



ConnectiCare Benefits, Inc.

Individual Market
Choice Bronze Standard POS HSA
Schedule of Benefits
Non-Tiered Network Plan

The individual deductible and out-of-pocket maximum applies if you have coverage only for yourself. The family deductible and out-of-pocket maximum applies if you have coverage for yourself and one or more eligible dependents. Each individual on the family plan will only need to satisfy the individual deductible and out-of-pocket maximum, not the full family amount. Each individual's charges will accrue towards the family amounts.

Choice Network - Includes Providers in Connecticut only

Deductible and Out-of-Pocket Maximum	In-Network (INET) Member Pays	Out-of-network (OON) Member Pays
Plan deductible Individual Family (Deductible is combined for medical services and prescription drugs)	\$6,500 per member \$13,000 per family	\$13,000 per member \$26,000 per family
Separate Prescription Drug Deductible Individual Family	Included in Plan Deductible per member / per family	Included in Plan Deductible per member / per family
Out-of-Pocket Maximum Individual Family (Includes deductible, copayments and coinsurance for medical and pharmacy services)	\$7,225 per member \$14,450 per family	\$14,450 per member \$28,900 per family
Benefits	In-Network (INET) Member Pays	Out-of-network (OON) Member Pays
Provider Office Visits		
Adult/Pediatric Preventive Visits	No cost	50% coinsurance per visit; deductible does not apply
Primary Care Provider Office Visits (includes services for illness, injury, follow-up care and consultations)	20% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met
Specialist Office Visits	20% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met
Mental Health and Substance Use Disorder Office Visits	20% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met
Outpatient Diagnostic Services		

Benefits	In-Network (INET) Member Pays	Out-of-network (OON) Member Pays
Advanced Radiology (CT/PET Scan, MRI)	20% coinsurance per service after INET plan deductible is met	50% coinsurance per service after OON plan deductible is met
Laboratory Services	20% coinsurance per service after INET plan deductible is met	50% coinsurance per service after OON plan deductible is met
Non-Advanced Radiology (X-ray, Diagnostic)	20% coinsurance per service after INET plan deductible is met	50% coinsurance per service after OON plan deductible is met
Mammography Ultrasound/MRI (No cost for Screening and Diagnostic if within Federal and/or State regulations)	20% coinsurance per service after INET plan deductible is met	50% coinsurance per service after OON plan deductible is met
Prescription Drugs – Retail Pharmacy (cost share based on 30 day supply per prescription)		
Generic Drugs Tier 1	20% coinsurance per prescription after INET plan deductible is met	50% coinsurance per prescription after OON plan deductible is met
Preferred Brand Drugs Tier 2	25% coinsurance per prescription after INET plan deductible is met	50% coinsurance per prescription after OON plan deductible is met
Non-Preferred Brand Tier 3	30% coinsurance per prescription after INET plan deductible is met	50% coinsurance per prescription after OON plan deductible is met
Specialty Drugs Tier 4	30% coinsurance up to a maximum of \$500 per prescription after INET plan deductible is met	50% coinsurance per prescription after OON plan deductible is met
Prescription – Mail Order Pharmacy (up to a 90 day supply per prescription)		
Generic Drugs Tier 1	20% coinsurance per prescription after INET plan deductible is met	50% coinsurance per prescription after OON plan deductible is met
Preferred Brand Drugs Tier 2	25% coinsurance per prescription after INET plan deductible is met	50% coinsurance per prescription after OON plan deductible is met
Non-Preferred Brand Tier 3	30% coinsurance per prescription after INET plan deductible is met	50% coinsurance per prescription after OON plan deductible is met
Outpatient Rehabilitative and Habilitative Services (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.)		
Speech Therapy	20% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met
Physical and Occupational Therapy	20% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met
Other Services		
Chiropractic Services (up to 20 visits per calendar year)	20% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met
Diabetic Equipment and Supplies	20% coinsurance per equipment/ supply after INET plan deductible is met	50% coinsurance per equipment/ supply after OON plan deductible is met

Benefits	In-Network (INET) Member Pays	Out-of-network (OON) Member Pays
Durable Medical Equipment (DME)	20% coinsurance per equipment/supply after INET plan deductible is met	50% coinsurance per equipment/supply after OON plan deductible is met
Home Health Care Services (up to 100 visits per calendar year)	20% coinsurance per visit after INET plan deductible is met	25% coinsurance per visit after OON plan deductible is met
Outpatient Services (in a hospital or ambulatory facility)	20% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met
Inpatient Services		
Inpatient hospital services include mental health, substance use disorder, maternity, hospice, skilled nursing facility* and all IP settings. (*skilled nursing facility stay is limited to 90 days per calendar year)	20% coinsurance per admission after INET plan deductible is met	50% coinsurance per admission after OON plan deductible is met
Emergency and Urgent Care		
Ambulance Services	20% coinsurance per service after INET plan deductible is met	20% coinsurance per service after INET plan deductible is met
Emergency Room	20% coinsurance per visit after INET plan deductible is met	20% coinsurance per visit after INET plan deductible is met
Urgent Care Centers	20% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met
Pediatric Dental Care (for members under age 26)		
Diagnostic & Preventive	No cost	50% coinsurance per visit after OON plan deductible is met
Basic Services	40% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met
Major Services	50% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met
Orthodontia Services (medically necessary only)	50% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met
Pediatric Vision Care (for members under age 26)		

