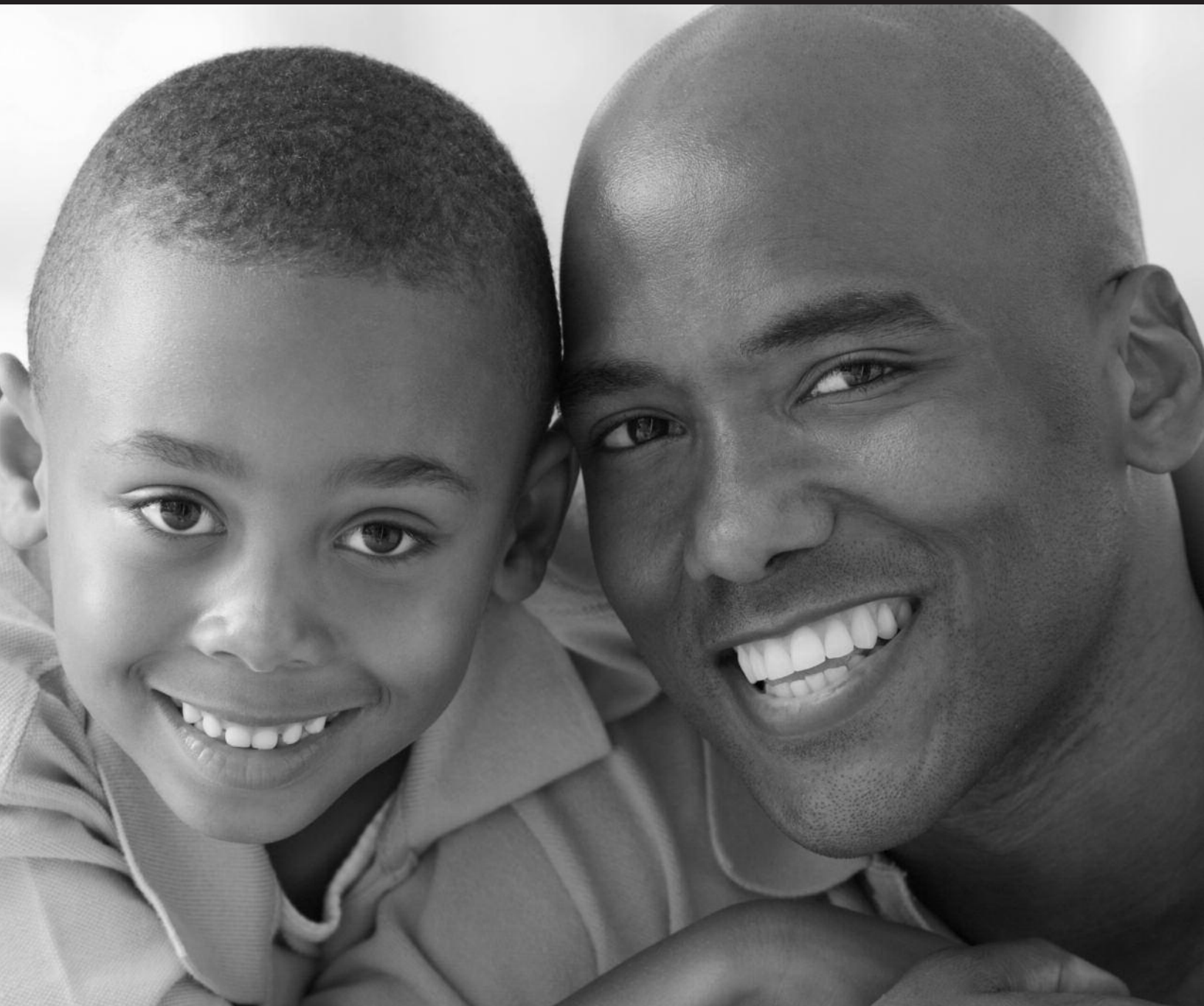


2012

MEMBER GUIDEBOOK

FOR CONNECTICARE® SOLO INDIVIDUAL HEALTH PLANS



ConnectiCare®
Solo
Individual health plans
the ConnectiCare way.

| | |
|---|----|
| 1. Why ConnectiCare? | |
| Our Reputation | 2 |
| Our Solutions | 2 |
| 2. How to Use This Booklet | |
| Determine if You Are Eligible to Apply | 4 |
| Review Information about Each Plan | 4 |
| Find Out How to Choose the Right Plan | 4 |
| Find Out How to Apply | 4 |
| 3. Connecticut Rating Areas | 5 |
| 4. Our Network Advantage | |
| Extensive Choice of Providers | 6 |
| Negotiated Discounts | 6 |
| Using a Non-Participating Provider Means Higher Out-of-Pocket Costs | 6 |
| 5. Which Plan Is Right for You? | |
| Key Questions to Ask | 7 |
| Overview of POS Plans | 7 |
| Overview of HDHP Plans | 9 |
| POS Plan Comparison Charts | 10 |
| HDHP Plan Comparison Charts | 22 |
| In-network Services Not Subject to Cost Share | 30 |
| Understanding Your Prescription Drug Coverage | 30 |
| Dental Plans | 32 |
| 6. Understanding HSAs | |
| What You Need To Know First | 33 |
| The ConnectiCare HSA Solution | 34 |
| 7. Things You Need to Know Before Applying | |
| Your Health History | 37 |
| Declinable Conditions | 37 |
| Height and Weight Chart | 38 |
| Steps to Apply | 39 |
| Rescissions | 41 |
| Renewability of Coverage | 41 |
| Renewal Provision | 41 |
| Exclusions and Limitations | 42 |
| 8. Important Contact Information | |
| Important Telephone Numbers and Addresses | 45 |

1. WHY CONNECTICARE?

We understand that you have many choices for individual health insurance. Thank you for choosing ConnectiCare. You'll find that our product for individuals and families, ConnectiCare SOLO, offers a wide selection of solutions to meet your need for affordable, quality health coverage. Our plans also come with the outstanding personal service that ConnectiCare is known for throughout the state.

ConnectiCare SOLO can be an ideal solution if you are:

- self-employed (1099 consultant/contractor)
- recently unemployed/between jobs
- a part-time/seasonal employee
- an early retiree
- employed by a company that doesn't offer health insurance
- dissatisfied with your present plan

This booklet is designed to explain ConnectiCare SOLO in clear, simple terms so you can decide which of our plan designs might work best for you.

You know us by heart

Because we are locally managed right here at our headquarters in Farmington, we know Connecticut. This makes us accessible and responsive to your needs.

Here are some other key reasons why, as our tagline says, "You know us by heart":

Our Reputation

- **You will receive industry-leading service:** ConnectiCare, Inc. received the highest member satisfaction score for customer service in Connecticut, according to the 2011 Consumer Assessment of Healthcare Providers and Systems (CAHPS). (Competitors included: Aetna, Anthem Blue Cross and Blue Shield, CIGNA, Oxford Health Plans, and United HealthCare.)

Our Solutions

- **You have access to our extensive provider network:** Made up of more than 20,000 health care professionals, hospitals and other facilities, our participating provider network offers convenient access to care no matter where you live in Connecticut. Members of our POS plans have the freedom to go outside the network for covered services (though benefits are paid at a lower level and non-participating providers may bill you for any outstanding balance).
- **You have the freedom to see participating specialists:** Because all of our ConnectiCare SOLO plans are "Open Access," you can seek care from a participating specialist without a referral from your Primary Care Provider. (This is the health care professional of your choice – a family practitioner, internist, pediatrician or nurse practitioner – who knows and understands your needs.)

- **Coverage for pre-existing conditions:** We cover pre-existing conditions from the effective date of the policy for persons under age 19 who apply for coverage as dependents. NOTE: Persons under age 19 may NOT apply for coverage as a subscriber. We cover pre-existing conditions from the effective date of the policy for persons age 19 and over who pass medical underwriting and are accepted into the plan.
- **Your health is at the heart of everything we do.** ConnectiCare Touchpoints, our comprehensive program of discounts, services and information, is designed to empower you to take an active role in your health. Touchpoints puts the necessary online tools at your fingertips, from making healthy choices to keeping track of checkups. (For more information on Touchpoints, go to www.connecticare.com.)
- **You can speak to our own clinically experienced staff:** Our Health Management Programs, a feature of ConnectiCare Touchpoints, are designed, run and adapted “in-house” by ConnectiCare employees with experience as registered nurses. These programs help members manage heart disease, diabetes, asthma and chronic obstructive pulmonary disease (COPD).



2. HOW TO USE THIS BOOKLET

Choosing the right health insurance plan can be confusing and complicated. This booklet is designed to help make the process easier to understand, and to help save you time.

Please Note: The benefit descriptions in this booklet are only a brief summary. The Membership Agreement or Certificate of Coverage that you will receive after you enroll will prevail for all benefits, conditions, limitations and exclusions.

Determine If You Are Eligible

Your first step in considering ConnectiCare SOLO is to make sure you are eligible to apply.

You may apply for ConnectiCare SOLO if you meet the following criteria:

- Legal resident of Connecticut
- Between 19 and 64 years of age
- Not enrolled in Medicare
- Single or married, or one of the following:
 - Dependent spouse
 - Civil union/domestic partner*
 - Dependent child age 26 who is not covered under a group health plan.

Please note: Dependents under age 19 must enroll within 61 days of a qualifying event or during our annual Open Enrollment.** Only the dependent(s) experiencing a qualifying event can enroll. Examples of a qualifying event include:

- Birth of a natural child
- Adopting a child
- Adding step-children due to marriage
- Losing previous health care coverage (within 31 days of this qualifying event)

Spouses and dependents age 19 and over can apply anytime and are subject to medical underwriting.

Note: Persons under age 19 may not apply for coverage as a subscriber.

Special exemption: For those individuals with policies issued March 1, 2010, or prior, ConnectiCare will allow the policyholder to add a dependent, regardless of age, anytime, and we will medically underwrite each case and accept or deny the dependent.

** Domestic partners must submit the Domestic Partner Verification Form or other satisfactory certification as we determine. CAUTION: Domestic partners are not recognized by the IRS as legal dependents for HSA funding. You should consult with your ConnectiCare agent and your tax advisor before establishing an HSA.*

*** A special Open Enrollment period will take place during August for September 1st, effective dates.*

Review Information About Each Plan

Once you have determined that you are eligible to apply, the next step is to carefully review information about each ConnectiCare SOLO plan option. Look carefully to see what services are covered, and what cost-shares you will be responsible for paying.

Find Out How To Choose The Right Plan

Everyone's financial situation and health care needs are different. Because ConnectiCare SOLO is designed to meet the needs of a wide range of individuals, you can find the plan that works best for your unique situation. And your ConnectiCare SOLO Agent is there to guide you through the process. For more information, please see page 7.

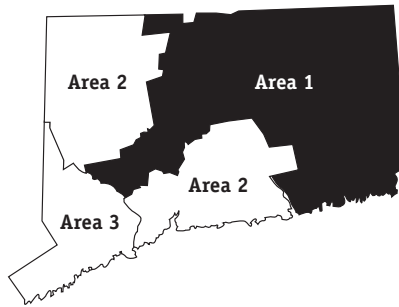
Find Out How To Apply

Once you've selected the ConnectiCare SOLO plan that's right for you, it's time to apply. Our application process is simple – especially if you apply online. See “How to Apply” for more information.

3. CONNECTICARE RATING AREAS

Your monthly premium as a ConnectiCare SOLO member will depend on your age and the area of Connecticut in which you live. If you move from one area to another, you are required to notify ConnectiCare within 30 days. Your renewal premium will reflect your new rating area.

ConnectiCare SOLO has three rating areas, which are shown in the maps below:



Area 1 (Hartford, New London, Tolland and Windham counties*)

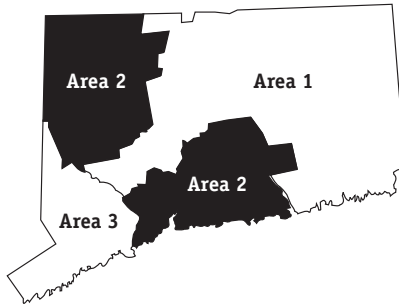
Hartford County: Avon, Berlin, Bloomfield, Bristol, Burlington, Canton, East Granby, East Hartford, East Windsor, Enfield, Farmington, Glastonbury, Granby, Hartford, Hartland, Manchester, Marlborough, New Britain, Newington, Plainville, Rocky Hill, Simsbury, Southington, South Windsor, Suffield, West Hartford, Wethersfield, Windsor, Windsor Locks

New London County: Bozrah, Colchester, East Lyme, Franklin, Griswold, Groton, Lebanon, Ledyard, Lisbon, Lyme, Montville, New London, North Stonington, Norwich, Old Lyme, Preston, Salem, Sprague, Stonington, Voluntown, Waterford

Tolland County: Andover, Bolton, Columbia, Coventry, Ellington, Hebron, Mansfield, Somers, Stafford, Tolland, Union, Vernon, Willington

Windham County: Ashford, Brooklyn, Canterbury, Chaplin, Eastford, Hampton, Killingly, Plainfield, Pomfret, Putnam, Scotland, Sterling, Thompson, Windham, Woodstock

***Note:** Area 1 also includes these towns from **New Haven County:** Beacon Falls, Cheshire, Middlebury, Naugatuck, Oxford, Prospect, South Britain, Southbury, Waterbury and Wolcott.



