

ConnectiCare Benefits At A Glance



Affordable, quality health coverage for all offered through Access Health CT. Learn more at ConnectiCareSales.com.

Call today! (877) 751-6670 (TTY: 711)

	Value Bronze Alternative EPO	Choice Bronze Alternative EPO	Choice Bronze Alternative POS with Dental and Vision	
Offered Off-Exchange	Yes	Yes	Yes	Yes
In-Network (INN)/Out-of-Network (OON)	In-Network	In-Network	In-Network	Out-of-Network
BENEFITS AND COST SHARE HIGHLIGHTS				
Deductible (Ind/Fam)	\$7,000 / \$14,000	\$7,000 / \$14,000	\$7,000 / \$14,000	\$15,000 / \$30,000
Drug Deductible (Ind/Fam)	Comb. w/Med	Comb. w/Med	Comb. w/Med	Comb. w/Med
Out of Pocket Max (Ind/Fam)	\$11,000 / \$22,000	\$11,000 / \$22,000	\$11,000 / \$22,000	\$20,000 / \$40,000
Emergency Room Facility	45% after ded	45% after ded	45% after ded	45% after INN ded
Urgent Care Services	\$100	\$100	\$100	50% after ded
INPATIENT SERVICES				
Inpatient Facility Fee <i>*Professional Fees May Apply</i>	45% after ded	45% after ded	45% after ded	50% after ded
OUTPATIENT PROFESSIONAL OFFICE VISITS SERVICES				
Primary Care	\$60	\$60	\$60	50% after ded
Specialty Care	\$80 after ded	\$80 after ded	\$80 after ded	50% after ded
Rehabilitative and Habilitative Services	\$30 after ded	\$30 after ded	\$30 after ded	50% after ded
Mental / Behavioral Health Services / Substance Use Disorder Services	\$60	\$60	\$60	50% after ded

Retail Rx (cost share based on 30-day supply per prescription) Insulin and non-insulin drugs are covered up to a max of \$25 for each 30-day supply.
§ Mail-order is available for non-specialty drugs marked "MAIL" on the formulary. For mail-order Rx, a 90-day supply is provided at three times (3x) the 30-day retail cost-sharing amount.

SERVICES WITHOUT
ANY DEDUCTIBLE

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	Value Bronze Alternative EPO	Choice Bronze Alternative EPO	Choice Bronze Alternative POS with Dental and Vision	
Offered Off-Exchange	Yes	Yes	Yes	Yes
In-Network (INN)/Out-of-Network (OON)	In-Network	In-Network	In-Network	Out-of-Network
OUTPATIENT HOSPITAL FACILITY SERVICES				
Outpatient Facility Fee	45% after ded	45% after ded	45% after ded	50% after ded
Outpatient Professional Fee	45% after ded	45% after ded	45% after ded	50% after ded
Advanced Imaging and Specialized Scanning Services	45% after ded	45% after ded	45% after ded	50% after ded
Routine X-Ray and Diagnostic Services	45% after ded	45% after ded	45% after ded	50% after ded
Laboratory Tests	\$25 after ded	\$25 after ded	\$25 after ded	50% after ded
PRESCRIPTION DRUGS [§]				
Preventive Drugs	No charge	No charge	No charge	50% after ded
Preferred Generic Drugs	\$20	\$20	\$20	50% after ded
Preferred Brand Drugs	\$100 after ded	\$100 after ded	\$100 after ded	50% after ded
Non-Preferred Drugs	40% after ded	40% after ded	40% after ded	50% after ded
Specialty Drugs	50% after ded	50% after ded	50% after ded	50% after ded

