ConnectiCare 2025 Preferred Product Portfolio

FlexPOS Plans

	1	2	3
	FlexPOS-CNT-30-50-500-Day-P24	**FlexPOS-CNT-P1500-30-45-P24**	**FlexPOS-CNT-P1500-40-60-P24**
Plan/Medical Deductible			
Plan Deductible (Individual/Family)	N/A	$1,500/$3,000	$1,500/$3,000
Maximum Out-of-Pocket (MOOP) (Individual/Family)	$7,000/$14,000	$6,850/$13,700	$7,500/$15,000
In-Network Medical Benefits			
Telemedicine visits through Teladoc360® Primary Care Provider (PCP)/Behavioral Health (BH)	$0	$0	$0
Primary Care Provider (PCP)	$30	$30	$40
Specialist	$50	$45	$60
Urgent Care	$75	$100	$100
Emergency Room	$250	$350	$500
Freestanding Outpatient Surgery	$250	$0 after deductible	$0 after deductible
Hospital Outpatient Surgery	$500	$0 after deductible	$0 after deductible
Inpatient Hospital	$500 day/$2,000 admit	$0 after deductible	$0 after deductible
Non-Advanced Independent Facility	$40	$40	$40
Non-Advanced Hospital Facility	$40	$40	$40 after deductible
Advanced Radiology Independent Facility	$75 (up to 5 copays)	$75 (up to 5 copays)	$75 (up to 5 copays)
Advanced Radiology Hospital Facility	$75 (up to 5 copays)	$75 after deductible (up to 5 copays)	$75 after deductible (up to 5 copays)
Laboratory Independent Facility	$10	$10	$10
Laboratory Hospital Facility	$10	$10	$25 after deductible
Physical Therapy/Occupational Therapy/Speech Therapy (40 Visits)	$30	$30	$30
Chiropractor (20 Visits)	$50	$45	$60
Home Health Care (100 Visits)	$25	$25	$25
Outpatient Mental Health	$30	$30	$40
Durable Medical Equipment	50%	50%	50%
Routine Vision	$50	$45	$60
Out-of-Network Medical Benefits			
Deductible (Individual/Family)	$5,000/$10,000	$5,000/$10,000	$5,000/$10,000
Coinsurance	70%/30%	70%/30%	70%/30%
Maximum Out-of-Pocket (MOOP) (Individual/Family)	$10,000/$20,000	$10,000/$20,000	$10,000/$20,000
Prescription Drug (PD) Benefits			
4 Tier Rx Option	$10/$35/$60/50% to $500 max	$10/$35/$60/50% to $500 max	$10/$35/$60/50% to $500 max
3 Tier Rx Option	$10/$30/$60	$10/$30/$60	$10/$30/$60

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. In Massachusetts, group health insurance is underwritten by ConnectiCare of Massachusetts, Inc. (CMI), a licensed HMO. 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.

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ConnectiCare 2025 Preferred Product Portfolio

FlexPOS Plans

	4	5	6
	FlexPOS-CNT-P5000-30-45-P24	FlexPOS-CNT-P6000-25-50-P24	FlexPOS-CNT-P2500-40-60-20%-P24
Plan/Medical Deductible			
Plan Deductible (Individual/Family)	$5,000/$10,000	$6,000/$12,000	$2,500/$5,000
Maximum Out-of-Pocket (MOOP) (Individual/Family)	$8,000/$16,000	$8,000/$16,000	$8,000/$16,000
In-Network Medical Benefits			
Telemedicine visits through Teladoc360® Primary Care Provider (PCP)/Behavioral Health (BH)	$0	$0	$0
Primary Care Provider (PCP)	$30	$25	$40
Specialist	$45	$50	$60
Urgent Care	$100	$100	$100
Emergency Room	$350	$500	$350
Freestanding Outpatient Surgery	$0 after deductible	$0 after deductible	20% after deductible
Hospital Outpatient Surgery	$0 after deductible	$0 after deductible	20% after deductible
Inpatient Hospital	$0 after deductible	$0 after deductible	20% after deductible
Non-Advanced Independent Facility	$45	$50	$40
Non-Advanced Hospital Facility	$45 after deductible	$0 after deductible	20% after deductible
Advanced Radiology Independent Facility	$75 (up to 5 copays)	$75 (up to 5 copays)	$75 after deductible (up to 5 copays)
Advanced Radiology Hospital Facility	$75 after deductible (up to 5 copays)	$0 after deductible	20% after deductible
Laboratory Independent Facility	$10	$10	$20
Laboratory Hospital Facility	$25	$0 after deductible	20% after deductible
Physical Therapy/Occupational Therapy/Speech Therapy (40 Visits)	$30	$30	$30
Chiropractor (20 Visits)	$45	$50	$60
Home Health Care (100 Visits)	$25	$25	$25
Outpatient Mental Health	$30	$25	$40
Durable Medical Equipment	50%	50%	50%
Routine Vision	$45	$50	$60
Out-of-Network Medical Benefits			
Deductible (Individual/Family)	$8,000/$16,000	$10,000/$20,000	$5,000/$10,000
Coinsurance	50%/50%	50%/50%	50%/50%
Maximum Out-of-Pocket (MOOP) (Individual/Family)	$12,000/$24,000	$16,000/$32,000	$10,000/$20,000
Prescription Drug (PD) Benefits			
4 Tier Rx Option	$10/$35/$60/50% to $500 max	$10/$35/$60/50% to $500 max	$10/$35/$60/50% to $500 max
3 Tier Rx Option	$10/$30/$60	$10/$30/$60	$10/$30/$60

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ConnectiCare 2025 Preferred Product Portfolio