Benefits	In-Network (INET) Member Pays	Out-of-network (OON) Member Pays
Prescription Eye Glasses Services must be provided by a participating VSP Provider to receive In-Network benefits (one pair of frames and lenses or contact lens per calendar year)	Lenses: \$0 copayment after INET plan deductible is met Collection Frame: \$0 copayment after INET plan deductible is met Non-collection frame: Members choosing to upgrade from a collection frame to a noncollection 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	50% coinsurance per visit after OON plan deductible is met
Routine Eye Exam Services must be provided by a participating VSP Provider to receive In-Network benefits (one exam per calendar year)	20% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met
Additional Covered Services		
Adult Routine Eye Exam Services must be provided by a participating VSP Provider to receive In-Network benefits (for members over age 26 - one exam per calendar year)	20% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met
Allergy Injections (Unlimited)	20% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met
Allergy Testing (one visit per calendar year)	20% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met
Artificial Limbs (includes associated supplies and equipment)	20% coinsurance after INET plan deductible is met	50% coinsurance after OON plan deductible is met
Infusion therapy (when services are rendered in a Specialist office or Freestanding Infusion Center)	20% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met
Modified Food Products and Specialized Formula	20% coinsurance after INET plan deductible is met	50% coinsurance after OON plan deductible is met
Outpatient mental health, alcohol and substance use disorder treatment (intensive outpatient treatment and partial hospitalization)	20% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met

Benefits	In-Network (INET) Member Pays	Out-of-network (OON) Member Pays
Retail Clinic	20% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met
Telemedicine Services (services rendered by a Teladoc® provider)	General Medical and Mental Health Services: 0% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met
Important information		
• This is a brief summary of benefits. Refer to your ConnectiCare Benefits, Inc. Evidence of Coverage (EOC) for complete details on benefits, conditions, limitations and exclusions. All benefits described are per member per calendar year. • 90-day supply of select maintenance medications are available to be filled at any pharmacy in the network. • Ovarian cancer screening and monitoring services coverage and cost share details are available in your EOC. • Mammogram screenings, breast ultrasounds, and breast MRIs – Please refer to the EOC for details. • Insulin and noninsulin drugs are covered up to a cost share maximum of \$25 for each 30-day supply. • Diabetes Devices and Diabetic Ketoacidosis Devices are covered up to a cost share maximum of \$100 per 30-day supply. • Please refer to your EOC for additional cost share maximums regarding diabetic services. Some diabetic services fall under preventive care and cost share may be waived. • An ambulatory surgery center is a facility that exclusively provides outpatient surgical services to patients who do not require hospitalization and whose expected stay in the center does not exceed 24 hours. Ambulatory surgery centers are not owned by a hospital. • An outpatient hospital facility offers surgical procedures and related care that, in the opinion of the attending physician, can be safely performed without requiring overnight inpatient hospital care. Outpatient hospital facilities are owned by a hospital or hospital system. • If you have questions regarding your plan, visit our website at www.connecticare.com or call us at (860) 674-5757 or 1-800-251-7722. • To learn more about your Teladoc® benefits contact Teladoc® at teladochealth.com/connecticarecore or call 1-800-835-2362 (TTY: 711). • Out-of-Network reimbursement is based on the maximum allowable amount. Members are responsible for paying any charges in excess of this amount. Please refer to your ConnectiCare Benefits, Inc. EOC for more information. • Under this program covered prescription drugs and supplies are put into categories (i.e. tiers) to designate how they are to be covered and the member's cost-share. The placement of a drug or supply into one of the tiers is determined by the ConnectiCare Pharmacy Services Department and approved by the ConnectiCare Pharmacy & Therapeutics Committee based on the drugs or supplies clinical effectiveness and cost, not on whether it is a generic drug or supply or brand name drug or supply. • Amounts paid by members because they must pay a price difference for a brand name drug do not count towards meeting any deductible, coinsurance, copayment, coinsurance or cost share maximum. • Most specialty drugs are dispensed through specialty pharmacies by mail, up to 30-day supply. Specialty Pharmacies have the same member cost share as all other participating pharmacies and are not part of the ConnectiCare extended day supply program. • Many services require that you obtain our Prior Authorization prior to obtaining care. Please refer to the "Prior Authorization Addendum" in your EOC for a detailed list of services or call member services at 1-800-251-7722. Without Prior Authorization for medically necessary covered services prescribed or rendered by Non-Participating providers, benefits may be reduced by the lesser of \$500 or 50%. • For mental health and substance use disorder services call 1-888-946-4658 to obtain Prior Authorization. • In-network preventive and wellness services as defined by the United States Preventive Service Task Force (USPSTF), including immunizations recommended by the Advisory Committee on Immunizations Practices		

at the Centers for Disease Control (CDC), and preventive care and screenings supported by the Health Resources and Services Administration (HRSA) are exempt from all cost shares under the Patient Protection and Affordable Care Act (PPACA). Visit our website at www.connecticare.com to view a list of preventive and wellness services.