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SERVICES WITHOUT
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Offered Off-Exchange In-Network (INN)/Out-of-Network (OON)	Choice Bronze Standard POS		Choice Bronze Standard POS HDHP		Choice Bronze Standard Lite POS	
	Yes	Yes	Yes	Yes	Yes	Yes
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
BENEFITS AND COST SHARE HIGHLIGHTS						
Deductible (Ind/Fam)	\$8,000 / \$16,000	\$16,000 / \$32,000	\$6,500 / \$13,000	\$13,000 / \$26,000	\$8,000 / \$16,000	\$16,000 / \$32,000
Drug Deductible (Ind/Fam)	Comb. w/Med	Comb. w/Med	Comb. w/Med	Comb. w/Med	Comb. w/Med	Comb. w/Med
Out of Pocket Max (Ind/Fam)	\$12,000 / \$24,000	\$24,000 / \$48,000	\$8,500 / \$17,000	\$17,000 / \$34,000	\$12,000 / \$24,000	\$24,000 / \$48,000
Emergency Room Facility	\$450 after ded	\$450 after INN ded	20% after ded	20% after INN ded	20% after ded	20% after INN ded
Urgent Care Services	\$120	50% after ded	20% after ded	50% after ded	20% after ded	50% after ded
INPATIENT SERVICES						
Inpatient Facility Fee <i>*Professional Fees May Apply</i>	\$500 per day after ded (\$1,000 max per admission)	50% per admission after ded	20% after ded	50% after ded	20% after ded	50% after ded
OUTPATIENT PROFESSIONAL OFFICE VISITS SERVICES						
Primary Care	\$60	50% after ded	20% after ded	50% after ded	20% after ded	50% after ded
Specialty Care	\$120	50% after ded	20% after ded	50% after ded	20% after ded	50% after ded
Rehabilitative and Habilitative Services	\$30 after ded	50% after ded	20% after ded	50% after ded	20% after ded	50% after ded
Mental / Behavioral Health Services / Substance Use Disorder Services	\$60	50% after ded	20% after ded	50% after ded	20% after ded	50% after ded

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SERVICES WITHOUT ANY DEDUCTIBLE

ConnectiCare Benefits At A Glance



Offered Off-Exchange In-Network (INN)/Out-of-Network (OON)	Choice Bronze Standard POS		Choice Bronze Standard POS HDHP		Choice Bronze Standard Lite POS	
	Yes	Yes	Yes	Yes	Yes	Yes
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
OUTPATIENT HOSPITAL FACILITY SERVICES						
Outpatient Facility Fee	\$500 after ded at an Outpatient Hospital Facility \$300 after ded at an Ambulatory Surgery Center	50% after ded	20% after ded	50% after ded	20% after ded	50% after ded
Outpatient Professional Fee	\$0 after ded	50% after ded	20% after ded	50% after ded	20% after ded	50% after ded
Advanced Imaging and Specialized Scanning Services	\$75 after ded up to a combined annual maximum of \$375 for MRI and CAT scans; \$400 for PET scans	50% after ded	20% after ded	50% after ded	20% after ded	50% after ded
Routine X-Ray and Diagnostic Services	\$40 after ded	50% after ded	20% after ded	50% after ded	20% after ded	50% after ded
Laboratory Tests	\$40	50% after ded	20% after ded	50% after ded	20% after ded	50% after ded
PRESCRIPTION DRUGS [§]						
Preventive Drugs	No charge	50% after ded	No charge	50% after ded	No charge	50% after ded
Preferred Generic Drugs	\$15	50% after ded	20% after ded	50% after ded	20% after ded	50% after ded
Preferred Brand Drugs	\$50	50% after ded	25% after ded	50% after ded	20% after ded	50% after ded
Non-Preferred Drugs	50% after ded	50% after ded	30% after ded	50% after ded	20% after ded	50% after ded
Specialty Drugs	50% after ded (\$500 max per prescription)	50% after ded	30% after ded (\$500 max per prescription)	50% after ded	20% after ded	50% after ded

Retail Rx (cost share based on 30-day supply per prescription) Insulin and non-insulin drugs are covered up to a max of \$25 for each 30-day supply.
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SERVICES WITHOUT ANY DEDUCTIBLE

