ConnectiCare Benefits, Inc.

# Passage Silver Alternative PCP POS (CSR 87%)
# Individual Market

**Passage plans require selection of an in-network PCP upon enrollment.**
**A referral from your primary care provider is required to see a specialist.**

| Deductible and Out-of-Pocket Maximum | IN-NETWORK (INET) MEMBER PAYS | OUT-OF-NETWORK (OON) MEMBER PAYS |
|---|---|---|
| **Plan Deductible**<br>*Individual*<br>*Family* | <br>$1,250 per Member<br>$2,500 per Family | <br>$10,000 per Member<br>$20,000 per Family |
| **Separate Prescription Drug Deductible**<br>*Individual*<br>*Family* | <br>$100 per Member<br>$200 per Family | <br>$500 per Member<br>$1,000 per Family |
| **Out-of-Pocket Maximum**<br>*(Includes deductible, copayments and coinsurance)* | $2,200 per Member<br>$4,400 per Family | $15,000 per Member<br>$30,000 per Family |
| **Benefits** | **IN-NETWORK (INET) MEMBER PAYS** | **OUT-OF-NETWORK (OON) MEMBER PAYS** |
| **Provider Office Visits** | | |
| **Adult Preventive Visit** | No cost | 50% coinsurance per visit |
| **Infant/Pediatric Preventive Visit** | No cost | 50% coinsurance per visit |
| **Primary Care Provider Office Visits**<br>*(includes services for illness, injury, follow-up care and consultations)* | $5 copayment per visit | 50% coinsurance per visit after OON plan deductible is met |
| **Specialist Office Visits** | $30 copayment per visit | 50% coinsurance per visit after OON plan deductible is met |

| Benefits | IN-NETWORK (INET)<br>MEMBER PAYS | OUT-OF-NETWORK (OON)<br>MEMBER PAYS |
|---|---|---|
| **Mental Health and Substance Abuse Office Visit** | $30 copayment per visit | 50% coinsurance per visit after OON plan deductible is met |
| **Outpatient Diagnostic Services** | **IN-NETWORK (INET)<br>MEMBER PAYS** | **OUT-OF-NETWORK (OON)<br>MEMBER PAYS** |
| **Advanced Radiology**<br>*(CT/PET Scan, MRI)* | $75 copayment per service after INET plan deductible is met up to a combined annual maximum of $375 for MRI and CAT scans; $400 for PET scans | 50% coinsurance per visit after OON plan deductible is met |
| **Laboratory Services** | No Cost | 50% coinsurance per visit after OON plan deductible is met |
| **Non-Advanced Radiology**<br>*(X-ray, Diagnostic, Baseline Mammography, Screening Tomosynthesis)* | $30 copayment per service | 50% coinsurance per visit after OON plan deductible is met |
| **Mammography Ultrasound** | $20 copayment per service | 50% coinsurance per service after OON plan deductible is met |
| **Prescription Drugs - Retail Pharmacy**<br>*(30 day supply per prescription)* | **IN-NETWORK (INET)<br>MEMBER PAYS** | **OUT-OF-NETWORK (OON)<br>MEMBER PAYS** |
| **Tier 1 Prescription Drugs**<br>*(Generic Drugs)* | $5 copayment per prescription | 50% coinsurance per prescription after OON prescription drug deductible is met |
| **Tier 2 Prescription Drugs**<br>*(Preferred Brand Drugs)* | $30 copayment per prescription | 50% coinsurance per prescription after OON prescription drug deductible is met |
| **Tier 3 Prescription Drugs**<br>*(Non-Preferred Brand Drugs)* | 50% coinsurance up to a maximum of $200 per prescription after INET prescription drug deductible is met | 50% coinsurance per prescription after OON prescription drug deductible is met |
| **Tier 4 Prescription Drugs**<br>*(Specialty Drugs)* | 50% coinsurance up to a maximum of $400 per prescription after INET prescription drug deductible is met | 50% coinsurance per prescription after OON prescription drug deductible is met |
| **Prescription Drugs - Mail Order**<br>*(90 day supply per prescription)* | **IN-NETWORK (INET)<br>MEMBER PAYS** | **OUT-OF-NETWORK (OON)<br>MEMBER PAYS** |
| **Tier 1 Prescription Drugs**<br>*(Generic Drugs)* | $10 copayment per prescription | Not covered |

