POS-OA-CAL-30-45-2500HospDed Point-Of-Service Open Access Calendar Year Plan Benefit Summary

This is a brief summary of benefits. Refer to your Membership Agreement or consult with your benefits manager for more information. The Membership Agreement will prevail for all benefits, conditions, limitations and exclusions. All benefits described below are per Member per **Calendar year**. All benefit limits/maximums are listed in the Plan pays column of this summary. A Referral from your Primary Care Provider is not required.

Personalized for: Max Restaurant Group

	IN-NETWORK		OUT-OF-NETWORK	
Benefit Deductible *(This Benefit Deductible is combined for ambulatory services (outpatient) and inpatient services)*	$2,500 per Member $5,000 per Family		None	
Calendar Year Plan Deductible	None		$3,500 per Member $10,500 per Family	
Coinsurance Maximum *(Maximum does not include Plan Deductibles or Benefit Deductibles)*	Not Applicable		$2,000 per Member $6,000 per Family	
Out-of-Pocket Maximum *(Maximum includes Plan Deductible and Coinsurance Maximum only. Benefit Deductible's are not included if applicable)*	None		$5,500 per Member $16,500 per Family	
Out-of-Network Reimbursement	None		**Plan will reimburse the coinsurance percentage of the Maximum Allowable Amount.**	
Lifetime Maximum Benefit	Unlimited		Unlimited	
PREVENTIVE SERVICES (Refer to the "Prevention and Wellness" section of this summary for a complete list of services)	**MEMBER PAYS**	**PLAN PAYS**	**MEMBER PAYS**	**PLAN PAYS**
Adult Physical Exam (one exam per year when provided by a PCP)	No Member cost	100%	30% after Plan Deductible	70% after Plan Deductible
Infant / Pediatric Physical Exam (frequency limits apply and the exam must be provided by a PCP)	No Member cost	100%	30% after Plan Deductible	70% after Plan Deductible
Gynecological Preventive Exam (one exam per year)	No Member cost	100%	30% after Plan Deductible	70% after Plan Deductible
Preventive Laboratory Services (Complete blood count and Urinalysis, one test per year)	No Member cost	100%	30% after Plan Deductible	70% after Plan Deductible
Baseline Routine Mammography (ages 35 - 40)	$10 Copayment per visit	100% after Copayment	30% after Plan Deductible	70% after Plan Deductible

PREVENTIVE SERVICES (Refer to the "Prevention and Wellness" section of this summary for a complete list of services)	MEMBER PAYS	PLAN PAYS	MEMBER PAYS	PLAN PAYS
Annual Routine Mammography (over age 40)	No Member cost	100%	30% after Plan Deductible	70% after Plan Deductible
Annual Routine Vision Exam (one exam per year when provided by an Optometrist or Ophthalmologist)	$10 Copayment per visit	100% after Copayment	Additional cost in excess of $30	Up to $30
OUTPATIENT SERVICES				
Primary Care Provider Office Services (includes services for illness, injury, sickness, follow-up care and consultations)	$30 Copayment per visit	100% after Copayment	30% after Plan Deductible	70% after Plan Deductible
Specialist Office Services (includes services for illness, injury, sickness, follow-up care and consultations)	$45 Copayment per visit	100% after Copayment	30% after Plan Deductible	70% after Plan Deductible
Gynecological Office Services	$30 Copayment per visit	100% after Copayment	30% after Plan Deductible	70% after Plan Deductible
Maternity Care Office Services	$30 Copayment (for initial visit only)	100% after initial Copayment	30% after Plan Deductible	70% after Plan Deductible
Allergy Testing	Applicable office visit Copayment up to the benefit maximum; then no coverage	100% after Copayment up to $315 every two years	30% after Plan Deductible up to the benefit maximum; then no coverage	70% after Plan Deductible up to $315 every two years
Laboratory Services (includes services performed in a Hospital or laboratory facility)	No Member cost	100%	30% after Plan Deductible	70% after Plan Deductible
Non-Advanced Radiology (includes services performed in a Hospital or radiology facility)	$10 Copayment per visit	100% after Copayment	30% after Plan Deductible	70% 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 five Copayments per year	100% after Copayment	30% after Plan Deductible	70% after Plan Deductible
Outpatient Rehabilitative Therapy (includes services combined for physical, speech, and occupational therapy)	$45 Copayment per visit up to the visit maximum; then no coverage	100% after Copayment up to 40 visits per year	30% after Plan Deductible up to the visit maximum; then no coverage	70% after Plan Deductible up to 40 visits per year
Chiropractic Services	$45 Copayment per visit up to the visit maximum; then no coverage	100% after Copayment up to 20 visits per year	30% after Plan Deductible up to the visit maximum; then no coverage	70% after Plan Deductible up to 20 visits per year
Retail Clinic	$30 Copayment per visit	100% after Copayment	30% after Plan Deductible	70% after Plan Deductible

