



ConnectiCare Benefits, Inc.

**Individual Market  
Choice Catastrophic POS with Dental and Vision  
Schedule of Benefits  
Non-Tiered Network Plan**

Choice Network - Includes Providers in Connecticut only

<b>Deductible and Out-of-Pocket Maximum</b>	<b>In-Network (INET) Member Pays</b>	<b>Out-of-network (OON) Member Pays</b>
<b>Plan deductible</b> Individual Family (Deductible is combined for medical services and prescription drugs)	\$10,600 per member \$21,200 per family	\$15,000 per member \$30,000 per family
<b>Separate Prescription Drug Deductible</b> Individual Family	Included in Plan Deductible per member / per family	Included in Plan Deductible per member / per family
<b>Out-of-Pocket Maximum</b> Individual Family (Includes deductible, copayments and coinsurance for medical and pharmacy services)	\$10,600 per member \$21,200 per family	\$20,000 per member \$40,000 per family
<b>Benefits</b>	<b>In-Network (INET) Member Pays</b>	<b>Out-of-network (OON) Member Pays</b>
<b>Provider Office Visits</b>		
<b>Adult/Pediatric Preventive Visits</b>	No cost	50% coinsurance per visit; deductible does not apply
<b>Primary Care Provider Office/ Telemedicine Visits</b> (includes services for illness, injury, follow-up care and consultations)	\$30 copayment per visit for the first 3 visits combined with mental health and substance use disorder visits then 0% coinsurance per visit after INET plan deductible is met <i>(Deductible is waived for first 3 visits)</i>	50% coinsurance per visit after OON plan deductible is met
<b>Telemedicine Services</b> (services rendered by a Teladoc® provider)	<b>General Medical and Mental Health Services:</b> 0% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met
<b>Specialist Office/Telemedicine Visits</b>	0% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met

<b>Benefits</b>	<b>In-Network (INET) Member Pays</b>	<b>Out-of-network (OON) Member Pays</b>
<b>Mental Health and Substance Use Disorder Office Visits</b>	\$30 copayment per visit for the first 3 visits combined with primary care provider office visits then 0% coinsurance per visit after INET plan deductible is met <i>(Deductible is waived for first 3 visits)</i>	50% coinsurance per visit after OON plan deductible is met
<b>Outpatient Diagnostic Services</b>		
<b>Advanced Radiology</b> (CT/PET Scan, MRI)	0% coinsurance per service after INET plan deductible is met	50% coinsurance per service after OON plan deductible is met
<b>Laboratory Services</b>	0% coinsurance per service after INET plan deductible is met	50% coinsurance per service after OON plan deductible is met
<b>Non-Advanced Radiology</b> (X-ray, Diagnostic)	0% coinsurance per service after INET plan deductible is met	50% coinsurance per service after OON plan deductible is met
<b>Mammography Ultrasound/MRI</b> (No cost for Screening and Diagnostic if within Federal and/or State regulations)	0% coinsurance per service after INET plan deductible is met	50% coinsurance per service after OON plan deductible is met
<b>Prescription Drugs – Retail Pharmacy (cost share based on 30 day supply per prescription)</b>		
<b>Generic Drugs</b> Tier 1	0% coinsurance per prescription after INET plan deductible is met	50% coinsurance per prescription after OON plan deductible is met
<b>Preferred Brand Drugs</b> Tier 2	0% coinsurance per prescription after INET plan deductible is met	50% coinsurance per prescription after OON plan deductible is met
<b>Non-Preferred Brand</b> Tier 3	0% coinsurance per prescription after INET plan deductible is met	50% coinsurance per prescription after OON plan deductible is met
<b>Specialty Drugs</b> Tier 4	0% coinsurance per prescription after INET plan deductible is met	50% coinsurance per prescription after OON plan deductible is met
<b>Prescription – Mail Order Pharmacy (up to a 90 day supply per prescription)</b>		
<b>Generic Drugs</b> Tier 1	0% coinsurance per prescription after INET plan deductible is met	50% coinsurance per prescription after OON plan deductible is met
<b>Preferred Brand Drugs</b> Tier 2	0% coinsurance per prescription after INET plan deductible is met	50% coinsurance per prescription after OON plan deductible is met
<b>Non-Preferred Brand</b> Tier 3	0% coinsurance per prescription after INET plan deductible is met	50% coinsurance per prescription after OON plan deductible is met
<b>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.)</b>		
<b>Speech Therapy</b>	0% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met
<b>Physical and Occupational Therapy</b>	0% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met

