



Choice Bronze Alternative POS with Dental

If you are eligible for automatic renewal, **you'll be enrolled in the 2026 plan unless you take action to change or cancel your plan.** Renewal information you received from Access Health CT had information on automatic renewals and how they work. You can contact **your broker, ConnectiCare or Access Health CT** for information on other plans and help enrolling in one.

Plan Overview	2025 Plan Year	2026 Plan Year
Plan Name	Choice Bronze Alternative POS with Dental	Choice Bronze Alternative POS with Dental and Vision
Plan Metal Level	Bronze	Bronze
Product Type	POS	POS
Deductible		
Individual In-Network (INET)	\$7,000 per member	No change
Family In-Network	\$14,000 per family	No change
Individual Out-of-Network (OON)	\$15,000 per member	No change
Family Out-of-Network	\$30,000 per family	No change
Prescription Drug Deductible		
Individual In-Network	Combined with medical	No change
Family In-Network	Combined with medical	No change
Individual Out-of-Network	Combined with medical	No change
Family Out-of-Network	Combined with medical	No change
Out-of-Pocket Maximum		
Individual In-Network	\$9,200 per member	No change
Family In-Network	\$18,400 per family	No change
Individual Out-of-Network	\$20,000 per member	No change
Family Out-of-Network	\$40,000 per family	No change
Physician Office Visits		
Preventive Care/Screenings/ Immunizations	In-network: No cost	No change
	Out-of-network: 50% coinsurance per visit; deductible waived	No change
Primary Care (injury or illness)	In-network: \$50 copayment per visit; deductible waived	No change
	Out-of-network: 50% coinsurance per visit after OON plan deductible is met	No change
Telemedicine Visits Through Teladoc®	In-network: Primary care, mental health, and general medical services: No cost Dermatologist: \$70 copayment per visit after INET plan deductible is met	In-network: General medical and mental health services: No cost
	Out-of-network: 50% coinsurance per visit after OON plan deductible is met	No change
Specialist	In-network: \$70 copayment per visit after INET plan deductible is met	No change
	Out-of-network: 50% coinsurance per visit after OON plan deductible is met	No change
Mental Health and Substance Use Disorder	In-network: \$50 copayment per visit; deductible waived	No change
	Out-of-network: 50% coinsurance per visit after OON plan deductible is met	No change

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Emergency/Urgent Care		
Urgent Care Center or Facility	In-network: \$100 copayment per visit; deductible waived	No change
	Out-of-network: 50% coinsurance per visit after OON plan deductible is met	No change
Emergency Room (copay waived if admitted)	In-network: 45% coinsurance per visit after INET plan deductible is met	No change
	Out-of-network: Same as in-network	No change
Pediatric Dental Care (for members under age 26)		
Diagnostic and Preventive	In-network: No cost	No change
	Out-of-network: 50% coinsurance per visit after OON plan deductible is met	No change
Basic Services	In-network: 50% coinsurance per visit after INET plan deductible is met	No change
	Out-of-network: 50% coinsurance per visit after OON plan deductible is met	No change
Major Services	In-network: 50% coinsurance per visit after INET plan deductible	No change
	Out-of-network: 50% coinsurance per visit after OON plan deductible is met	No change
Orthodontia Services (medically necessary only)	In-network: 50% coinsurance per visit after INET plan deductible is met	No change
	Out-of-network: 50% coinsurance per visit after OON plan deductible is met	No change
Pediatric Vision Care (for members under age 26)		
Services must be provided by a participating VSP Provider to receive In-Network benefits.		
Routine Eye Exam (one exam per calendar year)	In-network: \$70 copayment per visit; deductible waived	No change
	Out-of-network: 50% coinsurance per visit after OON plan deductible is met	No change
Prescription Eyeglasses (one pair of frames and lenses or contact lenses per calendar year)	In-network: Lenses: 50% after INET plan deductible is met; Collection frame: 50% after INET plan deductible is met	No change
	Non-collection frame: Members choosing to upgrade from a collection frame to a non-collection frame will be given a credit substantially equal to the cost of the collection frame and will be entitled to any discount negotiated by the carrier with the retailer	No change
	Out-of-network: 50% coinsurance per visit after OON plan deductible is met	No change
Hospital Services		
Inpatient (including mental health, substance use disorder, maternity, hospice, and skilled nursing facility: skilled nursing facility stay is limited to 90 days per calendar year.)	In-network: 45% coinsurance per admission after INET plan deductible is met	No change
	Out-of-network: 50% coinsurance per admission after OON plan deductible is met	No change
Outpatient (performed at an outpatient hospital facility)	In-network: 45% coinsurance per visit after INET plan deductible is met	No change
	Out-of-network: 50% coinsurance per visit after OON plan deductible is met	No change
Outpatient (performed at an ambulatory surgery center)	In-network: \$500 copayment per visit after INET plan deductible is met	No change
	Out-of-network: 50% coinsurance per visit after OON plan deductible is met	No change

