Plans Through Access Health CT

2025

ConnectiCare

Creating Healthier Futures

Your health is your greatest strength. Helping you maintain it is ours. That's why at ConnectiCare, we go beyond coverage to connect you with conveniently located doctors and health and wellness resources that can help keep you healthy.

This guide has information on 2025 plans sold through Access Health CT, Connecticut's official health insurance marketplace.

Get the Benefits and Services You Need

ConnectiCare plans include many benefits that help you and your family stay healthy, including:

- Preventive care at $0 cost-share for services like annual checkups, screenings, flu shots, and other vaccinations.*
- Prescription drug coverage. Some drugs, like birth control and medicine to prevent heart disease, are available at $0 cost-share.
- Lower out-of-pocket costs when using independent outpatient and radiology facilities.
- Mental health care for substance use disorder, anxiety, depression, and other behavioral health conditions.
- Specialist care, diagnostic testing, and hospital treatment.
- Pediatric dental and vision coverage for members through age 26.
- Emergency and urgent care wherever you travel.**

$0

Teladoc® Primary360

Most ConnectiCare plans offer convenient telemedicine with a **$0** copay and **$0** deductible* for virtual primary care, mental health, and 24/7 on-demand, nonemergency care through phone, video, or mobile app messaging.*** Plus, dermatology is available with a specialist cost-share. See the same primary care provider (PCP) with no limit on visits.

*$0 cost-share preventive care means that you will not have a copay or have to pay toward your deductible or coinsurance for the services. Sometimes, a preventive care visit leads to other medical care or tests, even at the same appointment. You should check with your doctor or doctor's staff during your visit to see if there are services you may be billed for.

**Subject to limitations.

***Telemedicine is not appropriate for all covered services, and restrictions apply. Not all services available 24/7. For primary care, members must be 18 or older; for Teladoc mental health services, members must be 13 or older. HSA-compatible plans are subject to a deductible.

Dental

Dental exams are an important part of your overall health

Preventive dental treatment — including checkups, cleanings, and x-rays — can help lower risks associated with heart disease, diabetes, pregnancy, and other conditions.

Here are the ways that our plans offer dental coverage:

- All plans come with pediatric dental benefits through age 26. Pediatric dental includes diagnostic, preventive, basic, and major services.
- Two of our plans include preventive dental coverage for adults: Choice Catastrophic POS with Dental, and Choice Bronze Alternative POS with Dental.
- We also offer two standalone dental plans that can be purchased with or without a ConnectiCare medical plan: ConnectiCare Basic Dental Plan and ConnectiCare Standard Dental Plan. For coverage details, see pages 14-17.

Use "Find a Doctor" on **connecticare.com** to find participating dentists in the ConnectiCare dental network.

Member Choice Pharmacy Benefit

Members on maintenance medicines (drugs you take every day, month after month) get convenient, 90-day supplies with a choice of filling these prescriptions at either CVS or Walgreens, or through Express Scripts (ESI) mail order.

Other prescriptions can be filled at any in-network pharmacy.* You have the option to switch your pharmacy chain once per plan year.

*Please note, if you choose to fill maintenance medicines at CVS, Walgreens will become out-of-network for you. If you select Walgreens, CVS will become out-of-network. ESI mail order for maintenance drugs will continue to be an option at any time, even after you choose a retail network. Copayments for 90-day supplies will be the same whether filling through home delivery or the participating pharmacy.

Extras! The ConnectiCare Difference

BenefitHub Discount Program

Save on clothing, electronics, gift certificates, cars, vacations, and more.

Health Assessment Gift Card

Get a $20 gift card for answering health assessment questions.

HUSK Marketplace Wellness Discounts

- Gym and fitness center memberships.
- On-demand fitness.
- Wellness products.

Vision Discount Program

Get 25% to 30% off frames, lenses, and prescription contacts when using a participating optician.

Choosing Your Plan

You want your health care dollars to work hard for you. So, take some time to review your plan options and choose the one that meets your needs and budget.

Types of ConnectiCare Plans

Choice	You may use any of the doctors, hospitals, labs, and facilities in our large Choice Network covering Connecticut.
Value	These plans feature our tailored Value Network, which is a subset of our Choice Network. It may be the right solution for individuals who can choose care options within a more localized area. Not all hospitals and their affiliated doctors participate in the Value Network.
POS	Choosing a plan with "POS" (point of service) in its name means you'll be able to visit out-of-network doctors, but you'll pay more.
HSA	Stands for "health savings account." HSA plans allow you to save by using pre-tax money for qualified health care expenses.

Metal Levels

Here's the range of premiums and out-of-pocket costs for all types of plans.

Metal Level	Premiums	Out-of-Pocket Costs	Plan Pays*
Gold	Higher	Lower	80%
Silver	Moderate	Moderate	70%
Bronze	Lowest	Highest	60%

Networks

Using doctors in your plan's network can help save you money. Go to **connecticare.com** and use "Find a Doctor" to find doctors and facilities in your plan's network. Search by network and choose "Through Access Health CT," then choose your plan type.