EMERGENCY / URGENT CARE				
Walk-In/Urgent Care Centers	$75 Copayment per visit	100% after Copayment	$75 Copayment per visit	100% after Copayment
Emergency Room (Copayments waived if admitted)	$150 Copayment per visit	100% after Copayment	$150 Copayment per visit	100% after Copayment
Ambulance Services	No Member cost	100%	No Member cost	100%
HOSPITAL SERVICES				
Inpatient Hospital Services, Including Room & Board	No Member cost after Benefit Deductible	100% after Benefit Deductible	30% after Plan Deductible	70% after Plan Deductible
Ambulatory Services (Outpatient) (includes services performed in a Hospital or ambulatory facility)	No Member cost after Benefit Deductible	100% after Benefit Deductible	30% after Plan Deductible	70% after Plan Deductible
Skilled Nursing and Rehabilitation Facilities	No Member cost up to the visit maximum; then no coverage	100% up to 90 days	30% after Plan Deductible up to the visit maximum; then no coverage	70% after Plan Deductible up to 90 days
MENTAL HEALTH SERVICES				
Inpatient Mental Health Services (including inpatient acute, residential and partial hospitalization programs)	No Member cost after Benefit Deductible	100% after Benefit Deductible	30% after Plan Deductible	70% after Plan Deductible
Inpatient Alcohol and Substance Abuse Treatment (including inpatient acute, residential and partial hospitalization programs)	No Member cost after Benefit Deductible	100% after Benefit Deductible	30% after Plan Deductible	70% after Plan Deductible
Outpatient Mental Health, Alcohol and Substance Abuse Treatment (including office visits, professional services provided in the home and intensive outpatient treatment programs)	$30 Copayment per visit	100% after Copayment	30% after Plan Deductible	70% after Plan Deductible
OTHER SERVICES				
Durable Medical Equipment Including Prosthetics and Disposable Medical Supplies	50%	50%	50% after Plan Deductible	50% after Plan Deductible
Diabetic Equipment and Supplies	20%	80%	30% after Plan Deductible	70% after Plan Deductible
Home Health Services	No Member cost up to the visit maximum; then no coverage	100% up to 100 visits per year	25% after $50 Benefit Deductible up to the visit maximum; then no coverage	75% after $50 Benefit Deductible up to 100 visits per year

PREVENTION AND WELLNESS

In-Network Prevention and wellness services as defined by the United States Preventive Service Task Force (listed below) are exempt from all member cost shares (deductible, copayment and coinsurance) under the Patient Protection and Affordable Care Act (PPACA). These services are identified by the specific coding your Provider submits to ConnectiCare. Service coding must match ConnectiCare's coding list to be exempt from all cost sharing.

