ConnectiCare

Individual Market

Choice Gold Standard POS

Benefit Summary
Non-Tiered Network Plan

Benefits	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Plan Deductible *Individual* *Family*	$1,300 per Member $2,600 per Family	$3,000 per Member $6,000 per Family
Separate Prescription Drug Deductible *Individual* *Family*	$50 per Member $100 per Family	$350 per Member $700 per Family
Out-of-Pocket Maximum *Individual* *Family* *(Includes deductible, copayments and coinsurance)*	$5,000 per Member $10,000 per Family	$10,000 per Member $20,000 per Family
Benefits	**In-Network (INET) Member Pays**	**Out-of-Network (OON) Member Pays**
Provider Office Visits		
Adult/Pediatric Preventive Visits	No cost	30% coinsurance per visit
Primary Care Provider Office Visits *(includes services for illness, injury, follow-up care and consultations)*	$20 copayment per visit	30% coinsurance per visit after OON plan deductible is met
Specialist Office Visits	$40 copayment per visit	30% coinsurance per visit after OON plan deductible is met
Mental Health and Substance Abuse Office Visits	$20 copayment per visit	30% 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)*	$65 copayment per service up to a combined annual maximum of $375 for MRI and CAT scans; $400 for PET scans	30% coinsurance per service after OON plan deductible is met
Laboratory Services	$10 copayment per service after INET plan deductible is met	30% coinsurance per service after OON plan deductible is met
Non-Advanced Radiology *(X-ray, Diagnostic)*	$40 copayment per service after INET plan deductible is met	30% coinsurance per service after OON plan deductible is met
Mammography Ultrasound	$20 copayment per service	30% 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	$5 copayment per prescription	30% coinsurance per prescription after OON prescription drug deductible is met
Preferred Brand Drugs Tier 2	$25 copayment per prescription	30% coinsurance per prescription after OON prescription drug deductible is met
Non-Preferred Brand Drugs Tier 3	$50 copayment per prescription	30% coinsurance per prescription after OON prescription drug deductible is met
Specialty Drugs Tier 4	20% coinsurance up to a maximum of $100 per prescription after INET prescription drug deductible is met	30% coinsurance per prescription after OON prescription drug deductible is met
Prescription Drugs - Mail Order Pharmacy (up to a 90 day supply per prescription)		
Generic Drugs Tier 1	$10 copayment per prescription	Not covered
Preferred Brand Drugs Tier 2	$50 copayment per prescription	Not covered

Benefits	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Non-Preferred Brand Drugs Tier 3	$100 copayment per prescription	Not covered
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 copayment per visit	30% coinsurance per visit after OON plan deductible is met
Physical and Occupational Therapy	$20 copayment per visit	30% coinsurance per visit after OON plan deductible is met
Other Services		
Chiropractic Services *(up to 20 visits per calendar year)*	$40 copayment per visit	30% coinsurance per visit after OON plan deductible is met
Diabetic Equipment and Supplies	30% coinsurance per equipment/supply	30% coinsurance per equipment/supply after OON plan deductible is met
Durable Medical Equipment (DME)	30% coinsurance per equipment/supply	30% coinsurance per equipment/supply after OON plan deductible is met
Home Health Care Services *(up to 100 visits per calendar year)*	No cost	25% coinsurance per visit after separate $50 deductible is met
Outpatient Services *in a hospital or ambulatory facility*	$500 copayment per visit after INET plan deductible is met	30% coinsurance per visit after OON plan deductible is met
Inpatient Services		
Inpatient hospital services *include mental health, substance abuse, maternity, hospice, skilled nursing facility*, and all IP settings.* **(skilled nursing facility stay is limited to 90 days per calendar year)*	$500 copayment per day up to a maximum of $1,000 per admission after INET plan deductible is met	30% coinsurance per admission after OON plan deductible is met
Emergency and Urgent Care		
Ambulance Services	No cost	No cost
Emergency Room	$200 copayment per visit	$200 copayment per visit
Urgent Care Centers	$50 copayment per visit	30% coinsurance per visit after OON plan deductible is met

Benefits	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Pediatric Dental Care (for children under age 20)		
Diagnostic & Preventive	No cost	50% coinsurance per visit after OON plan deductible is met
Basic Services	20% coinsurance per visit	50% coinsurance per visit after OON plan deductible is met
Major Services	40% coinsurance per visit	50% coinsurance per visit after OON plan deductible is met
Orthodontia Services *(medically necessary only)*	50% coinsurance per visit	50% coinsurance per visit after OON plan deductible is met
Pediatric Vision Care (for children under age 20)		
Prescription Eye Glasses *(one pair of frames and lenses or contact lens per calendar year)*	Lenses: $0 Collection frame: $0 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 a Specialist *(one exam per calendar year)*	$40 copayment per visit	30% coinsurance per visit after OON plan deductible is met
Other Covered Services		
Adult Routine Eye Exam by a Specialist - over age 20 *(one exam per calendar year)*	$40 copayment per visit	30% coinsurance per visit after OON plan deductible is met
Artificial Limbs *(includes associated supplies and equipment)*	20% coinsurance per equipment/supply	30% coinsurance per equipment/supply 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.
- 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 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.
- Many services require that you obtain our Pre-Certification or Pre-Authorization prior to obtaining care prescribed or rendered by Non-Participating providers or a benefit reduction may apply. Without pre-authorization you may be responsible for the total cost of the service or benefits may be reduced by the lesser of $500 or 50%. Refer to the “Pre-authorization and Pre-certification Addendum” in your policy for more details.
- For mental health, alcohol and substance abuse services call 1-888-946-4658 to obtain Pre-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.