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Outpatient Services		
Home Health Care (100 visit maximum per calendar year)	In-network: 25% coinsurance per visit; deductible waived	No change
	Out-of-network: 25% coinsurance per visit after separate \$50 deductible is met	No change
Advanced Radiology Hospital (CT/PET scan, MRI)	In-network: 45% coinsurance per service after INET plan deductible is met	No change
	Out-of-network: 50% coinsurance per service after OON plan deductible is met	No change
Advanced Radiology Independent (CT/PET scan, MRI)	In-network: \$75 copayment per service after INET plan deductible up to a combined annual maximum of \$375 for MRI and CAT scans; \$400 for PET scans at an Independent Facility	No change
	Out-of-network: 50% coinsurance per service after OON plan deductible is met	No change
Non-Advanced Radiology Hospital (x-ray, diagnostic)	In-Network: 45% coinsurance per service after INET plan deductible is met at a Hospital Facility	No change
	Out-of-network: 50% coinsurance per service after OON plan deductible is met	No change
Non-Advanced Radiology Independent (x-ray, diagnostic)	In-network: \$70 copayment per service after INET plan deductible is met	No change
	Out-of-network: 50% coinsurance per service after OON plan deductible is met	No change
Laboratory Services	In-network: \$25 copayment per service after INET plan deductible is met	No change
	Out-of-network: 50% coinsurance per service after OON plan deductible is met	No change
Physical and Occupational Therapy (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.)	In-network: \$30 copayment per visit after INET plan deductible is met	No change
	Out-of-network: 50% coinsurance per visit after OON plan deductible is met	No change
Speech Therapy (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.)	In-network: \$30 copayment per visit after INET plan deductible is met	No change
	Out-of-network: 50% coinsurance per visit after OON plan deductible is met	No change

Plan Overview	2025 Plan Year	2026 Plan Year
Prescription Drugs		
Tier 1	In-network: \$30 copayment per prescription; deductible waived	No change
	Out-of-network: 50% coinsurance per prescription after OON deductible is met	No change
Tier 2	In-network: \$100 copayment per prescription after INET plan deductible is met	No change
	Out-of-network: 50% coinsurance per prescription after OON deductible is met	No change
Tier 3	In-network: 50% coinsurance per prescription after INET deductible is met	No change
	Out-of-network: 50% coinsurance per prescription after OON deductible is met	No change
Tier 4	In-network: 50% coinsurance up to a maximum of \$500 per prescription after INET deductible is met	No change
	Out-of-network: 50% coinsurance per prescription after OON deductible is met	No change
Mail Order	2X In-Network retail copayment	3X In-Network retail copayment
Adult Dental Care (for members over age 26)		
Preventive (one exam and cleaning per 6-month period)	In-network: No cost	No change
	Out-of-network: 50% coinsurance per visit after OON plan deductible is met	No change
Routine (full mouth x-rays or panoramic x-rays at 36-month intervals and bitewing x-rays at 6-month intervals)	In-network: No cost	No change
	Out-of-network: 50% coinsurance per visit after OON plan deductible is met	No change
Adult Routine Vision Services (for members age 26 and older) Services must be provided by a participating VSP Provider to receive In-Network benefits		
Comprehensive Vision Exam (one exam per calendar year)	Not applicable	In-network: No cost
	Not applicable	Out-of-network: 50% coinsurance per visit after OON plan deductible is met
Routine Retinal Screening	Not applicable	In-network: \$39 copayment per exam; deductible waived
	Not applicable	Out-of-network: 50% coinsurance per visit after OON plan deductible is met
Prescription Glasses Frames: Limited to one pair of frames per calendar year (up to \$150 allowances) Lenses: Limited to one pair every calendar year Glasses and plastic single vision, lines bifocal, lines trifocal or lenticular lenses	Not applicable	In-network: No cost
	Not applicable	Out-of-network: 50% coinsurance per visit after OON plan deductible is met
Prescription Contact Lenses (in lieu of prescription glasses, material and services are limited to one pair of contact lenses up to \$150 every calendar year. Medically necessary contact lenses for specified medical conditions require Prior Authorizations)	Not applicable	In-network: No cost
	Not applicable	Out-of-network: 50% coinsurance per visit after OON plan deductible is met

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