



## Choice SOLO POS HSA Coins. \$6,250 ded. Calendar year High Deductible Health Plan for use with a Health Savings Account (HSA) (E)

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.

Your ConnectiCare health plan helps you get the care you need. Here are the most frequently used services. Refer to your policy on connecticare.com for a complete list of benefits.

<b>Free* Preventive Services</b>	
These services are free with your premium when you use an <b>in-network</b> doctor or facility. For a complete list of preventive services and to find a doctor, refer to connecticare.com.	
<ul style="list-style-type: none"> <li>• <b>Physical</b></li> <li>• <b>Well woman visit and pap test</b></li> <li>• <b>More than 25 screenings, including mammograms and colonoscopies</b></li> </ul>	<ul style="list-style-type: none"> <li>• <b>Flu shot</b></li> <li>• <b>Vaccinations</b></li> <li>• <b>Certain birth control and other prevention medications</b></li> </ul>
*Free preventive care means that you will not have a copayment or have to pay money toward your deductible or coinsurance for the services. Sometimes a preventive care visit leads to other medical care or tests, even at the same appointment. You should check with your doctor or doctor's staff during your visit to see if there are services you may be billed for.	

### Your care costs

	<b>In-network</b>	<b>Out-of-network</b>
<b>Your deductible</b> Deductible is combined for health services and prescription drugs	\$6,250 Individual \$12,500 Family	\$15,000 Individual \$30,000 Family
<b>Your out-of-pocket maximum</b>	\$6,600 Individual \$13,200 Family	\$30,000 Individual \$60,000 Family

Getting care within ConnectiCare's network typically costs you less. You may also get care outside of our network; however your share of the costs will be higher. Out-of-network doctors and facilities do not appear in the "Find a doctor" directory on connecticare.com.

After you've spent the maximum out-of-pocket amount in deductibles, copayments and coinsurance, ConnectiCare will pay 100% of your covered health care expenses for the remainder of the year.

<b>Screenings</b>	<b>In-network</b>	<b>Out-of-network</b>
<b>Breast ultrasound</b>	20% coinsurance after plan deductible	50% coinsurance after plan deductible
<b>Routine vision exam</b>	20% coinsurance deductible does not apply	50% coinsurance after plan deductible
<b>Allergy testing</b> one visit per year	20% coinsurance after plan deductible	50% coinsurance after plan deductible
<b>Ongoing Care and Sick Visits</b>	<b>In-network</b>	<b>Out-of-network</b>
<b>Primary care services</b>	20% coinsurance after plan deductible	50% coinsurance after plan deductible

<b>Ongoing Care and Sick Visits</b>	<b>In-network</b>	<b>Out-of-network</b>
<b>Specialist services</b>	20% coinsurance after plan deductible	50% coinsurance after plan deductible
<b>Gynecologist services</b>	20% coinsurance after plan deductible	50% coinsurance after plan deductible
<b>Maternity and prenatal care visits</b>	No charge	50% coinsurance after plan deductible
<b>Allergy injections</b> up to 20 visits per year	20% coinsurance after plan deductible	50% coinsurance after plan deductible
<b>Telemedicine visit</b>	20% coinsurance after plan deductible	50% coinsurance after plan deductible
<b>Retail clinic</b>	20% coinsurance after plan deductible	50% coinsurance after plan deductible
<b>Lab and Radiology</b> Performed in a hospital, lab or radiology facility	<b>In-network</b>	<b>Out-of-network</b>
<b>Laboratory services</b>	20% coinsurance after plan deductible	50% coinsurance after plan deductible
<b>Non-advanced radiology</b> (X-ray, diagnostic, baseline mammography, screening tomosynthesis)	20% coinsurance after plan deductible	50% coinsurance after plan deductible
<b>Advanced radiology</b> MRI, PET and CAT scan and nuclear cardiology	20% coinsurance after plan deductible	50% coinsurance after plan deductible
<b>Sudden or Unexpected Care</b> The same cost share applies for both in-network and out-of-network services	<b>In-network</b>	<b>Out-of-network</b>
<b>Urgent care or other walk-in clinic</b>	20% coinsurance after plan deductible	Same as in-network benefit
<b>Emergency room</b>	20% coinsurance after plan deductible	Same as in-network benefit
<b>Ambulance</b>	20% coinsurance after plan deductible	Same as In-network benefit
<b>Hospital Stays</b>	<b>In-network</b>	<b>Out-of-network</b>
<b>Inpatient hospital services, including room and board</b>	20% coinsurance after plan deductible	50% coinsurance after plan deductible
<b>Skilled nursing and rehabilitation facilities</b> up to 90 days per year	20% coinsurance after plan deductible	50% coinsurance after plan deductible
<b>Outpatient and Home Care</b>	<b>In-network</b>	<b>Out-of-network</b>
<b>Hospital outpatient facilities</b>	20% coinsurance after plan deductible	50% coinsurance after plan deductible

