ConnectiCare

Individual Market
Choice SOLO POS HSA Coins. $6,500 ded.

High deductible Health Plan for use with a Health Savings Account (HSA) (E)
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.

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	$15,000 per member $30,000 per family
Separate Prescription Drug Deductible Individual Family	N/A per member N/A per family	N/A per member N/A per family
Out-of-Pocket Maximum Individual Family (Includes deductible, copayments and coinsurance for medical and pharmacy services)	$8,300 per member $16,600 per family	$30,000 per member $60,000 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 after plan deductible
Primary Care Provider Office/ Telemedicine Visits (includes services for illness, injury, follow-up care and consultations)	25% coinsurance after plan deductible	50% coinsurance after plan deductible
Telemedicine Services (services rendered by a Teladoc® provider)	**General Medical and Mental Health Services:** 0% coinsurance after plan deductible	50% coinsurance after plan deductible

Benefits	In-Network (INET) Member Pays	Out-of-network (OON) Member Pays
Specialist Office/Telemedicine Visits	25% coinsurance after plan deductible	50% coinsurance after plan deductible
Mental Health and Substance Use Disorder Office Visits	25% coinsurance after plan deductible	50% coinsurance after plan deductible
Outpatient Diagnostic Services		
Advanced Radiology (CT/PET Scan, MRI)	25% coinsurance after plan deductible	50% coinsurance after plan deductible
Laboratory Services	25% coinsurance after plan deductible	50% coinsurance after plan deductible
Non-Advanced Radiology (X-ray, Diagnostic)	25% coinsurance after plan deductible	50% coinsurance after plan deductible
Mammography Ultrasound/MRI (No cost for Screening and Diagnostic if within Federal and/or State regulations)	25% coinsurance after plan deductible	50% coinsurance after plan deductible
Prescription Drugs – Retail Pharmacy (cost share based on 30 day supply per prescription)		
Generic Drugs Tier 1	$10 copayment/prescription after plan deductible	50% coinsurance after plan deductible
Preferred Brand Drugs Tier 2	$60 copayment/prescription after plan deductible	50% coinsurance after plan deductible
Non-Preferred Brand Tier 3	50% coinsurance up to a maximum of $500 per prescription after plan deductible	50% coinsurance after plan deductible
Specialty Drugs Tier 4	50% coinsurance up to a maximum of $750 per prescription after plan deductible (specialty retail only)	50% coinsurance after plan deductible
Prescription – Mail Order Pharmacy (up to a 90 day supply per prescription)		
Generic Drugs Tier 1	$30 copayment/prescription after plan deductible	50% coinsurance after plan deductible
Preferred Brand Drugs Tier 2	$180 copayment/prescription after plan deductible	50% coinsurance after plan deductible
Non-Preferred Brand Tier 3	50% coinsurance up to a maximum of $1,500 per prescription after plan deductible	50% coinsurance after plan deductible
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	25% coinsurance after plan deductible	50% coinsurance after plan deductible

Benefits	In-Network (INET) Member Pays	Out-of-network (OON) Member Pays
Physical and Occupational Therapy	25% coinsurance after plan deductible	50% coinsurance after plan deductible
Other Services		
Chiropractic Services (up to 20 visits per calendar year)	25% coinsurance after plan deductible	50% coinsurance after plan deductible
Diabetic Equipment and Supplies	25% coinsurance after plan deductible	50% coinsurance after plan deductible
Durable Medical Equipment (DME)	25% coinsurance after plan deductible	50% coinsurance after plan deductible
Home Health Care Services (up to 100 visits per calendar year)	25% coinsurance after plan deductible	25% coinsurance after plan deductible
Outpatient Services (in a hospital or ambulatory facility)	25% coinsurance after plan deductible	50% coinsurance after plan deductible
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)	25% coinsurance after plan deductible	50% coinsurance after plan deductible
Emergency and Urgent Care		
Ambulance Services	25% coinsurance after plan deductible	Same as In-network benefit
Emergency Room	25% coinsurance after plan deductible	Same as in-network benefit
Urgent Care Centers	25% coinsurance after plan deductible	50% coinsurance after plan deductible
Pediatric Dental Care (for members under age 26)		
Diagnostic & Preventive	No cost	50% coinsurance after plan deductible
Basic Services	50% coinsurance after plan deductible	50% coinsurance after plan deductible
Major Services	50% coinsurance after plan deductible	50% coinsurance after plan deductible
Orthodontia Services (medically necessary only)	50% coinsurance after plan deductible	50% coinsurance after plan deductible

Benefits	**In-Network (INET) Member Pays**	**Out-of-network (OON) Member Pays**
Pediatric Vision Care (for members under age 26) **Services Must be provided by a participating VSP Provider to receive In-network benefits**		
Prescription Eye Glasses (one pair of frames and lenses per calendar year)	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	50% coinsurance after plan deductible
Routine Eye Exam (one exam per calendar year)	25% coinsurance; deductible does not apply	50% coinsurance after plan deductible
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)	25% coinsurance after plan deductible	50% coinsurance after plan deductible
Allergy Injections (unlimited)	25% coinsurance after plan deductible	50% coinsurance after plan deductible
Allergy Testing (one visit per calendar year)	25% coinsurance after plan deductible	50% coinsurance after plan deductible
Artificial Limbs (includes associated supplies and equipment)	20% coinsurance after plan deductible	50% coinsurance after plan deductible
Infusion therapy (when services are rendered in a Specialist office or Freestanding Infusion Center)	25% coinsurance after plan deductible	50% coinsurance after plan deductible
Modified Food Products and Specialized Formula	25% coinsurance after plan deductible	50% coinsurance after plan deductible
Outpatient mental health, alcohol and substance use disorder treatment (intensive outpatient treatment and partial hospitalization)	25% coinsurance after plan deductible	50% coinsurance after plan deductible
Retail Clinic	25% coinsurance after plan deductible	50% coinsurance after plan deductible
Important information		
• This is a brief summary of benefits. Refer to your ConnectiCare, Inc. **Evidence of Coverage (EOC)** for complete details on benefits, conditions, limitations and exclusions, or consult with your benefits manager.		

- 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 $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.
- To learn more about your **Teladoc®** benefits contact **Teladoc®** at teladochealth.com/connecticarecore or call 1-800-835-2362 (TTY: 711).
- 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.
- 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, 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 supply's 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 or cost share maximum.
- Most specialty drugs are dispensed through specialty pharmacies by mail, up to a 30-day supply. Specialty Pharmacies have the same member cost share as all other participating pharmacies and are not part of ConnectiCare's 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 service 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, alcohol 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.