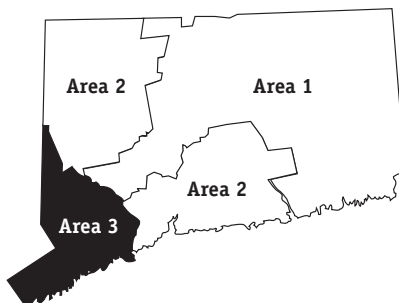
Area 2 (Litchfield, Middlesex and New Haven counties*)

Litchfield County: Barkhamsted, Bethlehem, Bridgewater, Canaan, Colebrook, Cornwall, Goshen, Harwinton, Kent, Litchfield, Morris, New Hartford, New Milford, Norfolk, North Canaan, Plymouth, Roxbury, Salisbury, Sharon, Thomaston, Torrington, Warren, Washington, Watertown, Winchester, Woodbury

Middlesex County: Chester, Clinton, Cromwell, Deep River, Durham, East Haddam, East Hampton, Essex, Haddam, Killingworth, Middlefield, Middletown, Old Saybrook, Portland, Westbrook

New Haven County: Ansonia, Bethany, Branford, Derby, East Haven, Guilford, Hamden, Madison, Meriden, Milford, New Haven, North Branford, North Haven, Orange, Seymour, Wallingford, West Haven, Woodbridge

***Note:** The following towns are included in Area 1: Beacon Falls, Cheshire, Middlebury, Naugatuck, Oxford, Prospect, South Britain, Southbury, Waterbury and Wolcott.



Area 3 (Fairfield County)

Fairfield County: Bethel, Bridgeport, Brookfield, Danbury, Darien, Easton, Fairfield, Greenwich, Monroe, New Canaan, New Fairfield, Newtown, Norwalk, Shelton, Sherman, Stamford, Stratford, Redding, Ridgefield, Trumbull, Weston, Westport, Wilton

4. OUR NETWORK ADVANTAGE

Extensive Choice of Participating Providers

As a member, you'll have access to more than 20,000 participating providers in Connecticut, New York and western Massachusetts. To locate a participating physician, specialist or other health care practitioner, visit our online participating provider directory at www.connecticare.com for the most recent information. You may also consult our printed participating provider directory. To request a copy, contact Member Services at **1-800-251-7722**.

Negotiated Discounts

As a member, you also may enjoy significant savings on covered services due to our negotiated discounts with participating providers. Participating providers must accept the discounted ConnectiCare rate as payment in full for covered services – they cannot bill you for the balance.

Using a Non-participating Provider Means Higher Out-of-pocket Costs

If you enroll in one of our ConnectiCare SOLO POS plans, you will have the freedom to choose to go outside the participating provider network for covered services. However, you will generally receive a lower level of benefits if you go out-of-network, and the “non-participating” provider may bill you for any difference between the doctor’s charge and ConnectiCare’s negotiated reimbursement.



5. WHICH PLAN IS RIGHT FOR YOU?

Key Questions To Ask

Choosing a health plan is one of the most important decisions you make. ConnectiCare SOLO offers a variety of plan designs to fit a variety of different needs and budgets. How do you go about picking the right one? First, it's important to seek guidance from your ConnectiCare Agent. This person serves an important role in helping you understand your options.

Here are some questions to help guide you and your ConnectiCare Agent in selecting a plan:

- **Are you comfortable with having an up-front deductible?** (This is a total amount you must pay for benefits under your plan during the contract year before ConnectiCare begins paying for those benefits.) If yes, consider one of our POS Up-Front Deductible Plans, with deductible options ranging from \$500 to \$10,000, or one of our High-Deductible Health Plans (HDHPs.)
- **Do you prefer having a copayment for most in-network services rather than an up-front deductible?** (A copayment is a flat fee you pay for certain benefits, like doctor visits and prescription drugs.) If this is your preference, one of our POS Hospital Deductible Plans may be a good fit. These plans only apply a deductible to hospital services – ambulatory (outpatient hospital, including free-standing outpatient surgery centers) and inpatient.
- **Are you interested in a low-premium plan that can be combined with the tax advantages of a Health Savings Account (HSA)?** Carefully review our selection of High-Deductible Health Plans (HDHPs), which are designed to work in concert with an HSA fund. Be sure you understand the

responsibilities of having an HSA before opening one. (See the section on HSAs on page 33 for more information.)

Remember, when choosing a plan be sure to understand your coverage needs, your financial situation and your comfort level with cost-sharing. And work closely with your ConnectiCare Agent to make sure that all your questions are answered.

All plans being sold meet the new health care reform requirements of the Patient Protection and Affordable Care Act.

ConnectiCare SOLO POS Plans

We offer three different “families” of POS Open Access Plans: Up-front Deductible, Hospital Deductible and High-Deductible Health Plans (see next section). Each family of plans provides the freedom to choose providers in-network or out-of-network without a referral from your Primary Care Provider (PCP). You can use our in-network participating providers to receive the highest level of benefits, or you may choose to go out-of-network to visit a doctor of your choice and receive a lower level of benefits.

- Within the POS Upfront Deductible family, there are many different plans to choose from based on the deductible level. Each plan has an in-network plan deductible for individual or family, and a separate out-of-network plan deductible for individual or family. The contract-year deductible must be met before the plan begins to provide benefits except for preventive care. Once the deductible is met, other cost-shares, such as copayments, will apply.

WHICH PLAN?

- The Hospital Deductible Plans have an in-network deductible that combines ambulatory services (outpatient) and inpatient services. Copayments apply for most other in-network services. There is a separate out-of-network plan deductible for the contract year.
- The POS Copay and Deductible Plan has copayments for all in-network office visits; the plan deductible does not apply. All other services are subject to the plan deductible and coinsurance except for preventative care.



ConnectiCare SOLO High-Deductible Health Plans

Our High-Deductible Health Plans (HDHPs) are a good choice if you are comfortable with greater cost-sharing in exchange for a lower monthly plan premium.

With an HDHP, you are required to meet an upfront deductible for the contract year except for preventative care. The deductible amount varies according to the plan you choose. In general, the higher the upfront deductible is, the lower the plan premium will be. You should also know that once the deductible is met, covered services will be subject to a copayment or coinsurance.

ConnectiCare SOLO offers two HDHP options:

- **Point-of-Service Open Access HDHP:** Provides the greatest freedom of choice in-network and out-of-network. You can use our participating providers to receive a generally higher level of benefits, or you may choose to go out-of-network to visit a doctor of your choice and receive a generally lower level of benefits.

These plans have an up-front, **in-network** plan deductible for individual or family, and an **out-of-network** plan deductible for individual or family. On three of the POS HDHP options, the in-network and out-of-network deductible are separate; while on a fourth POS HDHP option (the \$5,000 Individual/ \$10,000 Family), the deductibles are combined. Whether combined or separate, these contract-year deductibles must be met before the plan begins to provide benefits.

(Note: The contract-year deductibles can be reached by any combination of covered health services or covered prescription drug services. The individual contract-year

deductible only applies if you are the sole policyholder on the contract. If you have family coverage (two or more covered lives), then covered health services and covered prescription drugs will be applied to the family contract-year deductible until the total amount is met without regard to which family member uses the benefits.)

- **HMO Open Access HDHP:** Allows you to see any participating specialist without first obtaining a referral from your PCP. You must meet a contract-year individual deductible or contract-year family deductible before the plan begins to provide benefits except for preventative care.

(Note: The contract-year deductibles can be reached by any combination of covered health services or covered prescription drug services. The individual deductible only applies if you are the sole policyholder on the contract. If you have family coverage (two or more covered lives), 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.)

SOLO Dental Plans

Our ConnectiCare® SOLO Dental Plan is new for January 1, 2012. SOLO Dental offers coverage for a wide range of preventive care including exams, X-rays and fillings, as well as some restorative services. And, research suggests that good oral health is an important aspect of your overall health and well being. So, consider adding ConnectiCare's SOLO Dental Plan along with your medical plan for comprehensive coverage and your overall wellness. For complete details on the new dental plan, see the benefit summary on page 32.

PLAN COMPARISON CHARTS

| | POS Hospital Deductible \$2,500/\$5,000 - D | POS Hospital Deductible \$5,000/\$10,000 - D |
|---|--|--|
| CONTRACT YEAR COST-SHARE | In-Network | Out-of-Network |
| Benefit Deductible (Deductible is combined for Ambulatory Services (outpatient) and Inpatient Services including Mental Health and Alcohol and Substance Abuse) | \$2,500 / \$5,000 Not applicable | \$5,000 / \$10,000 Not applicable |
| Individual / Family Plan Deductible | Not applicable | Not applicable |
| Individual / Family Coinsurance Maximum (Maximum does not include the Plan Deductible) | Not applicable | Not applicable |
| Individual / Family Out-of-Pocket Maximum (Maximum includes Plan Deductible and Coinsurance) | \$10,000 / \$20,000 | \$10,000 / \$20,000 |
| Member Coinsurance | Not applicable | Not applicable |
| Lifetime Maximum Benefit | Unlimited | Unlimited |
| COVERED HEALTH SERVICES (Cost-shares for the following services are the same for both plan options.) | | |
| Routine Physical Exam | No Member cost | 50% after Plan Deductible |
| Gynecological Annual Preventive Exam Office Services | No Member cost | 50% after Plan Deductible |
| Primary Care Providers Office Services | \$30 Copayment per visit | 50% after Plan Deductible |
| Specialist Office Services | \$45 Copayment per visit | 50% after Plan Deductible |
| Maternity Care | <i>Not a covered benefit</i> | <i>Not a covered benefit</i> |
| Outpatient Laboratory Services | No Member cost | 50% after Plan Deductible |
| Non-Advanced Radiology Services | \$45 Copayment per visit | 50% after Plan Deductible |
| Advanced Radiology Services (includes MRI, PET and CAT Scan) | \$75 Copayment per visit up to 5 Copayments per year | 50% after Plan Deductible |
| Outpatient Rehabilitative Therapy (up to 20 visits) | \$45 Copayment per visit | 50% after Plan Deductible |
| Chiropractic Services (up to 10 visits) | \$45 Copayment per visit | 50% after Plan Deductible |
| Walk-In / Urgent Care Services | \$75 Copayment per visit | Same as In-Network |
| Emergency Room | \$150 Copayment per visit | Same as In-Network |
| Emergency Ambulance Services | No Member cost | Same as In-Network |
| Outpatient Ambulatory Services | No Member cost after Benefit Deductible | 50% after Plan Deductible |
| Hospitalization for Illness or Injury (excludes maternity) | No Member cost after Benefit Deductible | 50% after Plan Deductible |
| Home Health Services (up to 80 visits) | No Member cost | 25% (Plan Deductible Waived) |
| Skilled Nursing and Rehabilitation Facilities (up to 80 days) | No Member cost after Benefit Deductible | 50% after Plan Deductible |
| Durable Medical Equipment & Disposable Medical Supplies | 50% | 50% after Plan Deductible |

PRESCRIPTION DRUG OPTION

Option I – 30-Day supply through participating retail pharmacies
(Copay is 2X through mail-order)

Tier 1

\$15

Tier 2

50% (\$200 Deductible)

Tier 3

50% (\$200 Deductible)

