

Choice Gold Alternative POS

If you are eligible for automatic renewal, **you'll be enrolled in the 2024 plan unless you take action to change or cancel your plan.** Renewal information you received from Access Health CT had information on automatic renewals and how they work. You can contact **your broker, ConnectiCare, or Access Health CT** for information on other plans and help enrolling in one.

Plan Overview	2023 Plan Year	2024 Plan Year
Plan Name	Choice Gold Alternative POS With Dental	Choice Gold Alternative POS
Plan Metal Level	Gold	Gold
Product Type	POS	POS
Deductible		
Individual In-Network (INET)	\$3,500 per member	\$2,000 per member
Family In-Network	\$7,000 per family	\$4,000 per family
Individual Out-of-Network (OON)	\$7,000 per member	No change
Family Out-of-Network	\$14,000 per family	No change
Prescription Drug Deductible		
Individual In-Network	Combined with medical	\$75 per member
Family In-Network	Combined with medical	\$150 per family
Individual Out-of-Network	Combined with medical	\$500 per member
Family Out-of-Network	Combined with medical	\$1,000 per family
Out-of-Pocket Maximum		
Individual In-Network	\$7,900 per member	\$8,300 per member
Family In-Network	\$15,800 per family	\$16,600 per family
Individual Out-of-Network	\$12,000 per member	No change
Family Out-of-Network	\$24,000 per family	No change
Physician Office Visits		
Preventive Care/Screenings/Immunizations	In-network: No cost	No change
	Out-of-network: 50% coinsurance per visit	No change
Primary Care (injury or illness)	In-network: \$30 copayment per visit; deductible waived	In-network: \$40 copayment per visit; deductible waived
	Out-of-network: 50% coinsurance per visit after OON plan deductible is met	No change
Telemedicine Visits Through Teladoc® Primary Care – members must be age 18 or older	In-network: Primary care, mental health, and general medical services: No cost Dermatologist: \$50 copayment per visit; deductible waived	No change
	Out-of-network: 50% coinsurance per visit after OON plan deductible is met	No change
Specialist	In-network: \$50 copayment per visit; deductible waived	No change
	Out-of-network: 50% coinsurance per visit after OON plan deductible is met	No change
Mental Health and Substance Use	In-network: \$50 copayment per visit; deductible waived	No change
	Out-of-network: 50% coinsurance per visit after OON plan deductible is met	No change

Plan Overview	2023 Plan Year	2024 Plan Year
Emergency/Urgent Care		
Emergency Room	In-network: 20% coinsurance per visit after INET deductible is met	In-network: 30% coinsurance per visit after INET plan deductible is met
	Out-of-network: Same as in-network	Out-of-network: Same as in-network
Urgent Care Center or Facility	In-network: \$50 copayment per visit; deductible waived	In-network: 30% coinsurance per visit; deductible waived
	Out-of-network: 50% coinsurance per visit after OON plan deductible is met	No change
Pediatric Dental Care (for members under age 26)		
Diagnostic and Preventive	In-network: No cost	No change
	Out-of-network: 50% coinsurance per visit after OON plan deductible is met	No change
Basic Services	In-network: 50% coinsurance per visit; deductible waived	In-network: 50% coinsurance per visit after INET plan deductible is met
	Out-of-network: 50% coinsurance per visit after OON plan deductible is met	No change
Major Services	In-network: 50% coinsurance per visit; deductible waived	In-network: 50% coinsurance per visit after INET plan deductible is met
	Out-of-network: 50% coinsurance per visit after OON plan deductible is met	No change
Orthodontia Services (medically necessary only)	In-network: 50% coinsurance per visit; deductible waived	In-network: 50% coinsurance per visit after INET plan deductible is met
	Out-of-network: 50% coinsurance per visit after OON plan deductible is met	No change
Pediatric Vision Care (for members under age 26)		
Routine Eye Exam by Specialist (one exam per calendar year)	In-network: \$30 copayment per visit; deductible waived	In-network: \$50 copayment per visit; deductible waived
	Out-of-network: 50% coinsurance per visit after OON plan deductible is met	No change
Prescription Eyeglasses (one pair of frames and lenses or contact lenses per calendar year)	In-network: Lenses: 50% coinsurance Collection frame: 50% coinsurance	In-network: Lenses: 50% coinsurance after INET plan deductible is met; Collection frame: 50% coinsurance after INET plan deductible is met
	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 change
	Out-of-network: 50% coinsurance per visit after OON plan deductible is met	No change
Hospital Services		
Inpatient (including mental health, substance use, maternity, hospice, and skilled nursing facility; skilled nursing facility stay is limited to 90 days per calendar year.)	In-network: 20% coinsurance per admission after INET plan deductible is met	In-network: 30% coinsurance per admission after INET plan deductible is met
	Out-of-network: 50% coinsurance per admission after OON plan deductible is met	No change

