



INDIVIDUAL POS OUTLINE OF COVERAGE

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

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
CALENDAR YEAR COST SHARE		
■ Individual Plan Deductible	None	\$5,000
■ Family Plan Deductible	None	\$10,000
■ Individual Out-of-Pocket Maximum (includes Plan Deductible and Coinsurance)	None	\$10,000
■ Family Out-of-Pocket Maximum (includes Plan Deductible and Coinsurance)	None	\$20,000
■ Out-of-Network Reimbursement	None	Plan will reimburse up to 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 year	30% after Plan Deductible
■ Skilled Nursing and Rehabilitation Facilities (up to 90 days)	No Member cost	30% after Plan Deductible
MISCELLANEOUS HOSPITAL SERVICES		
■ Emergency Room (Copayment waived if admitted)	\$150 Copayment per visit	\$150 Copayment per visit
■ Walk-In/Urgent Care Centers	\$50 Copayment per visit	\$50 Copayment per visit
SURGICAL SERVICES		
■ Ambulatory Services (Outpatient) (includes services performed in a Hospital or ambulatory facility)	\$500 Copayment per visit	30% after Plan Deductible
ANESTHESIA SERVICES		
■ Anesthesia and oxygen services	Included in Hospital Services	Included in Hospital Services

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

	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER COST
IN-HOSPITAL MEDICAL SERVICES		
■ Inpatient medical services	Included in Hospital 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)	\$25 Copayment per visit	30% after Plan Deductible
■ Specialist Office Services (includes services for illness, injury, sickness, follow-up care and consultations)	\$35 Copayment per visit	30% after Plan Deductible
■ Gynecological Preventive Exam Office Services	\$35 Copayment per visit	30% after Plan Deductible
■ Maternity Care Office Services	Not a covered benefit	Not a covered benefit
OTHER BENEFITS		
■ Ambulance Services	No Member cost	No Member cost after Plan Deductible
■ Home Health Services (up to 100 visits)	No Member cost	25%
■ Laboratory Services (includes services performed in a Hospital or laboratory facility)	No Member cost	30% after Plan Deductible
■ Non-Advanced Radiology (includes services performed in a Hospital or radiology facility)	\$10 Copayment per visit	30% 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	30% after Plan Deductible
■ Chiropractic Services (up to 10 visits)	\$35 Copayment per visit	30% after Plan Deductible
■ Outpatient Rehabilitative Therapy (up to 20 visits combined for physical, speech, and occupational therapy)	\$35 Copayment per visit	30% after Plan Deductible
■ Routine Vision Exam (one per year)	\$35 Copayment	30% after Plan Deductible
■ Disposable Medical Supplies (up to \$300)	20%	30% after Plan Deductible
■ Durable Medical Equipment Including Prosthetics (up to \$1,500)	20%	30% after Plan Deductible
■ Ostomy Supplies and Equipment (up to \$1,000)	20%	30% after Plan Deductible
LIFETIME MAXIMUM	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
BENEFIT DEDUCTIBLE		
This benefit deductible is combined for Ambulatory Services (Outpatient) and Inpatient Services including mental health and alcohol and substance abuse		
■ Individual Plan Deductible	\$2,000	None
■ Family Plan Deductible	\$4,000	None
CALENDAR YEAR COST SHARE		
■ Individual Plan Deductible	None	\$5,000
■ Family Plan Deductible	None	\$10,000
■ Individual Out-of-Pocket Maximum (includes Plan Deductible and Coinsurance)	None	\$10,000
■ Family Out-of-Pocket Maximum (includes Plan Deductible and Coinsurance)	None	\$20,000
■ Out-of-Network Reimbursement	None	Plan will reimburse up to 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)	\$2,000 per Individual, \$4,000 per Family	30% after Plan Deductible
■ Skilled Nursing and Rehabilitation Facilities (up to 90 days)	No Member cost	30% after Plan Deductible
MISCELLANEOUS HOSPITAL SERVICES		
■ Emergency Room (Copayment waived if admitted)	\$150 Copayment per visit	\$150 Copayment per visit
■ Walk-In/Urgent Care Centers	\$50 Copayment per visit	\$50 Copayment per visit
SURGICAL SERVICES		
■ Ambulatory Services (Outpatient) (includes services performed in a Hospital or ambulatory facility)	\$2,000 per Individual, \$4,000 per Family	30% after Plan Deductible