*Average amount plan pays for covered services.

Financial Help Is Available

We encourage you to visit **accesshealthct.com** and enter your income information to see if you qualify for financial assistance. If you do, you will need to enroll in a plan through Access Health CT to receive financial assistance.*

Catastrophic plans are also available for eligible individuals under age 30 and for those who qualify for an affordability or hardship exemption through Access Health CT.

What Happens After You Enroll

After you enroll in an individual or family plan, if your plan has a monthly premium, you'll receive a bill. For your coverage to begin, you must pay the bill by the due date on your invoice. Please note that if you don't pay your premium on time, you will not be considered a member of the plan and any services you receive will not be covered.

Soon after your coverage is effective, you'll receive your member ID card. We encourage all members to set up an account on our member portal, **my.connecticare.com**, and select a primary care provider (PCP).

Find a glossary of health terms to know at **connecticare.com/plans/glossary**.

*Access Health CT is the only place you can get financial help to pay for your coverage.

Choice Plans

Plan name/Metal level	Choice Gold Standard POS	Choice Gold Alternative POS
NETWORK ACCESS	**Connecticut only**	**Connecticut only**
PLAN/MEDICAL DEDUCTIBLE		
Deductible (individual/family)	$1,200/$2,400	$2,000/$4,000
Maximum out-of-pocket limit (individual/family)	$7,375/$14,750	$7,900/$15,800
IN-NETWORK MEDICAL BENEFITS		
Preventive care/screenings/immunizations	$0	$0
Primary care provider (PCP) services	$20 copay (deductible waived)	$40 copay (deductible waived)
Telemedicine visits through Teladoc**	**Primary care, mental health, and general medical services:** $0 (deductible waived) **Dermatologist:** $40 copay (deductible waived)	**Primary care, mental health, and general medical services:** $0 (deductible waived) **Dermatologist:** $50 copay (deductible waived)
Specialist services	$40 copay (deductible waived)	$50 copay (deductible waived)
Mental health and substance use office visits	$20 copay (deductible waived)	$40 copay (deductible waived)
Vision	$40 copay (deductible waived)	$50 copay (deductible waived)
Walk-in/urgent care center	$50 copay (deductible waived)	30% coinsurance (deductible waived)
Worldwide emergency coverage***	$400 copay (deductible waived)	30% coinsurance after deductible
Hospital – inpatient treatment	$500 copay/day $1,000 maximum per admission after deductible	30% coinsurance after deductible
Hospital – outpatient treatment	$500 copay after deductible	30% coinsurance after deductible
Outpatient surgery in independent locations	$300 copay after deductible	$250 copay (deductible waived)
Lab services	$10 copay (deductible waived)	$10 copay (deductible waived)
X-rays	$40 copay after deductible	**Independent facility:** $50 copay (deductible waived) **Hospital facility:** 30% coinsurance after deductible
Advanced imaging (CT scans and MRI)	$65 copay $375 maximum (deductible waived)	**Independent facility:** $75 copay (deductible waived) **Hospital facility:** 30% coinsurance after deductible
OUT-OF-NETWORK MEDICAL BENEFITS		
Deductible (individual/family)	$3,000/$6,000	$7,000/$14,000
Coinsurance	30%	50%
Maximum out-of-pocket limit (individual/family)	$14,750/$29,500	$12,000/$24,000
PRESCRIPTION DRUG BENEFITS		
Prescription drug (Rx) deductible (individual/family)	$50/$100	$75/$150
Tier 1 – Generic drugs	$5 copay (deductible waived)	$10 copay (deductible waived)
Tier 2 – Preferred brand drugs	$35 copay (deductible waived)	$40 copay (deductible waived)
Tier 3 – Non-preferred brand drugs	$60 copay (deductible waived)	$60 copay after Rx deductible
Tier 4 – Specialty drugs	20% coinsurance $100 maximum per prescription after Rx deductible	20% coinsurance $150 maximum per prescription after Rx deductible

*Integrated medical and prescription drug deductible.

**Telemedicine is not appropriate for all covered services, and restrictions apply. For primary care, members must be 18 or older; for Teladoc mental health services, members must be 13 or older.