FlexPOS Plans

	7	8	9
	FlexPOS-CNT-P2500-40-60-P24	FlexPOS-CNT-P3000-40-60-P24	FlexPOS-CNT-P5000-35-60-P24
Plan/Medical Deductible			
Plan Deductible (Individual/Family)	$2,500/$5,000	$3,000/$6,000	$5,000/$10,000
Maximum Out-of-Pocket (MOOP) (Individual/Family)	$8,000/$16,000	$9,000/$18,000	$9,000/$18,000
In-Network Medical Benefits			
Telemedicine visits through Teladoc360® Primary Care Provider (PCP)/Behavioral Health (BH)	$0	$0	$0
Primary Care Provider (PCP)	$40	$40	$35
Specialist	$60	$60	$60
Urgent Care	$100	$100	$100
Emergency Room	$500	$500	$450
Freestanding Outpatient Surgery	$500	$500	$500
Hospital Outpatient Surgery	$0 after deductible	$0 after deductible	$0 after deductible
Inpatient Hospital	$0 after deductible	$0 after deductible	$0 after deductible
Non-Advanced Independent Facility	$50	$50	$60
Non-Advanced Hospital Facility	$50 after deductible	$50 after deductible	$0 after deductible
Advanced Radiology Independent Facility	$75 (up to 5 copays)	$75 (up to 5 copays)	$75 (up to 5 copays)
Advanced Radiology Hospital Facility	$75 after deductible (up to 5 copays)	$75 after deductible (up to 5 copays)	$0 after deductible
Laboratory Independent Facility	$10	$10	$20
Laboratory Hospital Facility	$25 after deductible	$25 after deductible	$0 after deductible
Physical Therapy/Occupational Therapy/Speech Therapy (40 Visits)	$30	$30	$30
Chiropractor (20 Visits)	$60	$60	$60
Home Health Care (100 Visits)	$25	$25	$25
Outpatient Mental Health	$40	$40	$35
Durable Medical Equipment	50%	50%	50% after deductible
Routine Vision	$60	$60	$60
Out-of-Network Medical Benefits			
Deductible (Individual/Family)	$8,000/$16,000	$8,000/$16,000	$10,000/$20,000
Coinsurance	50%/50%	50%/50%	50%/50%
Maximum Out-of-Pocket (MOOP) (Individual/Family)	$12,000/$24,000	$12,000/$24,000	$15,000/$30,000
Prescription Drug (PD) Benefits			
4 Tier Rx Option	$10/$35/$60/50% to $500 max	$10/$35/$60/50% to $500 max	$10/$35/$60/50% to $500 max
3 Tier Rx Option	$10/$30/$60	$10/$30/$60	$10/$30/$60

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ConnectiCare 2025 Preferred Product Portfolio

FlexPOS Plans

	10	11	12
	FlexPOS-CNT-P5000-50-60-P24	FlexPOS-CNT-P6500-30-70-0-P24	FlexPOS-CNT-P3000-30-45-20%-P24
Plan/Medical Deductible			
Plan Deductible (Individual/Family)	$5,000/$10,000	$6,500/$13,000	$3,000/$6,000
Maximum Out-of-Pocket (MOOP) (Individual/Family)	$9,000/$18,000	$9,200/$18,400	$8,000/$16,000
In-Network Medical Benefits			
Telemedicine visits through Teladoc360® Primary Care Provider (PCP)/Behavioral Health (BH)	$0	$0	$0
Primary Care Provider (PCP)	$50	$30	$30
Specialist	$60	$70	$45
Urgent Care	$200	$100	$100
Emergency Room	$450	$500	20% after deductible
Freestanding Outpatient Surgery	$500	$500	$500
Hospital Outpatient Surgery	$500 after deductible	$0 after deductible	20% after deductible
Inpatient Hospital	$750 day/$3,000 admin after deductible	$0 after deductible	20% after deductible
Non-Advanced Independent Facility	$50	$70	$40
Non-Advanced Hospital Facility	$50 after deductible	$0 after deductible	$40
Advanced Radiology Independent Facility	$75 (up to 5 copays)	$75 (up to 5 copays)	20% after deductible
Advanced Radiology Hospital Facility	$75 after deductible (up to 5 copays)	$0 after deductible	20% after deductible
Laboratory Independent Facility	$20	$10	$10
Laboratory Hospital Facility	$40	$25 after deductible	$10
Physical Therapy/Occupational Therapy/Speech Therapy (40 Visits)	$30	$30	$30
Chiropractor (20 Visits)	$60	$70	$45
Home Health Care (100 Visits)	$25	$25	20%
Outpatient Mental Health	$50	$30	$30
Durable Medical Equipment	50% after deducible	50%	50% after deductible
Routine Vision	$60	$70	$45
Out-of-Network Medical Benefits			
Deductible (Individual/Family)	$8,000/$16,000	$10,000/$20,000	$6,000/$12,000
Coinsurance	50%/50%	50%/50%	50%/50%
Maximum Out-of-Pocket (MOOP) (Individual/Family)	$15,000/$30,000	$15,000/$30,000	$12,000/$24,000
Prescription Drug (PD) Benefits			
4 Tier Rx Option	$10/$35/$60/50% to $500 max	$10/$35/$60/50% to $500 max	$10/$35/$60/50% to $500 max
3 Tier Rx Option	$10/$30/$60	$10/$30/$60	$10/$30/$60

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ConnectiCare 2025 Preferred Product Portfolio