| **Prescription Drugs - Mail Order**<br>*(90 day supply per prescription)* | **IN-NETWORK (INET)**<br>**MEMBER PAYS** | **OUT-OF-NETWORK (OON)**<br>**MEMBER PAYS** |
|---|---|---|
| **Tier 2 Prescription Drugs**<br>*(Preferred Brand Drugs)* | $60 copayment per prescription | Not covered |
| **Tier 3 Prescription Drugs**<br>*(Non-Preferred Brand Drugs)* | 50% coinsurance up to a maximum of $400 per prescription after INET prescription drug deductible is met | Not covered |
| **Outpatient Rehabilitative and Habilitative Services** | **IN-NETWORK (INET)**<br>**MEMBER PAYS** | **OUT-OF-NETWORK (OON)**<br>**MEMBER PAYS** |
| **Speech Therapy**<br>*(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)* | $30 copayment per visit | 50% coinsurance per visit after OON plan deductible is met |
| **Physical and Occupational Therapy**<br>*(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)* | $30 copayment per visit | 50% coinsurance per visit after OON plan deductible is met |
| **Other Services** | **IN-NETWORK (INET)**<br>**MEMBER PAYS** | **OUT-OF-NETWORK (OON)**<br>**MEMBER PAYS** |
| **Chiropractic Services**<br>*(up to 20 visits per calendar year)* | $30 copayment per visit | 50% coinsurance per visit after OON plan deductible is met |
| **Diabetic Equipment & Supplies** | 50% coinsurance per equipment/supply after INET plan deductible is met | 50% coinsurance per equipment/supply after OON plan deductible is met |
| **Durable Medical Equipment (DME)** | 50% 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**<br>*(up to 100 visits per calendar year)* | $25 copayment per visit | 25% coinsurance per visit after separate $50 deductible is met |
| **Outpatient Services**<br>*(in a hospital or ambulatory facility)* | $400 copayment per visit after INET plan deductible is met | 50% coinsurance per visit after OON plan deductible is met |

| Inpatient Hospital Services | IN-NETWORK<br>MEMBER PAYS | OUT-OF-NETWORK<br>MEMBER PAYS |
|---|---|---|
| **Inpatient Hospital services**<br>***(including mental health, substance abuse, maternity, hospice and skilled nursing facility*)***<br>**(skilled nursing facility stay is limited to 90 days per calendar year)* | $400 copayment per day to a maximum of $1,600 per admission after INET plan deductible is met | 50% coinsurance per visit after OON plan deductible is met |
| **Emergency and Urgent Care** | **IN-NETWORK<br>MEMBER PAYS** | **OUT-OF-NETWORK<br>MEMBER PAYS** |
| **Ambulance Services** | $150 copayment per visit after INET plan deductible is met | $150 copayment per visit after INET plan deductible is met |
| **Emergency Room** | $150 copayment per visit after INET plan deductible is met | $150 copayment per visit after INET plan deductible is met |
| **Urgent Care Centers** | $50 copayment per visit | 50% coinsurance per visit after OON plan deductible is met |
| **Pediatric Dental Care**<br>*(for children under age 20)* | **IN-NETWORK<br>MEMBER PAYS** | **OUT-OF-NETWORK<br>MEMBER PAYS** |
| **Diagnostic & Preventive** | No cost | 50% coinsurance per visit after OON plan deductible is met |
| **Basic Services** | 50% 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**<br>*(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**<br>*(for children under age 20)* | **IN-NETWORK**<br>**MEMBER PAYS** | **OUT-OF-NETWORK**<br>**MEMBER PAYS** |
|---|---|---|
| **Prescription Eye Glasses**<br>*(one pair of frames and lenses or contact lens per calendar year)* | Lenses: $0<br>Collection frame: $0<br>Non-collection frame: Members choosing to upgrade from a collection frame to a non-collection 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 | Not covered |
| **Routine Eye Exam by Specialist**<br>*(one exam per calendar year)* | $30 copayment per visit | 50% coinsurance per visit after OON plan deductible is met |
| **Adult Vision Care**<br>*(over age 20)* | **IN-NETWORK**<br>**MEMBER PAYS** | **OUT-OF-NETWORK**<br>**MEMBER PAYS** |
| **Routine Eye Exam by Specialist**<br>*(one exam per calendar year)* | $30 copayment per visit | 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. Policy for complete details on benefits, conditions, limitations and exclusions. All benefits described are per member per Calendar year.
- 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.
- ConnectiCare offers a Telemedicine benefit for all members. The type of provider you see will determine the cost share and will follow the PCP or Specialist office visit.
- Out-of-Network reimbursement is based on the maximum allowable amount. Members are responsible to pay any charges in excess of this amount. Please refer to your ConnectiCare Benefits, Inc. policy 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.
- 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 Voluntary Mail Order Program. The Member Cost Share for Specialty Pharmacy is different from the Cost Share for ConnectiCare's Mail Order program.