ConnectiCare

ConnectiCare Insurance Company Inc.

Individual Market

Compass EPO Gold Alternative

Benefit Summary

Tiered Network Plan

Compass Network - Includes Providers in Connecticut only

Deductible and Out-of-Pocket Maximum	**Preferred Provider In-Network (INET) Member Pays**	**Participating Provider In-Network (INET) Member Pays**	**Out-of-Network (OON) Member pays**
Plan Deductible Individual Family	$2,500 per member $5,000 per family	$4,000 per member $8,000 per family	N/A per member N/A per family
Separate Prescription Drug Deductible Individual Family	Included in Plan Deductible per member / per family	Included in Plan Deductible per member / per family	N/A per member N/A per family
Out-of-Pocket Maximum Individual Family (Includes deductibles, copayments and coinsurance)	$8,500 per member $17,000 per family		N/A per member N/A per family
Benefits	**Preferred Provider In-Network (INET) Member Pays**	**Participating Provider In-Network (INET) Member Pays**	**Out-of-Network (OON) Member pays**
Provider Office Visits			
Adult/Pediatric Preventive Visits	No cost	Same as Preferred Provider cost share	Not covered
Primary Care Provider Office/Telemedicine Visits (includes services for illness, injury, follow-up care and consultations)	$20 copayment per visit	40% coinsurance per visit after INET plan deductible is met	Not covered
Telemedicine Services (services rendered by a Teladoc® provider)	No cost	See primary care or specialist office visits	Not covered
Specialist Office/Telemedicine Visits	$45 copayment per visit	Same as Preferred Provider cost share	Not covered
Mental Health and Substance Abuse Office Visits	$45 copayment per visit	Same as Preferred Provider cost share	Not covered

Benefits	Preferred Provider In-Network (INET) Member Pays	Participating Provider In-Network (INET) Member Pays	Out-of-Network (OON) Member pays
Outpatient Diagnostic Services			
Advanced Radiology (CT/PET Scan, MRI)	20% coinsurance per visit after INET plan deductible is met $40 copayment per service up to a combined annual maximum of $375 for MRI and CAT scans; $400 for PET scans at a Freestanding Facility	40% coinsurance per visit after INET plan deductible is met	Not covered
Laboratory Services	$10 copayment per service	Same as Preferred Provider cost share	Not covered
Non-Advanced Radiology (X-ray, Diagnostic)	20% coinsurance per service after INET plan deductible is met at a Preferred Hospital Facility $10 copayment per service at a Freestanding Facility	40% coinsurance per service after INET plan deductible is met at a Hospital Facility Same as Preferred Provider cost share when done at a Freestanding facility	Not covered
Mammography Ultrasound	20% coinsurance per service after INET plan deductible is met at a Preferred Hospital Facility $10 copayment per service at a Freestanding Facility	40% coinsurance per service after INET plan deductible is met at a Hospital Facility Same as Preferred Provider cost share when done at a Freestanding facility	Not covered
Prescription Drugs – Retail Pharmacy (cost share based on 30-day supply per prescription)			
Generic Drugs Tier 1	$5 copayment per prescription	Same as Preferred Provider cost share	Not covered
Preferred Brand Drugs Tier 2	$40 copayment per prescription	Same as Preferred Provider cost share	Not covered

Benefits	Preferred Provider In-Network (INET) Member Pays	Participating Provider In-Network (INET) Member Pays	Out-of-Network (OON) Member pays
Non-Preferred Brand Drugs Tier 3	50% coinsurance per prescription after INET plan deductible is met	Same as Preferred Provider cost share	Not covered
Specialty Drugs Tier 4	50% coinsurance up to a maximum of $500 per prescription after INET plan deductible is met	Same as Preferred Provider cost share	Not covered
Prescription – Mail Order Pharmacy (up to a 90-day supply per prescription)			
Generic Drugs Tier 1	$10 copayment per prescription	Same as Preferred Provider cost share	Not covered
Preferred Brand Drugs Tier 2	$80 copayment per prescription	Same as Preferred Provider cost share	Not covered
Non-Preferred Brand Drugs Tier 3	50% coinsurance per prescription after INET plan deductible is met	Same as Preferred Provider cost share	Not covered
Outpatient Rehabilitative and Habilitative Services (40 visits per calendar year limit combined for Rehabilitative physical, speech and occupational therapies. Separate 40 visits per calendar year limit combined for Habilitative speech, physical and occupational therapies.)			
Speech Therapy	$45 copayment per visit after INET plan deductible is met	Same as Preferred Provider cost share	Not covered
Physical and Occupational Therapy	$30 copayment per visit after INET plan deductible is met	Same as Preferred Provider cost share	Not covered
Other Services			
Chiropractic Services (up to 20 visits per calendar year)	$45 copayment per visit	Same as Preferred Provider cost share	Not covered
Diabetic Equipment and Supplies	20% coinsurance per equipment/ supply	Same as Preferred Provider cost share	Not covered
Durable Medical Equipment (DME)	20% coinsurance per equipment/ supply	Same as Preferred Provider cost share	Not covered