ConnectiCare Benefits At A Glance



Offered Off-Exchange In-Network (INN)/ Out-of-Network (OON)	Choice Silver Standard POS		Choice Silver Standard POS (CSR 73%)		Choice Silver Standard POS (CSR 87%)		Choice Silver Standard POS (CSR 94%)	
	Yes	Yes	No	No	No	No	No	No
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
BENEFITS AND COST SHARE HIGHLIGHTS								
Deductible (Ind/Fam)	\$5,500 / \$11,000	\$11,000 / \$22,000	\$5,000 / \$10,000	\$11,000 / \$22,000	\$415 / \$830	\$11,000 / \$22,000	\$0	\$11,000 / \$22,000
Drug Deductible (Ind/Fam)	\$250 / \$500	\$500 / \$1,000	\$250 / \$500	\$500 / \$1,000	\$50 / \$100	\$500 / \$1,000	\$0	\$500 / \$1,000
Out of Pocket Max (Ind/Fam)	\$10,550 / \$21,100	\$21,100 / \$42,200	\$9,600 / \$19,200	\$21,100 / \$42,200	\$3,500 / \$7,000	\$21,100 / \$42,200	\$2,500 / \$5,000	\$21,100 / \$42,200
Emergency Room Facility	\$450 after ded	\$450 after INN ded	\$450 after ded	\$450 after INN ded	\$150 after ded	\$150 after INN ded	\$50	\$50
Urgent Care Services	\$100	40% after ded	\$100	40% after ded	\$35	40% after ded	\$25	40% after ded
INPATIENT SERVICES								
Inpatient Facility Fee <i>*Professional Fees May Apply</i>	\$500 per day after ded (\$2,000 max per admission)	40% after ded	\$500 per day after ded (\$2,000 max per admission)	40% after ded	\$100 per day after ded (\$400 max per admission)	40% after ded	\$75 per day (\$300 max per admission)	40% after ded

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SERVICES WITHOUT ANY DEDUCTIBLE

2027

ConnectiCare Benefits At A Glance



Offered Off-Exchange In-Network (INN)/ Out-of-Network (OON)	Choice Silver Standard POS		Choice Silver Standard POS (CSR 73%)		Choice Silver Standard POS (CSR 87%)		Choice Silver Standard POS (CSR 94%)	
	Yes	Yes	No	No	No	No	No	No
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
OUTPATIENT PROFESSIONAL OFFICE VISITS SERVICES								
Primary Care	\$48	40% after ded	\$48	40% after ded	\$35	40% after ded	\$15	40% after ded
Specialty Care	\$80	40% after ded	\$80	40% after ded	\$50	40% after ded	\$30	40% after ded
Rehabilitative and Habilitative Services	\$30	40% after ded	\$30	40% after ded	\$20	40% after ded	\$20	40% after ded
Mental / Behavioral Health Services / Substance Use Disorder Services	\$48	40% after ded	\$48	40% after ded	\$35	40% after ded	\$15	40% after ded

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	Choice Silver Standard POS		Choice Silver Standard POS (CSR 73%)		Choice Silver Standard POS (CSR 87%)		Choice Silver Standard POS (CSR 94%)	
	Yes	Yes	No	No	No	No	No	No
Offered Off-Exchange								
In-Network (INN)/ Out-of-Network (OON)	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
OUTPATIENT HOSPITAL FACILITY SERVICES								
Outpatient Facility Fee	\$500 after ded at an Outpatient Hospital Facility \$300 after ded at an Ambulatory Surgery Center	40% after ded	\$200 after ded at an Outpatient Hospital Facility \$100 after ded at an Ambulatory Surgery Center	40% after ded	\$100 after ded at an Outpatient Hospital Facility \$60 after ded at an Ambulatory Surgery Center	40% after ded	\$75 at an Outpatient Hospital Facility \$45 at an Ambulatory Surgery Center	40% after ded
Outpatient Professional Fee	\$0 after ded	40% after ded	\$0 after ded	40% after ded	\$0 after ded	40% after ded	\$0	40% after ded
Advanced Imaging and Specialized Scanning Services	\$75 up to a combined annual maximum of \$375 for MRI and CAT scans; \$400 for PET scans	40% after ded	\$75 up to a combined annual maximum of \$375 for MRI and CAT scans; \$400 for PET scans	40% after ded	\$60 up to a combined annual maximum of \$360 for MRI and CAT scans; \$400 for PET scans	40% after ded	\$50 up to a combined annual maximum of \$350 for MRI and CAT scans; \$400 for PET scans	40% after ded
Routine X-Ray and Diagnostic Services	\$50 after ded	40% after ded	\$40 after ded	40% after ded	\$30 after ded	40% after ded	\$25	40% after ded
Laboratory Tests	\$40	40% after ded	\$25	40% after ded	\$25	40% after ded	\$20	40% after ded