FlexPOS Plans

	13 FlexPOS-CNT-P3500-30-50-10%-P24	14 FlexPOS-CNT-U3000-20%-P24
Plan/Medical Deductible		
Plan Deductible (Individual/Family)	$3,500/$7,000	$3,000/$6,000
Maximum Out-of-Pocket (MOOP) (Individual/Family)	$8,000/$16,000	$8,500/$17,000
In-Network Medical Benefits		
Telemedicine visits through Teladoc360® Primary Care Provider (PCP)/Behavioral Health (BH)	$0	$0
Primary Care Provider (PCP)	$30	20% after deductible
Specialist	$50	20% after deductible
Urgent Care	$100	20% after deductible
Emergency Room	10% after deductible	20% after deductible
Freestanding Outpatient Surgery	$500	20% after deductible
Hospital Outpatient Surgery	10% after deductoble	20% after deductible
Inpatient Hospital	10% after deductible	20% after deductible
Non-Advanced Independent Facility	$50	20% after deductible
Non-Advanced Hospital Facility	10% after deductible	20% after deductible
Advanced Radiology Independent Facility	$75 (up to 5 copays)	20% after deductible
Advanced Radiology Hospital Facility	10% after deductible	20% after deductible
Laboratory Independent Facility	$10	20% after deductible
Laboratory Hospital Facility	10% after deductible	20% after deductible
Physical Therapy/Occupational Therapy/Speech Therapy (40 Visits)	$30	20% after deductible
Chiropractor (20 Visits)	$50	20% after deductible
Home Health Care (100 Visits)	10%	20%
Outpatient Mental Health	$30	20% after deductible
Durable Medical Equipment	50% after deductible	20% after deductible
Routine Vision	$50	20% after deductible
Out-of-Network Medical Benefits		
Deductible (Individual/Family)	$8,000/$16,000	$8,000/$16,000
Coinsurance	50%/50%	50%/50%
Maximum Out-of-Pocket (MOOP) (Individual/Family)	$12,000/$24,000	$12,000/$24,000
Prescription Drug (PD) Benefits		
4 Tier Rx Option	$10/$35/$60/50% to $500 max	$10/$35/$60/50% to $500 max
3 Tier Rx Option	$10/$30/$60	$10/$30/$60

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ConnectiCare 2025 Preferred Product Portfolio

FlexPOS Plans

	15 FlexPOS-CNT-P2500-40-25%-0-P24	16 FlexPOS-CNT-P8700-60-50%-0-P24	17 FlexPOS-CNT-P5000-50-70-30%-P24
Plan/Medical Deductible			
Plan Deductible (Individual/Family)	$2,500/$5,000	$8,700/$17,400	$5,000/$10,000
Maximum Out-of-Pocket (MOOP) (Individual/Family)	$6,000/$12,000	$9,000/$18,000	$8,550/$17,100
In-Network Medical Benefits			
Telemedicine visits through Teladoc360® Primary Care Provider (PCP)/Behavioral Health (BH)	$0	$0	$0
Primary Care Provider (PCP)	$40	$60	$50
Specialist	25% after deductible	50% after deductible	$70
Urgent Care	25% after deductible	50% after deductible	30% after deductible
Emergency Room	25% after deductible	50% after deductible	30% after deductible
Freestanding Outpatient Surgery	25% after deductible	50% after deductible	30% after deductible
Hospital Outpatient Surgery	25% after deductible	50% after deductible	30% after deductible
Inpatient Hospital	25% after deductible	50% after deductible	30% after deductible
Non-Advanced Independent Facility	25% after deductible	50% after deductible	30% after deductible
Non-Advanced Hospital Facility	25% after deductible	50% after deductible	30% after deductible
Advanced Radiology Independent Facility	25% after deductible	50% after deductible	30% after deductible
Advanced Radiology Hospital Facility	25% after deductible	50% after deductible	30% after deductible
Laboratory Independent Facility	25% after deductible	50% after deductible	30% after deductible
Laboratory Hospital Facility	25% after deductible	50% after deductible	30% after deductible
Physical Therapy/Occupational Therapy/Speech Therapy (40 Visits)	25% after deductible	50% after deductible	30% after deductible
Chiropractor (20 Visits)	25% after deductible	50% after deductible	30% after deductible
Home Health Care (100 Visits)	25%	25%	25%
Outpatient Mental Health	$0	$0	$50
Durable Medical Equipment	25% after deductible	50% after deductible	30% after deductible
Routine Vision	25% after deductible	50% after deductible	$70
Out-of-Network Medical Benefits			
Deductible (Individual/Family)	$5,000/$10,000	$15,000/$30,000	$6,350/$12,700
Coinsurance	50%/50%	50%/50%	50%/50%
Maximum Out-of-Pocket (MOOP) (Individual/Family)	$10,000/$20,000	$20,000/$40,000	$15,000/$30,000
Prescription Drug (PD) Benefits			
4 Tier Rx Option	$10/$35/$60/50% to $500 max	$10/$35/$60/50% to $500 max	$10/$35/$60/50% to $500 max
3 Tier Rx Option	$10/$30/$60	$10/$30/$60	$10/$30/$60

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ConnectiCare 2025 Preferred Product Portfolio

HDHP HSA Plans

	18 FlexPOS-CNT-HSA-1650I/3300F-P24-A*	19 FlexPOS-CNT-HSA-2000I/4000F-P24-A*	20 FlexPOS-CNT-HSA-2500I/5000F-P24-A*
Plan/Medical Deductible			
Plan Deductible (Individual/Family)	$1,650/$3,300	$2,000/$4,000	$2,500/$5,000
Maximum Out-of-Pocket (MOOP) (Individual/Family)	$5,000/$10,000	$6,000/$12,000	$6,000/$12,000
In-Network Medical Benefits			
Telemedicine visits through Teladoc360® Primary Care Provider (PCP)/Behavioral Health (BH)	$0 after deductible	$0 after deductible	$0 after deductible
Primary Care Provider (PCP)	$0 after deductible	$0 after deductible	$0 after deductible
Specialist	$0 after deductible	$0 after deductible	$0 after deductible
Urgent Care	$0 after deductible	$0 after deductible	$0 after deductible
Emergency Room	$0 after deductible	$0 after deductible	$0 after deductible
Freestanding Outpatient Surgery	$0 after deductible	$0 after deductible	$0 after deductible
Hospital Outpatient Surgery	$0 after deductible	$0 after deductible	$0 after deductible
Inpatient Hospital	$0 after deductible	$0 after deductible	$0 after deductible
Non-Advanced Independent Facility	$0 after deductible	$0 after deductible	$0 after deductible
Non-Advanced Hospital Facility	$0 after deductible	$0 after deductible	$0 after deductible
Advanced Radiology Independent Facility	$0 after deductible	$0 after deductible	$0 after deductible
Advanced Radiology Hospital Facility	$0 after deductible	$0 after deductible	$0 after deductible
Laboratory Independent Facility	$0 after deductible	$0 after deductible	$0 after deductible
Laboratory Hospital Facility	$0 after deductible	$0 after deductible	$0 after deductible
Physical Therapy/Occupational Therapy/Speech Therapy (40 Visits)	$0 after deductible	$0 after deductible	$0 after deductible
Chiropractor (20 Visits)	$0 after deductible	$0 after deductible	$0 after deductible
Home Health Care (100 Visits)	$0 after deductible	$0 after deductible	$0 after deductible
Outpatient Mental Health	$0 after deductible	$0 after deductible	$0 after deductible
Durable Medical Equipment	$0 after deductible	$0 after deductible	$0 after deductible
Routine Vision	$0	$0	$0
Out-of-Network Medical Benefits			
Deductible (Individual/Family)	$5,000/$10,000	$5,000/$10,000	$5,000/$10,000
Coinsurance	70%/30%	70%/30%	70%/30%
Maximum Out-of-Pocket (MOOP) (Individual/Family)	$10,000/$20,000	$10,000/$20,000	$10,000/$20,000
Prescription Drug (PD) Benefits			
4 Tier Rx Option	$10/$35/$60/50% to $500 max after PD	$10/$35/$60/50% to $500 max after PD	$10/$35/$60/50% to $500 max after PD
3 Tier Rx Option	$10/$30/$60 after PD	$10/$30/$60 after PD	$10/$30/$60 after PD

