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	Passage SOLO HMO Copay/Coins. $7,500 ded.	Choice SOLO HMO Copay/Coins. $7,700 ded.
Product type	HMO	HMO
Deductible		
Individual in-network	$7,500 per member	$7,700 per member
Family in-network	$15,000 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 **Out-of-network:** Not covered	No change
Primary care (injury or illness)	**In-network:** $40 copayment/visit, deductible does not apply **Out-of-network:** Not covered	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:** $60 copayment/visit, deductible does not apply **Out-of-network:** N/A	No change
Specialist	**In-network:** $60 copayment/visit, deductible does not apply **Out-of-network:** Not covered	No change
Mental health and substance use	**In-network:** $60 copayment/visit, deductible does not apply **Out-of-network:** Not covered	**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:** 50% 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:** 50% coinsurance after plan deductible **Out-of-network:** Not covered	No change
Hospital outpatient facilities	**In-network:** 50% coinsurance after plan deductible **Out-of-network:** Not covered	No change
Ambulatory surgical center	**In-network:** $500 copayment/visit after plan deductible **Out-of-network:** Not covered	**In-network:** $500 copayment; deductible does not apply **Out-of-network:** 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:** Not covered	No change
Advanced radiology (CT/PET scan, MRI) Hospital facility	**In-network:** 50% coinsurance after plan deductible **Out-of-network:** Not covered	No change
Advanced Radiology (CT/PET scan, MRI) Independent facility	**In-network:** 50% coinsurance, deductible does not apply **Out-of-network:** Not covered	No change
Non-advanced radiology (X-ray, diagnostic) Hospital facility	**In-network:** 50% coinsurance after plan deductible **Out-of-network:** Not covered	No change
Non-advanced radiology (X-ray, diagnostic) Independent facility	**In-network:** $20 copayment/service after plan deductible **Out-of-network:** Not covered	**In-network:** $60 copayment/service, deductible does not apply **Out-of-network:** Not covered
Laboratory services Hospital facility	**In-network:** 50% coinsurance after plan deductible **Out-of-network:** Not covered	**In-network:** $25 copayment/service; deductible does not apply **Out-of-network:** Not covered
Laboratory services Independent facility	**In-network:** $20 copayment/service after plan deductible **Out-of-network:** Not covered	**In-network:** $25 copayment/service; deductible does not apply **Out-of-network:** Not covered
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:** 50% coinsurance after plan deductible **Out-of-network:** Not covered	**In-network:** $30 copayment/visit after plan deductible **Out-of-network:** Not covered
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:** 50% coinsurance after plan deductible **Out-of-network:** Not covered	**In-network:** $30 copayment/visit after plan deductible **Out-of-network:** Not covered
Prescription drugs		
Preferred generic (Tier 1)	**In-network:** $15 copayment/prescription, deductible does not apply **Out-of-network:** Not covered	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:** Not covered	No change
Preferred brand (Tier 3)	**In-network:** $60 copayment/prescription after plan deductible **Out-of-network:** Not covered	**In-network:** $50 copayment/ prescription; deductible does not apply **Out-of-network:** Not covered

Plan overview	2024 plan year	2025 plan year
Prescription drugs (continued)		
Non-preferred brand (Tier 4)	**In-network:** 50% coinsurance up to a maximum of $500 per prescription after plan deductible **Out-of-network:** Not covered	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:** Not covered	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:** Not covered	No change
Pediatric-only dental services (for members under age 26)		
Pediatric dental diagnostic and preventive	**In-network:** No cost **Out-of-network:** Not covered	No change
Pediatric dental services Basic, major, and orthodontia services (medically necessary)	**In-network:** 50% coinsurance after plan deductible **Out-of-network:** Not covered	No change
Pediatric vision services (for members under age 26)		
Routine eye exam	**In-network:** $50 copayment/visit, deductible does not apply **Out-of-network:** Not covered	**In-network:** $25 copayment/visit, deductible does not apply **Out-of-network:** Not covered
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:** Not covered	No change