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

	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER COST
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 Physician Office Services (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
■ Specialist Office Services (includes services for illness, injury, sickness, follow-up care and consultations)	\$45 Copayment per visit	30% after Plan Deductible
■ Gynecological Preventive Exam Office Services	\$45 Copayment per visit	30% after Plan Deductible
■ Maternity Care Office Services	Not a covered benefit	Not a covered benefit
OTHER BENEFITS		
■ Ambulance Services	No Member cost	No Member cost after Plan Deductible
■ Home Health Services (up to 100 visits)	No Member cost	25%
■ Laboratory Services (includes services performed in a Hospital or laboratory facility)	No Member cost	30% after Plan Deductible
■ Non-Advanced Radiology (includes services performed in a Hospital or radiology facility)	\$10 Copayment per visit	30% 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	30% after Plan Deductible
■ Chiropractic Services (up to 10 visits)	\$45 Copayment per visit	30% after Plan Deductible
■ Outpatient Rehabilitative Therapy (up to 20 visits combined for physical, speech, and occupational therapy)	\$45 Copayment per visit	30% after Plan Deductible
■ Routine Vision Exam (one per year)	\$45 Copayment	30% after Plan Deductible
■ Disposable Medical Supplies (up to \$300)	20%	30% after Plan Deductible
■ Durable Medical Equipment Including Prosthetics (up to \$1,500)	20%	30% after Plan Deductible
■ Ostomy Supplies and Equipment (up to \$1,000)	20%	30% after Plan Deductible
LIFETIME MAXIMUM	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
CALENDAR YEAR COST SHARE		
■ Individual Plan Deductible	\$500	\$1,500
■ Family Plan Deductible	\$1,000	\$3,000
■ Individual Out-of-Pocket Maximum (includes Plan Deductible and Coinsurance)	None	\$3,000
■ Family Out-of-Pocket Maximum (includes Plan Deductible and Coinsurance)	None	\$6,000
■ Out-of-Network Reimbursement	None	Plan will reimburse up to 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 admission after Plan Deductible	30% after Plan Deductible
■ Skilled Nursing and Rehabilitation Facilities (up to 90 days)	No Member cost after Plan Deductible	30% after Plan Deductible
MISCELLANEOUS HOSPITAL SERVICES		
■ Emergency Room (Copayment waived if admitted)	\$150 Copayment per visit after Plan Deductible	\$150 Copayment per visit after Plan Deductible
■ Walk-In/Urgent Care Centers	\$50 Copayment per visit after Plan Deductible	\$50 Copayment per visit after Plan Deductible
SURGICAL SERVICES		
■ Ambulatory Services (Outpatient) (includes services performed in a Hospital or ambulatory facility)	\$250 Copayment per visit after Plan Deductible	30% after Plan Deductible
ANESTHESIA SERVICES		
■ Anesthesia and oxygen services	Included in Hospital Services	Included in Hospital Services