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Offered Off-Exchange In-Network (INN)/ Out-of-Network (OON)	Choice Silver Standard POS		Choice Silver Standard POS (CSR 73%)		Choice Silver Standard POS (CSR 87%)		Choice Silver Standard POS (CSR 94%)	
	Yes	Yes	No	No	No	No	No	No
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
PRESCRIPTION DRUGS [§]								
Preventive Drugs	No charge	40% after RX ded	No charge	40% after RX ded	No charge	40% after RX ded	No charge	40% after RX ded
Preferred Generic Drugs	\$10	40% after RX ded	\$10	40% after RX ded	\$10	40% after RX ded	\$5	40% after RX ded
Preferred Brand Drugs	\$50 after RX ded	40% after RX ded	\$50 after RX ded	40% after RX ded	\$25	40% after RX ded	\$15	40% after RX ded
Non-Preferred Drugs	\$75 after RX ded	40% after RX ded	\$75 after RX ded	40% after RX ded	\$40 after RX ded	40% after RX ded	\$35	40% after RX ded
Specialty Drugs	20% after RX ded (\$200 max per prescription)	40% after RX ded	20% after RX ded (\$100 max per prescription)	40% after RX ded	20% after RX ded (\$60 max per prescription)	40% after RX ded	20% (\$60 max per prescription)	40% after RX ded

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ConnectiCare Benefits At A Glance



Offered Off-Exchange In-Network (INN)/Out-of-Network (OON)	Choice Covered Connecticut Program (87)		Choice Covered Connecticut Program (94)	
	No	No	No	No
	In-Network	Out-of-Network	In-Network	Out-of-Network
BENEFITS AND COST SHARE HIGHLIGHTS				
Deductible (Ind/Fam)	State: \$415 / \$830 Member: \$0	State: \$11,000 / \$22,000 Member: \$0	\$0	State: \$11,000 / \$22,000 Member: \$0
Drug Deductible (Ind/Fam)	State: \$50 / \$100 Member: \$0	State: \$500 / \$1,000 Member: \$0	\$0	State: \$500 / \$1,000 Member: \$0
Out of Pocket Max (Ind/Fam)	State: \$3,500 / \$7,000 Member: \$0	State: \$21,100 / \$42,200 Member: \$0	State: \$2,500 / \$5,000 Member: \$0	State: \$21,100 / \$42,200 Member: \$0
Emergency Room Facility	State: \$150 after ded Member: \$0	State: \$150 after INN ded Member: \$0	State: \$50 Member: \$0	State: \$50 Member: \$0
Urgent Care Services	State: \$35 Member: \$0	State: 40% after ded Member: \$0	State: \$25 Member: \$0	State: 40% after ded Member: \$0
INPATIENT SERVICES				
Inpatient Facility Fee <i>*Professional Fees May Apply</i>	State: \$100 day / \$400 admit after ded Member: \$0	State: 40% after ded Member: \$0	State: \$75 per day (\$300 max per admission) Member: \$0	State: 40% after ded Member: \$0

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SERVICES WITHOUT ANY DEDUCTIBLE

