ConnectiCare

Please review the information below carefully. This chart explains the changes in cost-sharing, if any, between your current 2024 plan and the new plan you will automatically be enrolled in for 2025.

To make a change, contact your broker or call us at **800-723-2986** (TTY: **711**).

| Plan overview | 2024 plan year | 2025 plan year |
|---|---|---|
| **Plan name** | Choice SOLO HMO Copay/Coins. $8,000 ded. | Choice SOLO HMO Copay/Coins. $7,700 ded. |
| **Product type** | HMO | HMO |
| **Deductible** | | |
| **Individual in-network** | $8,000 per member | $7,700 per member |
| **Family in-network** | $16,000 per family | $15,400 per family |
| **Individual out-of-network** | N/A | No change |
| **Family out-of-network** | N/A | No change |
| **Prescription drug deductible** | | |
| **Individual in-network** | Combined with medical | No change |
| **Family in-network** | Combined with medical | No change |
| **Individual out-of-network** | N/A | No change |
| **Family out-of-network** | N/A | No change |
| **Out-of-pocket maximum** | | |
| **Individual in-network** | $9,450 per member | $9,000 per member |
| **Family in-network** | $18,900 per family | $18,000 per family |
| **Individual out-of-network** | N/A | No change |
| **Family out-of-network** | N/A | No change |
| **Physician office visits** | | |
| **Preventive care/screenings/immunizations** | **In-network:** No cost<br>**Out-of-network:** Not covered | No change |
| **Primary care**<br>(injury or illness) | **In-network:** $40 copayment/visit, deductible does not apply<br>**Out-of-network:** Not covered | No change |
| **Telemedicine visits through Teladoc®**<br>Primary care – members must be age 18 or older | **In-network:**<br>**Primary care, mental health, and general medical services:** No cost<br>**Dermatologist:** $60 copayment/visit, deductible does not apply<br>**Out-of-network:** N/A | No change |
| **Specialist** | **In-network:** $60 copayment/visit, deductible does not apply<br>**Out-of-network:** Not covered | No change |
| **Mental health and substance use** | **In-network:** $60 copayment/visit, deductible does not apply<br>**Out-of-network:** Not covered | **In-network**: $40 copayment/visit, deductible does not apply<br>**Out-of-network:** No change |
| **Emergency/urgent care** | | |
| **Urgent care centers** | **In-network:** $100 copayment/visit, deductible does not apply<br>**Out-of-network:** Same as in-network benefit | No change |
| **Emergency room** | **In-network:** 35% coinsurance after plan deductible<br>**Out-of-network:** Same as in-network benefit | **In-network:** 50% coinsurance after plan deductible<br>**Out-of-network:** No change |