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

	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER COST
IN-HOSPITAL MEDICAL SERVICES		
■ Inpatient medical services	Included in Hospital 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 in-network preventive care services. Refer to Plan Deductible Information for details.)	\$25 Copayment per visit after Plan Deductible	30% after Plan Deductible
■ Specialist Office Services (includes services for illness, injury, sickness, follow-up care and consultations)	\$35 Copayment per visit after Plan Deductible	30% after Plan Deductible
■ Gynecological Preventive Exam Office Services	\$35 Copayment per visit	30% 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	No Member cost after Plan Deductible
■ Home Health Services (up to 100 visits)	No Member cost	25%
■ Laboratory Services (includes services performed in a Hospital or laboratory facility)	No Member cost after Plan Deductible	30% after Plan Deductible
■ Non-Advanced Radiology (includes services performed in a Hospital or radiology facility)	No Member cost after Plan Deductible	30% 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	30% after Plan Deductible
■ Chiropractic Services (up to 10 visits)	\$35 Copayment per visit after Plan Deductible	30% after Plan Deductible
■ Outpatient Rehabilitative Therapy (up to 20 visits combined for physical, speech, and occupational therapy)	\$35 Copayment per visit after Plan Deductible	30% after Plan Deductible
■ Routine Vision Exam (one per year)	\$35 Copayment	30% after Plan Deductible
■ Disposable Medical Supplies (up to \$300)	20% after Plan Deductible	30% after Plan Deductible
■ Durable Medical Equipment Including Prosthetics (up to \$1,500)	20% after Plan Deductible	30% after Plan Deductible
■ Ostomy Supplies and Equipment (up to \$1,000)	20% after Plan Deductible	30% after Plan Deductible
LIFETIME MAXIMUM	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
CALENDAR YEAR COST SHARE		
■ Individual Plan Deductible	\$1,000	\$2,000
■ Family Plan Deductible	\$2,000	\$4,000
■ Individual Out-of-Pocket Maximum (includes Plan Deductible and Coinsurance)	None	\$5,000
■ Family Out-of-Pocket Maximum (includes Plan Deductible and Coinsurance)	None	\$10,000
■ Out-of-Network Reimbursement	None	Plan will reimburse up to 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 admission after Plan Deductible	30% after Plan Deductible
■ Skilled Nursing and Rehabilitation Facilities (up to 90 days)	No Member cost after Plan Deductible	30% after Plan Deductible
MISCELLANEOUS HOSPITAL SERVICES		
■ Emergency Room (Copayment waived if admitted)	\$150 Copayment per visit after Plan Deductible	\$150 Copayment per visit after Plan Deductible
■ Walk-In/Urgent Care Centers	\$50 Copayment per visit after Plan Deductible	\$50 Copayment per visit after Plan Deductible
SURGICAL SERVICES		
■ Ambulatory Services (Outpatient) (includes services performed in a Hospital or ambulatory facility)	\$250 Copayment per visit after Plan Deductible	30% after Plan Deductible
ANESTHESIA SERVICES		
■ Anesthesia and oxygen services	Included in Hospital Services	Included in Hospital Services

