

# ConnectiCare Benefits At A Glance



Affordable, quality health coverage for all. Learn more at [ConnectiCareSales.com](https://ConnectiCareSales.com).

Call today! (866) 714-8990 (TTY: 711)

In-Network (INN)/Out-of-Network (OON) Off-Exchange Plans	Choice SOLO POS HSA Coins. \$6,500 ded.		Choice SOLO HMO HSA \$7,500 ded.	Choice SOLO HMO Copay/ Coins. \$7,700 ded.
	In-Network	Out-of-Network	In-Network	In-Network
<b>VALUE BASICS</b>				
Teladoc Virtual Care Visits 24/7/365	No-Cost	50% after ded	No-Cost	No-Cost
Annual Wellness Visit - Adults	No-Cost	50% after ded	No-Cost	No-Cost
Routine Preventive Screenings - Children & Adults	No-Cost	50% after ded	No-Cost	No-Cost
Routine Vision Exam - Children (Ages under 26)	25%	50% after ded	\$50	\$40
Routine Eyewear - Children (Ages under 26)	50% after ded	50% after ded	50% after ded	50% after ded
Preventive Prescription Drugs	No-Cost	50% after ded	No-Cost	No-Cost
24-Hour Nurse Advice Line	No-Cost	N/A	No-Cost	No-Cost
Plan Options with Adult Vision & Dental Services	Optional	Not covered	Optional	Optional
<b>BENEFITS AND COST SHARE HIGHLIGHTS</b>				
Deductible (Ind/Fam)	\$6,500 / \$13,000	\$15,000 / \$30,000	\$7,500 / \$15,000	\$7,700 / \$15,400
Drug Deductible (Ind/Fam)	Comb. w/ Med	Comb. w/ Med	Comb. w/ Med	Comb. w/ Med
Out of Pocket Max (Ind/Fam)	\$8,300 / \$16,600	\$30,000 / \$60,000	\$8,300 / \$16,600	\$9,500 / \$19,000
Emergency Room Facility	25% after ded	25% after INN ded	30% after ded	50% after ded
Urgent Care Services	25% after ded	50% after ded	\$100 after ded	\$100

\*\*Retail Rx (cost share based on 30 day supply per prescription) Insulin and non-insulin drugs are covered up to a max of \$25 for each 30-day supply.  
 § Mail-order is available for non-specialty drugs marked "MAIL" on the formulary. For mail-order Rx, a 90-day supply is provided at three times (3x) the 30-day retail cost-sharing amount.

**SERVICES WITHOUT ANY DEDUCTIBLE**

# ConnectiCare Benefits At A Glance



In-Network (INN)/Out-of-Network (OON) Off-Exchange Plans	Choice SOLO POS HSA Coins. \$6,500 ded.		Choice SOLO HMO HSA \$7,500 ded.	Choice SOLO HMO Copay/ Coins. \$7,700 ded.
	In-Network	Out-of-Network	In-Network	In-Network
<b>INPATIENT SERVICES</b>				
Inpatient Facility Fee <i>*Professional Fees May Apply</i>	25% after ded	50% after ded	30% after ded	50% after ded
<b>OUTPATIENT PROFESSIONAL OFFICE VISITS SERVICES</b>				
Primary Care	25% after ded	50% after ded	\$40 after ded	\$40
Specialty Care	25% after ded	50% after ded	\$50 after ded	\$75
Rehabilitative and Habilitative Services	25% after ded	50% after ded	\$50 after ded	\$30 after ded
Mental / Behavioral Health Services / Substance Use Disorder Services	25% after ded	50% after ded	\$40 after ded	\$40

\*\*Retail Rx (cost share based on 30 day supply per prescription) Insulin and non-insulin drugs are covered up to a max of \$25 for each 30-day supply.  
 § Mail-order is available for non-specialty drugs marked "MAIL" on the formulary. For mail-order Rx, a 90-day supply is provided at three times (3x) the 30-day retail cost-sharing amount.

**SERVICES WITHOUT ANY DEDUCTIBLE**

# ConnectiCare Benefits At A Glance



In-Network (INN)/Out-of-Network (OON) Off-Exchange Plans	Choice SOLO POS HSA Coins. \$6,500 ded.		Choice SOLO HMO HSA \$7,500 ded.	Choice SOLO HMO Copay/ Coins. \$7,700 ded.
	In-Network	Out-of-Network	In-Network	In-Network
<b>OUTPATIENT HOSPITAL FACILITY SERVICES</b>				
Outpatient Facility Fee	25% after ded	50% after ded	30% after ded at an Outpatient Hospital Facility \$500 after ded at an Ambulatory Surgery Center	50% after ded at an Outpatient Hospital Facility \$500 at an Ambulatory Surgery Center
Outpatient Professional Fee	25% after ded	50% after ded	30% after ded at an Outpatient Hospital Facility \$0 after ded at an Ambulatory Surgery Center	50% after ded at an Outpatient Hospital Facility \$0 at an Ambulatory Surgery Center
Advanced Imaging and Specialized Scanning Services	25% after ded	50% after ded	30% after ded at an Outpatient Facility Center \$75 after ded at Independent Provider	50% after ded at an Outpatient Facility Center 50% at Independent Provider