ConnectiCare Benefits At A Glance



Offered Off-Exchange In-Network (INN)/Out-of-Network (OON)	Choice Covered Connecticut Program (87)		Choice Covered Connecticut Program (94)	
	No	No	No	No
	In-Network	Out-of-Network	In-Network	Out-of-Network
OUTPATIENT PROFESSIONAL OFFICE VISITS SERVICES				
Primary Care	State:\$35 Member: \$0	State: 40% after ded Member: \$0	State: \$15 Member: \$0	State: 40% after ded Member: \$0
Specialty Care	State: \$50 Member: \$0	State: 40% after ded Member: \$0	State: \$30 Member: \$0	State: 40% after ded Member: \$0
Rehabilitative and Habilitative Services	State: \$20 Member: \$0	State: 40% after ded Member: \$0	State: \$20 Member: \$0	State: 40% after ded Member: \$0
Mental / Behavioral Health Services / Substance Use Disorder Services	State:\$35 Member: \$0	State: 40% after ded Member: \$0	State: \$15 Member: \$0	State: 40% after ded Member: \$0

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Offered Off-Exchange In-Network (INN)/Out-of-Network (OON)	Choice Covered Connecticut Program (87)		Choice Covered Connecticut Program (94)	
	No	No	No	No
	In-Network	Out-of-Network	In-Network	Out-of-Network
OUTPATIENT HOSPITAL FACILITY SERVICES				
Outpatient Facility Fee	State: \$100 after ded at an Outpatient Hospital Facility Member: \$0 State: \$60 after ded at an Ambulatory Surgery Center Member: \$0	State: 40% after ded Member: \$0	State: \$75 at an Outpatient Hospital Facility Member: \$0 State: \$45 at an Ambulatory Surgery Center Member: \$0	State: 40% after ded Member: \$0
Outpatient Professional Fee	State: \$0 after ded Member: \$0	State: 40% after ded Member: \$0	\$0	State: 40% after ded Member: \$0
Advanced Imaging and Specialized Scanning Services	State: \$60 up to a combined annual maximum of \$360 for MRI and CAT scans; \$400 for PET scans Member: \$0	State: 40% after ded Member: \$0	State: \$50 up to a combined annual maximum of \$350 for MRI and CAT scans; \$400 for PET scans Member: \$0	State: 40% after ded Member: \$0
Routine X-Ray and Diagnostic Services	State: \$30 after ded Member: \$0	State: 40% after ded Member: \$0	State: \$25 Member: \$0	State: 40% after ded Member: \$0
Laboratory Tests	State: \$25 Member: \$0	State: 40% after ded Member: \$0	State: \$20 Member: \$0	State: 40% after ded Member: \$0

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Offered Off-Exchange In-Network (INN)/Out-of-Network (OON)	Choice Covered Connecticut Program (87)		Choice Covered Connecticut Program (94)	
	No	No	No	No
	In-Network	Out-of-Network	In-Network	Out-of-Network
PRESCRIPTION DRUGS [§]				
Preventive Drugs	No charge	State: 40% after RX ded Member: \$0	No charge	State: 40% after RX ded Member: \$0
Preferred Generic Drugs	State: \$10 Member: \$0	State: 40% after RX ded Member: \$0	State: \$5 Member: \$0	State: 40% after RX ded Member: \$0
Preferred Brand Drugs	State: \$25 Member: \$0	State: 40% after RX ded Member: \$0	State: \$15 Member: \$0	State: 40% after RX ded Member: \$0
Non-Preferred Drugs	State: \$40 after RX ded Member: \$0	State: 40% after RX ded Member: \$0	State: \$35 Member: \$0	State: 40% after RX ded Member: \$0
Specialty Drugs	State: 20% after RX ded (\$60 max per prescription) Member: \$0	State: 40% after RX ded Member: \$0	State: 20% (\$60 max per prescription) Member: \$0	State: 40% after RX ded Member: \$0