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

	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER COST
IN-HOSPITAL MEDICAL SERVICES		
■ Inpatient medical services	Included in Hospital 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 in-network preventive care services. Refer to Plan Deductible Information for details.)	\$25 Copayment per visit after Plan Deductible	30% after Plan Deductible
■ Specialist Office Services (includes services for illness, injury, sickness, follow-up care and consultations)	\$35 Copayment per visit after Plan Deductible	30% after Plan Deductible
■ Gynecological Preventive Exam Office Services	\$35 Copayment per visit	30% 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	No Member cost after Plan Deductible
■ Home Health Services (up to 100 visits)	No Member cost	25%
■ Laboratory Services (includes services performed in a Hospital or laboratory facility)	No Member cost after Plan Deductible	30% after Plan Deductible
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■ Outpatient Rehabilitative Therapy (up to 20 visits combined for physical, speech, and occupational therapy)	\$35 Copayment per visit after Plan Deductible	30% after Plan Deductible
■ Routine Vision Exam (one per year)	\$35 Copayment	30% after Plan Deductible
■ Disposable Medical Supplies (up to \$300)	20% after Plan Deductible	30% after Plan Deductible
■ Durable Medical Equipment Including Prosthetics (up to \$1,500)	20% after Plan Deductible	30% after Plan Deductible
■ Ostomy Supplies and Equipment (up to \$1,000)	20% after Plan Deductible	30% after Plan Deductible
LIFETIME MAXIMUM	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
CALENDAR YEAR COST SHARE		
■ Individual Plan Deductible	\$2,000	\$4,000
■ Family Plan Deductible	\$4,000	\$6,000
■ Individual Out-of-Pocket Maximum (includes Plan Deductible and Coinsurance)	None	\$10,000
■ Family Out-of-Pocket Maximum (includes Plan Deductible and Coinsurance)	None	\$15,000
■ Out-of-Network Reimbursement	None	Plan will reimburse up to 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 admission after Plan Deductible	30% after Plan Deductible
■ Skilled Nursing and Rehabilitation Facilities (up to 90 days)	No Member cost after Plan Deductible	30% after Plan Deductible
MISCELLANEOUS HOSPITAL SERVICES		
■ Emergency Room (Copayment waived if admitted)	\$150 Copayment per visit after Plan Deductible	\$150 Copayment per visit after Plan Deductible
■ Walk-In/Urgent Care Centers	\$50 Copayment per visit after Plan Deductible	\$50 Copayment per visit after Plan Deductible
SURGICAL SERVICES		
■ Ambulatory Services (Outpatient) (includes services performed in a Hospital or ambulatory facility)	\$250 Copayment per visit after Plan Deductible	30% after Plan Deductible
ANESTHESIA SERVICES		
■ Anesthesia and oxygen services	Included in Hospital Services	Included in Hospital Services

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

	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER COST
IN-HOSPITAL MEDICAL SERVICES		
■ Inpatient medical services	Included in Hospital 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 in-network preventive care services. Refer to Plan Deductible Information for details.)	\$25 Copayment per visit after Plan Deductible	30% after Plan Deductible
■ Specialist Office Services (includes services for illness, injury, sickness, follow-up care and consultations)	\$35 Copayment per visit after Plan Deductible	30% after Plan Deductible
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■ Maternity Care Office Services	Not a covered benefit	Not a covered benefit
OTHER BENEFITS		
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■ Durable Medical Equipment Including Prosthetics (up to \$1,500)	20% after Plan Deductible	30% after Plan Deductible
■ Ostomy Supplies and Equipment (up to \$1,000)	20% after Plan Deductible	30% after Plan Deductible
LIFETIME MAXIMUM	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

EXCLUSIONS AND LIMITATIONS

The following is a list of services, supplies, etc., that are excluded under the policy unless otherwise noted.

- Abdominoplasty
- All assistive communication devices
- Any treatments or services related to the provision 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 the non-covered benefit were covered by the Plan
- Any treatment for which there is Insufficient Evidence Of Therapeutic Value for the use for which it is being prescribed is not covered
- Attorney fees
- 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
- 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
- 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 IV cardiac rehabilitation is always excluded
- Care provided by home health aides that is not patient care of a medical or therapeutic nature or care provided by non-licensed professionals
- 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.
- 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
- Contraceptive drugs and devices, except to the extent applicable insurance law requires coverage for these items
- Cord blood retrieval and storage
- 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 the 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; hemangioma; liposuction; otoplasty; 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; and vascular birthmark removal, (except when the vascular birthmark causes significant impairment of physical or mechanical function)
- Custodial Care, convalescent care, domiciliary care, and rest home care
- Dental services, including but not limited to: anesthesia, except as otherwise required by applicable law; bite appliances or night guards; bone grafts; correction of congenital malformation, including osteotomies; correction of oral malocclusion; dental implants; prosthetic devices, except as otherwise provided herein; and repair, restoration or re-implantation of teeth following an injury
- Experimental or Investigational medical, surgical and other health care treatments and procedures
- Eyeglasses and contact lenses
- Eye surgeries and procedures primarily for the purpose of correcting refractive defects of the eyes
- Health and behavior assessments that are used to identify the psychological, behavioral, emotional, cognitive and social factors important to the prevention, treatment, or management of physical health problems
- Hearing aids except as otherwise required by applicable law
- 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 the policy
- Infertility services not specifically covered under the “Infertility Services” section of the Policy, including any Riders 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 Policy or any Riders; medications for sexual dysfunction; recruitment, selection and screening and any other expenses of egg, embryo and sperm donors; reversal of surgical sterilization; reversal of voluntary sterilization; and surrogacy and all charges associated with surrogacy.

