ConnectiCare®

HMO-OA-CAL-HSA-2500I/5000F-04 Calendar Year Benefit Summary

HMO Open Access High Deductible Health Plan (HDHP) for use with a Health Savings Account (HSA)

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.

The Individual Deductible applies if you have coverage only for yourself and not for any Dependents. The Family Deductible applies if you have coverage for yourself and one or more Eligible Dependents. In addition, if you have family coverage, any applicable copayment, coinsurance or cost share maximums will apply until the total is met for the family, without regard to how much any one family member has met.

Personalized for: Max Restaurant Group

	IN-NETWORK	
Calendar Year Plan Deductible *(Deductible is combined for health services and prescription drugs)*	$2,500 Individual $5,000 Family	
Lifetime Maximum Benefit	Unlimited	
PREVENTIVE SERVICES (Refer to the "Prevention and Wellness" section of this summary for a complete list of services)	**MEMBER PAYS**	**PLAN PAYS**
Adult Annual Physical Exam (one exam per year when provided by a PCP)	No Member cost *(Plan Deductible waived)*	100% *(Plan Deductible waived)*
Infant / Pediatric Physical Exam (frequency limits apply and the exam must be provided by a PCP)	No Member cost *(Plan Deductible waived)*	100% *(Plan Deductible waived)*
Gynecological Annual Preventive Exam (one exam per year)	No Member cost *(Plan Deductible waived)*	100% *(Plan Deductible waived)*
Preventive Laboratory Services (Complete blood count and Urinalysis, one test per year)	No Member cost *(Plan Deductible waived)*	100% *(Plan Deductible waived)*
Baseline Routine Mammography (ages 35-40)	No Member cost after Plan Deductible	100% after Plan Deductible
Annual Routine Mammography (over age 40)	No Member cost *(Plan Deductible waived)*	100% *(Plan Deductible waived)*
Annual Routine Vision Exam (one exam per year when provided by an Optometrist or Ophthalmologist)	No Member cost *(Plan Deductible waived)*	100% *(Plan Deductible waived)*
OUTPATIENT SERVICES		
Primary Care Provider Office Services (includes services for illness, injury, sickness, follow-up care and consultations)	No Member cost after Plan Deductible	100% after Plan Deductible

OUTPATIENT SERVICES		
Specialist Office Services (includes services for illness, injury, sickness, follow-up care and consultations)	No Member cost after Plan Deductible	100% after Plan Deductible
Gynecological Office Services	No Member cost after Plan Deductible	100% after Plan Deductible
Maternity Care Office Services	No Member cost after Plan Deductible	100% after Plan Deductible
Allergy Testing	No Member cost after Plan Deductible up to the benefit maximum; then no coverage	100% after Plan Deductible up to $315 every two years
Laboratory Services (includes services performed in a Hospital or laboratory facility)	No Member Cost after Plan Deductible	100% after Plan Deductible
Non-Advanced Radiology (includes services performed in a Hospital or radiology facility)	No Member Cost after Plan Deductible	100% 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	100% after Plan Deductible
Outpatient Rehabilitative Therapy (includes services combined for physical, speech, and occupational therapy)	No Member cost after Plan Deductible up to the visit maximum; then no coverage	100% after Plan Deductible up to 20 visits per year
Chiropractic Services	No Member cost after Plan Deductible up to the visit maximum; then no coverage	100% after Plan Deductible up to 10 visits per year
Retail Clinic	No Member cost after Plan Deductible	100% after Plan Deductible
EMERGENCY / URGENT CARE		
Walk-In/Urgent Care Centers	No Member Cost after Plan Deductible	100% after Plan Deductible
Emergency Room	No Member Cost after Plan Deductible	100% after Plan Deductible
Ambulance Services	No Member cost after Plan Deductible	100% after Plan Deductible
HOSPITAL SERVICES		
Inpatient Hospital Services, Including Room & Board	No Member cost after Plan Deductible	100% after Plan Deductible
Ambulatory Services (Outpatient) (includes services performed in a Hospital or ambulatory facility)	No Member cost after Plan Deductible	100% after Plan Deductible
Skilled Nursing and Rehabilitation Facilities	No Member cost after Plan Deductible up to the visit maximum; then no coverage	100% after Plan Deductible up to 60 days per year
MENTAL HEALTH SERVICES		
Inpatient Alcohol and Substance Abuse Treatment (including inpatient acute, residential and partial hospitalization programs)	No Member cost after Plan Deductible	100% after Plan Deductible