***Subject to limitations.

Choice Bronze Standard POS	Choice Bronze Alternative POS With Dental	Choice Bronze Standard POS HSA
Connecticut only	**Connecticut only**	**Connecticut only**
$6,550/$13,100*	$7,000/$14,000*	$6,500/$13,000*
$9,100/$18,200	$9,200/$18,400	$7,225/$14,450
$0	$0	$0
$40 copay (deductible waived)	$50 copay (deductible waived)	20% coinsurance after deductible
Primary care, mental health, and general medical services: $0 (deductible waived) **Dermatologist:** $70 copay after deductible	**Primary care, mental health, and general medical services:** $0 (deductible waived) **Dermatologist:** $70 copay after deductible	**Primary care, mental health, and general medical services:** 0% coinsurance after deductible **Dermatologist:** 20% coinsurance after deductible
$70 copay after deductible	$70 copay after deductible	20% coinsurance after deductible
$40 copay (deductible waived)	$50 copay (deductible waived)	20% coinsurance after deductible
$70 copay after deductible	$70 copay (deductible waived)	20% coinsurance after deductible
$75 copay (deductible waived)	$100 copay (deductible waived)	20% coinsurance after deductible
$450 copay after deductible	45% coinsurance after deductible	20% coinsurance after deductible
$500 copay/day $1,000 maximum per admission after deductible	45% coinsurance after deductible	20% coinsurance after deductible
$500 copay after deductible	45% coinsurance after deductible	20% coinsurance after deductible
$300 copay after deductible	$500 copay after deductible	20% coinsurance after deductible
$20 copay (deductible waived)	$25 copay after deductible	20% coinsurance after deductible
$40 copay after deductible	**Independent facility:** $70 copay after deductible **Hospital facility:** 45% coinsurance after deductible	20% coinsurance after deductible
$75 copay $375 maximum after deductible	**Independent facility:** $75 copay after deductible **Hospital facility:** 45% coinsurance after deductible	20% coinsurance after deductible
$13,100/$26,200	$15,000/$30,000	$13,000/$26,000
50%	50%	50%
$18,200/$36,400	$20,000/$40,000	$14,450/$28,900
Plan has integrated deductible with medical (see above)*	Plan has integrated deductible with medical (see above)*	Plan has integrated deductible with medical (see above)*
$15 copay (deductible waived)	$30 copay (deductible waived)	20% coinsurance after deductible
$50 copay (deductible waived)	$100 copay after deductible	25% coinsurance after deductible
50% coinsurance after deductible	50% coinsurance after deductible	30% coinsurance after deductible
50% coinsurance $500 maximum per prescription after deductible	50% coinsurance $500 maximum per prescription after deductible	30% coinsurance $500 maximum per prescription after deductible

Choice Plans

Plan name/Metal level	Choice Silver Standard POS	Choice Silver Standard POS (CSR 73%)
		Available for i
NETWORK ACCESS	**Connecticut only**	**Connecticut only**
PLAN/MEDICAL DEDUCTIBLE		
Deductible (individual/family)	$5,000/$10,000	$5,000/$10,000
Maximum out-of-pocket limit (individual/family)	$9,100/$18,200	$7,350/$14,700
IN-NETWORK MEDICAL BENEFITS		
Preventive care/screenings/immunizations	$0	$0
Primary care provider (PCP) services	$40 copay (deductible waived)	$40 copay (deductible waived)
Telemedicine visits through Teladoc***	**Primary care, mental health, and general medical services:** $0 (deductible waived) **Dermatologist:** $60 copay (deductible waived)	**Primary care, mental health, and general medical services:** $0 (deductible waived) **Dermatologist:** $60 copay (deductible waived)
Specialist services	$60 copay (deductible waived)	$60 copay (deductible waived)
Mental health and substance use office visits	$40 copay (deductible waived)	$40 copay (deductible waived)
Vision	$60 copay (deductible waived)	$60 copay (deductible waived)
Walk-in/urgent care center	$75 copay (deductible waived)	$75 copay (deductible waived)
Worldwide emergency coverage†	$450 copay after deductible	$450 copay after deductible
Hospital – inpatient treatment	$500 copay/day $2,000 maximum per admission after deductible	$500 copay/day $2,000 maximum per admission after deductible
Hospital – outpatient treatment	$500 copay after deductible	$500 copay after deductible
Outpatient surgery in independent locations	$300 copay after deductible	$300 copay after deductible
Lab services	$25 copay (deductible waived)	$25 copay (deductible waived)
X-rays	$40 copay after deductible	$40 copay after deductible
Advanced imaging (CT scans and MRI)	$75 copay $375 maximum (deductible waived)	$75 copay $375 maximum (deductible waived)
OUT-OF-NETWORK MEDICAL BENEFITS		
Deductible (individual/family)	$10,000/$20,000	$10,000/$20,000
Coinsurance	40%	40%
Maximum out-of-pocket limit (individual/family)	$18,200/$36,400	$18,200/$36,400
PRESCRIPTION DRUG BENEFITS		
Prescription drug (Rx) deductible (individual/family)	$250/$500	$250/$500
Tier 1 – Generic drugs	$10 copay (deductible waived)	$10 copay (deductible waived)
Tier 2 – Preferred brand drugs	$45 copay after Rx deductible	$45 copay after Rx deductible
Tier 3 – Non-preferred brand drugs	$70 copay after Rx deductible	$70 copay after Rx deductible
Tier 4 – Specialty drugs	20% coinsurance $200 maximum per prescription after Rx deductible	20% coinsurance $100 maximum per prescription after Rx deductible

* Catastrophic plans are available to those under age 30 and those who qualify for an affordability or hardship exemption through Access Health CT. .

**Integrated medical and prescription drug deductible.

***Telemedicine is not appropriate for all covered services, and restrictions apply. For primary care, members must be 18 or older; for Teladoc mental health services, members must be 13 or older.

†Subject to limitations.