*"A" means the plan has an “Aggregate” deductible, and "E" means the plan has an “Embedded” deductible.

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ConnectiCare 2025 Preferred Product Portfolio

HDHP HSA Plans

	21	22	23
	FlexPOS-CNT-HSA-3000I/ 6000F-P24-A*	FlexPOS-CNT-HSA-3500I/ 7000F-P24-E*	FlexPOS-CNT-HSA-4000I/ 8000F-P24-E*
Plan/Medical Deductible			
Plan Deductible (Individual/Family)	$3,000/$6,000	$3,500/$7,000	$4,000/$8,000
Maximum Out-of-Pocket (MOOP) (Individual/Family)	$7,000/$14,000	$7,000/$14,000	$8,050/$16,100
In-Network Medical Benefits			
Telemedicine visits through Teladoc360® Primary Care Provider (PCP)/Behavioral Health (BH)	$0 after deductible	$0 after deductible	$0 after deductible
Primary Care Provider (PCP)	$0 after deductible	$0 after deductible	$0 after deductible
Specialist	$0 after deductible	$0 after deductible	$0 after deductible
Urgent Care	$0 after deductible	$0 after deductible	$0 after deductible
Emergency Room	$0 after deductible	$0 after deductible	$0 after deductible
Freestanding Outpatient Surgery	$0 after deductible	$0 after deductible	$0 after deductible
Hospital Outpatient Surgery	$0 after deductible	$0 after deductible	$0 after deductible
Inpatient Hospital	$0 after deductible	$0 after deductible	$0 after deductible
Non-Advanced Independent Facility	$0 after deductible	$0 after deductible	$0 after deductible
Non-Advanced Hospital Facility	$0 after deductible	$0 after deductible	$0 after deductible
Advanced Radiology Independent Facility	$0 after deductible	$0 after deductible	$0 after deductible
Advanced Radiology Hospital Facility	$0 after deductible	$0 after deductible	$0 after deductible
Laboratory Independent Facility	$0 after deductible	$0 after deductible	$0 after deductible
Laboratory Hospital Facility	$0 after deductible	$0 after deductible	$0 after deductible
Physical Therapy/Occupational Therapy/Speech Therapy (40 Visits)	$0 after deductible	$0 after deductible	$0 after deductible
Chiropractor (20 Visits)	$0 after deductible	$0 after deductible	$0 after deductible
Home Health Care (100 Visits)	$0 after deductible	$0 after deductible	$0 after deductible
Outpatient Mental Health	$0 after deductible	$0 after deductible	$0 after deductible
Durable Medical Equipment	$0 after deductible	$0 after deductible	$0 after deductible
Routine Vision	$0	$0	$0
Out-of-Network Medical Benefits			
Deductible (Individual/Family)	$5,000/$10,000	$5,000/$10,000	$10,000/$20,000
Coinsurance	70%/30%	70%/30%	70%/30%
Maximum Out-of-Pocket (MOOP) (Individual/Family)	$10,000/$20,000	$10,000/$20,000	$15,000/$30,000
Prescription Drug (PD) Benefits			
4 Tier Rx Option	$10/$35/$60/50% to $500 max after PD	$10/$35/$60/50% to $500 max after PD	$10/$35/$60/50% to $500 max after PD
3 Tier Rx Option	$10/$30/$60 after PD	$10/$30/$60 after PD	$10/$30/$60 after PD

*"A" means the plan has an “Aggregate” deductible, and "E" means the plan has an “Embedded” deductible.

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ConnectiCare 2025 Preferred Product Portfolio