- Massage, except when part of a prescribed physical or occupational therapy program if that program is a covered benefit
- Maternity care and treatment (pre-natal and post-natal), including home births, except that care related to complications of pregnancy is covered
- 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
- Neuropsychological and neurobehavioral testing, except when it is performed by an appropriately licensed neurologist, psychologist, or psychiatrist and when required by applicable law
- New Treatments for which we have not yet made a coverage policy
- Non-durable equipment such as orthopedic or prosthetic shoes, foot orthotics, and prophylactic anti-embolism stockings, (such as jobst stockings except when the Member has a history of deep vein thrombosis)
- Over-the-counter (OTC) devices of any kind, including but not limited to home testing or other kits and products, except as provided in the “Benefits” section of the Policy
- Peak flow meters, unless the Member is enrolled in our asthma health management program, is being actively case managed and the use of a peak flow meter is approved by us as part of a health management program value-added service or benefit
- Personal convenience or comfort items of any kind
- Private room accommodations and private duty nursing in a facility
- Routine foot care and treatment, unless Medically Necessary for neuro-circulatory conditions
- Routine physical exams and immunizations and follow-up care at an Urgent Care Center or an emergency room, except for suture removal at the same facility that applied the sutures
- Sensory and auditory integration therapy, unless covered under the “Birth To Three Program (Early Intervention Services)” subsection of the “Benefits” section of the Policy
- Services and supplies exceeding the applicable benefit maximums
- 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
- Sex change services
- Smoking cessation products, except as otherwise required by applicable law and when the product is obtained with a prescription and Pre-Authorized by us
- Solid organ transplants and bone marrow that are Experimental or Investigational
- Speech therapy for stuttering, lisp correction, or any speech impediment not related to illness or injury, except as required by applicable law
- Surgical treatment for morbid obesity
- Temporomandibular joint (TMJ) dysfunction or temporomandibular disease (TMD) syndrome: any non- surgical treatment, including but not limited to appliances, behavior modification, physical therapy, and prosthodontic therapy
- Third party coverage, such as other primary insurance, workers’ compensation and Medicare will not be duplicated
- Transportation, accommodation costs, and other non-medical expenses related to Health Services (whether they are recommended by a physician or not)
- Treatment services and supplies in a Veteran’s Hospital or any Federal Hospital, except as required by applicable law
- Vision and hearing examinations, except as set forth in the “Eye Care” and “Hearing Screenings” subsections of the policy
- Vision therapy and vision training
- War related treatment or supplies, whether the war is declared or undeclared
- Web visits, e-visits, and other on-line consultations, health evaluations using internet resources and telephone consultations
- 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.
- Services, supplies, vaccinations and medications required by third parties or obtained for foreign or domestic travel (e.g., employment, school, camp, licensing, insurance and travel)
- Services and supplies not specifically included in the policy. These include but are not limited to: non-medical supportive counseling services (individual or group); education services, including testing, training, rehabilitation for educational purposes and screening and treatment associated with learning disabilities; health club membership, exercise equipment; hypnosis (except as an integral part of psychotherapy), biofeedback (except when ordered by a physician to treat urinary incontinence), acupuncture, and certain holistic practices; weight loss/control treatment, programs and medications

IMPORTANT INFORMATION

Eligibility

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

- Be a resident of the State of Connecticut
- Be under age 65

Renewal Provision

We will renew your policy each time you send us the premium. Payment must be made on or before the due date or by the end of the calendar month the premium is due. Your policy stays 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) 674-5757 or 1-800-251-7722.

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