Retail Rx (cost share based on 30-day supply per prescription) Insulin and non-insulin drugs are covered up to a max of \$25 for each 30-day supply.
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Offered Off-Exchange In-Network (INN)/Out-of-Network (OON)	Choice Gold Standard POS		Choice Gold Alternative POS		Choice Gold Alternative EPO with Dental and Vision
			Choice Gold Alternative POS with Dental and Vision		
	Yes	Yes	Yes	Yes	Yes
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
BENEFITS AND COST SHARE HIGHLIGHTS					
Deductible (Ind/Fam)	\$2,000 / \$4,000	\$4,000 / \$8,000	\$2,000 / \$4,000	\$7,000 / \$14,000	\$2,000 / \$4,000
Drug Deductible (Ind/Fam)	\$50 / \$100	\$350 / \$700	Comb. w/Med	Comb. w/Med	Comb. w/Med
Out of Pocket Max (Ind/Fam)	\$8,500 / \$17,000	\$17,000 / \$34,000	\$8,000 / \$16,000	\$17,000 / \$34,000	\$8,000 / \$16,000
Emergency Room Facility	\$500	\$500	20% after ded	20% after INN ded	20% after ded
Urgent Care Services	\$70	30% after ded	\$60	50% after ded	\$60
INPATIENT SERVICES					
Inpatient Facility Fee <i>*Professional Fees May Apply</i>	\$500 per day after ded (\$1,000 per admission)	30% after ded	20% after ded	50% after ded	20% after ded
OUTPATIENT PROFESSIONAL OFFICE VISITS SERVICES					
Primary Care	\$30	30% after ded	\$25	50% after ded	\$25
Specialty Care	\$60	30% after ded	\$50	50% after ded	\$50
Rehabilitative and Habilitative Services	\$30	30% after ded	20% after ded	50% after ded	20% after ded
Mental / Behavioral Health Services / Substance Use Disorder Services	\$30	30% after ded	\$25	50% after ded	\$25

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Offered Off-Exchange In-Network (INN)/Out-of-Network (OON)	Choice Gold Standard POS		Choice Gold Alternative POS		Choice Gold Alternative EPO with Dental and Vision
			Choice Gold Alternative POS with Dental and Vision		
	Yes	Yes	Yes	Yes	Yes
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
OUTPATIENT HOSPITAL FACILITY SERVICES					
Outpatient Facility Fee	\$500 after ded at an Outpatient Hospital Facility	30% after ded	20% after ded	50% after ded	20% after ded
	\$300 after ded at an Ambulatory Surgery Center				
Outpatient Professional Fee	\$0 after ded	30% after ded	20% after ded	50% after ded	20% after ded
Advanced Imaging and Specialized Scanning Services	\$75 up to a combined annual maximum of \$375 for MRI and CAT scans; \$400 for PET scans	30% after ded	20% after ded	50% after ded	20% after ded
Routine X-Ray and Diagnostic Services	\$40 after ded	30% after ded	20% after ded	50% after ded	20% after ded
Laboratory Tests	\$25	30% after ded	\$10	50% after ded	\$10

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Offered Off-Exchange In-Network (INN)/Out-of-Network (OON)	Choice Gold Standard POS		Choice Gold Alternative POS		Choice Gold Alternative EPO with Dental and Vision
			Choice Gold Alternative POS with Dental and Vision		
	Yes	Yes	Yes	Yes	Yes
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
PRESCRIPTION DRUGS [§]					
Preventive Drugs	No charge	30% after RX ded	No charge	50% after ded	No charge
Preferred Generic Drugs	\$5	30% after RX ded	\$5	50% after ded	\$5
Preferred Brand Drugs	\$35	30% after RX ded	\$50	50% after ded	\$50
Non-Preferred Drugs	\$60	30% after RX ded	20% after ded	50% after ded	20% after ded
Specialty Drugs	20% after RX ded (\$100 max per prescription)	30% after RX ded	30% after ded	50% after ded	30% after ded

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Retail Rx (cost share based on 30-day supply per prescription) Insulin and non-insulin drugs are covered up to a max of \$25 for each 30-day supply.
§ Mail-order is available for non-specialty drugs marked "MAIL" on the formulary. For mail-order Rx, a 90-day supply is provided at three times (3x) the 30-day retail cost-sharing amount.

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