\$100 Coins Max per Script

Individual POS Upfront Deductible Plan Options

| CONTRACT YEAR COST-SHARE | POS Upfront Deductible \$500/\$1,000 - D | | POS Upfront Deductible \$750/\$1,500 - D | | POS Upfront Deductible \$1,000/\$2,000 - D | |
|--|--|------------------------|--|----------------------------|--|------------------------|
| | In-Network | Out-of-Network | In-Network | Out-of-Network | In-Network | Out-of-Network |
| Individual / Family Plan Deductible | \$500 / \$1,000 | \$2,000 / \$4,000 | \$750 / \$1,500 | \$2,000 / \$4,000 | \$1,000 / \$2,000 | \$3,000 / \$6,000 |
| Individual / Family Coinsurance Maximum (Maximum does not include the Plan Deductible) | Not applicable | \$3,000 / \$6,000 | Not applicable | \$3,000 / \$6,000 | Not applicable | \$4,000 / \$8,000 |
| Individual / Family Out-of-Pocket Maximum (Maximum includes Plan Deductible and Coinsurance) | Not applicable | \$5,000 / \$10,000 | Not applicable | \$5,000 / \$10,000 | Not applicable | \$7,000 / \$14,000 |
| Member Coinsurance | Not applicable | 50% | Not applicable | 50% | Not applicable | 50% |
| Lifetime Maximum Benefit | Unlimited | Unlimited | Unlimited | Unlimited | Unlimited | Unlimited |
| COVERED HEALTH SERVICES (Cost-shares for the following services are the same for all three plan options.) | | | | | | |
| Routine Physical Exam | No Member cost | | No Member cost | | 50% after Plan Deductible | |
| Gynecological Annual Preventive Exam Office Services | No Member cost | | No Member cost | | 50% after Plan Deductible | |
| Primary Care Providers Office Services | \$30 Copayment per visit after Plan Deductible | | \$30 Copayment per visit after Plan Deductible | | 50% after Plan Deductible | |
| Specialist Office Services | \$45 Copayment per visit after Plan Deductible | | \$45 Copayment per visit after Plan Deductible | | 50% after Plan Deductible | |
| Maternity Care | Not a covered benefit | | Not a covered benefit | | Not a covered benefit | |
| Outpatient Laboratory Services | No Member cost after Plan Deductible | | No Member cost after Plan Deductible | | 50% after Plan Deductible | |
| Non-Advanced Radiology Services | \$45 Copayment per visit after Plan Deductible | | \$45 Copayment per visit after Plan Deductible | | 50% after Plan Deductible | |
| Advanced Radiology Services (includes MRI, PET and CAT Scan) | \$75 Copayment per visit up to 5 Copayments per year after Plan Deductible | | \$75 Copayment per visit up to 5 Copayments per year after Plan Deductible | | 50% after Plan Deductible | |
| Outpatient Rehabilitative Therapy (up to 20 visits) | \$45 Copayment per visit after Plan Deductible | | \$45 Copayment per visit after Plan Deductible | | 50% after Plan Deductible | |
| Chiropractic Services (up to 10 visits) | \$45 Copayment per visit after Plan Deductible | | \$45 Copayment per visit after Plan Deductible | | 50% after Plan Deductible | |
| Walk-In / Urgent Care Services | \$75 Copayment per visit after Plan Deductible | | \$75 Copayment per visit after Plan Deductible | | Same as In-Network | |
| Emergency Room | \$150 Copayment per visit after Plan Deductible | | \$150 Copayment per visit after Plan Deductible | | Same as In-Network | |
| Emergency Ambulance Services | No Member cost after Plan Deductible | | No Member cost after Plan Deductible | | Same as In-Network | |
| Outpatient Ambulatory Services | \$500 Copayment per visit after Plan Deductible | | \$500 Copayment per visit after Plan Deductible | | 50% after Plan Deductible | |
| Hospitalization for Illness or Injury (excludes maternity) | \$500 Copayment per day up to \$2,000 per year after Plan Deductible | | \$500 Copayment per day up to \$2,000 per year after Plan Deductible | | 50% after Plan Deductible | |
| Home Health Services (up to 80 visits) | No Member cost (Plan Deductible Waived) | | No Member cost (Plan Deductible Waived) | | 25% (Plan Deductible Waived) | |
| Skilled Nursing and Rehabilitation Facilities (up to 80 days) | \$500 Copayment per day up to \$2,000 per year after Plan Deductible | | \$500 Copayment per day up to \$2,000 per year after Plan Deductible | | 50% after Plan Deductible | |
| Durable Medical Equipment & Disposable Medical Supplies | 50% after Plan Deductible | | 50% after Plan Deductible | | 50% after Plan Deductible | |
| PRESCRIPTION DRUG OPTION | | | | | | |
| Option I – 30-Day supply through participating retail pharmacies (Copay is 2X through mail-order) | Tier 1 | | Tier 2 | | Tier 3 | |
| | \$15 | 50% (\$200 Deductible) | \$15 | 50% (\$200 Deductible) | 50% (\$200 Deductible) | 50% (\$200 Deductible) |
| | | | | \$100 Coins Max per Script | | |

Rates displayed are quoted rates only. Plans and rates are subject to approval by the Connecticut Insurance Department. Final rates are subject to change based on medical history, federal and state regulations, and ConnectiCare's underwriting guidelines.

Individual POS Upfront Deductible Plan Options

| CONTRACT YEAR COST-SHARE | POS Upfront Deductible \$2,000/\$4,000 - D | | POS Upfront Deductible \$2,500/\$5,000 - D | |
|---|--|----------------------------|--|------------------------------|
| | In-Network | Out-of-Network | In-Network | Out-of-Network |
| Individual / Family Plan Deductible | \$2,000 / \$4,000 | \$4,000 / \$8,000 | \$2,500 / \$5,000 | \$5,000 / \$10,000 |
| Individual / Family Coinsurance Maximum (Maximum does not include the Plan Deductible) | Not applicable | \$6,000 / \$12,000 | Not applicable | \$5,000 / \$10,000 |
| Individual / Family Out-of-Pocket Maximum (Maximum includes Plan Deductible and Coinsurance) | Not applicable | \$10,000 / \$20,000 | Not applicable | \$10,000 / \$20,000 |
| Member Coinsurance | Not applicable | 50% | Not applicable | 50% |
| Lifetime Maximum Benefit | Unlimited | Unlimited | Unlimited | Unlimited |
| COVERED HEALTH SERVICES (Cost-shares for the following services are the same for both plan options.) | | | | |
| Routine Physical Exam | No Member cost | | | 50% after Plan Deductible |
| Gynecological Annual Preventive Exam Office Services | No Member cost | | | 50% after Plan Deductible |
| Primary Care Providers Office Services | \$30 Copayment per visit after Plan Deductible | | | 50% after Plan Deductible |
| Specialist Office Services | \$45 Copayment per visit after Plan Deductible | | | 50% after Plan Deductible |
| Maternity Care | <i>Not a covered benefit</i> | | | <i>Not a covered benefit</i> |
| Outpatient Laboratory Services | No Member cost after Plan Deductible | | | 50% after Plan Deductible |
| Non-Advanced Radiology Services | \$45 Copayment per visit after Plan Deductible | | | 50% after Plan Deductible |
| Advanced Radiology Services (includes MRI, PET and CAT Scan) | \$75 Copayment per visit up to 5 Copayments per year after Plan Deductible | | | 50% after Plan Deductible |
| Outpatient Rehabilitative Therapy (up to 20 visits) | \$45 Copayment per visit after Plan Deductible | | | 50% after Plan Deductible |
| Chiropractic Services (up to 10 visits) | \$45 Copayment per visit after Plan Deductible | | | 50% after Plan Deductible |
| Walk-In / Urgent Care Services | \$75 Copayment per visit after Plan Deductible | | | Same as In-Network |
| Emergency Room | \$150 Copayment per visit after Plan Deductible | | | Same as In-Network |
| Emergency Ambulance Services | No Member cost after Plan Deductible | | | Same as In-Network |
| Outpatient Ambulatory Services | \$500 Copayment per visit after Plan Deductible | | | 50% after Plan Deductible |
| Hospitalization for Illness or Injury (excludes maternity) | \$500 Copayment per day up to \$2,000 per year after Plan Deductible | | | 50% after Plan Deductible |
| Home Health Services (up to 80 visits) | No Member cost (Plan Deductible Waived) | | | 25% (Plan Deductible Waived) |
| Skilled Nursing and Rehabilitation Facilities (up to 80 days) | \$500 Copayment per day up to \$2,000 per year after Plan Deductible | | | 50% after Plan Deductible |
| Durable Medical Equipment & Disposable Medical Supplies | 50% after Plan Deductible | | | 50% after Plan Deductible |
| PRESCRIPTION DRUG OPTION | | | | |
| Tier 1 | | | | |
| Option I – 30-Day supply through participating retail pharmacies (Copy is 2X through mail-order) | \$15 | 50% (\$200 Deductible) | | 50% (\$200 Deductible) |
| Tier 2 | | | | |
| | | \$100 Coins Max per Script | | |
| Tier 3 | | | | |

Rates displayed are quoted rates only. Plans and rates are subject to approval by the Connecticut Insurance Department. Final rates are subject to change based on medical history, federal and state regulations, and ConnectiCare's underwriting guidelines.

Individual POS Upfront Deductible Plan Options

Coinsurance Plan Options

| CONTRACT YEAR COST-SHARE | POS Upfront Deductible \$1,000/\$2,000-30PCP-50%-D | POS Upfront Deductible \$2,500/\$5,000-30PCP-50%-D | POS Upfront Deductible \$5,000/\$10,000-30PCP-50%-D |
|--|--|--|---|
| | In-Network | Out-of-Network | Out-of-Network |
| Individual / Family Plan Deductible | \$1,000 / \$2,000 | \$5,000 / \$10,000 | \$5,000 / \$10,000 |
| Individual / Family Coinsurance Maximum (Maximum does not include the Plan Deductible) | \$3,000 / \$6,000 | \$10,000 / \$20,000 | \$10,000 / \$20,000 |
| Individual / Family Out-of-Pocket Maximum (Maximum includes Plan Deductible and Coinsurance) | \$4,000 / \$8,000 | \$15,000 / \$30,000 | \$15,000 / \$30,000 |
| Member Coinsurance | 50% | 50% | 50% |
| Lifetime Maximum Benefit | Unlimited | Unlimited | Unlimited |

COVERED HEALTH SERVICES (Cost-shares for the following services are the same for all plan options.)

| | In-Network Member Cost | Out-of-Network Member Cost |
|---|------------------------------|------------------------------|
| Routine Physical Exams | No Member cost | 50% after Plan Deductible |
| Gynecological Annual Preventive Exam Office Services | No Member cost | 50% after Plan Deductible |
| Primary Care Providers Office Services | \$30 Copayment per visit | 50% after Plan Deductible |
| Specialist Office Services | 50% after Plan Deductible | 50% after Plan Deductible |
| Maternity Care | <i>Not a covered benefit</i> | <i>Not a covered benefit</i> |
| Outpatient Laboratory Services | 50% after Plan Deductible | 50% after Plan Deductible |
| Non-Advanced Radiology Services | 50% after Plan Deductible | 50% after Plan Deductible |
| Advanced Radiology Services (includes MRI, PET and CAT Scan) | 50% after Plan Deductible | 50% after Plan Deductible |
| Outpatient Rehabilitative Therapy (up to 20 visits) | 50% after Plan Deductible | 50% after Plan Deductible |
| Chiropractic Services (up to 10 visits) | 50% after Plan Deductible | 50% after Plan Deductible |
| Walk-In / Urgent Care Services | 50% after Plan Deductible | Same as In-Network |
| Emergency Room | 50% after Plan Deductible | Same as In-Network |
| Emergency Ambulance Services | 50% after Plan Deductible | Same as In-Network |
| Outpatient Ambulatory Services | 50% after Plan Deductible | 50% after Plan Deductible |
| Hospitalization for Illness or Injury (excludes maternity) | 50% after Plan Deductible | 50% after Plan Deductible |
| Home Health Services (up to 80 visits) | 25% (Plan Deductible Waived) | 25% (Plan Deductible Waived) |
| Skilled Nursing and Rehabilitation Facilities (up to 80 days) | 50% after Plan Deductible | 50% after Plan Deductible |
| Durable Medical Equipment & Disposable Medical Supplies | 50% after Plan Deductible | 50% after Plan Deductible |

PRESCRIPTION DRUG OPTIONS

| | Tier 1 | Tier 2 | Tier 3 |
|--|--------|------------------------|--|
| Option I – 30-Day supply through participating retail pharmacies (Copay is 2X through mail-order) | \$15 | 50% (\$200 Deductible) | 50% (\$200 Deductible) \$100 Coins Max per Script |

Rates displayed are quoted rates only. Plans and rates are subject to approval by the Connecticut Insurance Department. Final rates are subject to change based on medical history, federal and state regulations, and ConnectiCare's underwriting guidelines.