Choice Silver Standard POS (CSR 87%)	Choice Silver Standard POS (CSR 94%)	Choice Catastrophic POS With Dental*
ndividuals and families up to 250% of the federal poverty level.		
Connecticut only	**Connecticut only**	**Connecticut only**
$475/$950	None	$9,200/$18,400**
$2,725/$5,450	$1,150/$2,300	$9,200/$18,400
$0	$0	$0
$20 copay (deductible waived)	$10 copay	$30 copay per visit for the first 3 visits Deductible applies for additional visits $0 after deductible
Primary care, mental health, and general medical services: $0 (deductible waived) **Dermatologist:** $45 copay (deductible waived)	**Primary care, mental health, and general medical services:** $0 **Dermatologist:** $30 copay	**Primary care, mental health, and general medical services:** $0 after deductible **Dermatologist:** $0 after deductible
$45 copay (deductible waived)	$30 copay	$0 after deductible
$20 copay (deductible waived)	$10 copay	$30 copay per visit for the first 3 visits Deductible applies for additional visits $0 after deductible
$45 copay (deductible waived)	$30 copay	$0 after deductible
$35 copay (deductible waived)	$25 copay	$0 after deductible
$150 copay after deductible	$50 copay	$0 after deductible
$100 copay/day $400 maximum per admission after deductible	$75 copay/day $300 maximum per admission	$0 after deductible
$100 copay after deductible	$75 copay	$0 after deductible
$60 copay after deductible	$45 copay	$0 after deductible
$10 copay (deductible waived)	$10 copay	$0 after deductible
$30 copay after deductible	$25 copay	$0 after deductible
$60 copay $360 maximum (deductible waived)	$50 copay $350 maximum	$0 after deductible
$10,000/$20,000	$10,000/$20,000	$15,000/$30,000
40%	40%	50%
$18,200/$36,400	$18,200/$36,400	$20,000/$40,000
$50/$100	None	Plan has integrated deductible with medical (see above)**
$10 copay (deductible waived)	$5 copay	$0 after deductible
$25 copay (deductible waived)	$10 copay	$0 after deductible
$40 copay after Rx deductible	$30 copay	$0 after deductible
20% coinsurance $60 maximum per prescription after Rx deductible	20% coinsurance $60 maximum per prescription	$0 after deductible

Value Plans

Plan name/Metal level	Value Gold Standard POS
NETWORK ACCESS	**Tailored network in Connecticut only**
PLAN/MEDICAL DEDUCTIBLE	
Deductible (individual/family)	$1,200/$2,400
Maximum out-of-pocket limit (individual/family)	$7,375/$14,750
IN-NETWORK MEDICAL BENEFITS	
Preventive care/screenings/immunizations	$0
Primary care provider (PCP) services	$20 copay (deductible waived)
Telemedicine visits through Teladoc**	**Primary care, mental health, and general medical services:** $0 (deductible waived)/**Dermatologist:** $40 copay (deductible waived)
Specialist services (some specialist services require a PCP's referral.)	$40 copay (deductible waived)
Mental health and substance use office visits	$20 copay (deductible waived)
Vision	$40 copay (deductible waived)
Walk-in/urgent care center	$50 copay (deductible waived)
Worldwide emergency coverage***	$400 copay (deductible waived)
Hospital – inpatient treatment	$500 copay/day $1,000 maximum per admission after deductible
Hospital – outpatient treatment	$500 copay after deductible
Outpatient surgery in independent locations	$300 copay after deductible
Lab services	$10 copay (deductible waived)
X-rays	$40 copay after deductible
Advanced imaging (CT scans and MRI)	$65 copay $375 maximum (deductible waived)
OUT-OF-NETWORK MEDICAL BENEFITS	
Deductible (individual/family)	$3,000/$6,000
Coinsurance	30%
Maximum out-of-pocket limit (individual/family)	$14,750/$29,500
PRESCRIPTION DRUG BENEFITS	
Prescription drug (Rx) deductible (individual/family)	$50/$100
Tier 1 – Generic drugs	$5 copay (deductible waived)
Tier 2 – Preferred brand drugs	$35 copay (deductible waived)
Tier 3 – Non-preferred brand drugs	$60 copay (deductible waived)
Tier 4 – Specialty drugs	20% coinsurance $100 maximum per prescription after Rx deductible

*Integrated medical and prescription drug deductible.

**Telemedicine is not appropriate for all covered services, and restrictions apply. For primary care, members must be 18 or older; for Teladoc mental health services, members must be 13 or older.

