



Small Group Market
FlexPOS \$30/\$50 \$2,000
Fixed Funding Solutions
Open Access Contract Plan Year
Benefit Summary
Non-Tiered Network Plan

Your ConnectiCare health plan helps you get the care you need. Here are the most frequently used services. Refer to your employer's Health Plan Description for a complete list of benefits. All benefits described below are per member per plan year.

| Deductible and Out-of-Pocket Maximum | In-Network (INET) Member Pays | Out-of-network (OON) Member Pays |
|---|--|--|
| Plan deductible | \$2,000 per member \$4,000 per family | \$4,000 per member \$8,000 per family |
| Separate Prescription Drug Deductible | None | Included in plan deductible |
| Out-of-Pocket Maximum Includes a combination of deductible, copayments and coinsurance for medical and pharmacy services | \$5,500 per member \$11,000 per family | \$11,000 per member \$22,000 per family |
| Benefits | In-Network (INET) Member Pays | Out-of-network (OON) Member Pays |
| Provider Office Visits | | |
| Adult/Pediatric Preventive Visits | No charge (frequency is based on age/ gender) | 50% coinsurance after plan deductible |
| Primary Care Provider Office/ Telemedicine Visits includes services for illness, injury, follow-up care and consultations | \$30 copayment/visit; deductible does not apply | 50% coinsurance after plan deductible |
| Telemedicine Services services rendered by a Teladoc® provider Primary Care - members must be 18 or older | Primary Care, Mental Health and General Medical Services: No charge Dermatologist: \$50 copayment/visit; deductible does not apply | 50% coinsurance after plan deductible |

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FlexPOS 30 50 136288
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| Benefits | In-Network (INET) Member Pays | Out-of-network (OON) Member Pays |
|---|---|--|
| Specialist Office/Telemedicine Visits | \$50 copayment/visit; deductible does not apply | 50% coinsurance after plan deductible |
| Mental Health and Substance Abuse Office Visits | \$50 copayment/visit; deductible does not apply | 50% coinsurance after plan deductible |
| Outpatient Diagnostic Services | | |
| Advanced Radiology CT/PET Scan, MRI | Independent Facility: \$100 copayment/service; deductible does not apply, up to five copayments per year, then copayment waived Hospital Facility: \$100 copayment/service after plan deductible | 50% coinsurance after plan deductible |
| Laboratory Services | \$10 copayment/visit; deductible does not apply | 50% coinsurance after plan deductible |
| Non-Advanced Radiology (X-ray, Diagnostic) | \$40 copayment/service; deductible does not apply | 50% coinsurance after plan deductible |
| Mammography Ultrasound | \$40 copayment/service; deductible does not apply | 50% coinsurance after plan deductible |
| Prescription Drugs - Retail Pharmacy (cost share based on 30 day supply per prescription) | | |
| Preferred Generic Tier 1 | \$10 copayment/prescription; deductible does not apply | 50% coinsurance after plan deductible |
| Non-preferred Generic Tier 2 | 50% coinsurance up to a maximum of \$250 per prescription; deductible does not apply | 50% coinsurance after plan deductible |
| Preferred Brand Tier 3 | \$50 copayment/prescription; deductible does not apply | 50% coinsurance after plan deductible |
| Non-Preferred Brand Tier 4 | 50% coinsurance up to a maximum of \$500 per prescription; deductible does not apply | 50% coinsurance after plan deductible |
| Specialty Drugs - (cost share up to 30 day supply per prescription - These drugs generally require pre-authorization and may require special handling) | | |
| Preferred Specialty Tier 5 | 50% coinsurance up to a maximum of \$500 per prescription; deductible does not apply | Not covered |
| Non-Preferred Specialty Tier 6 | 50% coinsurance up to a maximum of \$750 per prescription; deductible does not apply | Not covered |
| Prescription - Mail Order Pharmacy (up to a 90 day supply per prescription) | | |

