ConnectiCare

Individual Market
Choice SOLO HMO Copay/Coins. $8,000 ded.
Benefit Summary
Non-Tiered Network Plan

Deductible and Out-of-Pocket Maximum	In-Network (INET) Member Pays	Out-of-network (OON) Member Pays
Plan deductible Individual Family (Deductible is combined for medical services and prescription drugs)	 $8,000 per member $16,000 per family	 N/A per member N/A per family
Separate Prescription Drug Deductible Individual Family	 N/A per member N/A per family	 N/A per member N/A per family
Out-of-Pocket Maximum Individual Family (Includes deductible, copayments and coinsurance for medical and pharmacy services)	 $9,450 per member $18,900 per family	 N/A per member N/A per family
Benefits	**In-Network (INET) Member Pays**	**Out-of-network (OON) Member Pays**
Provider Office Visits		
Adult/Pediatric Preventive Visits	No cost	N/A
Primary Care Provider Office/ Telemedicine Visits (includes services for illness, injury, follow-up care and consultations)	$40 copayment/visit deductible does not apply	N/A
Telemedicine Services (services rendered by a Teladoc® provider) Primary Care – members must be 18 or older	**Primary Care, Mental Health and General Medical Services:** No cost **Dermatologists:** $60 copayment/visit; deductible does not apply	N/A
Specialist Office/Telemedicine Visits	$60 copayment/visit deductible does not apply	N/A
Mental Health and Substance Abuse Office Visits	$60 copayment/visit; deductible does not apply	N/A

Benefits	In-Network (INET) Member Pays	Out-of-network (OON) Member Pays
Outpatient Diagnostic Services		
Advanced Radiology (CT/PET Scan, MRI)	35% coinsurance; deductible does not apply at an Independent Facility 35% coinsurance after plan deductible at a Hospital Facility	N/A
Laboratory Services	$20 copayment/service after plan deductible at an Independent Facility 35% coinsurance after plan deductible at a Hospital Facility	N/A
Non-Advanced Radiology (X-ray, Diagnostic)	$50 copayment/service; deductible does not apply at an Independent Facility 35% coinsurance after plan deductible at a Hospital Facility	N/A
Mammography Ultrasound/MRI (No cost for Screening and Diagnostic if within Federal and/or State regulations)	$50 copayment/service; deductible does not apply at an Independent Facility 35% coinsurance after plan deductible at a Hospital Facility	N/A
Prescription Drugs – Retail Pharmacy (cost share based on 30-day supply per prescription)		
Preferred Generic Tier 1	$15 copayment/prescription; deductible does not apply	N/A
Non-preferred Generic Tier 2	50% coinsurance up to a maximum of $250 per prescription after plan deductible	N/A
Preferred Brand Tier 3	$50 copayment/prescription; deductible does not apply	N/A
Non-Preferred Brand Tier 4	50% coinsurance up to a maximum of $500 per prescription after plan deductible	N/A
Specialty Drugs – (cost share up to 30-day supply per prescription - These drugs generally require pre-authorization and may require special handling)		
Preferred Specialty Tier 5	50% coinsurance up to a maximum of $500 per prescription after plan deductible (specialty retail only)	N/A
Non-Preferred Specialty Tier 6	50% coinsurance up to a maximum of $750 per prescription after plan deductible (specialty retail only)	N/A

Benefits	In-Network (INET) Member Pays	Out-of-network (OON) Member Pays
Prescription – Mail Order Pharmacy (up to a 90-day supply per prescription)		
Preferred Generic Tier 1	$30 copayment/prescription; deductible does not apply	N/A
Non-preferred Generic Tier 2	50% coinsurance up to a maximum of $500 per prescription after plan deductible	N/A
Preferred Brand Tier 3	$100 copayment/prescription; deductible does not apply	N/A
Non-Preferred Brand Tier 4	50% coinsurance up to a maximum of $1,000 per prescription after plan deductible	N/A
Outpatient Rehabilitative and Habilitative Services (40 visits per calendar year limit combined for Rehabilitative physical, speech and occupational therapies. Separate 40 visits per calendar year limit combined for Habilitative speech, physical and occupational therapies.)		
Speech Therapy	$60 copayment/visit after plan deductible	N/A
Physical and Occupational Therapy	$30 copayment/visit after plan deductible	N/A
Other Services		
Chiropractic Services (up to 20 visits per calendar year)	$60 copayment/visit after plan deductible	N/A
Diabetic Equipment and Supplies	35% coinsurance after plan deductible	N/A
Durable Medical Equipment (DME)	35% coinsurance after plan deductible	N/A
Home Health Care Services (up to 100 visits per calendar year)	25% coinsurance; deductible does not apply	N/A
Outpatient Services (in a hospital or ambulatory facility)	$500 copayment/visit; deductible does not apply at an Ambulatory Facility 35% coinsurance after plan deductible at an Outpatient Hospital Facility	N/A
Inpatient Services		
Inpatient hospital services include mental health, substance abuse, maternity, hospice, skilled nursing facility* and all IP settings. (*skilled nursing facility stay is limited to 90 days per calendar year)	35% coinsurance after plan deductible	N/A

