ConnectiCare

# Small Group Market
# FlexPOS HSA $5,000 50%
# Fixed Funding Solutions
# Open Access Contract Plan Year (E)
# Benefit Summary
# Non-Tiered Network Plan

The individual deductible and out-of-pocket maximum applies if you have coverage only for yourself. The family deductible and out-of-pocket maximum applies if you have coverage for yourself and one or more eligible dependents. Each individual on the family plan will only need to satisfy the individual deductible and out-of-pocket maximum, not the full family amount. Each individual's charges will accrue towards the family amounts.

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**<br>Deductible is combined for medical services and prescription drugs | $5,000 per member<br>$10,000 per family | $10,000 per member<br>$20,000 per family |
| **Separate Prescription Drug Deductible** | Included in plan deductible | Included in plan deductible |
| **Out-of-Pocket Maximum**<br>Includes a combination of deductible, copayments and coinsurance for medical and pharmacy services | $6,750 per member<br>$13,500 per family | $13,500 per member<br>$27,000 per family |
| **Benefits** | **In-Network (INET) Member Pays** | **Out-of-network (OON) Member Pays** |
| **Provider Office Visits** | | |
| **Adult/Pediatric Preventive Visits** | No charge<br>(frequecncy is based on age/ gender) | 50% coinsurance<br>after plan deductible |
| **Primary Care Provider Office/ Telemedicine Visits**<br>includes services for illness, injury, follow-up care and consultations | $30 copayment/visit<br>after plan deductible | 50% coinsurance<br>after plan deductible |

| Benefits | In-Network (INET)<br>Member Pays | Out-of-network (OON)<br>Member Pays |
|---|---|---|
| **Telemedicine Services**<br>services rendered by a Teladoc® provider<br><br>Primary Care - members must be 18 or older | **Primary Care, Mental Health and General Medical Services:**<br>0% coinsurance<br>after plan deductible<br><br>**Dermatologist:**<br>$50 copayment/visit<br>after plan deductible | 50% coinsurance<br>after plan deductible |
| **Specialist Office/Telemedicine Visits** | $50 copayment/visit<br>after plan deductible | 50% coinsurance<br>after plan deductible |
| **Mental Health and Substance Abuse Office Visits** | $50 copayment<br>after plan deductible | 50% coinsurance<br>after plan deductible |
| **Outpatient Diagnostic Services** | | |
| **Advanced Radiology**<br>CT/PET Scan, MRI | **Independent Facility:**<br>$100 copayment/service<br>after plan deductible<br><br>**Hospital Facility:**<br>50% coinsurance<br>after plan deductible | 50% coinsurance<br>after plan deductible |
| **Laboratory Services** | $10 copayment/visit<br>after plan deductible | 50% coinsurance<br>after plan deductible |
| **Non-Advanced Radiology**<br>X-ray, Diagnostic | $40 copayment/service<br>after plan deductible | 50% coinsurance<br>after plan deductible |
| **Mammography Ultrasound** | $40 copayment/service<br>after plan deductible | 50% coinsurance<br>after plan deductible |
| **Prescription Drugs – Retail Pharmacy (cost share based on 30 day supply per prescription)** | | |
| **Preferred Generic**<br>Tier 1 | $10 copayment/prescription<br>after plan deductible | 50% coinsurance<br>after plan deductible |
| **Non-preferred Generic**<br>Tier 2 | 50% coinsurance up to a maximum of $250 per prescription<br>after plan deductible | 50% coinsurance<br>after plan deductible |
| **Preferred Brand**<br>Tier 3 | $50 copayment/prescription<br>after plan deductible | 50% coinsurance<br>after plan deductible |
| **Non-Preferred Brand**<br>Tier 4 | 50% coinsurance up to a maximum of $500 per prescription<br>after plan deductible | 50% coinsurance<br>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**<br>Tier 5 | 50% coinsurance up to a maximum of $500 per prescription<br>after plan deductible | Not covered |

| Benefits | In-Network (INET) Member Pays | Out-of-network (OON) Member Pays |
|---|---|---|
| **Non-Preferred Specialty** Tier 6 | 50% coinsurance up to a maximum of $750 per prescription after plan deductible | Not covered |
| **Prescription – Mail Order Pharmacy (up to a 90 day supply per prescription)** | | |
| **Preferred Generic** Tier 1 | $20 copayment/prescription after plan deductible | Not covered |
| **Non-preferred Generic** Tier 2 | 50% coinsurance up to a maximum of $500 per prescription after plan deductible | Not covered |
| **Preferred Brand** Tier 3 | $100 copayment/prescription after plan deductible | Not covered |
| **Non-Preferred Brand** Tier 4 | 50% coinsurance up to a maximum of $1,000 per prescription after plan deductible | Not covered |
| **Outpatient Rehabilitative Services (40 visits per contract year limit combined for Rehabilitative physical, speech and occupational therapies.)** | | |
| **Speech Therapy** | $50 copayment/visit after plan deductible | 50% coinsurance after plan deductible |
| **Physical and Occupational Therapy** | $50 copayment/visit after plan deductible | 50% coinsurance after plan deductible |
| **Other Services** | | |
| **Chiropractic Services** up to 20 visits per contract year | $50 copayment/visit after plan deductible | 50% coinsurance after plan deductible |
| **Diabetic Equipment and Supplies** | 50% coinsurance after plan deductible | 50% coinsurance after plan deductible |
| **Durable Medical Equipment** (DME) including prosthetics and disposable medical supplies | 50% coinsurance after plan deductible | 50% coinsurance after plan deductible |
| **Home Health Care Services** up to 100 visits per contract year | 50% coinsurance after plan deductible | 50% coinsurance after plan deductible |
| **Outpatient Services** in a hospital or ambulatory facility | 50% coinsurance 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 | 50% coinsurance after plan deductible | 50% coinsurance after plan deductible |

| Benefits | In-Network (INET) Member Pays | Out-of-network (OON) Member Pays |
|---|---|---|
| **Emergency and Urgent Care** | | |
| **Ambulance Services** | 50% coinsurance after plan deductible | Same as In-network benefit |
| **Emergency Room** | 50% coinsurance after plan deductible | Same as In-network benefit |
| **Walk-In Center** | $75 copayment/visit after plan deductible | 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 after plan deductible | 50% coinsurance after plan deductible |
| **Annual routine mammography** age 40 or older | No charge | 50% coinsurance after plan deductible |
| **Gynecologist Services** | $50 copayment/visit after plan deductible | 50% coinsurance after plan deductible |
| **Outpatient mental health, alcohol and substance abuse treatment** intensive outpatient treatment and partial hospitalization | 50% coinsurance after plan deductible | 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 after plan deductible | 50% coinsurance after plan deductible |

**Important information**

- 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.
- To learn more about your Teladoc® benefits contact Teladoc® a 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.
- Refer to ConnectiCare's Pharmacy Center online at www.connecticare.com for the Value List of drugs that are not subject to the member's cost share.
- Your plan is administered by ConnectiCare Insurance Company, Inc.