ConnectiCare Insurance Company Inc.

Individual Market
FlexPOS Platinum Alternative
Benefit Summary
Non-Tiered Network Plan

FlexPOS Network - Includes Providers in Connecticut, New York through EmblemHealth Prime and Nationally through First Health network

Deductible and Out-of-Pocket Maximum	**In-Network (INET) Member Pays**	**Out-of-Network (OON) Member Pays**
Plan deductible Individual Family	$1,200 per member $2,400 per family	$5,000 per member $10,000 per family
Separate Prescription Drug Deductible Individual Family	$200 per member $400 per family	$350 per member $700 per family
Out-of-Pocket Maximum Individual Family (Includes deductible, copayments and coinsurance)	$3,000 per member $6,000 per family	$8,000 per member $16,000 per family
Benefits	**In-Network (INET) Member Pays**	**Out-of-Network (OON) Member Pays**
Provider Office Visits		
Adult/Pediatric Preventive Visits	No cost	50% coinsurance per visit
Primary Care Provider Office/ Telemedicine Visits (includes services for illness, injury, follow-up care and consultations)	$20 copayment per visit	50% coinsurance per visit after OON plan deductible is met
Telemedicine Services (services rendered by a Teladoc® provider)	No cost	50% coinsurance per visit after OON plan deductible is met
Specialist Office/Telemedicine Visits	$30 copayment per visit	50% coinsurance per visit after OON plan deductible is met
Mental Health and Substance Abuse Office Visits	$20 copayment per visit	50% coinsurance per visit after OON plan deductible is met
Outpatient Diagnostic Services		

Benefits	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Advanced Radiology (CT/PET Scan, MRI)	$70 copayment per service up to a combined annual maximum of $350 for MRI and CAT scans; $400 for PET scans after INET plan deductible is met at a Hospital Facility $70 copayment per service up to a combined annual maximum of $350 for MRI and CAT scans; $400 for PET scans at a Freestanding Facility	50% coinsurance per service after OON plan deductible is met
Laboratory Services	$10 copayment per service	50% coinsurance per service after OON plan deductible is met
Non-Advanced Radiology (X-ray, Diagnostic)	$40 copayment per service	50% coinsurance per service after OON plan deductible is met
Mammography Ultrasound	$40 copayment per service	50% coinsurance per service after OON plan deductible is met
Prescription Drugs – Retail Pharmacy (cost share based on 30 day supply per prescription)		
Generic Drugs Tier 1	$5 copayment per prescription	50% coinsurance per prescription after OON prescription drug deductible is met
Preferred Brand Drugs Tier 2	$20 copayment per prescription	50% coinsurance per prescription after OON prescription drug deductible is met
Non-Preferred Brand Tier 3	$60 copayment per prescription after INET prescription drug deductible is met	50% coinsurance per prescription after OON prescription drug deductible is met
Specialty Drugs Tier 4	50% coinsurance up to a maximum of $250 per prescription after INET prescription drug deductible is met	50% coinsurance per prescription after OON prescription drug deductible is met
Prescription – Mail Order Pharmacy (up to a 90 day supply per prescription)		
Generic Drugs Tier 1	$10 copayment per prescription	50% coinsurance per prescription after OON prescription drug deductible is met
Preferred Brand Drugs Tier 2	$40 copayment per prescription	50% coinsurance per prescription after OON prescription drug deductible is met
Non-Preferred Brand Tier 3	$120 copayment per prescription after INET prescription drug deductible is met	50% coinsurance per prescription after OON prescription drug deductible is met

Benefits	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Outpatient Rehabilitative and Habilitative Services (40 visits per contract year limit combined for Rehabilitative physical, speech and occupational therapies. Separate 40 visits per contract year limit combined for Habilitative speech, physical and occupational therapies.)		
Speech Therapy	$30 copayment per visit	50% coinsurance per visit after OON plan deductible is met
Physical and Occupational Therapy	$25 copayment per visit	50% coinsurance per visit after OON plan deductible is met
Other Services		
Chiropractic Services (up to 20 visits per calendar year)	$40 copayment per visit	50% coinsurance per visit after OON plan deductible is met
Diabetic Equipment and Supplies	10% coinsurance per equipment/ supply	50% coinsurance per equipment/ supply after OON plan deductible is met
Durable Medical Equipment (DME)	10% coinsurance per equipment/ supply	50% coinsurance per equipment/ supply after OON plan deductible is met
Home Health Care Services (up to 100 visits per calendar year)	No cost	25% coinsurance per visit after separate $50 deductible is met
Outpatient Services (in a hospital or ambulatory facility)	10% coinsurance per visit after INET plan deductible is met at an Outpatient Hospital Facility $200 copayment per visit at an Ambulatory Facility	50% coinsurance per visit after OON plan deductible is met
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)	10% coinsurance per admission after INET plan deductible is met	50% coinsurance per admission after OON plan deductible is met
Emergency and Urgent Care		
Ambulance Services	0% coinsurance after INET plan deductible is met	0% coinsurance after INET plan deductible is met
Emergency Room	$100 copayment per visit after INET plan deductible is met	$100 copayment per visit after INET plan deductible is met
Urgent Care Centers	$50 copayment per visit	50% coinsurance per visit after OON plan deductible is met
Pediatric Dental Care (for children under age 26)		
Diagnostic & Preventive	No cost	50% coinsurance per visit after OON plan deductible is met

Benefits	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Basic Services	20% coinsurance per visit	50% coinsurance per visit after OON plan deductible is met
Major Services	20% coinsurance per visit	50% coinsurance per visit after OON plan deductible is met
Orthodontia Services (medically necessary only)	20% coinsurance per visit	50% coinsurance per visit after OON plan deductible is met
Pediatric Vision Care (for children under age 26)		
Prescription Eye Glasses (one pair of frames and lenses or contact lens per calendar year)	Lenses: $0 Collection frame: $0 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	Not covered
Routine Eye Exam by a Specialist (one exam per calendar year)	$40 copayment per visit	50% coinsurance per visit after OON plan deductible is met
Additional Covered Services		
Adult Routine Eye Exam by a Specialist - over age 26 (one exam per calendar year)	$40 copayment per visit	50% coinsurance per visit after OON plan deductible is met
Allergy Injections (up to 20 visits per year)	See primary care or specialist office visits	50% coinsurance per visit after OON plan deductible is met
Allergy Testing (up to one visit per year)	See primary care or specialist office visits	50% coinsurance per visit after OON plan deductible is met
Artificial Limbs (includes associated supplies and equipment)	10% coinsurance	50% coinsurance after OON plan deductible is met
Outpatient mental health, alcohol and substance abuse treatment (intensive outpatient treatment and partial hospitalization)	No cost	50% coinsurance per visit after OON plan deductible is met
Retail Clinic	$20 copayment per visit	50% coinsurance per visit after OON plan deductible is met

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.
- 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 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).
- 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 ConnectiCare Insurance Company, Inc. policy for more information.
- 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 30-day supply. Specialty Pharmacies have the same member cost share as all other participating pharmacies and are not part of the ConnectiCare's Voluntary Mail Order program.
- Many services require that you obtain our Pre-Certification or Pre-Authorization prior to obtaining care prescribed or rendered by Non-Participating providers or a benefit reduction may apply. Without pre-authorization you may be responsible for the total cost of the service or benefits may be reduced by the lesser of $500 or 50%. Refer to the "Pre-Authorization and Pre-Certification Addendum" in your policy for more details.
- 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 for from all cost shares under the Patient Protection and Affordable Care Act (PPACA). Visit our website at www.connecticare.com to view a list of preventive and wellness services.