***Subject to limitations.

Value Bronze Standard POS	Value Bronze Standard POS HSA
Tailored network in Connecticut only	**Tailored network in Connecticut only**
$6,550/$13,100*	$6,500/$13,000*
$9,100/$18,200	$7,225/$14,450
$0	$0
$40 copay (deductible waived)	20% coinsurance after deductible
Primary care, mental health, and general medical services: $0 (deductible waived)/**Dermatologist:** $70 copay after deductible	**Primary care, mental health, and general medical services:** 0% coinsurance after deductible **Dermatologist:** 20% coinsurance after deductible
$70 copay after deductible	20% coinsurance after deductible
$40 copay (deductible waived)	20% coinsurance after deductible
$70 copay after deductible	20% coinsurance after deductible
$75 copay (deductible waived)	20% coinsurance after deductible
$450 copay after deductible	20% coinsurance after deductible
$500 copay/day $1,000 maximum per admission after deductible	20% coinsurance after deductible
$500 copay after deductible	20% coinsurance after deductible
$300 copay after deductible	20% coinsurance after deductible
$20 copay (deductible waived)	20% coinsurance after deductible
$40 copay after deductible	20% coinsurance after deductible
$75 copay $375 maximum after deductible	20% coinsurance after deductible
$13,100/$26,200	$13,000/$26,000
50%	50%
$18,200/$36,400	$14,450/$28,900
Plan has integrated deductible with medical (see above)*	Plan has integrated deductible with medical (see above)*
$15 copay (deductible waived)	20% coinsurance after deductible
$50 copay (deductible waived)	25% coinsurance after deductible
50% coinsurance after deductible	30% coinsurance after deductible
50% coinsurance $500 maximum per prescription after deductible	30% coinsurance $500 maximum per prescription after deductible

Value Plans

Plan name/Metal level	Value Silver Standard POS
NETWORK ACCESS	**Tailored network in Connecticut only**
PLAN/MEDICAL DEDUCTIBLE	
Deductible (individual/family)	$5,000/$10,000
Maximum out-of-pocket limit (individual/family)	$9,100/$18,200
IN-NETWORK MEDICAL BENEFITS	
Preventive care/screenings/immunizations	$0
Primary care provider (PCP) services	$40 copay (deductible waived)
Telemedicine visits through Teladoc*	**Primary care, mental health, and general medical services:** $0 (deductible waived) **Dermatologist:** $60 copay (deductible waived)
Specialist services	$60 copay (deductible waived)
Mental health and substance use office visits	$40 copay (deductible waived)
Vision	$60 copay (deductible waived)
Walk-in/urgent care center	$75 copay (deductible waived)
Worldwide emergency coverage**	$450 copay after deductible
Hospital – inpatient treatment	$500 copay/day $2,000 maximum per admission after deductible
Hospital – outpatient treatment	$500 copay after deductible
Outpatient surgery in independent locations	$300 copay after deductible
Lab services	$25 copay (deductible waived)
X-rays	$40 copay after deductible
Advanced imaging (CT scans and MRI)	$75 copay $375 maximum (deductible waived)
OUT-OF-NETWORK MEDICAL BENEFITS	
Deductible (individual/family)	$10,000/$20,000
Coinsurance	40%
Maximum out-of-pocket limit (individual/family)	$18,200/$36,400
PRESCRIPTION DRUG BENEFITS	
Prescription drug (Rx) deductible (individual/family)	$250/$500
Tier 1 – Generic drugs	$10 copay (deductible waived)
Tier 2 – Preferred brand drugs	$45 copay after Rx deductible
Tier 3 – Non-preferred brand drugs	$70 copay after Rx deductible
Tier 4 – Specialty drugs	20% coinsurance $200 maximum per prescription after Rx deductible

*Telemedicine is not appropriate for all covered services, and restrictions apply. For primary care, members must be 18 or older; for Teladoc mental health services, members must be 13 or older.

**Subject to limitations.

Value Silver Standard POS (CSR 73%)	Value Silver Standard POS (CSR 87%)	Value Silver Standard POS (CSR 94%)
Available to individuals and families up to 250% of the federal poverty level.		
Tailored network in Connecticut only	Tailored network in Connecticut only	Tailored network in Connecticut only
$5,000/$10,000	$475/$950	None
$7,350/$14,700	$2,725/$5,450	$1,150/$2,300
$0	$0	$0
$40 copay (deductible waived)	$20 copay (deductible waived)	$10 copay
Primary care, mental health, and general medical services: $0 (deductible waived) **Dermatologist:** $60 copay (deductible waived)	**Primary care, mental health, and general medical services:** $0 (deductible waived) **Dermatologist:** $45 copay (deductible waived)	**Primary care, mental health, and general medical services:** $0 **Dermatologist:** $30 copay
$60 copay (deductible waived)	$45 copay (deductible waived)	$30 copay
$40 copay (deductible waived)	$20 copay (deductible waived)	$10 copay
$60 copay (deductible waived)	$45 copay (deductible waived)	$30 copay
$75 copay (deductible waived)	$35 copay (deductible waived)	$25 copay
$450 copay after deductible	$150 copay after deductible	$50 copay
$500 copay/day $2,000 maximum per admission after deductible	$100 copay/day $400 maximum per admission after deductible	$75 copay/day $300 maximum per admission
$500 copay after deductible	$100 copay after deductible	$75 copay
$300 copay after deductible	$60 copay after deductible	$45 copay
$25 copay (deductible waived)	$10 copay (deductible waived)	$10 copay
$40 copay after deductible	$30 copay after deductible	$25 copay
$75 copay $375 maximum (deductible waived)	$60 copay $360 maximum (deductible waived)	$50 copay $350 maximum
$10,000/$20,000	$10,000/$20,000	$10,000/$20,000
40%	40%	40%
$18,200/$36,400	$18,200/$36,400	$18,200/$36,400
$250/$500	$50/$100	None
$10 copay (deductible waived)	$10 copay (deductible waived)	$5 copay
$45 copay after Rx deductible	$25 copay (deductible waived)	$10 copay
$70 copay after Rx deductible	$40 copay after Rx deductible	$30 copay
20% coinsurance $100 maximum per prescription after Rx deductible	20% coinsurance $60 maximum per prescription after Rx deductible	20% coinsurance $60 maximum per prescription