HDHP HSA Plans

	24	25	26
	FlexPOS-CNT-HSA-5000I/ 10000F-P24-E*	FleXPOS-CNT-HSA-6500I/ 13000F-P24-E*	FlexPOS-CNT-HSA-1650I/3300F-30-45-P24-A*
Plan/Medical Deductible			
Plan Deductible (Individual/Family)	$5,000/$10,000	$6,500/$13,000	$1,650/$3,300
Maximum Out-of-Pocket (MOOP) (Individual/Family)	$8,050/$16,100	$8,050/$16,100	$5,000/$10,000
In-Network Medical Benefits			
Telemedicine visits through Teladoc360® Primary Care Provider (PCP)/Behavioral Health (BH)	$0 after deductible	$0 after deductible	$0 after deductible
Primary Care Provider (PCP)	$0 after deductible	$0 after deductible	$30 after deductible
Specialist	$0 after deductible	$0 after deductible	$45 after deductible
Urgent Care	$0 after deductible	$0 after deductible	$100 after deductible
Emergency Room	$0 after deductible	$0 after deductible	$350 after deductible
Freestanding Outpatient Surgery	$0 after deductible	$0 after deductible	$200 after deductible
Hospital Outpatient Surgery	$0 after deductible	$0 after deductible	$350 after deductible
Inpatient Hospital	$0 after deductible	$0 after deductible	$350 day/$1,400 admin after deductible
Non-Advanced Independent Facility	$0 after deductible	$0 after deductible	$40 after deductible
Non-Advanced Hospital Facility	$0 after deductible	$0 after deductible	$40 after deductible
Advanced Radiology Independent Facility	$0 after deductible	$0 after deductible	$75 after deductible (up to 5 copays)
Advanced Radiology Hospital Facility	$0 after deductible	$0 after deductible	$75 after deductible (up to 5 copays)
Laboratory Independent Facility	$0 after deductible	$0 after deductible	$10 after deductible
Laboratory Hospital Facility	$0 after deductible	$0 after deductible	$25 after deductible
Physical Therapy/Occupational Therapy/Speech Therapy (40 Visits)	$0 after deductible	$0 after deductible	$30 after deductible
Chiropractor (20 Visits)	$0 after deductible	$0 after deductible	$45 after deductible
Home Health Care (100 Visits)	$0 after deductible	$0 after deductible	$25 after deductible
Outpatient Mental Health	$0 after deductible	$0 after deductible	$30 after decutible
Durable Medical Equipment	$0 after deductible	$0 after deductible	50% after deductible
Routine Vision	$0	$0	$45
Out-of-Network Medical Benefits			
Deductible (Individual/Family)	$10,000/$20,000	$12,000/$24,000	$3,000/$6,000
Coinsurance	70%/30%	50%/50%	70%/30%
Maximum Out-of-Pocket (MOOP) (Individual/Family)	$15,000/$30,000	$18,000/$36,000	$10,000/$20,000
Prescription Drug (PD) Benefits			
4 Tier Rx Option	$10/$35/$60/50% to $500 max after PD	$10/$35/$60/50% to $500 max after PD	$10/$35/$60/50% to $500 max after PD
3 Tier Rx Option	$10/$30/$60 after PD	$10/$30/$60 after PD	$10/$30/$60 after PD

*"A" means the plan has an “Aggregate” deductible, and "E" means the plan has an “Embedded” deductible.

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ConnectiCare 2025 Preferred Product Portfolio

HDHP HSA Plans

	27	28	29
	FlexPOS-CNT-HSA-3500I/ 7000F-40-60-P24-E*	FlexPOS-CNT-HSA-5000I/ 10000F-30-45-P24-E*	FleXPOS-CNT-HSA-6500I/ 13000F-40-60-P24-E*
Plan/Medical Deductible			
Plan Deductible (Individual/Family)	$3,500/$7,000	$5,000/$10,000	$6,500/$13,000
Maximum Out-of-Pocket (MOOP) (Individual/Family)	$8,000/$16,000	$8,050/$16,100	$8,050/$16,100
In-Network Medical Benefits			
Telemedicine visits through Teladoc360® Primary Care Provider (PCP)/Behavioral Health (BH)	$0 after deductible	$0 after deductible	$0 after deductible
Primary Care Provider (PCP)	$40 after deductible	$30 after deductible	$40 after deductible
Specialist	$60 after deductible	$45 after deductible	$60 after deductible
Urgent Care	$100 after deductible	$100 after deductible	$100 after deductible
Emergency Room	$350 after deductible	$350 after deductible	$350 after deductible
Freestanding Outpatient Surgery	$250 after deductible	$125 after deductible	$125 after deductible
Hospital Outpatient Surgery	$500 after deductible	$250 after deductible	$250 after deductible
Inpatient Hospital	$500 day/$2,000 admin after deductible	$500 day/$2,000 admin after deductible	$500 day/$2,000 admin after deductible
Non-Advanced Independent Facility	$40 after deductible	$40 after deductible	$40 after deductible
Non-Advanced Hospital Facility	$60 after deductible	$40 after deductible	$40 after deductible
Advanced Radiology Independent Facility	$75 after deductible (up to 5 copays)	$75 after deductible (up to 5 copays)	$75 after deductible (up to 5 copays)
Advanced Radiology Hospital Facility	$75 after deductible (up to 5 copays)	$75 after deductible (up to 5 copays)	$75 after deductible (up to 5 copays)
Laboratory Independent Facility	$10 after deductible	$10 after deductible	$10 after deductible
Laboratory Hospital Facility	$25 after deductible	$10 after deductible	$25 after deductible
Physical Therapy/Occupational Therapy/Speech Therapy (40 Visits)	$30 after deductible	$30 after deductible	$30 after deductible
Chiropractor (20 Visits)	$60 after deductible	$45 after deductible	$60 after deductible
Home Health Care (100 Visits)	$25 after deductible	$25 after deductible	$25 after deductible
Outpatient Mental Health	$40 after deductible	$30 after deductible	$40 after deductible
Durable Medical Equipment	50% after deductible	50% after deductible	50% after deductible
Routine Vision	$60	$45	$60
Out-of-Network Medical Benefits			
Deductible (Individual/Family)	$5,000/$10,000	$10,000/$20,000	$15,000/$30,000
Coinsurance	70%/30%	50%/50%	70%/30%
Maximum Out-of-Pocket (MOOP) (Individual/Family)	$10,000/$20,000	$15,000/$30,000	$20,000/$40,000
Prescription Drug (PD) Benefits			
4 Tier Rx Option	$10/$35/$60/50% to $500 max after PD	$10/$35/$60/50% to $500 max after PD	$10/$35/$60/50% to $500 max after PD
3 Tier Rx Option	$10/$30/$60 after PD	$10/$30/$60 after PD	$10/$30/$60 after PD

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ConnectiCare 2025 Preferred Product Portfolio