Benefits	Preferred Provider In-Network (INET) Member Pays	Participating Provider In-Network (INET) Member Pays	Out-of-Network (OON) Member pays
Home Health Care Services (up to 100 visits per calendar year)	$25 copayment per visit	Same as Preferred Provider cost share	Not covered
Outpatient Services (in a hospital or ambulatory facility)	20% coinsurance per visit after INET plan deductible is met at a Preferred Outpatient Hospital Facility $300 copayment per visit at an Ambulatory Facility	40% coinsurance per visit after INET plan deductible is met at an Outpatient Hospital Facility Same as Preferred Provider cost share for Outpatient behavioral health, mental health and substance abuse services	Not covered
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 calendar year)	20% coinsurance per admission after INET plan deductible is met at a Preferred Hospital Facility	40% coinsurance per admission after INET plan deductible is met The cost share for Inpatient behavioral health, mental health and substance abuse services is the same as Preferred Provider	Not covered
Emergency and Urgent Care			
Ambulance Services	20% coinsurance per service after INET plan deductible is met	Same as Preferred Provider cost share	20% coinsurance per service after INET plan deductible is met
Emergency Room	20% coinsurance per visit after INET plan deductible is met	Same as Preferred Provider cost share	20% coinsurance per visit after INET plan deductible is met
Urgent Care Centers	$75 copayment per visit	Same as Preferred Provider cost share	Not covered
Pediatric Dental Care (for children under age 26)			

Benefits	Preferred Provider In-Network (INET) Member Pays	Participating Provider In-Network (INET) Member Pays	Out-of-Network (OON) Member pays
Diagnostic & Preventive	No cost	Same as Preferred Provider cost share	Not covered
Basic Services	50% coinsurance per visit	Same as Preferred Provider cost share	Not covered
Major Services	50% coinsurance per visit	Same as Preferred Provider cost share	Not covered
Orthodontia Services (medically necessary only)	50% coinsurance per visit	Same as Preferred Provider cost share	Not covered
Pediatric Vision Care (for children under age 26)			
Prescription Eyeglasses (one pair of frames and lenses or contact lens per calendar year)	Lenses: 50% Collection frame: 50% Non-collection frame: Members choosing to upgrade from a collection frame to a non-collection frame will be given a credit substantially equal to the cost of the collection frame and will be entitled to any discount negotiated by the carrier with the retailer No Member cost when services are rendered by an Indian Health Service provider	Same as Preferred Provider cost share	Not covered
Routine Eye Exam by a Specialist (one exam per calendar year)	$45 copayment per visit	Same as Preferred Provider cost share	Not covered
Additional Covered Services			
Adult Routine Eye Exam by a Specialist - over age 26 (one exam per calendar year)	$45 copayment per visit	Same as Preferred Provider cost share	Not covered

Benefits	Preferred Provider In-Network (INET) Member Pays	Participating Provider In-Network (INET) Member Pays	Out-of-Network (OON) Member pays
Allergy Injections (up to 20 visits per year)	$20 copayment per visit	See Participating Primary Care Provider or Specialist cost share	Not covered
Allergy Testing (up to one visit per year)	$20 copayment per visit	See Participating Primary Care Provider or Specialist cost share	Not covered
Artificial Limbs (includes associated supplies and equipment)	20% coinsurance	Same as Preferred Provider cost share	Not covered
Outpatient mental health, alcohol and substance abuse treatment (intensive outpatient treatment and partial hospitalization)	20% coinsurance after INET plan deductible is met	Same as Preferred Provider cost share	Not covered
Retail Clinic	40% coinsurance per visit after INET plan deductible is met	Same as Preferred Provider cost share	Not covered

IMPORTANT INFORMATION

- This is a brief summary of benefits. Refer to your ConnectiCare Insurance Company, Inc. policy for complete details on benefits, conditions, limitations and exclusions. All benefits described are per member per calendar year.
- Mammogram screenings, breast ultrasounds, and breast MRIs – Please refer to the policy for details.
- Insulin and noninsulin drugs are covered up to a cost share maximum of $25 for each 30-day supply.
- Diabetes Devices and Diabetic Ketoacidosis Devices are covered up to a cost share maximum of $100 per 30-day supply.
- Please refer to the policy for additional cost share maximums regarding diabetic services. Some diabetic services fall under preventive care and cost share may be waived.
- This Compass plan has a tiered network which offers you the opportunity to pay less when you visit a "Preferred" PCP or hospital. Preferred PCPs and hospitals can be found in the "Find a doctor" directory on www.connecticare.com. These providers are identified with the compass symbol. You can still visit other health care providers who accept your plan, they're called "Participating Providers" but you will pay more.
- An ambulatory surgery center is a facility that exclusively provides outpatient surgical services to patients who do not require hospitalization and whose expected stay in the center does not exceed 24 hours. Ambulatory surgery centers are not owned by a hospital.
- An outpatient hospital facility offers surgical procedures and related care that, in the opinion of the attending physician, can be safely performed without requiring overnight inpatient hospital care. Outpatient hospital facilities are owned by a hospital or hospital system.
- If you have questions regarding your plan, visit our website at http://www.connecticare.com or call us at (860) 674-5757 or 1-800-251-7722.
- To learn more about your **Teladoc®** benefits contact **Teladoc®** at teladoc.com/connecticare or call 1-800-835-2362 (TTY: 711).
- Services rendered by non-participating providers require that you obtain written Pre-Authorization from us in order for the treatment to be covered under this plan. Without pre-authorization you may be responsible for the total cost of the service. Refer to the "Managed Care Rules and Guidelines" section in your policy for more details.

- 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 drugs or supplies clinical effectiveness and cost, not on whether it is a generic drug or supply or brand name drug or supply.
- Amounts paid by members because they must pay a price difference for a brand name drug do not count towards meeting any deductible, coinsurance, copayment, coinsurance or cost share maximum.
- 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 Voluntary Mail Order program.
- For mental health, alcohol and substance abuse services call 1-888-946-4658 to obtain Pre-Authorization.
- In-network preventive and wellness services as defined by the United States Preventive Service Task Force (USPSTF), including immunizations recommended by the Advisory Committee on Immunizations Practices at the Centers for Disease Control (CDC), and preventive care and screenings supported by the Health Resources and Services Administration (HRSA) are exempt from all cost shares under the Patient Protection and Affordable Care Act (PPACA). Visit our website at http://www.connecticare.comto view a list of preventive and wellness services.