MENTAL HEALTH SERVICES		
Inpatient Mental Health Services (including inpatient acute, residential and partial hospitalization programs)	No Member cost after Plan Deductible	100% 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)	No Member cost after Plan Deductible	100% after Plan Deductible
OTHER SERVICES		
Durable Medical Equipment Including Prosthetics and Disposable Supplies	No Member cost after Plan Deductible	100% after Plan Deductible
Diabetic Equipment and Supplies	No Member cost after Plan Deductible	100% after Plan Deductible
Home Health Services	No Member cost after Plan Deductible up to the visit maximum; then no coverage	100% after Plan 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.
- 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.
- If you are a Massachusetts resident, please refer to your *Amendatory Rider for Massachusetts Mandated Benefits* for additional details of your benefits.
- If you are a Massachusetts resident, this plan along with Pharmacy services meets Massachusetts Minimum Creditable standards for 2012.

Benefits are Pending Department of Insurance Approval

ConnectiCare®

Prescription Drug Copayment Plan - HMO Open Access High Deductible Health Plan (HDHP) for Use with Health Savings Account (HSA) 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**.

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PRESCRIPTION DRUGS		
Covered prescription drugs through retail Participating Pharmacies or our mail order service. **Generics are dispensed unless the provider writes Dispense as Written on the prescription.** Your Plan includes the following: Mandatory Drug Substitution, Generic Substitution Program, Tiered Cost-Share Program, and Voluntary Mail Order Program.		
	IN-NETWORK	
Calendar Year Plan Deductible	$2,500 Individual $5,000 Family The Calendar Year Deductible can be reached by any combination of covered Health Services or covered prescription drug services. If you have Family coverage, then covered Health Services and covered prescription drugs will be applied to the Family Plan Deductible until the total amount is met without regard to which family member uses the benefits.	
Pharmacy Cost-Share Maximum (Maximum does not include Deductible)	$1,000 Individual $2,000 Family This is the maximum amount that you or your covered dependents will pay for the year. Once the specified amount is met, you will no longer have to pay a Cost-Share amount for a covered prescription drug or supply for the remainder of that year.	
RETAIL PHARMACY (up to a 30-day supply per prescription)	**MEMBER PAYS**	**PLAN PAYS**
Tier 1 drugs	$15 Copayment per 30 day supply after Plan Deductible up to Pharmacy Cost-Share Maximum	100% after Plan Deductible and Copayment and Pharmacy Cost-Share Maximum
Tier 2 drugs	$25 Copayment per 30 day supply after Plan Deductible up to Pharmacy Cost-Share Maximum	100% after Plan Deductible and Copayment and Pharmacy Cost-Share Maximum
Tier 3 drugs	$40 Copayment per 30 day supply after Plan Deductible up to Pharmacy Cost-Share Maximum	100% after Plan Deductible and Copayment and Pharmacy Cost-Share Maximum
MAIL ORDER PHARMACY (up to a 90-day supply per prescription)	**MEMBER PAYS**	**PLAN PAYS**
Tier 1 drugs	$30 Copayment per 90 day supply after Plan Deductible up to Pharmacy Cost-Share Maximum	100% after Plan Deductible and Copayment and Pharmacy Cost-Share Maximum
Tier 2 drugs	$50 Copayment per 90 day supply after Plan Deductible up to Pharmacy Cost-Share Maximum	100% after Plan Deductible and Copayment and Pharmacy Cost-Share Maximum

MAIL ORDER PHARMACY (up to a 90-day supply per prescription)	MEMBER PAYS	PLAN PAYS
Tier 3 drugs	$80 Copayment per 90 day supply after Plan Deductible up to Pharmacy Cost-Share Maximum	100% after Plan Deductible and Copayment and Pharmacy Cost-Share Maximum

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.
- Amounts paid by Members because they must pay a price difference for a Brand Name Drug do not count towards meeting any Deductible, Coinsurance, Copayment, or Pharmacy Coinsurance Maximum.
- 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.

Benefits are Pending Department of Insurance Approval