# Choice Gold Alternative POS

If you are eligible for automatic renewal, **you'll be enrolled in the 2025 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 | 2024 Plan Year | 2025 Plan Year |
|---|---|---|
| **Plan Name** | **Choice Gold Alternative POS** | **Choice Gold Alternative POS** |
| Plan Metal Level | Gold | Gold |
| Product Type | POS | POS |
| **Deductible** | | |
| Individual In-Network (INET) | $2,000 per member | No change |
| Family In-Network | $4,000 per family | No change |
| 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 | $75 per member | No change |
| Family In-Network | $150 per family | No change |
| Individual Out-of-Network | $500 per member | No change |
| Family Out-of-Network | $1,000 per family | No change |
| **Out-of-Pocket Maximum** | | |
| Individual In-Network | $8,300 per member | $7,900 per member |
| Family In-Network | $16,600 per family | $15,800 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; deductible waived | No change |
| Primary Care (injury or illness) | In-network: $40 copayment per visit; deductible waived | No change |
| | Out-of-network: 50% coinsurance per visit after OON plan deductible is met | No change |
| Telemedicine Visits Through Teladoc® Primary Care – members must be 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 Abuse | In-network: $50 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 |

ConnectiCare

| Plan Overview | 2024 Plan Year | 2025 Plan Year |
|---|---|---|
| **Emergency/Urgent Care** | | |
| Urgent Care Center or Facility | In-network: 30% coinsurance per visit; deductible waived | No change |
| | Out-of-network: 50% coinsurance per visit after OON plan deductible is met | No change |
| Emergency Room (copay waived if admitted) | In-network: 30% coinsurance per visit after INET plan deductible is met | No change |
| | Out-of-network: Same as in-network | 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 after INET plan deductible is met | No change |
| | Out-of-network: 50% coinsurance per visit after OON plan deductible is met | No change |
| Major Services | In-network: 50% coinsurance per visit after INET plan deductible is met | No change |
| | 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 after INET plan deductible is met | No change |
| | 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: $50 copayment per visit; deductible waived | No change |
| | 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% after INET plan deductible is met; Collection frame: 50% 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 abuse, maternity, hospice, and skilled nursing facility: skilled nursing facility stay is limited to 90 days per calendar year.) | In-network: 30% coinsurance per admission after INET plan deductible is met | No change |
| | Out-of-network: 50% coinsurance per admission after OON plan deductible is met | No change |
| Outpatient (performed at an outpatient hospital facility) | In-network: 30% coinsurance per visit after INET plan deductible is met | No change |
| | Out-of-network: 50% coinsurance per visit after OON plan deductible is met | No change |
| Outpatient (performed at an ambulatory surgery center) | In-network: $250 copayment per visit; deductible waived | No change |
| | Out-of-network: 50% coinsurance per visit after OON plan deductible is met | No change |

| Plan Overview | 2024 Plan Year | 2025 Plan Year |
|---|---|---|
| **Outpatient Services** | | |
| Home Health Care<br>(100 visit maximum per calendar year) | In-network: 25% coinsurance per visit after separate $50 deductible is met | No change |
| | Out-of-network: 25% coinsurance per visit after separate $50 deductible is met | No change |
| Advanced Radiology —<br>Hospital (CT/PET scan, MRI) | In-network: 30% coinsurance per service after INET plan deductible is met | No change |
| | Out-of-network: 50% coinsurance per service after OON plan deductible is met | No change |
| Advanced Radiology —<br>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; deductible waived | No change |
| | Out-of-network: 50% coinsurance per service after OON plan deductible is met | No change |
| Non-Advanced Radiology -—<br>Hospital (x-ray, diagnostic) | In-network: 30% coinsurance per service after INET plan deductible is met | No change |
| | Out-of-network: 50% coinsurance per service after OON plan deductible is met | No change |
| Non-Advanced Radiology —<br>Independent (x-ray, diagnostic) | In-network: $50 copayment per service; deductible waived | No change |
| | 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<br>(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% coinsurance per visit after INET plan deductible is met | No change |
| | Out-of-network: 50% coinsurance per visit after OON plan deductible is met | No change |
| Speech Therapy<br>(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% coinsurance per visit after INET plan deductible is met | No change |
| | Out-of-network: 50% coinsurance per visit after OON plan deductible is met | No change |

| Plan Overview | 2024 Plan Year | 2025 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 prescription drug deductible is met | No change |
| Tier 2 | In-network: $40 copayment per prescription; deductible waived | No change |
| | Out-of-network: 50% coinsurance per prescription after OON prescription drug deductible is met | No change |
| Tier 3 | In-network: $60 copayment per prescription after INET prescription drug deductible is met | No change |
| | Out-of-network: 50% coinsurance per prescription after OON prescription drug deductible is met | No change |
| Tier 4 | In-network: 20% coinsurance up to a maximum of $150 per prescription after INET prescription drug deductible is met | No change |
| | Out-of-network: 50% coinsurance per prescription after OON prescription drug deductible is met | No change |





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