- Routine Physical Exam and appropriate screening and counseling for adults, one per year
- Preventive Care and screenings for infants, children and adolescents supported by the Health Resources and Services Administration
- Preventive Care and screenings for women supported by the Health Resources and Services Administration
- Bone Density Screenings, age 60 or older, one every 23 months
- Screening for colorectal cancer using fecal occult blood testing, sigmoidoscopy, or colonoscopy; age 50 or older, one per year
- Routine Mammography Screening, age 40 or older, one per year
- Immunizations recommended by the Advisory Committee on Immunization Practices of the CDC
- Outpatient Laboratory Services, one per year:
  - Cervical Cancer and Cervical Dysplasia Screening - Pap Smear
  - Lipid Cholesterol Screening for adults and children at risk
  - Fasting Plasma Glucose or Hemoglobin A1c, age 18 or older for people at risk for diabetes
  - Hematocrit and Hemoglobin, for children up to age 21
  - Lead screening, for children up to age 6
  - Tuberculin testing, for children up to age 21
  - Chlamydia, Syphilis and Gonorrhea screening for females all ages
  - Human immunodeficiency virus screening - HIV testing, no limit
  - Screening for phenylketonuria (PKU) in newborns, under 3 months of age
  - Screening for sickle cell disease in newborns, under 3 months of age
- Routine Vision Screening, up to age 21, one per year when services are rendered by a Primary Care Provider
- Routine hearing screening up to age 21 when rendered by a Primary Care Provider
- Developmental, Autism, and Psychosocial/behavioral assessments when rendered by a Primary Care Provider
- Dietary counseling for adults with hyperlipidemia or obesity
- Tobacco Cessation interventions
- Screening for Hepatitis B, Iron Deficient Anemia, Rh (D) Blood Typing and Asymptomatic Bacteriuria in women who are pregnant
- Screening for Abdominal Aortic Aneurysm in men age 65 - 75 who have ever smoked
- BRCA counseling and genetic screening for women at risk

Important Information

- If you have questions regarding your Plan, visit our website at **www.connecticare.com** or call us at (860) 674-5757 or 1-800-251-7722.
- Many services require that you obtain our Pre-Certification or Pre-Authorization prior to obtaining care prescribed or rendered by Non-Participating providers or a Benefit Reduction will apply. For mental health, alcohol, and substance abuse services call 1-888-946-4658 to obtain Pre-Authorization.
- We track benefits internally and do not provide Members with a regular update of benefits that have been used. Members should keep a record of benefits they use to determine when they reached their benefit limit. Members will be responsible for paying in full any services rendered after the limit is reached.
- All benefit limits/maximums are combined for In-Network and Out-of-Network unless indicated otherwise.
- Out-of-Network reimbursement is based on the Maximum Allowable Amount. Members are responsible to pay any charges in excess of this amount. Please refer to your ConnectiCare Inc. Membership Agreement for more information.
- If you are a Massachusetts resident, please refer to your *Amendatory Rider for Massachusetts Mandated Benefits* for additional details of your benefits.

Benefits are Pending Department of Insurance Approval

Prescription Drug Copayment Plan Benefit Summary

This is a brief summary of your prescription drug benefits. Refer to your Prescription Drug Rider or consult with your benefits manager for more information. The Prescription Drug Rider and the Membership Agreement will prevail for all benefits, conditions, limitations and exclusions. All Benefits described below are per Member per **Calendar year**.

Personalized for: Max Restaurant Group

PRESCRIPTION DRUGS	IN-NETWORK		OUT-OF-NETWORK	
Covered prescription drugs through retail Participating Pharmacies or our mail order service. Generics are dispensed unless the Member pays the **Generic** Copayment 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.				
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	100% after Copayment	100%	Not a covered benefit
Tier 2 drugs	$30 Copayment per 30 day supply	100% after Copayment	100%	Not a covered benefit
Tier 3 drugs	$40 Copayment per 30 day supply	100% after Copayment	100%	Not a covered benefit
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	100% after Copayment	100%	Not a covered benefit
Tier 2 drugs	$60 Copayment per 90 day supply	100% after Copayment	100%	Not a covered benefit
Tier 3 drugs	$80 Copayment per 90 day supply	100% after Copayment	100%	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.
- If you are a Massachusetts resident, please refer to your Amendatory Rider for Massachusetts Mandated Benefits for additional details of your benefits.