<b>Outpatient and Home Care</b>	<b>In-network</b>	<b>Out-of-network</b>
<b>Ambulatory surgical center</b>	20% coinsurance after plan deductible	50% coinsurance after plan deductible
<b>Home health services</b> up to 100 visits per year	20% coinsurance after plan deductible	25% coinsurance after plan deductible
<b>Chiropractic services</b> up to 20 visits per year	20% coinsurance after plan deductible	50% coinsurance after plan deductible
<b>Outpatient Rehabilitative and Habilitative Services</b>	<b>In-network</b>	<b>Out-of-network</b>
<b>Physical and occupational therapy</b> up to 40 visits per year combined for physical, speech and occupational therapy (habilitative services have a separate 40 visit maximum)	20% coinsurance after plan deductible	50% coinsurance after plan deductible
<b>Speech therapy</b> up to 40 visits per year combined for physical, speech and occupational therapy (habilitative services have a separate 40 visit maximum)	20% coinsurance after plan deductible	50% coinsurance after plan deductible
<b>Mental Health and Substance Abuse</b>	<b>In-network</b>	<b>Out-of-network</b>
<b>Inpatient mental health services</b>	20% coinsurance after plan deductible	50% coinsurance after plan deductible
<b>Inpatient alcohol and substance abuse treatment</b>	20% coinsurance after plan deductible	50% coinsurance after plan deductible
<b>Outpatient mental health, alcohol and substance abuse treatment (office visits and home services)</b>	20% coinsurance after plan deductible	50% coinsurance after plan deductible
<b>Outpatient mental health, alcohol and substance abuse treatment (intensive outpatient treatment and partial hospitalization)</b>	20% coinsurance after plan deductible	50% coinsurance after plan deductible
<b>Supplies</b>	<b>In-network</b>	<b>Out-of-network</b>
<b>Breastfeeding supplies</b>	No charge	50% coinsurance after plan deductible
<b>Durable medical equipment including prosthetics and disposable medical supplies</b>	20% coinsurance after plan deductible	50% coinsurance after plan deductible
<b>Diabetic equipment and supplies</b>	20% coinsurance after plan deductible	50% coinsurance after plan deductible
<b>Modified food products and specialized formula pharmacy tier</b>	20% coinsurance after plan deductible	50% coinsurance after plan deductible

<b>Pediatric Only Services (for members under age 20)</b>	<b>In-network</b>	<b>Out-of-network</b>
<b>Pediatric dental diagnostic &amp; preventive</b>	No charge	50% coinsurance after plan deductible
<b>Pediatric dental services</b> Basic Restorative, Major Restorative and Orthodontia Services (medically necessary only)	20% coinsurance after plan deductible	50% coinsurance after plan deductible
<b>Pediatric vision routine eye exam</b> one exam per year	20% coinsurance deductible does not apply	50% coinsurance after plan deductible
<b>Pediatric prescription eye glasses</b> one pair of frames and lenses per year	Lenses: 20% coinsurance after plan deductible Collection frames: 20% coinsurance after plan deductible Non-collection frames: 20% coinsurance 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
<b>Prescription drugs</b> <b>Retail Pharmacy</b> - up to 30 day supply per prescription <b>Mail order Pharmacy</b> - up to 90 day supply per prescription	<b>In-network</b>	<b>Out-of-network</b> (Mail order drugs are not covered as an out-of-network benefit)
<b>Preferred generic drugs</b> (Tier 1)	\$5 copayment/prescription; after plan deductible (retail)  \$10 copayment/prescription; after plan deductible (mail order)	50% coinsurance after plan deductible (retail)
<b>Non-preferred generic drugs</b> (Tier 2)	50% coinsurance up to a maximum of \$200 per prescription; after plan deductible (retail)  50% coinsurance up to a maximum of \$400 per prescription; after plan deductible (mail order)	50% coinsurance after plan deductible (retail)
<b>Preferred brand drugs</b> (Tier 3)	\$60 copayment/prescription; after plan deductible (retail)  \$120 copayment/prescription; after plan deductible (mail order)	50% coinsurance after plan deductible (retail)
<b>Non-preferred brand drugs</b> (Tier 4)	50% coinsurance up to a maximum of \$200 per prescription; after plan deductible (retail)  50% coinsurance up to a maximum of \$400 per prescription; after plan deductible (mail order)	50% coinsurance after plan deductible (retail)
You can choose to get a brand-name drug instead of a generic, but you will pay more: the cost of the generic drug plus the difference in the price for the brand name. What you pay for the difference of the brand-name drug will also not count toward your plan's deductible or out-of-pocket costs. Refer to the drug list on <a href="http://Connecticare.com">Connecticare.com</a> to find the tier for your drug.		

<b>Specialty Drugs</b> (up to a 30 day supply per prescription) These drugs generally require pre-authorization and may require special handling	<b>In-network</b>	<b>Out-of-network</b>
<b>Preferred Specialty Drugs</b> (Tier 5)	50% coinsurance up to a maximum of \$500 per prescription; after plan deductible (specialty retail only)	50% coinsurance after plan deductible (specialty retail only)
<b>Non-Preferred Specialty Drugs</b> (Tier 6)	50% coinsurance up to a maximum of \$750 per prescription; after plan deductible (specialty retail only)	50% coinsurance after plan deductible (specialty retail only)

<b>Important Information</b>
<ul style="list-style-type: none"> <li>• This is a brief summary of benefits. Refer to your ConnectiCare Insurance Company, Inc. policy for complete details on benefits, conditions, limitations and exclusions, or consult with your benefits manager. All benefits described below are per member per Calendar year. A referral from your primary care provider is not required.</li> <li>• If you have questions regarding your plan, visit our website at <a href="http://www.connecticare.com">www.connecticare.com</a> or call us at (860) 674-5757 or 1-800-251-7722.</li> <li>• 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 Insurance Company, Inc. policy for more information.</li> <li>• 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 &amp; Therapeutics Committee based on the drug's or supply's clinical effectiveness and cost, not on whether it is a generic drug or supply or brand name drug or supply.</li> <li>• 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.</li> <li>• Refer to ConnectiCare's pharmacy center online at <a href="http://www.connecticare.com">www.connecticare.com</a> for the Value List of drugs that are not subject to the member's deductible.</li> </ul>