ConnectiCare Basic Dental Plan

Plan Overview		In-Network (INET) Member Pays	Out-of-Network (ONET) Member Pays
Deductible (does not apply to preventive and diagnostic services for in-network services)		$50 per member, up to 3 family members	$50 per member, up to 3 family members
Out-of-Pocket Maximum* For one child For two or more children		$350 $700	None
Diagnostic Services	**Limitations**		
Oral Exams	Two (2) times per year.	$0	30% after ONET deductible is met ($0 for covered persons under age 26)
Periapical Radiographs	Four (4) per year.		
Bitewing Radiographs	Four (4) bitewing x-rays per member per year.		
Panoramic or Complete Series Radiographs	One (1) full-mouth series of x-rays or one (1) panoramic film once every three (3) years.		
Preventive Services			
Cleanings	Two (2) times per year.	$0	30% after ONET deductible is met ($0 for covered persons under age 26)
Periodontal Scaling and Root Planing	Covered one (1) time per 36 months per quadrant.		
Periodontal Maintenance	Once every three (3) months following periodontic surgery.		
Fluoride*	Two (2) times per year.		
Sealants*	One (1) sealant per covered tooth every three (3) calendar years per covered child age 6 until age 14 birthdate.		
Basic Services (for covered persons under age 26 only*)			
Fillings	Fillings, excludes temporary fillings, covered per tooth every six (6) months.	20% after INET deductible is met	40% after ONET deductible is met
Simple Extractions	Routine removal of a tooth or teeth.		
Major Services (for covered persons under age 26 only*)			
Surgical Extractions	Surgery for removal of erupted tooth, fractured jaws, impactions, and lesions are covered. Corrective jaw surgery and surgery relating to accidental injury is not covered.	40% after INET deductible is met	50% after ONET deductible is met
Endodontic Therapy (i.e., Root Canal Treatment)	One (1) pulpotomy per tooth per lifetime. Pulp capping is not covered.		
Periodontal Therapy	Five (5) treatments of diseases of the gums and jaw, including two (2) periodontal maintenance procedure, per member per calendar year.		
Crowns and Cast Restorations	Includes: crowns; inlays; prosthetic services; removable, complete, and partial dentures; fixed bridges; crowns or inlays used as abutments. Replacements covered after five (5) years.		
Prosthodontics (Complete and Partial Dentures; Fixed Bridgework)	Includes: permanent dentures, fixed bridgework, and removable partial dentures; posts if evidence of root canal therapy on the tooth; pins once every six (6) months. Replacements covered after five (5) years from date of service. Insertion of fixed bridge and partial denture in same arch covered after five (5) years from date of service. Adjustment of appliances is covered after one (1) year of insertion.		
Other Services (for covered persons under age 26 only*)			
Medically Necessary Orthodontic	Includes office visits, orthodontic appliance, follow-up visits, and retention. Existing appliances are not covered.	50% after INET deductible is met	50% after ONET deductible is met

Annual Plan Maximums	
Plan Maximum (for covered persons under age 26*)	None
Plan Maximum (combined for in-network and out-of-network services for covered persons age 26 and older*)	$1,000 per person

*For child, stepchild, or other dependent child until end of plan year once dependent turns age 26.

Important Information
• This is a brief summary of benefits. Refer to your ConnectiCare Insurance Company, Inc. policy for complete details on coverage and benefits.
• If you have questions regarding your plan, please call Member Services at **855-999-2329** (TTY: **711**).
• Covered services provided by a non-participating dentist will be reimbursed at the maximum allowed amount. Members are responsible to pay the difference between the maximum allowable amount and the amount the provider charges. Please refer to your ConnectiCare Insurance Company, Inc. policy for more information.
• For a list of participating dentists, please call Member Services at **855-999-2329** (TTY: **711**) or visit **connecticare.com.**