HDHP HSA Plans

	30	31	32
	FlexPOS-CNT-HSA-2000I/ 4000F-20%-P24-A*	FlexPOS-CNT-HSA-2500I/ 5000F-10%-P24-A*	FlexPOS-CNT-HSA-3300I/6600F-20%-P24-E*
Plan/Medical Deductible			
Plan Deductible (Individual/Family)	$2,000/$4,000	$2,500/$5,000	$3,300/$6,600
Maximum Out-of-Pocket (MOOP) (Individual/Family)	$6,000/$12,000	$6,000/$12,000	$8,000/$16,000
In-Network Medical Benefits			
Telemedicine visits through Teladoc360® Primary Care Provider (PCP)/Behavioral Health (BH)	$0 after deductible	$0 after deductible	$0 after deductible
Primary Care Provider (PCP)	20% after deductible	10% after deductible	20% after deductible
Specialist	20% after deductible	10% after deductible	20% after deductible
Urgent Care	20% after deductible	10% after deductible	20% after deductible
Emergency Room	20% after deductible	10% after deductible	20% after deductible
Freestanding Outpatient Surgery	20% after deductible	10% after deductible	20% after deductible
Hospital Outpatient Surgery	20% after deductible	10% after deductible	20% after deductible
Inpatient Hospital	20% after deductible	10% after deductible	20% after deductible
Non-Advanced Independent Facility	20% after deductible	10% after deductible	20% after deductible
Non-Advanced Hospital Facility	20% after deductible	10% after deductible	20% after deductible
Advanced Radiology Independent Facility	20% after deductible	10% after deductible	20% after deductible
Advanced Radiology Hospital Facility	20% after deductible	10% after deductible	20% after deductible
Laboratory Independent Facility	20% after deductible	10% after deductible	20% after deductible
Laboratory Hospital Facility	20% after deductible	10% after deductible	20% after deductible
Physical Therapy/Occupational Therapy/Speech Therapy (40 Visits)	20% after deductible	10% after deductible	20% after deductible
Chiropractor (20 Visits)	20% after deductible	10% after deductible	20% after deductible
Home Health Care (100 Visits)	20% after deductible	10% after deductible	20% after deductible
Outpatient Mental Health	20% after deductible	10% after deductible	20% after deductible
Durable Medical Equipment	20% after deductible	10% after deductible	20% after deductible
Routine Vision	20%	10%	20%
Out-of-Network Medical Benefits			
Deductible (Individual/Family)	$5,000/$10,000	$5,000/$10,000	$6,000/$12,000
Coinsurance	50%/50%	50%/50%	50%/50%
Maximum Out-of-Pocket (MOOP) (Individual/Family)	$10,000/$20,000	$7,000/$14,000	$12,000/$24,000
Prescription Drug (PD) Benefits			
4 Tier Rx Option	$10/$35/$60/50% to $500 max after PD	$10/$35/$60/50% to $500 max after PD	$10/$35/$60/50% to $500 max after PD
3 Tier Rx Option	$10/$30/$60 after PD	$10/$30/$60 after PD	$10/$30/$60 after PD

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ConnectiCare 2025 Preferred Product Portfolio

HDHP HSA Plans

	33 FlexPOS-CNT-HSA-4000I/ 8000F-20%-P24-E*	34 FlexPOS-CNT-HSA-4500I/ 9000F-20%-P24-E*	35 FlexPOS-CNT-HSA-5000I/ 10000F-10%-P24-E*
Plan/Medical Deductible			
Plan Deductible (Individual/Family)	$4,000/$8,000	$4,500/$9,000	$5,000/$10,000
Maximum Out-of-Pocket (MOOP) (Individual/Family)	$8,050/$16,100	$8,050/$16,100	$8,050/$16,100
In-Network Medical Benefits			
Telemedicine visits through Teladoc360® Primary Care Provider (PCP)/Behavioral Health (BH)	$0 after deductible	$0 after deductible	$0 after deductible
Primary Care Provider (PCP)	20% after deductible	20% after deductible	10% after deductible
Specialist	20% after deductible	20% after deductible	10% after deductible
Urgent Care	20% after deductible	20% after deductible	10% after deductible
Emergency Room	20% after deductible	20% after deductible	10% after deductible
Freestanding Outpatient Surgery	20% after deductible	20% after deductible	10% after deductible
Hospital Outpatient Surgery	20% after deductible	20% after deductible	10% after deductible
Inpatient Hospital	20% after deductible	20% after deductible	10% after deductible
Non-Advanced Independent Facility	20% after deductible	20% after deductible	10% after deductible
Non-Advanced Hospital Facility	20% after deductible	20% after deductible	10% after deductible
Advanced Radiology Independent Facility	20% after deductible	20% after deductible	10% after deductible
Advanced Radiology Hospital Facility	20% after deductible	20% after deductible	10% after deductible
Laboratory Independent Facility	20% after deductible	20% after deductible	10% after deductible
Laboratory Hospital Facility	20% after deductible	20% after deductible	10% after deductible
Physical Therapy/Occupational Therapy/Speech Therapy (40 Visits)	20% after deductible	20% after deductible	10% after deductible
Chiropractor (20 Visits)	20% after deductible	20% after deductible	10% after deductible
Home Health Care (100 Visits)	20% after deductible	20% after deductible	10% after deductible
Outpatient Mental Health	20% after deductible	20% after deductible	10% after deductible
Durable Medical Equipment	20% after deductible	20% after deductible	10% after deductible
Routine Vision	20%	20%	10%
Out-of-Network Medical Benefits			
Deductible (Individual/Family)	$8,000/$16,000	$8,000/$16,000	$10,000/$20,000
Coinsurance	50%/50%	50%/50%	50%/50%
Maximum Out-of-Pocket (MOOP) (Individual/Family)	$15,000/$30,000	$15,000/$30,000	$15,000/$30,000
Prescription Drug (PD) Benefits			
4 Tier Rx Option	$10/$35/$60/50% to $500 max after PD	$10/$35/$60/50% to $500 max after PD	$10/$35/$60/50% to $500 max after PD
3 Tier Rx Option	$10/$30/$60 after PD	$10/$30/$60 after PD	$10/$30/$60 after PD

