



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 POS Copay/Coins. \$5,500 30% ded.	Choice SOLO POS Copay/Coins. \$5,500 30% ded.
Product type	POS	POS
Deductible		
Individual in-network	\$5,500 per member	No change
Family in-network	\$11,000 per family	No change
Individual out-of-network	\$15,000 per member	No change
Family out-of-network	\$30,000 per family	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	Combined with medical	No change
Family out-of-network	Combined with medical	No change
Out-of-pocket maximum		
Individual in-network	\$9,450 per member	\$8,000 per member
Family in-network	\$18,900 per family	\$16,000 per family
Individual out-of-network	\$30,000 per member	No change
Family out-of-network	\$60,000 per family	No change
Physician office visits		
Preventive care/screenings/immunizations	In-network: No cost Out-of-network: 50% coinsurance after plan deductible	No change
Primary care (injury or illness)	In-network: \$40 copayment/visit, deductible does not apply Out-of-network: 50% coinsurance after plan deductible	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: \$70 copayment/visit after plan deductible Out-of-network: 50% coinsurance after plan deductible	No change
Specialist	In-network: \$70 copayment/visit after plan deductible Out-of-network: 50% coinsurance after plan deductible	No change
Mental health and substance use	In-network: \$70 copayment/visit, deductible does not apply Out-of-network: 50% coinsurance after plan deductible	In-network: \$40 copayment/visit, deductible does not apply Out-of-network: No change
Emergency/urgent care		
Urgent care centers	In-network: \$100 copayment/visit, deductible does not apply Out-of-network: Same as in-network benefit	No change
Emergency room	In-network: 30% coinsurance after plan deductible Out-of-network: Same as in-network benefit	No change

Plan overview	2024 plan year	2025 plan year
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: 30% coinsurance after plan deductible Out-of-network: 50% coinsurance after plan deductible	No change
Hospital outpatient facilities	In-network: 30% coinsurance after plan deductible Out-of-network: 50% coinsurance after plan deductible	No change
Ambulatory surgical center	In-network: \$500 copayment/visit after plan deductible Out-of-network: 50% coinsurance after plan deductible	No change
Outpatient services		
Home health care (up to 100-visits per calendar-year)	In-network: 25% coinsurance, deductible does not apply Out-of-network: 25% coinsurance, deductible does not apply	No change
Advanced radiology (CT/PET scan, MRI) Hospital facility	In-network: 30% coinsurance after plan deductible Out-of-network: 50% coinsurance after plan deductible	No change
Advanced radiology (CT/PET scan, MRI) Independent facility	In-network: \$75 copayment/service after plan deductible (up to 5 copayments per year, then copayment waived) Out-of-network: 50% coinsurance after plan deductible	No change
Non-advanced radiology (X-ray, diagnostic) Hospital facility	In-network: 30% coinsurance after plan deductible Out-of-network: 50% coinsurance after plan deductible	No change
Non-advanced radiology (X-ray, diagnostic) Independent facility	In-network: \$35 copayment/service after plan deductible Out-of-network: 50% coinsurance after plan deductible	No change
Laboratory services Hospital Facility	In-network: 30% coinsurance after plan deductible Out-of-network: 50% coinsurance after plan deductible	No change
Laboratory services Independent facility	In-network: \$10 copayment/service after plan deductible Out-of-network: 50% coinsurance after plan deductible	No change
Physical and occupational therapy Up to 40 visits per year combined for physical, speech, and occupational therapy (habilitative services have a separate 40-visit maximum)	In-network: 30% coinsurance after plan deductible Out-of-network: 50% coinsurance after plan deductible	No change
Speech therapy Up to 40 visits per year combined for physical, speech, and occupational therapy (habilitative services have a separate 40-visit maximum)	In-network: 30% coinsurance after plan deductible Out-of-network: 50% coinsurance after plan deductible	No change

Plan overview	2024 plan year	2025 plan year
Prescription drugs		
Preferred generic (Tier 1)	In-network: \$10 copayment/prescription, deductible does not apply Out-of-network: 50% coinsurance after plan deductible	No change
Non-preferred generic (Tier 2)	In-network: 50% coinsurance up to a maximum of \$250 per prescription after plan deductible Out-of-network: 50% coinsurance after plan deductible	No change
Preferred brand (Tier 3)	In-network: \$60 copayment/prescription, deductible does not apply Out-of-network: 50% coinsurance after plan deductible	No change
Non-preferred brand (Tier 4)	In-network: 50% coinsurance up to a maximum of \$500 per prescription after plan deductible Out-of-network: 50% coinsurance after plan deductible	No change
Preferred specialty (Tier 5)	In-network: 50% coinsurance up to a maximum of \$500 per prescription after plan deductible (specialty retail only) Out-of-network: 50% coinsurance after plan deductible (specialty retail only)	No change
Non-preferred specialty (Tier 6)	In-network: 50% coinsurance up to a maximum of \$750 per prescription after plan deductible (specialty retail only) Out-of-network: 50% coinsurance after plan deductible (specialty retail only)	No change
Pediatric-only services (for members under age 26)		
Pediatric dental diagnostic and preventive	In-network: No cost Out-of-network: 50% coinsurance after plan deductible	No change
Pediatric dental services Basic, major, and orthodontia services (medically necessary)	In-network: 50% coinsurance after plan deductible Out-of-network: 50% coinsurance after plan deductible	No change
Pediatric vision routine eye exam	In-network: \$50 copayment/visit, deductible does not apply Out-of-network: 50% coinsurance after plan deductible	No change
Pediatric prescription eyeglasses 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. Out-of-network: 50% coinsurance after plan deductible	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.

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