



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 HSA Coins. \$6,000 ded.	Choice SOLO POS HSA Coins. \$6,000 ded.
Product type	POS	POS
Deductible		
Individual in-network	\$6,000 per member	No change
Family in-network	\$12,000 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	\$7,500 per member	No change
Family in-network	\$15,000 per family	No change
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	<b>In-network:</b> No cost <b>Out-of-network:</b> 50% coinsurance after plan deductible	No change
Primary care (injury or illness)	<b>In-network:</b> 25% coinsurance after plan deductible <b>Out-of-network:</b> 50% coinsurance after plan deductible	No change
Telemedicine visits through Teladoc® Primary care – members must be age 18 or older	<b>In-network:</b> <b>Primary care, mental health and general medical services:</b> No cost after plan deductible <b>Dermatologist:</b> 25% coinsurance after plan deductible <b>Out-of-network:</b> N/A	No change
Specialist	<b>In-network:</b> 25% coinsurance after plan deductible <b>Out-of-network:</b> 50% coinsurance after plan deductible	No change
Mental health and substance use	<b>In-network:</b> 25% coinsurance after plan deductible <b>Out-of-network:</b> 50% coinsurance after plan deductible	No change

Plan overview	2024 plan year	2025 plan year
<b>Emergency/urgent care</b>		
<b>Urgent care centers</b>	<b>In-network:</b> 25% coinsurance after plan deductible <b>Out-of-network:</b> Same as in-network benefit	No change
<b>Emergency room</b>	<b>In-network:</b> 25% coinsurance after plan deductible <b>Out-of-network:</b> Same as in-network benefit	No change
<b>Hospital services</b>		
<b>Inpatient</b> Including mental health, substance use, maternity, hospice, and skilled nursing facility* *Skilled nursing facility stay is limited to 90 days per calendar year.	<b>In-network:</b> 25% coinsurance after plan deductible <b>Out-of-network:</b> 50% coinsurance after plan deductible	No change
<b>Hospital outpatient facilities</b>	<b>In-network:</b> 25% coinsurance after plan deductible <b>Out-of-network:</b> 50% coinsurance after plan deductible	No change
<b>Ambulatory surgical center</b>	<b>In-network:</b> 25% coinsurance after plan deductible <b>Out-of-network:</b> 50% coinsurance after plan deductible	No change
<b>Outpatient services</b>		
<b>Home health care</b> (up to 100-visits per calendar-year)	<b>In-network:</b> 25% coinsurance after plan deductible <b>Out-of-network:</b> 25% coinsurance after plan deductible	No change
<b>Advanced radiology</b> (CT/PET scan, MRI) Hospital facility	<b>In-network:</b> 25% coinsurance after plan deductible <b>Out-of-network:</b> 50% coinsurance after plan deductible	No change
<b>Advanced radiology</b> (CT/PET scan, MRI) Independent facility	<b>In-network:</b> 25% coinsurance after plan deductible <b>Out-of-network:</b> 50% coinsurance after plan deductible	No change
<b>Non-advanced radiology</b> (X-ray, diagnostic) Hospital facility	<b>In-network:</b> 25% coinsurance after plan deductible <b>Out-of-network:</b> 50% coinsurance after plan deductible	No change
<b>Non-advanced radiology</b> (X-ray, diagnostic) Independent facility	<b>In-network:</b> 25% coinsurance after plan deductible <b>Out-of-network:</b> 50% coinsurance after plan deductible	No change
<b>Laboratory services</b>	<b>In-network:</b> 25% coinsurance after plan deductible <b>Out-of-network:</b> 50% coinsurance after plan deductible	No change
<b>Physical and occupational therapy</b> Up to 40 visits per year combined for physical, speech, and occupational therapy (habilitative services have a separate 40-visit maximum)	<b>In-network:</b> 25% coinsurance after plan deductible <b>Out-of-network:</b> 50% coinsurance after plan deductible	No change
<b>Speech therapy</b> Up to 40 visits per year combined for physical, speech, and occupational therapy (habilitative services have a separate 40-visit maximum)	<b>In-network:</b> 25% coinsurance after plan deductible <b>Out-of-network:</b> 50% coinsurance after plan deductible	No change

Plan overview	2024 plan year	2025 plan year
<b>Prescription drugs</b>		
<b>Preferred generic</b> (Tier 1)	<b>In-network:</b> \$10 copayment/prescription after plan deductible <b>Out-of-network:</b> 50% coinsurance after plan deductible	No change
<b>Non-preferred generic</b> (Tier 2)	<b>In-network:</b> 50% coinsurance up to a maximum of \$250 per prescription after plan deductible <b>Out-of-network:</b> 50% coinsurance after plan deductible	No change
<b>Preferred brand</b> (Tier 3)	<b>In-network:</b> \$60 copayment/prescription after plan deductible <b>Out-of-network:</b> 50% coinsurance after plan deductible	No change
<b>Non-preferred brand</b> (Tier 4)	<b>In-network:</b> 50% coinsurance up to a maximum of \$500 per prescription after plan deductible <b>Out-of-network:</b> 50% coinsurance after plan deductible	No change
<b>Preferred specialty</b> (Tier 5)	<b>In-network:</b> 50% coinsurance up to a maximum of \$500 per prescription after plan deductible (specialty retail only) <b>Out-of-network:</b> 50% coinsurance after plan deductible (specialty retail only)	No change
<b>Non-preferred specialty</b> (Tier 6)	<b>In-network:</b> 50% coinsurance up to a maximum of \$750 per prescription after plan deductible (specialty retail only) <b>Out-of-network:</b> 50% coinsurance after plan deductible (specialty retail only)	No change
<b>Pediatric-only services (for members under age 26)</b>		
<b>Pediatric dental diagnostic and preventive</b>	<b>In-network:</b> No cost <b>Out-of-network:</b> 50% coinsurance after plan deductible	No change
<b>Pediatric dental services</b> Basic, major, and orthodontia services (medically necessary)	<b>In-network:</b> 50% coinsurance after plan deductible <b>Out-of-network:</b> 50% coinsurance after plan deductible	No change
<b>Pediatric vision routine eye exam</b>	<b>In-network:</b> 25% coinsurance, deductible does not apply <b>Out-of-network:</b> 50% coinsurance after plan deductible	No change
<b>Pediatric prescription eyeglasses</b> One pair of frames and lenses or contact lenses per calendar year	<b>In-network:</b> 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. <b>Out-of-network:</b> 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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