| | | Copy and Deductible \$5,000/\$10,000 - 20% - D | |
|---|--|--|-----------------------------------|
| CONTRACT YEAR COST-SHARE | | In-Network | Out-of-Network |
| Individual / Family Plan Deductible | | \$5,000 / \$10,000 | \$10,000 / \$20,000 |
| Individual / Family Coinsurance Maximum (Maximum does not include the Plan Deductible) | | \$5,000 / \$10,000 | \$2,500 / \$5,000 |
| Individual / Family Out-of-Pocket Maximum (Maximum includes Plan Deductible and Coinsurance, Copayments are not included) | | \$10,000 / \$20,000 | \$12,500 / \$25,000 |
| Member Coinsurance | | 20% when applicable | 50% |
| Lifetime Maximum Benefit | | Unlimited | Unlimited |
| COVERED HEALTH SERVICES | | In-Network Member Cost | Out-of-Network Member Cost |
| Routine Physical Exam | | No Member cost | 50% after Plan Deductible |
| Gynecological Annual Preventive Exam Office Services | | No Member cost | 50% after Plan Deductible |
| Primary Care Providers Office Services | | \$30 Copayment per visit | 50% after Plan Deductible |
| Specialist Office Services | | \$45 Copayment per visit | 50% after Plan Deductible |
| Maternity Care | | <i>Not a covered benefit</i> | <i>Not a covered benefit</i> |
| Outpatient Laboratory Services | | 20% after Plan Deductible | 50% after Plan Deductible |
| Non-Advanced Radiology Services | | 20% after Plan Deductible | 50% after Plan Deductible |
| Advanced Radiology Services (includes MRI, PET and CAT Scan) | | 20% after Plan Deductible | 50% after Plan Deductible |
| Outpatient Rehabilitative Therapy (up to 20 visits) | | \$45 Copayment per visit | 50% after Plan Deductible |
| Chiropractic Services (up to 10 visits) | | \$45 Copayment per visit | 50% after Plan Deductible |
| Walk-In / Urgent Care Services | | \$50 Copayment per visit | Same as In-Network |
| Emergency Room | | 20% after Plan Deductible | Same as In-Network |
| Emergency Ambulance Services | | 20% after Plan Deductible | Same as In-Network |
| Ambulatory Services (Outpatient) | | 20% after Plan Deductible | 50% after Plan Deductible |
| Hospitalization for Illness or Injury (excludes maternity) | | 20% after Plan Deductible | 50% after Plan Deductible |
| Home Health Services (up to 80 visits) | | 20% (Plan Deductible Waived) | 25% (Plan Deductible Waived) |
| Skilled Nursing and Rehabilitation Facilities (up to 80 days) | | 20% after Plan Deductible | 50% after Plan Deductible |
| Durable Medical Equipment & Disposable Medical Supplies | | 50% after Plan Deductible | 50% after Plan Deductible |
| PRESCRIPTION DRUG OPTION | | Tier 1 | Tier 2 |
| Option I - 30-Day supply through participating retail pharmacies (Copay is 2X through mail-order) | | \$15 | 50% (\$200 Deductible) |
| | | | \$100 Coins Max per Script |
| | | Tier 3 | 50% (\$200 Deductible) |

Rates displayed are quoted rates only. Plans and rates are subject to approval by the Connecticut Insurance Department. Final rates are subject to change based on medical history, federal and state regulations, and ConnectiCare's underwriting guidelines.

Individual POS Upfront Deductible Plan Options

Coinsurance Plan Options

| | CONTRACT YEAR COST-SHARE | |
|--|--|---|
| | POS Upfront Deductible \$1,500/\$3,000 - 20% - D | POS Upfront Deductible \$2,500/\$5,000 - 20% - D |
| | In-Network | Out-of-Network |
| Individual / Family Plan Deductible | \$1,500 / \$3,000 | \$2,500 / \$5,000 |
| Individual / Family Coinsurance Maximum (Maximum does not include the Plan Deductible) | \$2,000 / \$4,000 | \$2,000 / \$4,000 |
| Individual / Family Out-of-Pocket Maximum (Maximum includes Plan Deductible and Coinsurance) | \$3,500 / \$7,000 | \$4,500 / \$9,000 |
| Member Coinsurance | 20% | 20% |
| Lifetime Maximum Benefit | Unlimited | Unlimited |
| COVERED HEALTH SERVICES (Cost-shares for the following services are the same for all plan options.) | | |
| Routine Physical Exam | No Member cost | 50% after Plan Deductible |
| Gynecological Annual Preventive Exam Office Services | No Member cost | 50% after Plan Deductible |
| Primary Care Providers Office Services | 20% after Plan Deductible | 50% after Plan Deductible |
| Specialist Office Services | 20% after Plan Deductible | 50% after Plan Deductible |
| Maternity Care | <i>Not a covered benefit</i> | <i>Not a covered benefit</i> |
| Outpatient Laboratory Services | 20% after Plan Deductible | 50% after Plan Deductible |
| Non-Advanced Radiology Services | 20% after Plan Deductible | 50% after Plan Deductible |
| Advanced Radiology Services (includes MRI, PET and CAT Scan) | 20% after Plan Deductible | 50% after Plan Deductible |
| Outpatient Rehabilitative Therapy (up to 20 visits) | 20% after Plan Deductible | 50% after Plan Deductible |
| Chiropractic Services (up to 10 visits) | 20% after Plan Deductible | 50% after Plan Deductible |
| Walk-In / Urgent Care Services | 20% after Plan Deductible | Same as In-Network |
| Emergency Room | 20% after Plan Deductible | Same as In-Network |
| Emergency Ambulance Services | 20% after Plan Deductible | Same as In-Network |
| Outpatient Ambulatory Services | 20% after Plan Deductible | 50% after Plan Deductible |
| Hospitalization for Illness or Injury (excludes maternity) | 20% after Plan Deductible | 50% after Plan Deductible |
| Home Health Services (up to 80 visits) | 20% (Plan Deductible Waived) | 25% (Plan Deductible Waived) |
| Skilled Nursing and Rehabilitation Facilities (up to 80 days) | 20% after Plan Deductible | 50% after Plan Deductible |
| Durable Medical Equipment & Disposable Medical Supplies | 50% after Plan Deductible | 50% after Plan Deductible |
| PRESCRIPTION DRUG OPTION | | |
| Option I – 30-Day supply through participating retail pharmacies (Copay is 2X through mail-order) | Tier 1 \$15 | Tier 2 50% (\$200 Deductible) \$100 Coins Max per Script |
| | | Tier 3 50% (\$200 Deductible) |

Rates displayed are quoted rates only. Plans and rates are subject to approval by the Connecticut Insurance Department. Final rates are subject to change based on medical history, federal and state regulations, and ConnectiCare's underwriting guidelines.

POS Upfront Deductible \$10,000 Combined – D

CONTRACT YEAR COST-SHARE

Individual / Family Plan Deductible (Deductible is combined for In- and Out-of-Network)

\$10,000 / \$20,000

Individual / Family Coinsurance Maximum (Maximum does not include the Plan Deductible)

\$10,000 / \$20,000

Individual / Family Out-of-Network Out-of-Pocket Maximum (Maximum includes Plan Deductible and Coinsurance Maximum)

\$20,000 / \$40,000

Member Out-of-Network Coinsurance

50%

Out-of-Network Lifetime Maximum Benefit

Unlimited

COVERED HEALTH SERVICES

In-Network Member Cost

Out-of-Network Member Cost

Routine Physical Exam

No Member cost

50% after Plan Deductible

Gynecological Annual Preventive Exam Office Services

No Member cost

50% after Plan Deductible

Primary Care Providers Office Services

No Member cost after Plan Deductible

50% after Plan Deductible

Specialist Office Services

No Member cost after Plan Deductible

50% after Plan Deductible

Maternity Care

Not a covered benefit

Not a covered benefit

Outpatient Laboratory Services

No Member cost after Plan Deductible

50% after Plan Deductible

Non-Advanced Radiology Services

No Member cost after Plan Deductible

50% after Plan Deductible

Advanced Radiology Services (includes MRI, PET and CAT Scan)

No Member cost after Plan Deductible

50% after Plan Deductible

Outpatient Rehabilitative Therapy (up to 20 visits)

No Member cost after Plan Deductible

50% after Plan Deductible

Chiropractic Services (up to 10 visits)

No Member cost after Plan Deductible

50% after Plan Deductible

Walk-In / Urgent Care Services

No Member cost after Plan Deductible

Same as In-Network

Emergency Room

No Member cost after Plan Deductible

Same as In-Network

Emergency Ambulance Services

No Member cost after Plan Deductible

Same as In-Network

Ambulatory Services (Outpatient)

No Member cost after Plan Deductible

50% after Plan Deductible

Hospitalization for Illness or Injury (excludes maternity)

No Member cost after Plan Deductible

50% after Plan Deductible

Home Health Services (up to 80 visits)

No Member cost (Plan Deductible Waived)

25% (Plan Deductible Waived)

Skilled Nursing and Rehabilitation Facilities (up to 80 days)

No Member cost after Plan Deductible

50% after Plan Deductible

Durable Medical Equipment & Disposable Medical Supplies

50% after Plan Deductible

50% after Plan Deductible

Rates displayed are quoted rates only. Plans and rates are subject to approval by the Connecticut Insurance Department. Final rates are subject to change based on medical history, federal and state regulations, and ConnectiCare's underwriting guidelines.

PRESCRIPTION DRUG OPTION**Tier 1****Tier 2****Tier 3**

Option I – 30-Day supply through participating retail pharmacies

\$15 50% (\$200 Deductible)

50% (\$200 Deductible)

(Copay is 2X through mail-order)

\$100 Coins Max per Script

Preventive Care and Wellness Services

IN-NETWORK SERVICES NOT SUBJECT TO COST SHARE

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, 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 contract year
- Routine Mammography Screening, age 40 or older, one per contract year
- Immunizations recommended by the Advisory Committee on Immunization Practices of the CDC
- Outpatient laboratory services, one per contract 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 and 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

This is a general description of benefits. Please refer to the detailed benefit summaries or applicable individual policy for benefit limits, exclusions and other details. Producers can access benefit summaries at www.connecticare.com. The policy will prevail for all benefits, conditions, limitations and exclusions.

Rates displayed are quoted rates only. Plans and rates are subject to approval by the Connecticut Insurance Department. Final rates are subject to change based on medical history, federal and state regulations, ConnectiCare's underwriting guidelines and effective dates of coverage.

ConnectiCare
Solo

Individual health plans the ConnectiCare way.

ConnectiCare[®]
You know us by 

Individual HMO High-Deductible Health Plan
For use with Health Savings Account (HSA)

| CONTRACT YEAR COST-SHARE | | HMO HDHP \$5,000 / \$10,000 Deductible - D |
|---|--|--|
| Individual / Family Plan Deductible (Plan Deductible is combined for health services and prescription drugs) | | \$5,000 / \$10,000 |
| Lifetime Maximum Benefit | | Unlimited |
| Copayment Maximum (Maximum includes perscription drug copayments only) | | \$1,000 / \$2,000 |
| Out-of-pocket Maximum (Maximum includes Plan Deductible for health and perscription drugs and Copayments for perscription drugs only) | | \$6,000 / \$12,000 |
| COVERED HEALTH SERVICES | | |
| Routine Physical Exam | | No Member cost (Plan Deductible waived) |
| Gynecological Annual Preventive Exam Office Services | | No Member cost (Plan Deductible waived) |
| Primary Care Providers Office Services | | No Member cost after Plan Deductible |
| Specialist Office Services | | No Member cost after Plan Deductible |
| Maternity Care | | No Member cost after Plan Deductible |
| Outpatient Laboratory Services | | No Member cost after Plan Deductible |
| Non-Advanced Radiology Services | | No Member cost after Plan Deductible |
| Advanced Radiology Services (includes MRI, PET and CAT Scan) | | No Member cost after Plan Deductible |
| Outpatient Rehabilitative Therapy (up to 20 visits) | | No Member cost after Plan Deductible |
| Chiropractic Services (up to 10 visits) | | No Member cost after Plan Deductible |
| Walk-In / Urgent Care Services | | No Member cost after Plan Deductible |
| Emergency Room | | No Member cost after Plan Deductible |
| Emergency Ambulance Services | | No Member cost after Plan Deductible |
| Outpatient Ambulatory Services | | No Member cost after Plan Deductible |
| Hospitalization for Illness or Injury | | No Member cost after Plan Deductible |
| Home Health Services (up to 80 visits) | | No Member cost after Plan Deductible |
| Skilled Nursing and Rehabilitation Facilities (up to 80 days) | | No Member cost after Plan Deductible |
| Durable Medical Equipment & Disposable Medical Supplies | | No Member cost after Plan Deductible |
| PRESCRIPTION DRUG OPTIONS | | |
| Individual / Family Plan Deductible (Deductible is combined for health services and prescription drugs) | | \$5,000 / \$10,000 |
| Individual / Family Copayment Maximum (Maximum does not include the Plan Deductible) | | \$1,000 / \$2,000 |
| Out-of-pocket Maximum (Maximum includes Plan Deductible for health and perscription drugs and Copayments for perscription drugs only) | | \$6,000 / \$12,000 |

Retail Pharmacy (Up to a 30-Day supply per prescription)

Tier 1 / Tier 2 / Tier 3

\$15 / \$25 / \$40 after Plan Deductible

Mail Order Pharmacy (Up to a 90-Day supply per prescription)

Tier 1 / Tier 2 / Tier 3

\$30 / \$50 / \$80 after Plan Deductible

Preventive Care and Wellness Services

IN-NETWORK SERVICES NOT SUBJECT TO COST SHARE

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, 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 contract year
- Routine Mammography Screening, age 40 or older, one per contract year
- Immunizations recommended by the Advisory Committee on Immunization Practices of the CDC
- Outpatient laboratory services, one per contract 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 and 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 hypertension 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

This is a general description of benefits. Please refer to the detailed benefit summaries or applicable individual policy for benefit limits, exclusions and other details. Producers can access benefit summaries at www.connecticare.com. The policy will prevail for all benefits, conditions, limitations and exclusions.

