



Please review the information below carefully. This chart explains the changes in cost-sharing, if any, between your current 2025 plan and the new plan you will automatically be enrolled in for 2026. To make a change, contact your broker or call us at **800-723-2986** (TTY: **711**).

Plan Overview	2025 Plan Year	2026 Plan Year
Plan Name	Choice SOLO HMO HSA \$6,500 ded.	Choice SOLO HMO HSA \$7,500 ded.
Product Type	HMO	HMO
Deductible		
Individual In-Network	\$6,500 per member	\$7,500 per member
Family In-Network	\$13,000 per family	\$15,000 per family
Individual Out-of-Network	N/A	No change
Family Out-of-Network	N/A	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	N/A	No change
Family Out-of-Network	N/A	No change
Out-of-Pocket Maximum		
Individual In-Network	\$7,800 per member	\$8,300
Family In-Network	\$15,600 per family	\$16,600
Individual Out-of-Network	N/A	No change
Family Out-of-Network	N/A	No change
Physician Office Visits		
Preventive Care/Screenings/ Immunizations	In-network: No cost Out-of-network: Not covered	No change
Primary Care (injury or illness)	In-network: \$40 copayment/visit after plan deductible Out-of-network: Not covered	No change
Telemedicine Visits Through Teladoc®	In-network: Primary care, mental health, and general medical services: No cost after plan deductible Dermatologist: \$50 copayment/visit after plan deductible Out-of-network: N/A	In-network: General medical and mental health services: No cost after plan deductible Out-of-network: N/A
Specialist	In-network: \$50 copayment/visit after plan deductible Out-of-network: Not covered	No change
Mental Health and Substance Use	In-network: \$40 copayment/visit after plan deductible Out-of-network: Not covered	No change
Emergency/Urgent Care		
Urgent Care Centers	In-network: \$100 copayment/visit after plan deductible Out-of-network: Same as in-network benefit	No change
Emergency Room	In-network: 30% coinsurance after plan deductible Out-of-network: Same as in-network benefit	No change

Plan Overview	2025 Plan Year	2026 Plan Year
Hospital Services		
Inpatient Including mental health, substance use, maternity, hospice, and skilled nursing facility* *Skilled nursing facility stay is limited to 90 days per calendar year.	In-network: 30% coinsurance after plan deductible Out-of-network: Not covered	No change
Hospital Outpatient Facilities	In-network: 30% coinsurance after plan deductible Out-of-network: Not covered	No change
Ambulatory Surgical Center	In-network: \$500 copayment/visit after plan deductible Out-of-network: Not covered	No change
Outpatient Services		
Home Health Care (up to 100 visits per calendar year)	In-network: 25% coinsurance after plan deductible Out-of-network: Not covered	No change
Advanced Radiology (CT/PET scan, MRI) Hospital facility	In-network: 30% coinsurance after plan deductible Out-of-network: Not covered	No change
Advanced Radiology (CT/PET scan, MRI) Independent facility	In-network: \$75 copayment/service after plan deductible (up to 5 copayments per year, then copayment waived) Out-of-network: Not covered	No change
Non-Advanced Radiology (X-ray, diagnostic) Hospital facility	In-network: 30% coinsurance after plan deductible Out-of-network: Not covered	No change
Non-Advanced Radiology (X-ray, diagnostic) Independent facility	In-network: \$35 copayment/service after plan deductible Out-of-network: Not covered	No change
Laboratory Services Hospital facility	In-network: 30% coinsurance after plan deductible Out-of-network: Not covered	No change
Laboratory Services Independent facility	In-network: \$10 copayment/service after plan deductible Out-of-network: Not covered	No change
Physical and Occupational Therapy Up to 40 visits per year combined for physical, speech, and occupational therapy (habilitative services have a separate 40-visit maximum)	In-network: \$30 copayment/visit after plan deductible Out-of-network: Not covered	No change
Speech Therapy Up to 40 visits per year combined for physical, speech, and occupational therapy (habilitative services have a separate 40-visit maximum)	In-network: \$50 copayment/visit after plan deductible Out-of-network: Not covered	No change
Prescription Drugs		
Generic	Preferred In-network: \$10 copayment/prescription after plan deductible Non-Preferred In-network: 50% coinsurance up to a maximum of \$250 per prescription after plan deductible Out-of-network: Not covered	In-network: \$10 copayment/prescription after plan deductible Out-of-network: Not covered
Preferred Brand	In-network: \$60 copayment/prescription after plan deductible Out-of-network: Not covered	No change

Plan Overview	2025 Plan Year	2026 Plan Year
Prescription Drugs (continued)		
Non-Preferred Brand	In-network: 50% coinsurance up to a maximum of \$500 per prescription after plan deductible Out-of-network: Not covered	No change
Specialty	Preferred In-network: 50% coinsurance up to a maximum of \$50 per prescription after plan deductible (specialty retail only) Non-Preferred In-network: 50% coinsurance up to a maximum of \$750 per prescription after plan deductible (specialty retail only) Out-of-network: Not covered	In-network: 50% coinsurance up to a maximum of \$750 per prescription after plan deductible (specialty retail only) Out-of-network: Not covered
Mail Order	2X In-network retail copayment	3X In-network retail copayment
Pediatric-Only Services (for members under age 26) Services Must Be Provided By a Participating VSP Provider		
Pediatric Dental Diagnostic and Preventive	In-network: No cost Out-of-network: Not covered	No change
Pediatric Dental Services Basic, major, and orthodontia services (medically necessary)	In-network: 50% coinsurance after plan deductible Out-of-network: Not covered	No change
Pediatric Vision Routine Eye Exam	In-network: \$50 copayment/visit, deductible does not apply Out-of-network: Not covered	No change
Pediatric Prescription Eyeglasses One pair of frames and lenses or contact lenses per calendar year	In-network: 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. Out-of-network: Not covered	No change

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