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ConnectiCare 2025 Preferred Product Portfolio

HDHP HSA Plans

	36 FlexPOS-CNT-HSA-5500I/ 11000F-30%-P24-E*	37 FlexPOS-CNT-HSA-6000I/ 12000F-20%-P24-E*
Plan/Medical Deductible		
Plan Deductible (Individual/Family)	$5,500/$11,000	$6,000/$12,000
Maximum Out-of-Pocket (MOOP) (Individual/Family)	$8,050/$16,100	$8,050/$16,100
In-Network Medical Benefits		
Telemedicine visits through Teladoc360® Primary Care Provider (PCP)/Behavioral Health (BH)	$0 after deductible	$0 after deductible
Primary Care Provider (PCP)	30% after deductible	20% after deductible
Specialist	30% after deductible	20% after deductible
Urgent Care	30% after deductible	20% after deductible
Emergency Room	30% after deductible	20% after deductible
Freestanding Outpatient Surgery	30% after deductible	20% after deductible
Hospital Outpatient Surgery	30% after deductible	20% after deductible
Inpatient Hospital	30% after deductible	20% after deductible
Non-Advanced Independent Facility	30% after deductible	20% after deductible
Non-Advanced Hospital Facility	30% after deductible	20% after deductible
Advanced Radiology Independent Facility	30% after deductible	20% after deductible
Advanced Radiology Hospital Facility	30% after deductible	20% after deductible
Laboratory Independent Facility	30% after deductible	20% after deductible
Laboratory Hospital Facility	30% after deductible	20% after deductible
Physical Therapy/Occupational Therapy/Speech Therapy (40 Visits)	30% after deductible	20% after deductible
Chiropractor (20 Visits)	30% after deductible	20% after deductible
Home Health Care (100 Visits)	30% after deductible	20% after deductible
Outpatient Mental Health	30% after deductible	20% after deductible
Durable Medical Equipment	30% after deductible	20% after deductible
Routine Vision	30%	20%
Out-of-Network Medical Benefits		
Deductible (Individual/Family)	$11,000/$22,000	$10,000/$20,000
Coinsurance	50%/50%	70%/30%
Maximum Out-of-Pocket (MOOP) (Individual/Family)	$16,000/$32,000	$15,000/$30,000
Prescription Drug (PD) Benefits		
4 Tier Rx Option	$10/$35/$60/50% to $500 max after PD	$10/$35/$60/50% to $500 max after PD
3 Tier Rx Option	$10/$30/$60 after PD	$10/$30/$60 after PD

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Value Plans

	38	39	40
	EPO-OA-CNT-P6500-30-70-0-VP24	EPO-OA-CNT-P2500-40-25%-0-VP24	EPO-OA-CNT-P8700-60-50%-0-VP24
Plan/Medical Deductible			
Plan Deductible (Individual/Family)	$6,500 / $13,000	$2,500 / $5,000	$8,700 Ind / $17,400 Fam
Maximum Out-of-Pocket (MOOP) (Individual / Family)	$9,200/$18,400	$6,000 / $12,000	$9,000 Ind / $18,000
In-Network Medical Benefits			
Telemedicine visits through Teladoc360® Primary Care Provider (PCP)/Behavioral Health (BH)	$0	$0	$0
Primary Care Provider (PCP)	$30	$40	$60
Specialist	$70	25% after deductible	50% after deductible
Urgent Care	$100	25% after deductible	50% after deductible
Emergency Room	$500	25% after deductible	50% after deductible
Freestanding Outpatient Surgery	$500	25% after deductible	50% after deductible
Hospital Outpatient Surgery	$0 after deductible	25% after deductible	50% after deductible
Inpatient Hospital	$0 after deductible	25% after deductible	50% after deductible
Non-Advanced Independent Facility	$70	25% after deductible	50% after deductible
Non-Advanced Hospital Facility	$0 after deductible	25% after deductible	50% after deductible
Advanced Radiology Independent Facility	$75 (up to 5 copays)	25% after deductible	50% after deductible
Advanced Radiology Hospital Facility	$0 after deductible	25% after deductible	50% after deductible
Laboratory Independent Facility	$10 copay	25% after deductible	50% after deductible
Laboratory Hospital Facility	$25 copay after deductible	25% after deductible	50% after deductible
Physical Therapy/Occupational Therapy/ Speech Therapy (40 Visits)	$30	25% after deductible	50% after deductible
Chiropractor (20 Visits)	$70	25% after deductible	50% after deductible
Home Health Care (100 Visits)	$25	25%	25%
Outpatient Mental Health	$30	$0	$0
Durable Medical Equipment	50%	25% after deductible	50% after deductible
Out-of-Network Medical Benefits			
Deductible (Individual/Family)	N/A	N/A	N/A
Coinsurance	N/A	N/A	N/A
Maximum Out-of-Pocket (MOOP) (Individual/Family)	N/A	N/A	N/A
Prescription Drug (PD) Benefits			
4 Tier Rx Option	$10/$35/$60/50% to $500 max	$10/$35/$60/50% to $500 max	$10/$35/$60/50% to $500 max
3 Tier Rx Option	$10/$30/$60	$10/$30/$60	$10/$30/$60

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ConnectiCare 2025 Preferred Product Portfolio