Rates displayed are quoted rates only. Plans and rates are subject to approval by the Connecticut Insurance Department. Final rates are subject to change based on medical history, federal and state regulations, and ConnectiCare's underwriting guidelines.



Individual health plans the ConnectiCare way.



Individual POS High Deductible Health Plan Options

For use with Health Saving Account (HSA)

| CONTRACT YEAR COST-SHARE | | POS HDHP \$1,500/\$3,000 Deductible - D |
|--|--|---|
| | | Out-of-Network |
| Individual / Family Plan Deductible (Deductible is combined for health services and prescription drugs) | In-Network | \$3,000 / \$6,000 |
| Individual / Family Cost-Share Maximum (Maximum is combined with Copayments and Coinsurance and is for health services and prescription drugs) | | \$4,000 / \$8,000 |
| Individual / Family Out-of-Pocket Maximum (Maximum includes Plan Deductible, Copayments and prescription drugs) | | \$7,000 / \$14,000 |
| Member Coinsurance | Not Applicable | 30% |
| Lifetime Maximum Benefit | Unlimited | Unlimited |
| COVERED HEALTH SERVICES (Cost-shares for the following services are the same for both plan options.) | | |
| Routine Physical Exam | No Member cost | 30% after Plan Deductible |
| Gynecological Annual Preventive Exam Office Services | No Member cost | 30% after Plan Deductible |
| Primary Care Providers Office Services | \$30 Copayment per visit after Plan Deductible | 30% after Plan Deductible |
| Specialist Office Services | \$45 Copayment per visit after Plan Deductible | 30% after Plan Deductible |
| Maternity Care | Not a covered benefit | Not a covered benefit |
| Outpatient Laboratory Services | No Member cost after Plan Deductible | 30% after Plan Deductible |
| Non-Advanced Radiology Services | \$45 Copayment per visit after Plan Deductible | 30% after Plan Deductible |
| Advanced Radiology Services (includes MRI, PET and CAT Scan) | \$75 Copayment per visit up to 5 Copayments per year after Plan Deductible | 30% after Plan Deductible |
| Outpatient Rehabilitative Therapy (up to 20 visits) | \$45 Copayment per visit after Plan Deductible | 30% after Plan Deductible |
| Chiropractic Services (up to 10 visits) | \$45 Copayment per visit after Plan Deductible | 30% after Plan Deductible |
| Walk-In / Urgent Care Services | \$75 Copayment per visit after Plan Deductible | Same as In-Network |
| Emergency Room | \$150 Copayment per visit after Plan Deductible | Same as In-Network |
| Emergency Ambulance Services | No Member cost after Plan Deductible | Same as In-Network |
| Outpatient Ambulatory Services | \$500 Copayment per visit after Plan Deductible | 30% after Plan Deductible |
| Hospitalization for Illness or Injury (excludes maternity) | \$500 Copayment per day up to \$2,000 per year after Plan Deductible | 30% after Plan Deductible |
| Home Health Services (up to 80 visits) | No Member cost after Plan Deductible | 25% after Plan Deductible |
| Skilled Nursing and Rehabilitation Facilities (up to 80 days) | \$500 Copayment per day up to \$2,000 per year after Plan Deductible | 30% after Plan Deductible |
| Durable Medical Equipment & Disposable Medical Supplies | No Member cost after Plan Deductible | 50% after Plan Deductible |
| PRESCRIPTION DRUG OPTIONS | | |
| Individual / Family Plan Deductible (Deductible is combined for health services and prescription drugs) | In-Network | \$3,000 / \$6,000 |
| Individual / Family Cost-Share Maximum (Maximum is combined with Copayments and Coinsurance and is for health services and prescription drugs) | | \$4,000 / \$8,000 |
| Individual / Family Out-of-Pocket Maximum (Maximum includes Plan Deductible, Copayments and prescription drugs) | | \$7,000 / \$14,000 |

Rates displayed are quoted rates only. Plans and rates are subject to approval by the Connecticut Insurance Department. Final rates are subject to change based on medical history, federal and state regulations, and ConnectiCare's underwriting guidelines.

| Retail Pharmacy (Up to a 30-Day supply per prescription) | | In-Network | Out-of-Network |
|--|--|---------------------------|---------------------------|
| Tier 1 / Tier 2 / Tier 3 | | 20% after Plan Deductible | 50% after Plan Deductible |
| Mail Order Pharmacy (Up to a 90-Day supply per prescription) | | In-Network | Out-of-Network |
| Tier 1 / Tier 2 / Tier 3 | | 20% after Plan Deductible | Not a covered benefit |

Rates displayed are quoted rates only. Plans and rates are subject to approval by the Connecticut Insurance Department. Final rates are subject to change based on medical history, federal and state regulations, and ConnecticutCare's underwriting guidelines.

| | POS HDHP \$3,000 / \$6,000 Deductible - D | |
|--|---|-----------------------------------|
| CONTRACT YEAR COST-SHARE | | |
| | In-Network | Out-of-Network |
| Individual / Family Plan Deductible (Deductible is combined for health services and prescription drugs) | \$3,000 / \$6,000 | \$6,000 / \$12,000 |
| Individual / Family Coinsurance Maximum (Maximum is combined with health services and prescription drugs) | Not applicable | \$4,000 / \$8,000 |
| Individual / Family Out-of-Pocket Maximum (Maximum includes Plan Deductible, Coinsurance for health services and prescription drugs) | \$3,000 / \$6,000 | \$10,000 / \$20,000 |
| Member Coinsurance | Not applicable | 30% |
| Lifetime Maximum Benefit | Unlimited | Unlimited |
| COVERED HEALTH SERVICES (Cost-shares for the following services are the same for both plan options.) | | |
| | In-Network Member Cost | Out-of-Network Member Cost |
| Routine Physical Exam | No Member cost | 30% after Plan Deductible |
| Gynecological Annual Preventive Exam Office Services | No Member cost | 30% after Plan Deductible |
| Primary Care Providers Office Services | No Member costs after Plan Deductible | 30% after Plan Deductible |
| Specialist Office Services | No Member costs after Plan Deductible | 30% after Plan Deductible |
| Maternity Care | <i>Not a covered benefit</i> | <i>Not a covered benefit</i> |
| Outpatient Laboratory Services | No Member cost after Plan Deductible | 30% after Plan Deductible |
| Non-Advanced Radiology Services | No Member costs after Plan Deductible | 30% after Plan Deductible |
| Advanced Radiology Services (includes MRI, PET and CAT Scan) | No Member costs after Plan Deductible | 30% after Plan Deductible |
| Outpatient Rehabilitative Therapy (up to 20 visits) | No Member costs after Plan Deductible | 30% after Plan Deductible |
| Chiropractic Services (up to 10 visits) | No Member costs after Plan Deductible | 30% after Plan Deductible |
| Walk-In / Urgent Care Services | No Member costs after Plan Deductible | Same as In-Network |
| Emergency Room | No Member costs after Plan Deductible | Same as In-Network |
| Emergency Ambulance Services | No Member cost after Plan Deductible | Same as In-Network |
| Outpatient Ambulatory Services | No Member costs after Plan Deductible | 30% after Plan Deductible |
| Hospitalization for Illness or Injury (excludes maternity) | No Member costs after Plan Deductible | 30% after Plan Deductible |
| Home Health Services (up to 80 visits) | No Member cost after Plan Deductible | 25% after Plan Deductible |
| Skilled Nursing and Rehabilitation Facilities (up to 80 days) | No Member costs after Plan Deductible | 30% after Plan Deductible |
| Durable Medical Equipment & Disposable Medical Supplies | No Member cost after Plan Deductible | 50% after Plan Deductible |
| PRESCRIPTION DRUG OPTIONS | | |
| | In-Network | Out-of-Network |
| Individual / Family Plan Deductible (Deductible is combined for health services and prescription drugs) | \$3,000 / \$6,000 | \$6,000 / \$12,000 |
| Individual / Family Coinsurance Maximum (Maximum is combined with health services and prescription drugs) | Not applicable | \$4,000 / \$8,000 |
| Individual / Family Out-of-Pocket Maximum (Maximum includes Plan Deductible, Coinsurance for health services and prescription drugs) | \$3,000 / \$6,000 | \$10,000 / \$20,000 |

Rates displayed are quoted rates only. Plans and rates are subject to approval by the Connecticut Insurance Department. Final rates are subject to change based on medical history, federal and state regulations, and ConnectiCare's underwriting guidelines.

| | In-Network | Out-of-Network |
|---|---------------------------------------|---------------------------|
| Retail Pharmacy (Up to a 30-Day supply per prescription) | | |
| Tier 1 / Tier 2 / Tier 3 | No Member costs after Plan Deductible | 50% after Plan Deductible |
| Mail Order Pharmacy (Up to a 90-Day supply per prescription) | | |
| Tier 1 / Tier 2 / Tier 3 | No Member costs after Plan Deductible | Not a covered benefit |

Rates displayed are quoted rates only. Plans and rates are subject to approval by the Connecticut Insurance Department. Final rates are subject to change based on medical history, federal and state regulations, and ConnecticutCare's underwriting guidelines.

POS HDHP \$2,000/\$4,000 Deductible - D

| | In-Network | Out-of-Network |
|---|---------------------------|---------------------------|
| CONTRACT YEAR COST-SHARE | | |
| Individual / Family Plan Deductible (Deductible is combined for health services and prescription drugs) | \$2,000 / \$4,000 | \$4,000 / \$8,000 |
| Individual / Family Coinsurance Maximum (Maximum does not include the Plan Deductible and is combined for health services and prescription drugs) | \$4,000 / \$8,000 | \$4,000 / \$8,000 |
| Individual / Family Out-of-Pocket Maximum (Maximum does not include the Plan Deductible and is combined for health services and prescription drugs) | \$6,000 / \$12,000 | \$8,000 / \$16,000 |
| Member Coinsurance | 20% | 30% |
| Lifetime Maximum Benefit | Unlimited | Unlimited |
| COVERED HEALTH SERVICES | | |
| Routine Physical Exam | No Member cost | 30% after Plan Deductible |
| Gynecological Annual Preventive Exam Office Services | No Member cost | 30% after Plan Deductible |
| Primary Care Providers Office Services | 20% after Plan Deductible | 30% after Plan Deductible |
| Specialist Office Services | 20% after Plan Deductible | 30% after Plan Deductible |
| Maternity Care | Not a covered benefit | Not a covered benefit |
| Outpatient Laboratory Services | 20% after Plan Deductible | 30% after Plan Deductible |
| Non-Advanced Radiology Services | 20% after Plan Deductible | 30% after Plan Deductible |
| Advanced Radiology Services (includes MRI, PET and CAT Scan) | 20% after Plan Deductible | 30% after Plan Deductible |
| Outpatient Rehabilitative Therapy (up to 20 visits) | 20% after Plan Deductible | 30% after Plan Deductible |
| Chiropractic Services (up to 10 visits) | 20% after Plan Deductible | 30% after Plan Deductible |
| Walk-In / Urgent Care Services | 20% after Plan Deductible | Same as In-Network |
| Emergency Room | 20% after Plan Deductible | Same as In-Network |
| Emergency Ambulance Services | 20% after Plan Deductible | Same as In-Network |
| Outpatient Ambulatory Services (including Colonoscopy) | 20% after Plan Deductible | Same as In-Network |
| Hospitalization for Illness or Injury (excludes maternity) | 20% after Plan Deductible | 30% after Plan Deductible |
| Home Health Services (up to 80 visits) | 20% after Plan Deductible | 25% after Plan Deductible |
| Skilled Nursing and Rehabilitation Facilities (up to 80 days) | 20% after Plan Deductible | 30% after Plan Deductible |
| Durable Medical Equipment & Disposable Medical Supplies | 20% after Plan Deductible | 50% after Plan Deductible |
| PRESCRIPTION DRUG OPTIONS | | |
| Individual / Family Plan Deductible (Deductible is combined for health services and prescription drugs) | \$2,000 / \$4,000 | \$4,000 / \$8,000 |
| Individual / Family Coinsurance Maximum (Maximum does not include the Plan Deductible and is combined for health services and prescription drugs) | \$4,000 / \$8,000 | \$4,000 / \$8,000 |
| Individual / Family Out-of-Pocket Maximum (Maximum does not include the Plan Deductible and is combined for health services and prescription drugs) | \$6,000 / \$12,000 | \$8,000 / \$16,000 |

| | In-Network | Out-of-Network |
|---|---------------------------|---------------------------|
| Retail Pharmacy (Up to a 30-Day supply per prescription) | | |
| Tier 1 / Tier 2 / Tier 3 | 20% after Plan Deductible | 50% after Plan Deductible |
| Mail Order Pharmacy (Up to a 90-Day supply per prescription) | | |
| Tier 1 / Tier 2 / Tier 3 | 20% after Plan Deductible | Not a covered benefit |

Individual POS Combined High Deductible Health Plan

For use with Health Saving Account (HSA)