<b>Benefits</b>	<b>In-Network (INET) Member Pays</b>	<b>Out-of-network (OON) Member Pays</b>
<b>Other Services</b>		
<b>Chiropractic Services</b> (up to 20 visits per calendar year)	0% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met
<b>Diabetic Equipment and Supplies</b>	0% coinsurance per equipment/supply after INET plan deductible is met	50% coinsurance per equipment/supply after OON plan deductible is met
<b>Durable Medical Equipment (DME)</b>	0% coinsurance per equipment/supply after INET plan deductible is met	50% coinsurance per equipment/supply after OON plan deductible is met
<b>Home Health Care Services</b> (up to 100 visits per calendar year)	0% coinsurance per visit after INET plan deductible is met	25% coinsurance per visit after OON plan deductible is met
<b>Outpatient Services</b> (in a hospital or ambulatory facility)	0% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met
<b>Inpatient Services</b>		
<b>Inpatient hospital services include mental health, substance use disorder, maternity, hospice, skilled nursing facility* and all IP settings.</b> (*skilled nursing facility stay is limited to 90 days per calendar year)	0% coinsurance per admission after INET plan deductible is met	50% coinsurance per admission after OON plan deductible is met
<b>Emergency and Urgent Care</b>		
<b>Ambulance Services</b>	0% coinsurance per service after INET plan deductible is met	0% coinsurance per service after INET plan deductible is met
<b>Emergency Room</b>	0% coinsurance per visit after INET plan deductible is met	0% coinsurance per visit after INET plan deductible is met
<b>Urgent Care Centers</b>	0% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met
<b>Pediatric Dental Care (for members under age 26)</b>		
<b>Diagnostic &amp; Preventive</b>	No cost	50% coinsurance per visit after OON plan deductible is met
<b>Basic Services</b>	0% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met
<b>Major Services</b>	0% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met
<b>Orthodontia Services</b> (medically necessary only)	0% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met
<b>Adult Dental Care (for members over age 26)</b>		

<b>Benefits</b>	<b>In-Network (INET) Member Pays</b>	<b>Out-of-network (OON) Member Pays</b>
<b>Adult Preventive Dental Care</b> for members over age 26	No cost	50% coinsurance per visit after OON plan deductible is met
<b>Adult Routine Dental Care</b> for members over age 26	No cost	50% coinsurance per visit after OON plan deductible is met
<b>Pediatric Vision Care (for members under age 26)</b>		
<b>Prescription Eye Glasses</b> Services must be provided by a participating VSP Provider to receive In-Network benefits  (one pair of frames and lenses or contact lens per calendar year)	Lenses: 0% coinsurance after INET plan deductible is met Collection Frame: 0% coinsurance after INET plan deductible is met Non-collection frame: Members choosing to upgrade from a collection frame to a noncollection 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	50% coinsurance per visit after OON plan deductible is met
<b>Routine Eye Exam</b> Services must be provided by a participating VSP Provider to receive In-Network benefits  (one exam per calendar year)	0% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met
<b>Adult Routine Vision Services (for members age 26 and older)</b> <b>Services must be provided by a participating VSP Provider to receive In-Network benefits.</b>		
<b>Comprehensive Vision Exam</b> (one exam per calendar year)	No cost	50% coinsurance per visit after OON plan deductible is met
<b>Routine Retinal Screening</b>	\$39 copayment per exam; deductible does not apply	50% coinsurance per visit after OON plan deductible is met
<b>Prescription Glasses</b> <b>Frames:</b> Limited to one pair of frames per calendar year (up to \$150 allowance)  <b>Lenses:</b> Limited to one pair every calendar year  Glass or plastic single vision, lined bifocal, lined trifocal or lenticular lenses	No cost	50% coinsurance per visit after OON plan deductible is met