\*\*Retail Rx (cost share based on 30 day supply per prescription) Insulin and non-insulin drugs are covered up to a max of \$25 for each 30-day supply.  
 § Mail-order is available for non-specialty drugs marked "MAIL" on the formulary. For mail-order Rx, a 90-day supply is provided at three times (3x) the 30-day retail cost-sharing amount.

**SERVICES WITHOUT ANY DEDUCTIBLE**

# ConnectiCare Benefits At A Glance



In-Network (INN)/Out-of-Network (OON) Off-Exchange Plans	Choice SOLO POS HSA Coins. \$6,500 ded.		Choice SOLO HMO HSA \$7,500 ded.	Choice SOLO HMO Copay/ Coins. \$7,700 ded.
	In-Network	Out-of-Network	In-Network	In-Network
<b>OUTPATIENT HOSPITAL FACILITY SERVICES</b>				
Routine X- Ray and Diagnostic Services	25% after ded	50% after ded	30% after ded at an Outpatient Facility Center  \$35 after ded at Independent Provider	50% after ded at an Outpatient Facility Center  \$60 at Independent Provider
Laboratory Tests	25% after ded	50% after ded	30% after ded at an Outpatient Facility Center  \$10 after ded at Independent Provider	\$25

\*\*Retail Rx (cost share based on 30 day supply per prescription) Insulin and non-insulin drugs are covered up to a max of \$25 for each 30-day supply.  
 § Mail-order is available for non-specialty drugs marked "MAIL" on the formulary. For mail-order Rx, a 90-day supply is provided at three times (3x) the 30-day retail cost-sharing amount.

**SERVICES WITHOUT ANY DEDUCTIBLE**

# ConnectiCare Benefits At A Glance



In-Network (INN)/Out-of-Network (OON) Off-Exchange Plans	Choice SOLO POS HSA Coins. \$6,500 ded.		Choice SOLO HMO HSA \$7,500 ded.	Choice SOLO HMO Copay/ Coins. \$7,700 ded.
	In-Network	Out-of-Network	In-Network	In-Network
<b>PRESCRIPTION DRUGS<sup>§</sup></b>				
Preventive Drugs	No charge	50% after ded	No charge	No charge
Preferred Generic Drugs	\$10 after ded	50% after ded	\$10 after ded	\$15
Preferred Brand Drugs	\$60 after ded	50% after ded	\$60 after ded	\$75
Non-Preferred Drugs	50% after ded (\$500 max per prescription)	50% after ded	50% after ded (\$500 max per prescription)	50% after ded
Specialty Drugs	50% after ded (\$750 max per prescription)	50% after ded	50% after ded (\$750 max per prescription)	50% after ded (\$750 max per prescription)

ConnectiCare complies with applicable federal civil rights laws and does not discriminate the basis of race, color, national origin, age, disability, or sex. ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 800-251-7722 (TTY: 711). ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-251-7722 (TTY: 711). Teladoc and related marks are trademarks of Teladoc Health, Inc. and are used by ConnectiCare with permission. ConnectiCare is the brand name used for products and services provided by one or more ConnectiCare group of subsidiary companies. In Connecticut, individual and family health coverage is underwritten by ConnectiCare, Inc. (CCI), a licensed health care center, or by ConnectiCare Benefits, Inc. (CBI) or ConnectiCare Insurance Company, Inc. (CICI), licensed insurers. Individual, family, and group dental coverage is underwritten by CICI. Group health coverage is insured by CCI or insured or administered by CICI. All insurance contracts, policies, and group benefit plans contain exclusions and limitations. Not all coverage is available in all markets. For costs and details of coverage, call or write your insurance broker or the company. ©2025 ConnectiCare, Inc. & Affiliates.

\*\*Retail Rx (cost share based on 30 day supply per prescription) Insulin and non-insulin drugs are covered up to a max of \$25 for each 30-day supply.  
 § Mail-order is available for non-specialty drugs marked "MAIL" on the formulary. For mail-order Rx, a 90-day supply is provided at three times (3x) the 30-day retail cost-sharing amount.

**SERVICES WITHOUT ANY DEDUCTIBLE**