ConnectiCare Standard Dental Plan

Plan Overview		In-Network (INET) Member Pays	Out-of-Network (ONET) Member Pays
Deductible (does not apply to preventive and diagnostic services for in-network services)		$60 per member, up to 3 family members	$60 per member, up to 3 family members
Out-of-Pocket Maximum* For one child For two or more children		$350 $700	None
Diagnostic Services	**Limitations**		
Oral Exams	Two (2) times per year.	$0	20% after ONET deductible is met
Periapical Radiographs	Four (4) per year.		
Bitewing Radiographs	Four (4) bitewing x-rays per member per year.		
Panoramic or Complete Series Radiographs	One (1) full-mouth series of x-rays or one (1) panoramic film once every three (3) years.		
Preventive Services			
Cleanings	Two (2) times per year.	$0	20% after ONET deductible is met
Periodontal Scaling and Root Planing	Covered one (1) time per 36 months per quadrant.		
Periodontal Maintenance	Once every three (3) months following periodontic surgery.		
Fluoride*	Two (2) times per year.		
Sealants*	One (1) sealant per covered tooth every three (3) calendar years per covered child age 6 until age 14 birthdate.		
Basic Services (waiting period applies to covered persons over age 26*)			
Fillings	Fillings, excludes temporary fillings, covered per tooth every six (6) months.	20% after INET deductible is met	40% after ONET deductible is met
Simple Extractions	Routine removal of a tooth or teeth.		
Major Services (waiting period applies to covered persons over age 26*)			
Surgical Extractions	Surgery for removal of erupted tooth, fractured jaws, impactions, and lesions are covered. Corrective jaw surgery and surgery relating to accidental injury is not covered.	40% after INET deductible is met	50% after ONET deductible is met
Endodontic Therapy (i.e., Root Canal Treatment)	One (1) pulpotomy per tooth per lifetime. Pulp capping is not covered.		
Periodontal Therapy	Five (5) treatments of diseases of the gums and jaw, including two (2) periodontal maintenance procedure, per member per calendar year.		
Crowns and Cast Restorations	Includes: crowns; inlays; prosthetic services; removable, complete, and partial dentures; fixed bridges; crowns or inlays used as abutments. Replacements covered after five (5) years.		
Prosthodontics (Complete and Partial Dentures; Fixed Bridgework)	Includes: permanent dentures, fixed bridgework; and removable partial dentures; posts if evidence of root canal therapy on the tooth; pins once every six (6) months. Replacements covered after five (5) years from date of service. Insertion of fixed bridge and partial denture in same arch covered after five (5) years from date of service. Adjustment of appliances is covered after one (1) year of insertion.		
Other Services (for covered persons under age 26 only*)			
Medically Necessary Orthodontic Services	Includes office visits, orthodontic appliance, follow-up visits, and retention. Existing appliances are not covered.	50% after INET deductible is met	50% after ONET deductible is met

Waiting Periods (for covered persons over age 26*)	
Applicable Waiting Period for Benefit	
Diagnostic and Preventive Services	No waiting period
Basic Services	6 months ^
Major Services	12 months ^

^Waiver of waiting period available with proof of prior coverage for these services under a dental insurance plan when the termination date was no more than 30 days prior to the effective date of this plan.

Annual Plan Maximums	
Plan Maximum (for covered persons under age 26*)	None
Plan Maximum (combined for in-network and out-of-network services for covered persons age 26 and older[1])	$2,000 per person

*For child, stepchild, or other dependent child until end of plan year once dependent turns 26.

Important Information

- This is a brief summary of benefits. Refer to your ConnectiCare Insurance Company, Inc. policy for complete details on coverage and benefits.
- If you have questions regarding your plan, please call Member Services at **855-999-2329** (TTY: **711**).
- Covered services provided by a non-participating dentist will be reimbursed at the maximum allowed amount. Members are responsible to pay the difference between the maximum allowable amount and the amount the provider charges. Please refer to your ConnectiCare Insurance Company, Inc. policy for more information.
- For a list of participating dentists, please call Member Services at **855-999-2329** (TTY: **711**) or visit **connecticare.com.**

Covered Connecticut Program

Created by the State of Connecticut and administered by the Connecticut Department of Social Services, the Covered Connecticut Program offers eligible individuals medical and dental benefits as well as Non-Emergency Medical Transportation for **$0 a month**!

Here's how it works: To be in the Covered Connecticut Program, you must enroll in a silver-level health plan through Access Health CT and use 100% of the advanced Premium Tax Credit (APTC) available to you. The State will then pay the monthly premium, as well as other costs such as deductibles and copays.

Who qualifies for the Covered Connecticut Program? This Program may benefit people who have recently lost coverage through HUSKY Health/Medicaid or can't afford health insurance.

You must:

- Be a Connecticut resident age 19-64.
- Have household income up to and including 175% of the Federal Poverty Level (FPL) and be ineligible for HUSKY Health/Medicaid due to income.
- Be eligible for financial help, including APTC and Cost-Sharing Reductions (CSRs), and use 100% of the available financial help.
- Enroll in a silver-level plan through Access Health CT.

Covered Connecticut Income Guidelines

Household Size	1	2	3	4	5	6	7	8
Income Limit	$26,355	$35,770	$45,185	$54,600	$64,015	$73,430	$82,845	$92,260

Get covered through the Covered Connecticut Program today! Call Access Health CT at **855-805-4325**, visit **accesshealthct.com** or call ConnectiCare at **833-545-1088** (TTY: **711**).

