ConnectiCare

Individual Market
Choice SOLO HMO HSA $6,500 ded.
High Deductible Health Plan for use with a Health Savings Account (HSA) (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.

Deductible and Out-of-Pocket Maximum	**In-Network (INET) Member Pays**	**Out-of-Network (OON) Member Pays**
Plan deductible Individual Family	$6,500 per member $13,000 per family	N/A per member N/A per family
Separate Prescription Drug Deductible Individual Family	N/A per member N/A per family	N/A per member N/A per family
Out-of-Pocket Maximum Individual Family (Include deductibles, copayments and coinsurance)	$6,900 per member $13,800 per family	N/A per member N/A per family
Benefits	**In-Network (INET) Member Pays**	**Out-of-Network (OON) Member Pays**
Provider Office Visits		
Adult/Pediatric Preventive Visits	No cost	N/A
Primary Care Provider Office Visits (includes services for illness, injury, follow-up care and consultations)	$40 copayment/visit after plan deductible	N/A
Specialist Office Visits	$50 copayment/visit after plan deductible	N/A
Mental Health and Substance Abuse Office Visits	$50 copayment/visit after plan deductible	N/A
Outpatient Diagnostic Services		

Benefits	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Advanced Radiology (CT/PET Scan, MRI)	$75 copayment/service after plan deductible up to five copayments per year, then copayments waived at a Freestanding Facility 30% coinsurance after plan deductible at an Outpatient Hospital Facility	N/A
Laboratory Services	$10 copayment/service after plan deductible	N/A
Non-Advanced Radiology (X-ray, Diagnostic)	$35 copayment/service after plan deductible at a Freestanding Facility 30% coinsurance after plan deductible at an Outpatient Hospital Facility	N/A
Mammography Ultrasound	$35 copayment/service after plan deductible at a Freestanding Facility 30% coinsurance after plan deductible at an Outpatient Hospital Facility	N/A
Prescription Drugs – Retail Pharmacy (cost share based on 30 day supply per prescription)		
Preferred Generic Tier 1	$10 copayment/prescription after plan deductible	N/A
Non-preferred Generic Tier 2	50% coinsurance up to a maximum of $250 per prescription after plan deductible	N/A
Preferred Brand Tier 3	$60 copayment/prescription after plan deductible	N/A
Non-Preferred Brand Tier 4	50% coinsurance up to a maximum of $500 per prescription after plan deductible	N/A
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 after plan deductible (specialty retail only)	N/A
Non-Preferred Specialty Tier 6	50% coinsurance up to a maximum of $750 per prescription after plan deductible (specialty retail only)	N/A

Benefits	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Prescription – Mail Order Pharmacy (up to a 90 day supply per prescription)		
Preferred Generic Tier 1	$20 copayment/prescription after plan deductible	N/A
Non-preferred Generic Tier 2	50% coinsurance up to a maximum of $500 per prescription after plan deductible	N/A
Preferred Brand Tier 3	$120 copayment/prescription after plan deductible	N/A
Non-Preferred Brand Tier 4	50% coinsurance up to a maximum of $1,000 per prescription after plan deductible	N/A
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	$50 copayment/visit after plan deductible	N/A
Physical and Occupational Therapy	$30 copayment/visit after plan deductible	N/A
Other Services		
Chiropractic Services up to 20 visits per calendar year	$50 copayment/visit after plan deductible	N/A
Diabetic Equipment and Supplies	30% coinsurance after plan deductible	N/A
Durable Medical Equipment (DME)	30% coinsurance after plan deductible	N/A
Home Health Care Services up to 100 visits per calendar year	25% coinsurance after plan deductible	N/A
Outpatient Services (in a hospital or ambulatory facility)	$500 copayment/visit after plan deductible at an Ambulatory Facility 30% coinsurance after plan deductible at an Outpatient Hospital Facility	N/A
Inpatient Services		

Benefits	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
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)	30% coinsurance after plan deductible	N/A
Emergency and Urgent Care		
Ambulance Services	30% coinsurance after plan deductible	Same as In-Network Benefit
Emergency Room	30% coinsurance after plan deductible	Same as In-Network Benefit
Urgent Care Centers	$100 copayment/visit after plan deductible	Same as In-Network Benefit
Pediatric Dental Care (for children under age 20)		
Diagnostic & Preventive	No cost	N/A
Basic Services	50% coinsurance after plan deductible	N/A
Major Services	50% coinsurance after plan deductible	N/A
Orthodontia Services (medically necessary only)	50% coinsurance after plan deductible	N/A
Pediatric Vision Care (for children under age 20)		
Prescription Eye Glasses one pair of frames and lenses per calendar year	Lenses: 50% after plan deductible Collection frames: 50% after plan deductible Non-collection frames: 50% after plan deductible up to the collection frame allowance; any amount over is payable by the member minus a 20% discount	N/A
Routine Eye Exam by a Specialist one exam per calendar year	$50 copayment/visit; deductible does not apply	N/A
Additional Covered Services		
Adult Routine Eye Exam by a Specialist - over age 20 one exam per calendar year	$50 copayment/visit; deductible does not apply	N/A
Allergy Injections up to 20 visits per calendar year	See primary care or specialist office visits	N/A

Benefits	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Allergy Testing one visit per calendar year	See primary care or specialist office visits	N/A
Artificial Limbs (includes associated supplies and equipment)	20% coinsurance after plan deductible	N/A
Inpatient Physician Services	30% coinsurance after plan deductible	N/A
Modified Food Products and Specialized Formula	30% coinsurance after plan deductible	N/A
Outpatient mental health, alcohol and substance abuse treatment intensive outpatient treatment and partial hospitalization	30% coinsurance after plan deductible	N/A
Retail Clinic	$40 copayment/visit after plan deductible	N/A
Telemedicine	See primary care or specialist office visits	N/A

Important information

- This is a brief summary of benefits. Refer to your ConnectiCare, Inc. policy for complete details on benefits, conditions, limitations and exclusions, or consult with your benefits manager.
- Mammogram screenings, breast ultrasounds, and breast MRIs – Please refer to the policy for details.
- 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.
- 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 supply's 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 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. 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.
- 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 membership agreement 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 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.