| Plan overview | 2024 plan year | 2025 plan year |
|---|---|---|
| **Hospital services** | | |
| **Inpatient**<br>Including mental health, substance use, maternity, hospice, and skilled nursing facility*<br>*Skilled nursing facility stay is limited to 90 days per calendar year. | **In-network:** 35% coinsurance after plan deductible<br>**Out-of-network:** Not covered | **In-network:** 50% coinsurance after plan deductible<br>**Out-of-network:** No change |
| **Hospital outpatient facilities** | **In-network:** 35% coinsurance after plan deductible<br>**Out-of-network:** Not covered | **In-network:** 50% coinsurance after plan deductible<br>**Out-of-network:** No change |
| **Ambulatory surgical center** | **In-network:** $500 copayment/visit, deductible does not apply<br>**Out-of-network:** Not covered | No change |
| **Outpatient services** | | |
| **Home health care**<br>(up to 100-visits per calendar-year) | **In-network:** 25% coinsurance, deductible does not apply<br>**Out-of-network:** Not covered | No change |
| **Advanced radiology**<br>(CT/PET Scan, MRI)<br>Hospital facility | **In-network:** 35% coinsurance after plan deductible<br>**Out-of-network:** Not covered | **In-network:** 50% coinsurance after plan deductible<br>**Out-of-network:** No change |
| **Advanced Radiology**<br>(CT/PET Scan, MRI)<br>Independent facility | **In-network:** 35% coinsurance, deductible does not apply<br>**Out-of-network:** Not covered | **In-network:** 50% coinsurance; deductible does not apply<br>**Out-of-network:** No change |
| **Non-advanced radiology**<br>(X-ray, diagnostic)<br>Hospital facility | **In-network:** 35% coinsurance after plan deductible<br>**Out-of-network:** Not covered | **In-network:** 50% coinsurance after plan deductible<br>**Out-of-network:** No change |
| **Non-advanced radiology**<br>(X-ray, diagnostic)<br>Independent facility | **In-network:** $50 copayment/service, deductible does not apply<br>**Out-of-network:** Not covered | **In-network:** $60 copayment/service, deductible does not apply<br>**Out-of-network:** Not covered |
| **Laboratory services**<br>Independent facility | **In-network:** 35% coinsurance after plan deductible<br>**Out-of-network:** Not covered | **In-network:** $25 copayment/service; deductible does not apply<br>**Out-of-network:** Not covered |
| **Laboratory services**<br>Hospital facility | **In-network:** 35% coinsurance after plan deductible<br>**Out-of-network:** Not covered | **In-network:** $25 copayment/service; deductible does not apply<br>**Out-of-network:** Not covered |
| **Physical and occupational therapy**<br>Up to 40 visits per year combined for physical, speech, and occupational therapy (habilitative services have a separate 40-visit maximum) | **In-network:** $30 copayment/visit after plan deductible<br>**Out-of-network:** Not covered | No change |
| **Speech therapy**<br>Up to 40 visits per year combined for physical, speech, and occupational therapy (habilitative services have a separate 40-visit maximum) | **In-network:** $60 copayment/visit after plan deductible<br>**Out-of-network:** Not covered | **In-network:** $30 copayment/visit after plan deductible<br>**Out-of-network:** Not covered |
| **Prescription drugs** | | |
| **Preferred generic**<br>(Tier 1) | **In-network:** $15 copayment/prescription, deductible does not apply<br>**Out-of-network:** Not covered | No change |
| **Non-preferred generic**<br>(Tier 2) | **In-network:** 50% coinsurance up to a maximum of $250 per prescription after plan deductible<br>**Out-of-network:** Not covered | No change |
| **Preferred brand**<br>(Tier 3) | **In-network:** $50 copayment/prescription, deductible does not apply<br>**Out-of-network:** Not covered | No change |

| Plan overview | 2024 plan year | 2025 plan year |
|---|---|---|
| **Prescription drugs (continued)** | | |
| **Non-preferred brand**<br>(Tier 4) | **In-network:** 50% coinsurance up to a maximum of $500 per prescription after plan deductible<br>**Out-of-network:** Not covered | No change |
| **Preferred specialty**<br>(Tier 5) | **In-network:** 50% coinsurance up to a maximum of $500 per prescription after plan deductible (specialty retail only)<br>**Out-of-network:** Not covered | No change |
| **Non-preferred specialty**<br>(Tier 6) | **In-network:** 50% coinsurance up to a maximum of $750 per prescription after plan deductible (specialty retail only)<br>**Out-of-network:** Not covered | No change |
| **Pediatric-only dental services (for members under age 26)** | | |
| **Pediatric dental diagnostic and preventive** | **In-network:** No cost<br>**Out-of-network:** Not covered | No change |
| **Pediatric dental services**<br>Basic, major, and orthodontia services (medically necessary) | **In-network:** 50% coinsurance after plan deductible<br>**Out-of-network:** Not covered | No change |
| **Pediatric vision services (for members under age 26)** | | |
| **Routine eye exam** | **In-network:** $25 copayment/visit, deductible does not apply<br>**Out-of-network:** Not covered | No change |
| **Prescription eyeglasses**<br>One pair of frames and lenses or contact lenses per calendar year | **In-network:** 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.<br>**Out-of-network:** Not covered | No change |

For ConnectiCare SOLO plans, coverage is provided by and services are administered as follows: In Connecticut: Individual HMO coverage is underwritten by ConnectiCare, Inc.; Individual POS coverage is underwritten by ConnectiCare Insurance Company, Inc. or ConnectiCare, Inc.