
■ <b>Specialist Office Services</b> (includes services for illness, injury, sickness, follow-up care and consultations)	\$35 Copayment per visit after Plan Deductible	30% after Plan Deductible
■ <b>Gynecological Preventive Exam Office Services</b>	\$35 Copayment per visit	30% after Plan Deductible
■ <b>Maternity Care Office Services</b>	<b>Not a covered benefit</b>	<b>Not a covered benefit</b>
<b>OTHER BENEFITS</b>		
■ <b>Ambulance Services</b>	No Member cost after Plan Deductible	No Member cost after Plan Deductible
■ <b>Home Health Services</b> (up to 100 visits)	No Member cost	25%
■ <b>Laboratory Services</b> (includes services performed in a Hospital or laboratory facility)	No Member cost after Plan Deductible	30% after Plan Deductible
■ <b>Non-Advanced Radiology</b> (includes services performed in a Hospital or radiology facility)	No Member cost after Plan Deductible	30% after Plan Deductible
■ <b>Advanced Radiology</b> (includes services for MRI, PET and CAT Scan, and Nuclear Cardiology performed in a Hospital or radiology facility)	No Member cost after Plan Deductible	30% after Plan Deductible
■ <b>Chiropractic Services</b> (up to 10 visits)	\$35 Copayment per visit after Plan Deductible	30% after Plan Deductible
■ <b>Outpatient Rehabilitative Therapy</b> (up to 20 visits combined for physical, speech, and occupational therapy)	\$35 Copayment per visit after Plan Deductible	30% after Plan Deductible
■ <b>Routine Vision Exam</b> (one per year)	\$35 Copayment	30% after Plan Deductible
■ <b>Disposable Medical Supplies</b> (up to \$300)	20% after Plan Deductible	30% after Plan Deductible
■ <b>Durable Medical Equipment Including Prosthetics</b> (up to \$1,500)	20% after Plan Deductible	30% after Plan Deductible
■ <b>Ostomy Supplies and Equipment</b> (up to \$1,000)	20% after Plan Deductible	30% after Plan Deductible
<b>LIFETIME MAXIMUM</b>	Unlimited	\$1,000,000

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

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	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER COST
<b>CALENDAR YEAR COST SHARE</b>		
■ <b>Individual Plan Deductible</b>	\$2,000	\$4,000
■ <b>Family Plan Deductible</b>	\$4,000	\$6,000
■ <b>Individual Out-of-Pocket Maximum</b> (includes Plan Deductible and Coinsurance)	None	\$10,000
■ <b>Family Out-of-Pocket Maximum</b> (includes Plan Deductible and Coinsurance)	None	\$15,000
■ <b>Out-of-Network Reimbursement</b>	None	Plan will reimburse up to the Maximum Allowable Amount
<b>DAILY HOSPITAL ROOM AND BOARD</b>		
■ <b>Hospitalization for Illness or Injury</b> (includes semi-private room and board; <b>excludes all maternity-related services</b> )	\$500 Copayment per admission after Plan Deductible	30% after Plan Deductible
■ <b>Skilled Nursing and Rehabilitation Facilities</b> (up to 90 days)	No Member cost after Plan Deductible	30% after Plan Deductible
<b>MISCELLANEOUS HOSPITAL SERVICES</b>		
■ <b>Emergency Room</b> (Copayment waived if admitted)	\$150 Copayment per visit after Plan Deductible	\$150 Copayment per visit after Plan Deductible
■ <b>Walk-In/Urgent Care Centers</b>	\$50 Copayment per visit after Plan Deductible	\$50 Copayment per visit after Plan Deductible
<b>SURGICAL SERVICES</b>		
■ <b>Ambulatory Services (Outpatient)</b> (includes services performed in a Hospital or ambulatory facility)	\$250 Copayment per visit after Plan Deductible	30% after Plan Deductible
<b>ANESTHESIA SERVICES</b>		
■ <b>Anesthesia and oxygen services</b>	Included in Hospital Services	Included in Hospital Services