Covered Connecticut Program plans

Plan name	Covered Connecticut Program (87)	
NETWORK ACCESS	**Choice, Connecticut Only**	
	Member Pays	**State Pays**
PLAN/MEDICAL DEDUCTIBLE		
Deductible (individual/family)	None	$475/$950
Maximum out-of-pocket limit (individual/family)	None	$2,725/$5,450
IN-NETWORK MEDICAL BENEFITS		
Preventive care/screenings/immunizations	$0	$0
Primary care provider (PCP) services	$0	$20 copay (deductible waived)
Telemedicine visits through Teladoc*	$0	Primary care, mental health, and general medical services: $0 (deductible waived)/ Dermatologist: $45 copay (deductible waived)
Specialist services	$0	$45 copay (deductible waived)
Mental health and substance use office visits	$0	$20 copay (deductible waived)
Vision	$0	$45 copay (deductible waived)
Walk-in/urgent care center	$0	$35 copay (deductible waived)
Worldwide emergency coverage**	$0	$150 copay after deductible
Hospital – inpatient treatment	$0	$100 copay/day $400 maximum per admission after deductible
Hospital – outpatient treatment	$0	$100 copay after deductible
Outpatient surgery in independent locations	$0	$60 copay after deductible
Lab services	$0	$10 copay (deductible waived)
X-rays	$0	$30 copay after deductible
Advanced imaging (CT scans and MRI)	$0	$60 copay $360 maximum (deductible waived)
PRESCRIPTION DRUG BENEFITS		
Prescription drug (Rx) deductible (individual/family)	None	$50/$100
Tier 1 – Generic drugs	$0	$10 copay (deductible waived)
Tier 2 – Preferred brand drugs	$0	$25 copay (deductible waived)
Tier 3 – Non-preferred brand drugs	$0	$40 copay after Rx deductible
Tier 4 – Specialty drugs	$0	20% coinsurance $60 maximum per prescription after Rx deductible

*Telemedicine is not appropriate for all covered services, and restrictions apply.

**Subject to limitations.

Covered Connecticut Program (94)		Covered Connecticut Program (87)		Covered Connecticut Program (94)	
Choice, Connecticut Only		Value, Tailored Network in Connecticut Only		Value, Tailored Network in Connecticut Only	
Member Pays	State Pays	Member Pays	State Pays	Member Pays	State Pays
None	None	None	$475/$950	None	None
None	$1,150/$2,300	None	$2,725/$5,450	None	$1,150/$2,300
$0	$0	$0	$0	$0	$0
$0	$10 copay	$0	$20 copay (deductible waived)	$0	$10 copay
$0	Primary care, mental health, and general medical services: $0 Dermatologist: $30 copay	$0	Primary care, mental health, and general medical services: $0 (deductible waived)Dermatologist: $45 copay (deductible waived)	$0	Primary care, mental health, and general medical services: $0 Dermatologist: $30 copay
$0	$30 copay	$0	$45 copay (deductible waived)	$0	$30 copay
$0	$10 copay	$0	$20 copay (deductible waived)	$0	$10 copay
$0	$30 copay	$0	$45 copay (deductible waived)	$0	$30 copay
$0	$25 copay	$0	$35 copay (deductible waived)	$0	$25 copay
$0	$50 copay	$0	$150 copay after deductible	$0	$50 copay
$0	$75 copay/day $300 maximum per admission	$0	$100 copay/day $400 maximum per admission after deductible	$0	$75 copay/day $300 maximum per admission
$0	$75 copay	$0	$100 copay after deductible	$0	$75 copay
$0	$45 copay	$0	$60 copay after deductible	$0	$45 copay
$0	$10 copay	$0	$10 copay (deductible waived)	$0	$10 copay
$0	$25 copay	$0	$30 copay after deductible	$0	$25 copay
$0	$50 copay $350 maximum	$0	$60 copay $360 maximum (deductible waived)	$0	$50 copay $350 maximum
None	None	None	$50/$100	None	None
$0	$5 copay	$0	$10 copay (deductible waived)	$0	$5 copay
$0	$10 copay	$0	$25 copay (deductible waived)	$0	$10 copay
$0	$30 copay	$0	$40 copay after Rx deductible	$0	$30 copay
$0	20% coinsurance $60 maximum per prescription	$0	20% coinsurance $60 maximum per prescription after Rx deductible	$0	20% coinsurance $60 maximum per prescription

175 Scott Swamp Road, Farmington, CT 06032 | connecticare.com

ConnectiCare

Call us at **800-723-2986** (TTY: **711**)
8 a.m. to 5 p.m., Monday through Friday

Extended hours Nov. 1 through Jan. 15:
8 a.m. to 7 p.m., Monday through Friday

Visit **chooseconnecticare.com** or **accesshealthct.com** to compare plan benefits, features, and premium rates.

Meet with us at a ConnectiCare Center. Go to **visitconnecticare.com** or call **877-523-6837** (TTY: **711**) to find locations and make an appointment.

To learn more, scan this QR code with your smartphone.

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