POS-HDHP \$5,000/\$10,000 Combined Deductible - D

| | In-Network | Out-of-Network |
|---|--------------------------------------|-----------------------------------|
| CONTRACT YEAR COST-SHARE | | |
| Individual / Family Plan Deductible (Deductible is combined for In- and Out-of-Network health services and prescription drugs) | \$5,000 / \$10,000 | \$5,000 / \$10,000 |
| Individual / Family Coinsurance Maximum (Maximum does not include the Plan Deductible and is combined for health services and prescription drugs) | Not Applicable | \$5,000 / \$10,000 |
| Individual / Family Copayment Maximum (Maximum does not include the Plan Deductible and includes copays for prescription drugs only) | \$1,000 / \$2,000 | Not Applicable |
| Individual / Family Out-of-Pocket Maximum (Maximum does not include the Plan Deductible and is combined for health services and prescription drugs) | \$6,000 / \$12,000 | \$10,000 / \$20,000 |
| Member Coinsurance | Not Applicable | 50% |
| Lifetime Maximum Benefit | Unlimited | Unlimited |
| COVERED HEALTH SERVICES | | |
| | In-Network Member Cost | Out-of-Network Member Cost |
| Routine Physical Exam | No Member cost | 50% after Plan Deductible |
| Gynecological Annual Preventive Exam Office Services | No Member cost | 50% after Plan Deductible |
| Primary Care Providers Office Services | No Member cost after Plan Deductible | 50% after Plan Deductible |
| Specialist Office Services | No Member cost after Plan Deductible | 50% after Plan Deductible |
| Maternity Care | <i>Not a covered benefit</i> | <i>Not a covered benefit</i> |
| Outpatient Laboratory Services | No Member cost after Plan Deductible | 50% after Plan Deductible |
| Non-Advanced Radiology Services | No Member cost after Plan Deductible | 50% after Plan Deductible |
| Advanced Radiology Services (includes MRI, PET and CAT Scan) | No Member cost after Plan Deductible | 50% after Plan Deductible |
| Outpatient Rehabilitative Therapy (up to 20 visits) | No Member cost after Plan Deductible | 50% after Plan Deductible |
| Chiropractic Services (up to 10 visits) | No Member cost after Plan Deductible | 50% after Plan Deductible |
| Walk-In / Urgent Care Services | No Member cost after Plan Deductible | Same as In-Network |
| Emergency Room | No Member cost after Plan Deductible | Same as In-Network |
| Emergency Ambulance Services | No Member cost after Plan Deductible | Same as In-Network |
| Outpatient Ambulatory Services | No Member cost after Plan Deductible | 50% after Plan Deductible |
| Hospitalization for Illness or Injury (excludes maternity) | No Member cost after Plan Deductible | 50% after Plan Deductible |
| Home Health Services (up to 80 visits) | No Member cost after Plan Deductible | 25% after Plan Deductible |
| Skilled Nursing and Rehabilitation Facilities (up to 80 days) | No Member cost after Plan Deductible | 50% after Plan Deductible |
| Durable Medical Equipment & Disposable Medical Supplies | No Member cost after Plan Deductible | 50% after Plan Deductible |
| PRESCRIPTION DRUG OPTIONS | | |
| Individual / Family Plan Deductible (Deductible is combined for In- and Out-of-Network health services and prescription drugs) | \$5,000 / \$10,000 | \$5,000 / \$10,000 |
| Individual / Family Coinsurance Maximum (Maximum does not include the Plan Deductible and is combined for health services and prescription drugs) | Not Applicable | \$5,000 / \$10,000 |
| Individual / Family Copayment Maximum (Maximum does not include the Plan Deductible and includes copays for prescription drugs only) | \$1,000 / \$2,000 | Not Applicable |
| Individual / Family Out-of-Pocket Maximum (Maximum does not include the Plan Deductible and is combined for health services and prescription drugs) | \$6,000 / \$12,000 | \$10,000 / \$20,000 |

Retail Pharmacy (Up to a 30-Day supply per prescription)

Tier 1 / Tier 2 / Tier 3

\$15 / \$25 / \$40

50% after Plan Deductible

Mail Order Pharmacy (Up to a 90-Day supply per prescription)

Tier 1 / Tier 2 / Tier 3

\$30 / \$50 / \$80

Not a Covered Benefit

Preventive Care and Wellness Services

IN-NETWORK SERVICES NOT SUBJECT TO COST SHARE

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, 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 contract year
- Routine Mammography Screening, age 40 or older, one per contract year
- Immunizations recommended by the Advisory Committee on Immunization Practices of the CDC
- Outpatient laboratory services, one per contract 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 and 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

This is a general description of benefits. Please refer to the detailed benefit summaries or applicable individual policy for benefit limits, exclusions and other details. Producers can access benefit summaries at www.connecticare.com. The policy will prevail for all benefits, conditions, limitations and exclusions.

Rates displayed are quoted rates only. Plans and rates are subject to approval by the Connecticut Insurance Department. Final rates are subject to change based on medical history, federal and state regulations, and ConnectiCare's underwriting guidelines.

ConnectiCare
Solo

Individual health plans the ConnectiCare way

ConnectiCare
You know us by

IN-NETWORK SERVICES NOT SUBJECT TO COST SHARE

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, 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 contract year
- Routine Mammography Screening, age 40 or older, one per contract year
- Immunizations recommended by the Advisory Committee on Immunization Practices of the CDC
- Outpatient laboratory services, one per contract 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 and 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

Understanding Your Prescription Drug Coverage

Prescription drugs and supplies are covered under the ConnectiCare SOLO HMO HDHP Plan. They're optional under the ConnectiCare SOLO POS Open Access and POS HDHP plans. If your plan includes benefits for prescription drugs, the drugs are placed in a tiered system that indicates what your cost-share amount will be.

Tier-one drugs have the lowest cost-share level, tier-two drugs have an intermediate cost-share level, and tier-three drugs have the highest cost-share level. To find out whether a particular medication is on ConnectiCare's drug list, and what tier it is, go to "Pharmacy Center" at www.connecticare.com, or call Member Services at 1-800-251-7722. Please note that the drug list can change during the year, so check the Web site or call the number above for the latest information.

If your prescription is available as a generic but you prefer to purchase the brand-name instead, you may do so. However, please note:

- You will be responsible for paying the generic cost-share plus the difference in price between the generic and the brand-name drug.
- The cost of the generic drug will go toward meeting the plan deductible – not the cost of the brand-name drug. (Applies to ConnectiCare SOLO High-Deductible Health Plans only.)



DENTAL PLANS

Plus Network: \$25 Deductible, 100%/0%/0%, Unlimited Max., No Ortho.

Dental Plan Benefits Summary for ConnectiCare SOLO Subscribers

| Participating Provider (In-Network Level Of Benefits) | Non-Participating Provider (Out-of-Network Level Of Benefits)* | Care Category | Procedure Code | Description By Illustration, Not By Limitation |
|---|--|---------------------------------|----------------------------|--|
| 100% | 100% | Diagnostic | 00100-00199 00331-00999 | Oral examination, diagnostic casts. |
| 100% | 100% | X-Rays | 00200-00330 | Complete mouth x-rays, periapical x-rays, bitewing x-rays, panoramic x-rays. |
| 100% | 100% | Preventive | 01000-01999 | Prophylaxis, fluoride applications, space maintainers. |
| 100% | 100% | Restorative** | 02000-02399 | The treatment of tooth decay by the use of amalgam and/or composite restorations. |
| 0% | 0% | Restorative-Crowns** | 2400-02999 | The use of gold, semiprecious, or nonprecious metals to restore a tooth or teeth which cannot be restored with amalgam or composite restorations. |
| 0% | 0% | Endodontics** | 3000-03999 | The treatment of the diseases of the nerve of the tooth. |
| 0% | 0% | Periodontics** | 04000-04999 | The treatment of the supporting tissues of the teeth, gums, and underlying bone, with either surgical or non surgical procedures (where applicable). |
| 0% | 0% | Prosthetics – Removable** | 05000-05399 05600-05899 | The replacement of missing teeth by the use of a removable appliance. |
| 0% | 0% | Prosthetics - Adjustment** | 05400-05799 | The repair or modification of existing removable and/or fixed appliances so that they can continue to be serviceable. |
| 0% | 0% | Prosthetics – Fixed, Implants** | 06000-06999 | The use of gold, semiprecious, precious metal or implant to replace a missing tooth or teeth, which cannot otherwise be replaced with a removable appliance. |
| 0% | 0% | Extractions** | 07000-07219 07250-07999 | The extraction, either simple or surgical, of either a single tooth or multiple teeth, the shaping of bone ridges, the removal of a tooth end abscess, etc. |
| 0% | 0% | Bony Impactions** | 7220-07249 | The surgical removal of teeth partially or fully covered by bone. |
| 0% | 0% | Orthodontics** | 08000-08999 | The straightening of teeth for dental health reasons. |
| 0% | 0% | General Services** | 09000-09999 | All other adjunctive general services as coded in the American Dental Association (ADA) Current Dental Terminology, which are not included in the specific categories listed, that are covered services. |

Deductibles and Maximums

| Participating Provider (In-Network Level Of Benefits) | Non-Participating Provider (Out-of-Network Level Of Benefits)* | |
|---|--|---|
| Unlimited | Unlimited | Annual Maximum Per Individual |
| \$25.00 | \$25.00 | Annual Deductible Per Individual |
| \$0.00 | \$0.00 | Orthodontic Lifetime Maximum Per Individual |

Benefit year effective date: 2012

As used herein, "Annual" means the benefit year in which dental care services are performed.

* For those subscribers electing to be served by a non-participating provider; submitted claims will be processed at any time during the benefit year and reimbursements will be made at the level of coverage listed under "Non-Participating Provider (Out-Of-Network Level of Benefits)" and in amounts up to the schedule of allowances paid to participating provider. Payments will be limited to the individual annual maximum listed above or that portion of the individual annual maximum, which may be remaining if care had previously been provided during the benefit year by a participating provider, subject to the plan's deductibles and standard exclusions and limitations.

** Care Category (ies) of coverage the deductible applies to.

6. UNDERSTANDING HSAs

If you are attracted to the premium savings of a ConnectiCare SOLO High-Deductible Health Plan (HDHP), you may wish to combine it with a Health Savings Account (HSA). The HSA fund offers a tax-favored solution for meeting the health plan deductible.

Note: HSAs can only be combined with a ConnectiCare SOLO HDHP. Our ConnectiCare SOLO POS plans are not HSA-compatible.

You are not *required* to open an HSA if you have an HDHP. However, millions of Americans have chosen to do so because an HSA offers these key advantages:

- The HSA allows you to place pre-tax money into an account to meet the deductible and any copayments, coinsurance or out-of-pocket costs of your ConnectiCare SOLO plan.
- HSA funds can be used to pay for a variety of other qualified medical expenses that are not covered by the ConnectiCare SOLO plan. These expenses include over-the-counter drugs, eyeglasses, dental services, prescriptions and other medical supplies. *For a complete list of qualified medical expenses, go to www.1hsa.com and scroll down to "About Health Savings Accounts." Click "IRS Guidelines" and "Eligible Medical Expenses."*
- All unused dollars in the account can be carried over from year to year.

PLEASE SEE "IMPORTANT NOTICE" ON THE INSIDE BACK COVER.

What You Need to Know First

HSAs have a number of unique features, but the arrangement can be confusing to some people. It's important to understand the following key points before choosing an HSA.

- **Do not open the HSA until your application to a ConnectiCare SOLO HDHP has been approved.**

- **Once your ConnectiCare SOLO application is approved, you should open the HSA fund as soon as possible.** In order to pay for medical expenses with the HSA, the fund must have been opened before the date that the claim was incurred. Even if you don't fund it, the account must be opened.

- **You should open the HSA even if you don't intend to fund it right away.** You will have until April 15th of the following year to fund up to the maximum amount set by the IRS.
- **You will fund the HSA—and you will own it.** The HSA is a personal savings account that earns tax-free interest. If you ever switch health plans or HSA administrators, you take the HSA account with you.
- **Contributions to the account may now exceed the plan deductible.** The maximum annual amount you are allowed to contribute in 2012 is \$3,100 for self-only coverage and \$6,250 for family coverage, as set by the IRS.
- **There are tax benefits.** Self-employed individuals may claim their HSA contributions as a tax deduction. Individuals who work for an employer may be able to deposit money into their HSA on a pre-tax basis. You should consult with your ConnectiCare Agent and your tax advisor on the tax benefits of an HSA account.
- **You can carry over your funds.** Unused dollars can be saved and carried over year after year. In doing so, these dollars are invested and earn tax-deferred interest.

The ConnectiCare HSA Solution

ConnectiCare has selected one of the nation's leading HSA administrators that can manage, administer and service your HSA. *First HSA* has worked with members of Congress in the development of today's HSA rules.