**POS UPFRONT PLAN DEDUCTIBLE— \$2,000 INDIVIDUAL/\$4,000 FAMILY, CONT.**

	<b>IN-NETWORK MEMBER COST</b>	<b>OUT-OF-NETWORK MEMBER COST</b>
<b>IN-HOSPITAL MEDICAL SERVICES</b>		
■ <b>Inpatient medical services</b>	Included in Hospital Services	Included in Hospital Services
<b>OUT-OF-HOSPITAL CARE</b>		
■ <b>Primary Care Physician Office Services</b> (includes services for illness, injury, sickness, follow-up care and consultations) (The Plan Deductible does not apply to some in-network preventive care services. Refer to Plan Deductible Information for details.)	\$25 Copayment per visit after Plan Deductible	30% after Plan Deductible
■ <b>Specialist Office Services</b> (includes services for illness, injury, sickness, follow-up care and consultations)	\$35 Copayment per visit after Plan Deductible	30% after Plan Deductible
■ <b>Gynecological Preventive Exam Office Services</b>	\$35 Copayment per visit	30% after Plan Deductible
■ <b>Maternity Care Office Services</b>	<b>Not a covered benefit</b>	<b>Not a covered benefit</b>
<b>OTHER BENEFITS</b>		
■ <b>Ambulance Services</b>	No Member cost after Plan Deductible	No Member cost after Plan Deductible
■ <b>Home Health Services</b> (up to 100 visits)	No Member cost	25%
■ <b>Laboratory Services</b> (includes services performed in a Hospital or laboratory facility)	No Member cost after Plan Deductible	30% after Plan Deductible
■ <b>Non-Advanced Radiology</b> (includes services performed in a Hospital or radiology facility)	No Member cost after Plan Deductible	30% after Plan Deductible
■ <b>Advanced Radiology</b> (includes services for MRI, PET and CAT Scan, and Nuclear Cardiology performed in a Hospital or radiology facility)	No Member cost after Plan Deductible	30% after Plan Deductible
■ <b>Chiropractic Services</b> (up to 10 visits)	\$35 Copayment per visit after Plan Deductible	30% after Plan Deductible
■ <b>Outpatient Rehabilitative Therapy</b> (up to 20 visits combined for physical, speech, and occupational therapy)	\$35 Copayment per visit after Plan Deductible	30% after Plan Deductible
■ <b>Routine Vision Exam</b> (one per year)	\$35 Copayment	30% after Plan Deductible
■ <b>Disposable Medical Supplies</b> (up to \$300)	20% after Plan Deductible	30% after Plan Deductible
■ <b>Durable Medical Equipment Including Prosthetics</b> (up to \$1,500)	20% after Plan Deductible	30% after Plan Deductible
■ <b>Ostomy Supplies and Equipment</b> (up to \$1,000)	20% after Plan Deductible	30% after Plan Deductible
<b>LIFETIME MAXIMUM</b>	Unlimited	\$1,000,000

# 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 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	

The Benefit Limit is a combined in-network and out-of-network Benefit Limit up 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.

Out-of-network pharmacy costs are a 30% 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.

- Colorectal cancer screenings, fecal occult blood test, sigmoidoscopy or colonoscopy (including an associated biopsy performed during a colonoscopy), age 50 or older, one per year
- Gynecological preventive exam, one per year
- Home Health Services
- Immunizations for:
  - Children* - Chickenpox, Diphtheria, Hemophilus Influenza B, Hepatitis A, Hepatitis B, Measles, Mumps, Pertussis, Pneumococcus, Polio, Rubella, and Tetanus
  - Adults* - Chickenpox, Influenza, Pneumococcus, and Tetanus
- Mammography screenings, age 40 or older, one per year
- Newborn well baby visits
- Outpatient laboratory services (one per year) associated with preventive exams limited to:
  - Cervical cancer screening - Pap tests
  - Cholesterol screening
  - Fasting plasma glucose
  - Hematocrit or hemoglobin
  - Lead screening
  - Urinalysis
- Prescription drugs covered under our **Prescription Drug Rider**
- Preventive exams for adult (one per year) and pediatric exams as coded by the most current edition of the 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 year
- Routine vision exam, one per year