Plan Overview	2023 Plan Year	2024 Plan Year
Hospital Services (Continued)		
Outpatient (performed at an outpatient hospital facility)	In-network: 20% coinsurance per visit after INET plan deductible is met	In-network: 30% coinsurance per visit after INET plan deductible is met
	Out-of-network: 50% coinsurance per visit after OON plan deductible is met	No change
Outpatient (performed at an ambulatory surgical center)	In-network: \$350 copayment per visit; deductible waived	In-network: \$250 copayment per visit; deductible waived
	Out-of-network: 50% coinsurance per visit after OON plan deductible is met	No change
Outpatient Services		
Home Health Care (100-visit calendar-year)	In-network: 20% coinsurance per visit; deductible waived	In-network: 25% coinsurance per visit after separate \$50 deductible is met
	Out-of-network: 25% coinsurance per visit after separate \$50 deductible is met	No change
Advanced Radiology – Hospital (CT/PET scan, MRI)	In-network: 20% coinsurance per service after INET plan deductible is met	In-network: 30% coinsurance per service after INET plan deductible is met
	Out-of-network: 50% coinsurance per service after OON plan deductible is met	No change
Advanced Radiology – Independent (CT/PET scan, MRI)	In-network: \$75 copayment per service up to a combined annual maximum of \$375 for MRI and CAT scans; \$400 for PET scans	No change
	Out-of-network: 50% coinsurance per service after OON plan deductible is met	No change
Non-Advanced Radiology – Hospital (x-ray, diagnostic)	In-network: 20% coinsurance per service after INET plan deductible is met	In-network: 30% coinsurance per service after INET plan deductible is met
	Out-of-network: 50% coinsurance per service after OON plan deductible is met	No change
Non-Advanced Radiology – Independent (x-ray, diagnostic)	In-network: \$25 copayment per service; deductible waived	In-network: \$50 copayment per service; deductible waived
	Out-of-network: 50% coinsurance per service after OON plan deductible is met	No change
Laboratory Services	In-network: \$10 copayment per service; deductible waived	No change
	Out-of-network: 50% coinsurance per service after OON plan deductible is met	No change
Physical and Occupational Therapy (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.)	In-network: \$30 copayment per visit after INET plan deductible is met	In-network: 30% coinsurance per visit after INET plan deductible is met
	Out-of-network: 50% coinsurance per visit after OON plan deductible is met	No change
Speech Therapy (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.)	In-network: \$60 copayment per visit after INET plan deductible is met	In-network: 30% coinsurance per visit after INET plan deductible is met
	Out-of-network: 50% coinsurance per visit after OON plan deductible is met	No change

Plan Overview	2023 Plan Year	2024 Plan Year
Prescription Drugs		
Tier 1	In-network: \$10 copayment per prescription; deductible waived	No change
	Out-of-network: 50% coinsurance per prescription after OON deductible is met	No change
Tier 2	In-network: \$50 copayment per prescription; deductible waived	In-network: \$40 copayment per prescription; deductible waived
	Out-of-network: 50% coinsurance per prescription after OON deductible is met	No change
Tier 3	In-network: 50% coinsurance per prescription after INET deductible is met	In-network: \$60 copayment per prescription after INET prescription drug deductible is met
	Out-of-network: 50% coinsurance per prescription after OON deductible is met	No change
Tier 4	In-network: 50% coinsurance up to a maximum of \$500 per prescription after INET deductible is met	In-network: 20% coinsurance up to a maximum of \$150 per prescription after INET prescription drug deductible is met
	Out-of-network: 50% coinsurance per prescription after OON deductible is met	No change
Adult Dental Care		
Preventive (one exam and cleaning per 6-month period)	In-network: No cost	Not covered
	Out-of-network: 50% coinsurance per visit after OON plan deductible is met	Not covered
Routine (full-mouth x-rays or panoramic x-rays at 36-month intervals and bitewing x-rays at 6-month intervals)	In-network: No cost	Not covered
	Out-of-network: 50% coinsurance per visit after OON plan deductible is met	Not covered

Coverage underwritten by ConnectiCare Benefits, Inc., only, not Access Health CT

Teladoc and related marks are trademarks of Teladoc Health, Inc. and are used by ConnectiCare with permission

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.

CCI_BR_OTH_63181_ChoiceGold_Alt-POS_Dental 9/23