Benefits	In-Network (INET) Member Pays	Out-of-network (OON) Member Pays
Emergency and Urgent Care		
Ambulance Services	35% coinsurance after plan deductible	Same as In-Network Benefit
Emergency Room	35% coinsurance after plan deductible	Same as In-Network Benefit
Urgent Care Centers	$100 copayment/visit; deductible does not apply	Same as In-Network Benefit
Pediatric Dental Care (for members under age 26)		
Diagnostic & Preventive	No cost	N/A
Basic Services	50% coinsurance after plan deductible	N/A
Major Services	50% coinsurance after plan deductible	N/A
Orthodontia Services (medically necessary only)	50% coinsurance after plan deductible	N/A
Pediatric Vision Care (for members under age 26)		
Prescription Eye Glasses (one pair of frames and lenses per calendar year)	Lenses: 50% after plan deductible Collection frames: 50% after plan deductible Non-collection frames: 50% after plan deductible up to the collection frame allowance; any amount over is payable by the member minus a 20% discount	N/A
Routine Eye Exam by a Specialist (one exam per calendar year)	$25 copayment/visit; deductible does not apply	N/A
Additional Covered Services		
Adult Routine Eye Exam by a Specialist (for members over age 26 - one exam per calendar year)	$25 copayment/visit; deductible does not apply	N/A
Allergy Injections (unlimited)	See primary care or specialist office visits	N/A
Allergy Testing (one visit per calendar year)	See primary care or specialist office visits	N/A

Benefits	In-Network (INET) Member Pays	Out-of-network (OON) Member Pays
Artificial Limbs (includes associated supplies and equipment)	20% coinsurance after plan deductible	N/A
Infusion therapy (when services are rendered in a Specialist office or Freestanding Infusion Center)	$60 copayment/visit deductible does not apply	N/A
Modified Food Products and Specialized Formula	35% coinsurance after plan deductible	N/A
Outpatient mental health, alcohol and substance abuse treatment (intensive outpatient treatment and partial hospitalization)	35% coinsurance after plan deductible	N/A
Retail Clinic	$40 copayment/visit; deductible does not apply	N/A

Important information

- This is a brief summary of benefits. Refer to your ConnectiCare, Inc. policy for complete details on benefits, conditions, limitations and exclusions, or consult with your benefits manager.
- 90-day supply of maintenance medications must be filled through Express Scripts home delivery or at either a participating CVS or Walgreens pharmacy. Each member has a choice of the pharmacy used.
- Ovarian cancer screening and monitoring services coverage and cost share details are available in your policy.
- Mammogram screenings, breast ultrasounds, and breast MRIs – Please refer to the policy for details.
- Insulin and noninsulin drugs are covered up to a cost share maximum of $25 for each 30-day supply.
- Diabetes Devices and Diabetic Ketoacidosis Devices are covered up to a cost share maximum of $100 per 30-day supply.
- Please refer to your policy for additional cost share maximums regarding diabetic services. Some diabetic services fall under preventive care and cost share may be waived.
- To learn more about your **Teladoc®** benefits contact **Teladoc®** at teladoc.com/connecticareor call 1-800-835-2362 (TTY: 711).
- If you have questions regarding your plan, visit our website at www.connecticare.comor call us at (860) 674-5757 or 1-800-251-7722.
- Under this program covered prescription drugs and supplies are put into categories (i.e., tiers) to designate how they are to be covered and the member's cost-share. The placement of a drug or supply into one of the tiers is determined by the ConnectiCare Pharmacy Services Department and approved by the ConnectiCare Pharmacy & Therapeutics Committee based on the drugs or supply's clinical effectiveness and cost, not on whether it is a generic drug or supply or brand name drug or supply.
- Amounts paid by members because they must pay a price difference for a brand name drug do not count towards meeting any deductible, coinsurance, copayment or cost share maximum.
- Most specialty drugs are dispensed through specialty pharmacies by mail, up to a 30-day supply. Specialty Pharmacies have the same member cost share as all other participating pharmacies and are not part of ConnectiCare's voluntary mail order program. The member cost share for specialty pharmacy is different from the cost share for ConnectiCare's mail order program.
- Many services require that you obtain written Pre-Authorization from us in order for the treatment to be covered under this plan, including services rendered by non-participating providers. Refer to the “Managed Care Rules and Guidelines” section in your policy for more details or call member service at 1-800-251-7722. Without pre-authorization you may be responsible for the total cost of the service.
- For mental health, alcohol and substance abuse services call 1-888-946-4658 to obtain Pre-Authorization.

- In-network preventive and wellness services as defined by the United States Preventive Service Task Force (USPSTF), including immunizations recommended by the Advisory Committee on Immunizations Practices at the Centers for Disease Control (CDC), and preventive care and screenings supported by the Health Resources and Services Administration (HRSA) are exempt for from all cost shares under the Patient Protection and Affordable Care Act (PPACA). Visit our website at www.connecticare.com to view a list of preventive and wellness services.