First HSA provides a full range of administrative and technical services for its HSA customers, including:

- Flexible and convenient contribution options
- Free account setup and monthly account administration for members of a ConnectiCare SOLO High-Deductible Health Plan with a *First HSA* account (subject to future change)
- An option for a free VISA payment card
- Automated telephone banking 24-hours a day, seven days a week
- E-statements or quarterly account statements that detail contributions, withdrawals, interest earned and ending balance
- Year-end tax statements
- Free integrated investment options through Charles Schwab
- Competitive interest rates
- 24/7 live customer services

For more information on First HSA, call toll-free 1-888-769-8696 or go to www.1hsa.com.



HSA SAVINGS EXAMPLES

The following illustrations show how an individual and a family, rolling over unused funds, might use a typical HSA over a three-year period. All cost information below is for example purposes only and does not necessarily reflect actual charges, your plan rules or HSA account rules. Administrative fees may be charged on account balances. The illustrations are based on hypothetical health plans.



Example #1

Mary has a \$1,500 High-Deductible Health Plan and an HSA that she contributes \$1,500 to annually.

| | | |
|---------------|----------------|--|
| YEAR 1 | \$1,500 | HSA contribution |
| | -\$300 | Medical expenses applied to the deductible and paid by the HSA |
| | <u>\$1,200</u> | HSA balance to be rolled over into year 2 |

In year 1, Mary sees her physician in his office several times for a minor medical problem and has \$300 applied to the deductible. She uses \$300 from her HSA, leaving a balance of \$1,200 in unused HSA funds that will be rolled over into year 2.

| | | |
|---------------|----------------|--|
| YEAR 2 | \$1,200 | HSA rollover from year 1 |
| | +\$1,500 | Contribution for year 2 |
| | <u>\$2,700</u> | HSA balance for year 2 |
| | -\$1,500 | Medical expenses applied to the deductible and paid by the HSA |
| | -\$225 | Prescription coinsurance amount paid by HSA |
| | <u>\$975</u> | HSA balance |
| | -\$700 | Medical expenses not covered by plan but paid by HSA |
| | <u>\$275</u> | HSA balance to be rolled over into year 3 |

In year 2, the \$1,200 rollover is combined with the year-2 total annual contribution of \$1,500 for a balance of \$2,700. During the year Mary receives covered medical services that total \$1,500, and prescription drug coinsurance costs of \$225. Both of these amounts apply to the deductible and are reimbursed from the HSA. Mary also incurs \$700 in medical costs for over-the-counter medications and contact lenses, which are not covered by her health plan but are considered qualified HSA expenses. These expenses are also reimbursed from her HSA, leaving a balance of \$275 to be rolled over to year 3.

| | | |
|---------------|----------------|--------------------------|
| YEAR 3 | \$275 | HSA rollover from year 2 |
| | \$1,500 | Contribution for year 3 |
| | <u>\$1,775</u> | HSA balance for year 3 |

In year 3, the year 2 rollover of \$275 is added to the year 3 total annual contribution of \$1,500 for a starting balance of \$1,775.



Example #2

The next illustration is a family plan. Bob, his wife Jane, and their two children have a \$5,000 High-Deductible Health Plan and contribute \$4,000 annually to their HSA.

| | | |
|---------------|----------------|--|
| YEAR 1 | \$4,000 | HSA contribution |
| | -\$1,000 | Medical expenses applied to the deductible and paid by the HSA |
| | <u>\$3,000</u> | HSA balance to be rolled over into year 2 |

In year 1, the family has \$1,000 in expenses applied to the deductible for an emergency room visit. The expenses are reimbursed from the HSA, leaving a balance of \$3,000 to be rolled over into year 2.

| | | |
|---------------|----------------|--|
| YEAR 2 | \$3,000 | HSA rollover from year 1 |
| | +\$4,000 | Contribution for year 2 |
| | <u>\$7,000</u> | HSA balance for year 2 |
| | -\$5,000 | Medical expenses applied to the deductible and paid by the HSA |
| | -\$225 | Prescription coinsurance amount paid by HSA |
| | <u>\$1,775</u> | HSA balance |
| | -\$1,000 | Medical expenses not covered by plan but paid by HSA |
| | <u>\$775</u> | HSA balance to be rolled over into year 3 |

In year 2, the \$3,000 in rollover funds is combined with the year-2 total annual contribution of \$4,000 for an HSA balance of \$7,000. The family incurs \$5,000 for an elective surgical procedure, and the amount is applied to the deductible. In addition, the family has prescriptions that result in coinsurance costs of \$225. The family also incurs \$1,000 in other medical expenses not covered by the health plan but considered qualified HSA expenses. Bob and Jane use the HSA account for reimbursement of the surgery, prescription coinsurance and other medical expenses, leaving \$775 to be rolled over into year 3.

| | | |
|---------------|----------------|--------------------------|
| YEAR 3 | \$775 | HSA rollover from year 2 |
| | +\$4,000 | Contribution for year 3 |
| | <u>\$4,775</u> | HSA balance for year 3 |

In year 3, the year 2 rollover of \$775 is added to the year 3 total annual contribution of \$4,000 for a total beginning HSA balance of \$4,775.

7. THINGS YOU NEED TO KNOW BEFORE APPLYING

Your Health History

It is important to know that not everyone will qualify for an individual policy with ConnectiCare.

ConnectiCare considers the health history of each individual who applies. This process is known as medical underwriting.

Declinable Conditions

If the applicant (or any dependents) has had/ currently has a condition mentioned on the Declinable Conditions list, the application will be declined or rated up (note: we will not decline coverage for any dependents under age 19 for pre-existing conditions):

This list is not all-inclusive and is subject to change.

Conditions

This list is not all-inclusive and is subject to change.

Addison's Disease

AIDS/HIV

*Amyotrophic Lateral Sclerosis
(ALS or Lou Gehrig's Disease)*

Alzheimer's Disease

Angina

Angioplasty

Ankylosing Spondylitis

Any Artery or Vein Bypass – including Heart

Bipolar disorder (manic depression)

Carcinoid Syndrome

*Chronic Lung Disease, including Emphysema,
Chronic Bronchitis & COPD*

Cirrhosis of the Liver

Congestive Heart Failure

Coronary Heart Disease

Crohn's Disease

Cystic Fibrosis

Diabetes – Type 1

*Gastric Bypass or any Intestinal Bypass or bariatric
(obesity) surgery*

Gaucher's Disease or other lipid storage disease

Hemiplegia

Hemophilia

Hepatitis B or C

Ischemic Heart Disease

Leukemia

Major Depression

Morbid Obesity – current or present

Multiple Sclerosis

Muscular Dystrophy

Myocardial Infarction (Heart Attack)

Obsessive-Compulsive Disorder (OCD)

Pacemaker/defibrillator

Paraplegia

Parkinson's Disease

Pregnancy/expectant parent

Psychosis

Pulmonary Fibrosis

Pulmonary Hypertension

Pulmonary Stenosis

Quadriplegia

Renal Failure

Rheumatoid Arthritis (Juvenile/Adult)

Sickle Cell Anemia

Sideroblastic Anemia

Sleep Apnea

Spina Bifida

Systemic Lupus

Thalassemia Major

*Any Transplant except Corneal
(Cardiac) Valve Replacement*

Height and Weight Table

AGE 14 AND OLDER

The Height and Weight Table below shows the maximum allowable weights for males and females age 14 and over. Applicants age 19 and over who do not fall within the guidelines may be declined or rated up. Accurate height and weight is required for all applicants on the application.

(Note: We do not decline coverage for dependent applicants under age 19 for pre-existing conditions.)

| HEIGHT | WEIGHT | HEIGHT | WEIGHT |
|--------|--------|--------|--------|
| 4'8" | 154 | 5'10" | 240 |
| 4'9" | 159 | 5'11" | 248 |
| 4'10" | 165 | 6'0" | 255 |
| 4'11" | 171 | 6'1" | 261 |
| 5'0" | 176 | 6'2" | 268 |
| 5'1" | 182 | 6'3" | 277 |
| 5'2" | 189 | 6'4" | 284 |
| 5'3" | 195 | 6'5" | 291 |
| 5'4" | 201 | 6'6" | 299 |
| 5'5" | 208 | 6'7" | 306 |
| 5'6" | 214 | 6'8" | 314 |
| 5'7" | 220 | 6'9" | 322 |
| 5'8" | 227 | 6'10" | 330 |
| 5'9" | 234 | 6'11" | 340 |

STEPS TO APPLY

Steps to Apply – ONLINE:

For added convenience, you can apply for ConnectiCare SOLO online. Your ConnectiCare Agent will send you an e-mail invitation that provides detailed information about the online enrollment process. Or, you can go directly to connecticare.com to apply or get a quote yourself. And, remember to select your agent from the list provided. Plus, you will be able to check online for an updated status of your application once it's submitted.

Online application has these advantages:

- It expedites the process because the Individual Application Packet (Parts 1-3) goes directly to our underwriting department.
- It helps to prevent you from leaving out necessary information.
- No postage is required.
- No mail delays or lost mail.
- It helps the environment by using less paper.

Steps to Apply – PAPER:

APPLICANTS MUST:

- 1) **Complete, sign and date the Individual Application/Change Form – PART 1 – no more than 60 days prior to the requested effective date.** Be sure to:
 - a. Check the box for the medical and dental plan being selected.
 - b. Check the boxes for the pharmacy co-pay and pharmacy annual maximum that are being selected (does not apply to HDHP plans).
 - c. Select a Primary Care Physician (PCP) for each family member applying for coverage and write the PCP name and Provider ID number in the appropriate boxes. For a complete list of participating providers and their ID numbers, go to “Find a Doctor” at www.connecticare.com or see our print directory. To request a copy, contact Member Services at 1-800-251-7722.
- 2) **Accurately and completely answer** all questions on the Individual Health Statement – PART 2 – for each family member applying for coverage.

If the applicant knowingly provides false information and/or omits information on the application or health statement and such information submitted or omitted materially affects the risk assumed by ConnectiCare, ConnectiCare will seek to have the policy rescinded.

- 3) Complete, sign and date the Underwriting Authorization Form – PART 3.
- 4) For dependents under age 18, the application must have a parent/guardian's signature and date – and the parent/guardian's full name must be printed on the application. Dependents age 18 and over must sign and date the application themselves.
Note: Persons under age 19 may not apply for coverage as a subscriber.
- 5) All completed forms must be signed, dated and received at ConnectiCare by the last day of the month for an effective date on the 1st of the next month. (i.e. A complete application received by January 31st would be eligible for a February 1st effective date. A complete application received on February 1st would be eligible for a March 1st effective date. *Please note that if the application is approved in these scenarios, at least two months of premium will be due right away.*)

Steps to Apply – ONLINE or PAPER:

- 6) **You do not have to submit your first premium payment with your application.** However, once you are approved, all premiums from the effective date of coverage are due by the first of the month following the date of the approval letter, or the effective date of the policy, if later. This could mean that you could owe us more than one month of premium and owe the premium quickly. All premiums not received by the first of the month for the month of coverage are considered past due. This applies to all premium payment methods – check, Electric Funds Transfer (EFT) and credit card.

6a) When paying your premium via EFT, there are two options to choose from:

- You can sign up for EFT along with your initial application. All you have to do is complete the EFT form and attach a voided check or statement savings deposit slip with your application. Complete, sign and date the Electronic Funds Transfer Form — **FORM 4**. **Be sure to include a check marked “Void”**.
- You can wait to sign up for EFT until after you are accepted by and enrolled in ConnectiCare SOLO. All you need to do is sign the front of the first invoice voucher and return it with your premium payment. For future payment drafts, we will use the checking account number that appears on the check you submit for the initial premium payment. You do not need to submit a separate form when enrolling in EFT this way.

6b) To pay your premium by credit card:

Log on to the secure member section of our website at www.connecticare.com. Click the following links:

- Members
- Managing Your Account
- Get Information About Your Plan
- Billing Invoice & Credit Card Payment

You will need to sign on to the website with a username and password to activate payment by credit card. If you are new to the website, you will need to register first to gain access.

To continue paying your premium by credit card on an ongoing basis, you will need to log on to the site and activate payment each month.

6c) To pay your premium by check:

Mail payments to:
ConnectiCare, Inc.
P.O. Box 416191
Boston, MA 02241-6191

7) If applicable, complete the Domestic Partner Verification Form or other satisfactory certification as we determine.

8) Effective dates for coverage are the first of the month following the date we receive your complete application.

Acceptance into the plan is based on our review of the Individual Health Statement(s) and the applicant meeting the eligibility requirements and underwriting criteria. As part of our medical underwriting, ConnectiCare may need access to your medical records and other medical information. It is your responsibility to provide us access to that medical information and to pay for any costs your physician’s office may charge to copy and send us those records. If we do not have complete medical information, your application will be incomplete, and will be withdrawn if you do not arrange to have the medical records provided to us within 45 days of the request. For additional copies of ConnectiCare SOLO forms, contact your Agent or call Member Services at 1-800-251-7722.

