Choice Gold Standard 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 Standard POS**	**Choice Gold Standard POS**
Plan Metal Level	Gold	Gold
Product Type	POS	POS
Deductible		
Individual In-Network (INET)	$1,300 per member	$1,200 per member
Family In-Network	$2,600 per family	$2,400 per family
Individual Out-of-Network (OON)	$3,000 per member	No change
Family Out-of-Network	$6,000 per family	No change
Prescription Drug Deductible		
Individual In-Network	$50 per member	No change
Family In-Network	$100 per family	No change
Individual Out-of-Network	$350 per member	No change
Family Out-of-Network	$700 per family	No change
Out-of-Pocket Maximum		
Individual In-Network	$7,375 per member	No change
Family In-Network	$14,750 per family	No change
Individual Out-of-Network	$14,750 per member	No change
Family Out-of-Network	$29,500 per family	No change
Physician Office Visits		
Preventive Care/Screenings/Immunizations	In-network: No cost	No change
	Out-of-network: 30% coinsurance per visit; deductible waived	No change
Primary Care (injury or illness)	In-network: $20 copayment per visit; deductible waived	No change
	Out-of-network: 30% 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: $40 copayment per visit; deductible waived	No change
	Out-of-network: 30% coinsurance per visit after OON plan deductible is met	No change
Specialist	In-network: $40 copayment per visit; deductible waived	No change
	Out-of-network: 30% coinsurance per visit after OON plan deductible is met	No change
Mental Health and Substance Abuse	In-network: $20 copayment per visit; deductible waived	No change
	Out-of-network: 30% 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: $50 copayment per visit; deductible waived	No change
	Out-of-network: 30% coinsurance per visit after OON plan deductible is met	No change
Emergency Room (copay waived if admitted)	In-network: $400 copayment per visit; deductible waived	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: 20% coinsurance per visit; deductible waived	No change
	Out-of-network: 50% coinsurance per visit after OON plan deductible is met	No change
Major Services	In-network: 40% coinsurance per visit; deductible waived	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; deductible waived	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: $40 copayment per visit; deductible waived	No change
	Out-of-network: 30% 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: $0 Collection frame: $0	No change
	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

Plan Overview	2024 Plan Year	2025 Plan Year
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: $500 copayment per day up to a maximum of $1,000 per admission after INET plan deductible is met	No change
	Out-of-network: 30% coinsurance per admission after OON plan deductible is met	No change
Outpatient (performed at an outpatient hospital facility)	In-network: $500 copayment per visit after INET plan deductible is met	No change
	Out-of-network: 30% coinsurance per visit after OON plan deductible is met	No change
Outpatient (performed at an ambulatory surgery center)	In-network: $300 copayment per visit after INET plan deductible is met	No change
	Out-of-network: 30% coinsurance per visit after OON plan deductible is met	No change
Outpatient Services		
Home Health Care (100 visit maximum per calendar year)	In-network: No cost	No change
	Out-of-network: 25% coinsurance per visit after separate $50 deductible is met	No change
Advanced Radiology (CT/PET scan, MRI)	In-network: $65 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: 30% coinsurance per service after OON plan deductible is met	No change
Non-Advanced Radiology (x-ray, diagnostic)	In-network: $40 copayment per service after INET plan deductible is met	No change
	Out-of-network: 30% coinsurance per service after OON plan deductible is met	No change
Laboratory Services	In-network: $10 copayment per service after INET plan deductible is met	In-network: $10 copayment per service; deductible waived
	Out-of-network: 30% 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: $20 copayment per visit; deductible waived	No change
	Out-of-network: 30% 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: $20 copayment per visit; deductible waived	No change
	Out-of-network: 30% 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: $5 copayment per prescription; deductible waived	No change
	Out-of-network: 30% coinsurance per prescription after OON prescription drug deductible is met	No change
Tier 2	In-network: $35 copayment per prescription; deductible waived	No change
	Out-of-network: 30% coinsurance per prescription after OON prescription drug deductible is met	No change
Tier 3	In-network: $60 copayment per prescription; deductible waived	No change
	Out-of-network: 30% coinsurance per prescription after OON prescription drug deductible is met	No change
Tier 4	In-network: 20% coinsurance up to a maximum of $100 per prescription after INET prescription drug deductible is met	No change
	Out-of-network: 30% coinsurance per prescription after OON prescription drug deductible is met	No change

ConnectiCare