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|---|---|--|
| Preferred Generic Tier 1 | \$20 copayment/prescription; deductible does not apply | Not covered |
| Non-preferred Generic Tier 2 | 50% coinsurance up to a maximum of \$500 per prescription; deductible does not apply | Not covered |
| Preferred Brand Tier 3 | \$100 copayment/prescription; deductible does not apply | Not covered |
| Non-Preferred Brand Tier 4 | 50% coinsurance up to a maximum of \$1,000 per prescription; deductible does not apply | Not covered |
| Outpatient Rehabilitative Services (40 visits per contract year limit combined for Rehabilitative physical, speech and occupational therapies.) | | |
| Speech Therapy | \$50 copayment/visit; deductible does not apply | 50% coinsurance after plan deductible |
| Physical and Occupational Therapy | \$50 copayment/visit; deductible does not apply | 50% coinsurance after plan deductible |
| Other Services | | |
| Chiropractic Services up to 20 visits per contract year | \$50 copayment/visit; deductible does not apply | 50% coinsurance after plan deductible |
| Diabetic Equipment and Supplies | 50% coinsurance; deductible does not apply | 50% coinsurance after plan deductible |
| Durable Medical Equipment (DME) including prosthetics and disposable medical supplies | 50% coinsurance; deductible does not apply | 50% coinsurance after plan deductible |
| Home Health Care Services up to 100 visits per contract year | No charge | 50% coinsurance after plan deductible |
| Outpatient Services in a hospital or ambulatory facility | \$500 copayment/visit after plan deductible | 50% coinsurance after plan deductible |
| Inpatient Services | | |
| Inpatient hospital services include mental health, substance abuse, maternity, hospice, skilled nursing facility* and all IP settings. *skilled nursing facility stay is limited to 90 days per contract year | \$500 per day up to \$2,500 per admission after plan deductible | 50% coinsurance after plan deductible |
| Emergency and Urgent Care | | |

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| Ambulance Services | \$200 copayment per trip; deductible does not apply | Same as In-network benefit |
| Emergency Room copayment waived if admitted | \$350 copayment/visit; deductible does not apply | Same as In-network benefit |
| Walk-In Center | \$75 copayment/visit; deductible does not apply | Same as In-network benefit |
| Additional Covered Services | | |
| Routine Eye Exam by a Specialist one exam per contract year | \$50 copayment/visit; deductible does not apply | 50% coinsurance after plan deductible |
| Allergy Injections up to 20 visits per contract year | Refer to your applicable primary care or specialist cost share | 50% coinsurance after plan deductible |
| Allergy Testing up to one visit per contract year | Refer to your applicable primary care or specialist cost share | 50% coinsurance after plan deductible |
| Baseline Routine Mammography ages 35-39 | \$40 copayment/service; deductible does not apply | 50% coinsurance after plan deductible |
| Annual routine mammography age 40 or older | No charge | 50% coinsurance after plan deductible |
| Gynecologist Services | \$50 copayment/visit; deductible does not apply | 50% coinsurance after plan deductible |
| Outpatient mental health, alcohol and substance abuse treatment intensive outpatient treatment and partial hospitalization | \$100 copayment/visit; deductible does not apply | 50% coinsurance after plan deductible |
| Prenatal Office Visits May not apply to all laboratory and radiology services - refer to your plan documents | No charge | 50% coinsurance after plan deductible |
| Retail Clinic | \$30 copayment/visit; deductible does not apply | 50% coinsurance after plan deductible |
| Important information | | |
| <ul style="list-style-type: none"> • This is a brief summary of benefits. Refer to your employer's Health Plan Description for complete details on benefits, conditions, limitations and exclusions, or consult with your benefits manager. All benefits described are per member per plan year. • If you have questions regarding your plan, visit our website at www.connecticare.com or call us at (860) 674-5757 or 1-800-251-7722. • Out-of-network reimbursement is based on the maximum allowable amount. Members are responsible to pay any charges in excess of this amount. Please refer to your employer's Health Plan Description for more information. • If you are a Massachusetts resident, this plan along with pharmacy services meets Massachusetts Minimum Creditable Coverage standards for 2024. | | |

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- To learn more about your Teladoc® benefits contact Teladoc® at teladoc.com/connecticare or call 1-800-835-2362 (TTY:711).
- 90-day supply of maintenance medications must be filled through Express Scripts home delivery or at either a participating CVS or Walgreens pharmacy. Each member has a choice of the pharmacy used.
- 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 drug's or supply's clinical effectiveness and cost, not on whether it is a generic drug or supply or brand name drug or supply.
- Most specialty drugs are dispensed through specialty pharmacies by mail, up to a 30 day supply. Specialty pharmacies have the same member cost share as all other participating pharmacies and are not part of ConnectiCare's Mandatory mail order program. The member cost share for specialty pharmacy is different from the cost share for ConnectiCare's mail order program.
- Your plan is administered by ConnectiCare Insurance Company, Inc.