ConnectiCare

Value Silver Standard POS (CSR 94%)

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	**Value Silver Standard POS (CSR 94%)**	**Value Silver Standard POS (CSR 94%)**
Plan Metal Level	Silver	Silver
Product Type	POS	POS
Deductible		
Individual In-Network (INET)	$0 per member	No change
Family In-Network	$0 per family	No change
Individual Out-of-Network (OON)	$10,000 per member	No change
Family Out-of-Network	$20,000 per family	No change
Prescription Drug Deductible		
Individual In-Network	$0 per member	No change
Family In-Network	$0 per family	No change
Individual Out-of-Network	$500 per member	No change
Family Out-of-Network	$1,000 per family	No change
Out-of-Pocket Maximum		
Individual In-Network	$1,150 per member	$1,350 per member
Family In-Network	$2,300 per family	$2,700 per family
Individual Out-of-Network	$18,200 per member	No change
Family Out-of-Network	$36,400 per family	No change
Physician Office Visits		
Preventive Care/Screenings/ Immunizations	In-network: No cost	No change
	Out-of-network: 40% coinsurance per visit; deductible waived	No change
Primary Care (injury or illness)	In-network: $10 copayment per visit	In-network: $15 copayment per visit
	Out-of-network: 40% 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: $30 copayment/visit	In-network: General medical and mental health services: No cost
	Out-of-network: 40% coinsurance per visit after OON plan deductible is met	No change
Specialist	In-network: $30 copayment per visit	No change
	Out-of-network: 40% coinsurance per visit after OON plan deductible is met	No change
Mental Health and Substance Use Disorder	In-network: $10 copayment per visit	In-network: $15 copayment per visit
	Out-of-network: 40% 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: $25 copayment per visit	No change
	Out-of-network: 40% coinsurance per visit after OON plan deductible is met	No change
Emergency Room (copay waived if admitted)	In-network: $50 copayment per visit	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: 40% coinsurance per visit	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	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	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: $30 copayment per visit	No change
	Out-of-network: 40% 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: $0 Collection frame: $0	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: $75 copayment per day up to a maximum of $300 per admission	No change
	Out-of-network: 40% coinsurance per admission after OON plan deductible is met	No change
Outpatient (performed at an outpatient hospital facility)	In-network: $75 copayment per visit	No change
	Out-of-network: 40% coinsurance per visit after OON plan deductible is met	No change
Outpatient (performed at an ambulatory surgery center)	In-network: $45 copayment per visit	No change
	Out-of-network: 40% coinsurance per visit after OON plan deductible is met	No change

Plan Overview	2025 Plan Year	2026 Plan Year
Outpatient Services		
Home Health Care (100 visit calendar year maximum)	In-network: No cost	No change
	Out-of-network: 25% coinsurance per visit after separate $50 deductible is met	No change
Advanced Radiology (CT/PET scan, MRI)	In-network: $50 copayment per service up to a combined annual maximum of $350 for MRI and CAT scans; $400 for PET scans	No change
	Out-of-network: 40% coinsurance per service after OON plan deductible is met	No change
Non-Advanced Radiology (x-ray, diagnostic)	In-network: $25 copayment per service	No change
	Out-of-network: 40% coinsurance per service after OON plan deductible is met	No change
Laboratory Services	In-network: $10 copayment per service	No change
	Out-of-network: 40% 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: $20 copayment per visit	No change
	Out-of-network: 40% 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: $20 copayment per visit	No change
	Out-of-network: 40% coinsurance per visit after OON plan deductible is met	No change
Prescription Drugs		
Tier 1	In-network: $5 copayment per prescription	No change
	Out-of-network: 40% coinsurance per prescription after OON prescription drug deductible is met	No change
Tier 2	In-network: $10 copayment per prescription	No change
	Out-of-network: 40% coinsurance per prescription after OON prescription drug deductible is met	No change
Tier 3	In-network: $30 copayment per prescription	No change
	Out-of-network: 40% coinsurance per prescription after OON prescription drug deductible is met	No change
Tier 4	In-network: 20% coinsurance up to a maximum of $60 per prescription	No change
	Out-of-network: 40% coinsurance per prescription after OON prescription drug deductible is met	No change
Mail Order	2X In-Network retail copayment	3X In-Network retail copayment