Benefits	In-Network (INET) Member Pays	Out-of-network (OON) Member Pays
<b>Prescription Contact Lenses</b> (In lieu of prescription glasses, materials 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.)	No cost	50% coinsurance per visit after OON plan deductible is met
<b>Additional Covered Services</b>		
<b>Allergy Injections</b> (Unlimited)	See primary care or specialist office visits	50% coinsurance per visit after OON plan deductible is met
<b>Allergy Testing</b> (one visit per calendar year)	See primary care or specialist office visits	50% coinsurance per visit after OON plan deductible is met
<b>Artificial Limbs</b> (includes associated supplies and equipment)	0% coinsurance after INET plan deductible is met	50% coinsurance after OON plan deductible is met
<b>Infusion therapy</b> (when services are rendered in a Specialist office or Freestanding Infusion Center)	0% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met
<b>Modified Food Products and Specialized Formula</b>	0% coinsurance after INET plan deductible is met	50% coinsurance after OON plan deductible is met
<b>Outpatient mental health, alcohol and substance use disorder treatment</b> (intensive outpatient treatment and partial hospitalization)	0% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met
<b>Retail Clinic</b>	0% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met
<b>Important information</b>		
<ul style="list-style-type: none"> <li>• This is a brief summary of benefits. Refer to your ConnectiCare Benefits, Inc. <b>Evidence of Coverage (EOC)</b> for complete details on benefits, conditions, limitations and exclusions. All benefits described are per member per calendar year.</li> <li>• 90-day supply of select maintenance medications are available to be filled at any pharmacy in the network.</li> <li>• Ovarian cancer screening and monitoring services coverage and cost share details are available in your EOC.</li> <li>• Mammogram screenings, breast ultrasounds, and breast MRIs – Please refer to the EOC for details.</li> <li>• Insulin and noninsulin drugs are covered up to a cost share maximum of \$25 for each 30-day supply.</li> <li>• Diabetes Devices and Diabetic Ketoacidosis Devices are covered up to a cost share maximum of \$100 per 30-day supply.</li> <li>• Please refer to your EOC for additional cost share maximums regarding diabetic services. Some diabetic services fall under preventive care and cost share may be waived.</li> <li>• An <b>ambulatory surgery center</b> is a facility that exclusively provides outpatient surgical services to patients who do not require hospitalization and whose expected stay in the center does not exceed 24 hours. Ambulatory surgery centers are not owned by a hospital.</li> </ul>		

- An **outpatient hospital facility** offers surgical procedures and related care that, in the opinion of the attending physician, can be safely performed without requiring overnight inpatient hospital care. Outpatient hospital facilities are owned by a hospital or hospital system.
- If you have questions regarding your plan, visit our website at [www.connecticare.com](http://www.connecticare.com) or call us at (860) 674-5757 or 1-800-251-7722.
- To learn more about your **Teladoc®** benefits contact **Teladoc®** at [teladochealth.com/connecticarecore](http://teladochealth.com/connecticarecore) or call 1-800-835-2362 (TTY: 711).
- Out-of-Network reimbursement is based on the maximum allowable amount. Members are responsible for paying any charges in excess of this amount. Please refer to your ConnectiCare Benefits, Inc. EOC for more information.
- 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 supplies 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, coinsurance or cost share maximum.
- Most specialty drugs are dispensed through specialty pharmacies by mail, up to 30-day supply. Specialty Pharmacies have the same member cost share as all other participating pharmacies and are not part of the ConnectiCare extended day supply program.
- Many services require that you obtain our Prior Authorization prior to obtaining care. Please refer to the "Prior Authorization Addendum" in your EOC for a detailed list of services or call member services at 1-800-251-7722. Without Prior Authorization for medically necessary covered services prescribed or rendered by Non-Participating providers, benefits may be reduced by the lesser of \$500 or 50%.
- For mental health and substance use disorder services call 1-888-946-4658 to obtain Prior 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 from all cost shares under the Patient Protection and Affordable Care Act (PPACA). Visit our website at [www.connecticare.com](http://www.connecticare.com) to view a list of preventive and wellness services.