Value Plans

	41 EPO-OA-CNT-P5000-50-70-30%-VP24	42 EPO-OA-CNT-HSA-3000I-6000F-VP24-A*	43 EPO-OA-CNT-HSA-3500-7000-40-60-VP24-E*
Plan/Medical Deductible			
Plan Deductible (Individual/Family)	$5,000 / $10,000	$3,000 Ind $6,000 Fam	$3,500 / $7,000
Maximum Out-of-Pocket (MOOP) (Individual / Family)	$8,550 / $17,100	$7,000 Ind $14,000 Fam	$8,000 /$16,000
In-Network Medical Benefits			
Telemedicine visits through Teladoc360® Primary Care Provider (PCP)/Behavioral Health (BH)	$0	$0 after deductible	$0 after deductible
Primary Care Provider (PCP)	$50	$0 after deductible	$40 after deductible
Specialist	$70	$0 after deductible	$60 after deductible
Urgent Care	30% after deductible	$0 after deductible	$100 after deductible
Emergency Room	30% after deductible	$0 after deductible	$350 after deductible
Freestanding Outpatient Surgery	30% after deductible	$0 after deductible	$250 after deductible
Hospital Outpatient Surgery	30% after deductible	$0 after deductible	$500 after deductible
Inpatient Hospital	30% after deductible	$0 after deductible	$500 day / $2,000 adm after deductible
Non-Advanced Independent Facility	30% after deductible	$0 after deductible	$40 after deductible
Non-Advanced Hospital Facility	30% after deductible	$0 after deductible	$60 after deductible
Advanced Radiology Independent Facility	30% after deductible	$0 after deductible	$75 after deductible (up to 5 copays)
Advanced Radiology Hospital Facility	30% after deductible	$0 after deductible	$75 after deductible (up to 5 copays)
Laboratory Independent Facility	30% after deductible	$0 after deductible	$10 after deductible
Laboratory Hospital Facility	30% after deductible	$0 after deductible	$25 after deductible
Physical Therapy/Occupational Therapy/ Speech Therapy (40 Visits)	30% after deductible	$0 after deductible	$30 after deductible
Chiropractor (20 Visits)	30% after deductible	$0 after deductible	$60 after deductible
Home Health Care (100 Visits)	25%	$0 after deductible	$25 Copay after deductible
Outpatient Mental Health	$50	$0 after deductible	$40 after deductible
Durable Medical Equipment	30% after deductible	$0 after deductible	50% after deductible
Out-of-Network Medical Benefits			
Deductible (Individual/Family)	N/A	N/A	N/A
Coinsurance	N/A	N/A	N/A
Maximum Out-of-Pocket (MOOP) (Individual/Family)	N/A	N/A	N/A
Prescription Drug (PD) Benefits			
4 Tier Rx Option	$10/$35/$60/50% to $500 max	$10/$35/$60/50% to $500 max after PD	$10/$35/$60/50% to $500 max after PD
3 Tier Rx Option	$10/$30/$60	$10/$30/$60 after deductible	$10/$30/$60 after deductible

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ConnectiCare 2025 Preferred Product Portfolio

Value Plans

	44 EPO-OA-CNT-HSA-5000-10000-30-45-VP24-E*	45 EPO-OA-CNT-HSA-6500-13000-40-60-VP24-E*	46 EPO-OA-CNT-HSA-2500I-5000F-VP24-A*	47 EPO-OA-CNT-HSA-4000-8000-20%-VP24-E*
Plan/Medical Deductible				
Plan Deductible (Individual/Family)	$5,000 / $10,000	$6,500 / $13,000	$2,500 $5,000	$4,000 / $8,000
Maximum Out-of-Pocket (MOOP) (Individual / Family)	$8,050 /$16,100	$8,050 /$16,100	$6,000 $12,000	$8,050 /$16,100
In-Network Medical Benefits				
Telemedicine visits through Teladoc360® Primary Care Provider (PCP)/Behavioral Health (BH)	$0 after deductible	$0 after deductible	$0 after deductible	$0 after deductible
Primary Care Provider (PCP)	$30 after deductible	$40 after deductible	10% after deductible	20% after deductible
Specialist	$45 after deductible	$60 after deductible	10% after deductible	20% after deductible
Urgent Care	$100 after deductible	$100 after deductible	10% after deductible	20% after deductible
Emergency Room	$350 after deductible	$350 after deductible	10% after deductible	20% after deductible
Freestanding Outpatient Surgery	$125 after deductible	$125 after deductible	10% after deductible	20% after deductible
Hospital Outpatient Surgery	$250 after deductible	$250 after deductible	10% after deductible	20% after deductible
Inpatient Hospital	$500 day / $2,000 adm after deductible	$500 day / $2000 adm after deductible	10% after deductible	20% after deductible
Non-Advanced Independent Facility	$40 after deductible	$40 after deductible	10% after deductible	20% after deductible
Non-Advanced Hospital Facility	$40 after deductible	$40 after deductible	10% after deductible	20% after deductible
Advanced Radiology Independent Facility	$75 after deductible (up to 5 copays)	$75 after deductible (up to 5 copays)	10% after deductible	20% after deductible
Advanced Radiology Hospital Facility	$75 after deductible (up to 5 copays)	$75 after deductible (up to 5 copays)	10% after deductible	20% after deductible
Laboratory Independent Facility	$10 after deductible	$10 after deductible	10% after deductible	20% after deductible
Laboratory Hospital Facility	$10 after deductible	$25 after deductible	10% after deductible	20% after deductible
Physical Therapy/Occupational Therapy/ Speech Therapy (40 Visits)	$30 after deductible	$30 after deductible	10% after deductible	20% after deductible
Chiropractor (20 Visits)	$45 after deductible	$60 after deductible	10% after deductible	20% after deductible
Home Health Care (100 Visits)	$25 Copay after deductible	$25 Copay after deductible	10% after deductible	20% after plan ded
Outpatient Mental Health	$30 after deductible	$40 after deductible	10% after deductible	20% after deductible
Durable Medical Equipment	50% after deductible	50% after deductible	10% after deductible	20% after deductible
Out-of-Network Medical Benefits				
Deductible (Individual/Family)	N/A	N/A	N/A	N/A
Coinsurance	N/A	N/A	N/A	N/A
Maximum Out-of-Pocket (MOOP) (Individual/Family)	N/A	N/A	N/A	N/A
Prescription Drug (PD) Benefits				
4 Tier Rx Option	$10/$35/$60/50% to $500 max after PD	$10/$35/$60/50% to $500 max after PD	$10/$35/$60/50% to $500 max after PD	$10/$35/$60/50% to $500 max after PD
3 Tier Rx Option	$10/$30/$60 after deductible	$10/$30/$60 after deductible	$10/$30/$60 after deductible	$10/$30/$60 after deductible

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