9) Final rates are subject to change based on a client’s medical history, correct ZIP code, ConnectiCare’s underwriting guidelines, state and federal regulations and effective date of coverage.

Rescissions

In making a determination whether to issue a policy or set a rate for an applicant, ConnectiCare will review and rely on the statements made by you or your authorized representative on the fully completed application and health statement. Any material omission, misrepresentation or misstatement about medical history, planned treatment or surgeries, weight/height or other information on the application or health statement will result in rescission of the policy, denial of an otherwise valid claim or other corrective action. Premiums paid will be used to offset claims paid by ConnectiCare on your behalf.

Renewability of Coverage

You are required to make the payment on or before the first of each month. There is a grace period of one calendar month. Your policy remains in force during this period. Your policy will renew annually on its anniversary date as long as premiums are current, unless you terminate your policy. To request termination, you must notify us in writing in advance.

Note: You must wait 12 months to re-apply for coverage if your membership is terminated for non-payment of premium.

You *may* have to wait *up* to 12 months to re-apply for coverage if you are declined coverage (depending on the reason for the decline).

Renewal Provision

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.



EXCLUSIONS AND LIMITATIONS

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

1. Abdominoplasty, lipectomy and panniculectomy.
2. All assistive communication devices.
3. Any treatment for which there is Insufficient Evidence Of Therapeutic Value for the use for which it is being prescribed is not covered.
4. Any treatment or services related to the provision of a non-covered benefit, including educational and administrative services related to the use or administration 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 non-covered benefit were covered by the Plan.
5. Attorney fees.
6. 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.
7. 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 and cord blood retrieval and storage.
8. 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 III Cardiac Rehabilitation may be covered as part of a health management program value-added service or benefit. Phase IV cardiac rehabilitation is always excluded.
9. 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.
10. 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".
11. 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 seborrheic 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 this 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,
 - Liposuction,
 - Otoplasty,
 - Reduction mammoplasty for Members under 18, (except or as described in the "Reconstructive Surgery" and "Durable Medical Equipment (DME) Including Prosthetics" subsections of the "Benefits" section of this Policy or as otherwise required by applicable law);
 - 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, except as otherwise described in the "Craniofacial Disorders" subsection of the "Benefits" section, and
 - Vascular birthmark removal (except when the vascular birthmark causes significant impairment of physical or mechanical function).
12. Custodial Care, convalescent care, domiciliary care, and rest home care. Also care provided by home health aides that is not patient care of a medical or therapeutic nature or care provided by non-licensed professionals.

13. Dental services, including but not limited to the following are excluded, except as otherwise provided in your Benefit Summary:
- Anesthesia, except as otherwise required by State law,
 - Bite appliances or night guards,
 - Bone grafts,
 - Correction of congenital malformation, including genial, mandibular or maxillary osteotomies, and vestibuloplasty,
 - Correction of oral malocclusion,
 - Crowns,
 - Dental implants,
 - Prosthetic devices, except as otherwise provided herein,
 - Repair, restoration or re-implantation of teeth following an injury, and
 - Tooth extractions, including impacted teeth
- NOTE: some Plan options cover limited dental care as described in the “Dental Care” provisions of the “Additional Services” subsection of the “Benefits” section of this Policy.**

You will know dental care is part of your Plan, if your Benefit Summary includes Dental Care provisions and corresponding Cost-Share amounts.

NOT ALL PLAN OPTIONS HAVE DENTAL CARE BENEFITS.
14. Education services, including testing, training, rehabilitative for educational purposes and screening and treatment associated with learning disabilities, unless covered under the “Autism Services” or “Birth To Three Program (Early Interventional Services)” subsections of the “Benefits” section.
15. Experimental Or Investigational treatment.
16. Family planning services, including but not limited to:
- Contraceptive drugs and devices, except to the extent applicable insurance law requires coverage for these items. When they are covered, they are covered under our *Prescription Drug Rider*. If you do not have our *Prescription Drug Rider* as part of this Plan, there is no coverage for contraceptive drugs and devices,
 - Home births (except that care related to complications of home births shall be covered),
 - Infertility services not specifically covered under the “Infertility Services” or “Genetic Testing” subsections of the “Benefits” section 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 “Infertility Services” or “Genetic Testing” subsections of the “Benefits” section.
 - Medications for sexual dysfunction.
 - Recruitment, selection and screening and any other expenses of donors (donors of eggs, embryos and sperm).
 - Reversal of surgical sterilization.
 - Surrogacy and all charges associated with surrogacy.
 - Labor doulas and labor coaches are excluded.
17. Foot orthotics, except if the member is diabetic.
18. Health club membership and exercise equipment.
19. Hearing aids, except as otherwise described in the “Durable Medical Equipment (DME), Including Prosthetics” subsection of the “Benefits” section.
20. Hypnosis (except as an integral part of psychotherapy), biofeedback (except when ordered by a physician to treat urinary incontinence), acupuncture, and certain holistic practices.
21. 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 this Policy or our *Prescription Drug Rider*, if applicable.
22. Massage, except when part of a prescribed physical or occupational therapy program if that program is a covered benefit.
23. Maternity care and treatment (pre-natal and post-natal) including home births are excluded, except that care related to complications of pregnancy is covered.
24. 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.
25. Neuropsychological and neurobehavioral testing, except when it is performed by an appropriately licensed neurologist, psychologist, or psychiatrist and when it is performed to assess the extent of any cognitive or developmental delays due to chemotherapy or radiation treatment in a child diagnosed with cancer.
26. New Treatments for which we have not yet made a coverage policy.
27. Non-durable equipment such as orthopedic or prosthetic shoes and prophylactic anti-embolism stockings, (such as jobst stockings except when the Member has a history of deep vein thrombosis and varicose veins).
28. Non-Emergency land ambulance/medical transport services to and from a physician’s office for routine care.
29. Non-Medically Necessary services or supplies.
30. Non-medical supportive counseling services (individual or group) for alcohol or substance abuse (e.g., Alcoholics Anonymous).
31. Overnight or day camps focused on illness or disability.
32. Over-the-counter (OTC) items of any kind, including but not limited to home testing or other kits and products, except as provided throughout the “Benefits” section.

EXCLUSIONS

33. Peak flow meters are excluded.
However, peak flow meters may be covered if:
 - The Member is enrolled in our asthma health management program,
 - Is being actively case managed, and
 - The use of the peak flow meter is approved by us.When those conditions are met, peak flow meters may be provided as part of an asthma health management program value-added service or as a benefit.
34. Personal convenience or comfort items of any kind.
35. Physical therapy, occupational therapy, speech therapy or chiropractic therapy that is long term or maintenance in nature.
36. Private room accommodations and private duty nursing in a facility.
37. Routine foot care and treatment, unless Medically Necessary for neuro-circulatory conditions.
38. Routine physical exams and immunizations at an Urgent Care Center.
39. Sensory and auditory integration therapy, unless covered under the “Autism Services” and “Birth To Three Program (Early Intervention Services)” subsections of the “Benefits” section.
40. Services and supplies exceeding the applicable benefit maximums.
41. Services and supplies not specifically included in this Policy, except as otherwise described in one of our supplemental coverage Riders, if applicable.
42. 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.
43. Services rendered at Hospital-based clinics are excluded unless the Hospital clinics are contracted with us for specific services.
44. Services (e.g., physical examinations, blood tests), supplies, vaccinations/immunizations and medications, including prophylactic, required by or received at a wilderness camp or a boarding school.
45. Services (e.g., physical examinations, blood tests), supplies, vaccinations/immunizations and medications, including prophylactic, required by third parties or obtained for foreign or domestic travel (e.g., employment, school, camp, licensing, insurance, travel and pursuant to a court order).
46. Sex change services.
47. Smoking cessation products are excluded, except to treat nicotine addiction. When that occurs, the product must be obtained with a prescription and Pre-Authorized.

In addition, we may also cover smoking cessation products if:

- The Member is enrolled in one of our health management programs,
- The Member is being actively case managed, and
- The use of the smoking cessation product is approved by us.

When those conditions are met, smoking cessation products may be provided as part of a health management program value-added service or as a benefit.

48. Speech therapy for stuttering, lisp correction, or any speech impediment not related to illness or injury, except as required by applicable law.
49. Temporomandibular joint (TMJ) dysfunction or temporomandibular disease (TMD) syndrome: any non-surgical treatment, including but not limited to appliances, behavior modification, physiotherapy, and prosthodontic therapy.
50. Third party coverage, such as other primary insurance, workers’ compensation and Medicare will not be duplicated.
51. Transportation, accommodation costs, and other non-medical expenses related to Health Services (whether they are recommended by a physician or not), except as otherwise described in the “Benefits” section.
52. Treatment of snoring in the absence of sleep apnea.
53. Vision services including:
 - Eyeglasses and contact lenses, unless the contact lenses are the only mechanism available to restore visual function for a Member who has no visual function or unless the Plan includes our Vision Care Rider and the Rider includes these items.
 - Eye surgeries and procedures primarily for the purpose of correcting refractive defects of the eyes,
 - Vision and hearing examinations, except as set forth in the “Eye Care” and “Hearing Screenings” subsections of the “Benefits” section, and
 - Vision therapy and vision training.
54. War related treatment or supplies, whether the war is declared or undeclared.
55. Web visits, e-visits, and other on-line consultations, health evaluations using internet resources, as well as telephone consultations.
56. Weight loss/control treatment, programs, clinics, medications, and surgical treatment for morbid obesity.
57. 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 or radiation therapy, as described in the “Durable Medical Supplies (DME), Including Prosthetics” subsection of the “Benefits” section.

CICI/OOC/POS/IND 02 (10/2010)

8. HOW TO CONTACT US

TELEPHONE NUMBERS

ConnectiCare Member Services:

(860) 674-5757 or 1-800-251-7722.

ConnectiCare Billing Department:

1-800-333-1733

For questions about Health Savings Accounts:

Call First HSA toll-free at 1-888-769-8696 or go to www.lhsa.com

MAILING ADDRESSES:

To submit a claim (except for mental/behavioral health):

ConnectiCare Claims
P.O. Box 546
Farmington, CT 06034-0546

To submit a mental/behavioral health claim:

ConnectiCare Claims
United Behavioral Health (UBH)
P.O. Box 30757
Salt Lake City, UT 84130-0757

To make a premium payment:

ConnectiCare, Inc.
P.O. Box 416191
Boston, MA 02241-6191



IMPORTANT NOTICE

There are some instances where your total health plan costs may be higher with a High-Deductible Health Plan (HDHP) than with a non-HDHP.

For families with an HDHP, the full family deductible must be met prior to having any claims paid.

Please note: There may be some rare circumstances in which the fee that is contracted between ConnectiCare and its providers can be higher than the billed rate. In these instances (less than 1% of all cases) a member will be required to pay the amount for these covered services even though the billed rate may be lower. This payment arrangement must be met to allow for the tax-qualified status of his or her HDHP.

ConnectiCare's HDHPs are intended to be appropriate for use with HSAs. The HDHPs have been designed to conform to Federal Internal Revenue Service (IRS) guidelines. However, the IRS has made no determination that the HDHPs are qualified. Whether or not an HSA used with these Plans will provide a ConnectiCare member with a tax advantage depends on a number of circumstances, including the member's personal coverage situation, contributions to and withdrawals from the HSA, other coverage a member or spouse may have, and changes to or interpretations of IRS rules. Members should consult with a qualified tax advisor in determining whether and how this option may provide them with a tax benefit. ConnectiCare cannot guarantee that tax benefits will accrue to anyone covered under the HDHPs.

ConnectiCare provides only health plan coverage and administration. First HSA provides HSA accounts and administration. The accounts are separate from ConnectiCare health plans and must be set up and administered by organizations qualified to offer HSAs. ConnectiCare is not responsible for the administration of any HSA or other financial accounts used in connection with its health coverage products, and you are not required to use ConnectiCare's preferred vendors to set up an HSA. First HSA may charge you a fee for the set-up or administration of your HSA.

This brochure is only a general overview of some HSA information. It is not intended to provide tax or legal advice of any kind, and neither the accuracy nor completeness of any information is guaranteed. Consult a qualified tax or legal professional with any tax or legal questions you may have. This is a brief summary of benefits and is not a guarantee of coverage. Refer to the appropriate ConnectiCare policy for more detailed information, exclusions and limitations. The policy will prevail for all benefits, conditions, limitations and exclusions.

HMO coverage is underwritten by ConnectiCare, Inc.; POS coverage is underwritten by ConnectiCare Insurance Company, Inc.



ConnectiCare®
Solo

Individual health plans
the **ConnectiCare** way.

175 Scott Swamp Road, Farmington, CT 06034
www.connecticare.com

HMO coverage is underwritten by ConnectiCare, Inc.; POS coverage is underwritten by ConnectiCare Insurance Company, Inc.
This plan is issued on an individual basis and is regulated as an individual health insurance plan.
This plan is not available to employer groups.