ConnectiCare

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