



**Individual Market**  
**Choice Silver Alternative POS (CSR 87%)**  
**Benefit Summary**  
**Non-Tiered Network Plan**

| Benefits   | In-Network (INET)<br>Member Pays   | Out-of-Network (OON)<br>Member Pays                        |
|--|--|--|
| <b>Plan Deductible</b><br><i>Individual</i><br><i>Family</i>   | \$1,000 per Member<br>\$2,000 per Family   | \$10,000 per Member<br>\$20,000 per Family                 |
| <b>Separate Prescription Drug Deductible</b><br><i>Individual</i><br><i>Family</i>   | N/A per Member<br>N/A per Family   | N/A per Member<br>N/A per Family                           |
| <b>Out-of-Pocket Maximum</b><br><i>Individual</i><br><i>Family</i><br><br><i>(Includes deductible, copayments and coinsurance)</i> | \$2,500 per Member<br>\$5,000 per Family   | \$15,000 per Member<br>\$30,000 per Family                 |
| Benefits   | In-Network (INET)<br>Member Pays   | Out-of-Network (OON)<br>Member Pays                        |
| <b>Provider Office Visits</b>  |  |  |
| <b>Adult/Pediatric Preventive Visits</b>   | No cost  | 50% coinsurance per visit                                  |
| <b>Primary Care Provider Office Visits</b><br><i>(includes services for illness, injury, follow-up care and consultations)</i>     | <b>At a Sanitas Medical Center:</b> No cost<br><b>All other in-network:</b> \$25 copayment per visit | 50% coinsurance per visit after OON plan deductible is met |
| <b>Specialist Office Visits</b>  | \$30 copayment per visit   | 50% coinsurance per visit after OON plan deductible is met |
| <b>Mental Health and Substance Abuse Office Visits</b>   | \$30 copayment per visit   | 50% coinsurance per visit after OON plan deductible is met |
| <b>Outpatient Diagnostic Services</b>  |  |  |

| <b>Benefits</b>   | <b>In-Network (INET)<br/>Member Pays</b>   | <b>Out-of-Network (OON)<br/>Member Pays</b>                       |
|---|--|---|
| <b>Advanced Radiology</b><br><i>(CT/PET Scan, MRI)</i>  | 10% coinsurance per service after INET plan deductible is met                          | 50% coinsurance per service after OON plan deductible is met      |
| <b>Laboratory Services</b>  | \$5 copayment per service  | 50% coinsurance per service after OON plan deductible is met      |
| <b>Non-Advanced Radiology</b><br><i>(X-ray, Diagnostic)</i>   | \$30 copayment per service   | 50% coinsurance per service after OON plan deductible is met      |
| <b>Mammography Ultrasound</b>   | \$20 copayment per service   | 50% coinsurance per service after OON plan deductible is met      |
| <b>Prescription Drugs - Retail Pharmacy</b><br>(cost share based on 30 day supply per prescription) |  |   |
| <b>Generic Drugs</b><br>Tier 1  | \$5 copayment per prescription   | 50% coinsurance per prescription after OON plan deductible is met |
| <b>Preferred Brand Drugs</b><br>Tier 2  | \$40 copayment per prescription  | 50% coinsurance per prescription after OON plan deductible is met |
| <b>Non-Preferred Brand Drugs</b><br>Tier 3  | 50% coinsurance up to \$150 maximum per prescription after INET plan deductible is met | 50% coinsurance per prescription after OON plan deductible is met |
| <b>Specialty Drugs</b><br>Tier 4  | 50% coinsurance up to \$300 maximum per prescription after INET plan deductible is met | 50% coinsurance per prescription after OON plan deductible is met |
| <b>Prescription Drugs - Mail Order Pharmacy</b><br>(up to a 90 day supply per prescription)         |  |   |
| <b>Generic Drugs</b><br>Tier 1  | \$10 copayment per prescription  | Not covered   |
| <b>Preferred Brand Drugs</b><br>Tier 2  | \$80 copayment per prescription  | Not covered   |
| <b>Non-Preferred Brand Drugs</b><br>Tier 3  | 50% coinsurance up to \$300 maximum per prescription after INET plan deductible is met | Not covered   |

| Benefits  | In-Network (INET)<br>Member Pays                                       | Out-of-Network (OON)<br>Member Pays                                   |
|---|--|---|
| <b>Outpatient Rehabilitative and Habilitative Services</b><br><i>(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)</i> |  |   |
| <b>Speech Therapy</b>   | \$30 copayment per visit   | 50% coinsurance per visit after OON plan deductible is met            |
| <b>Physical and Occupational Therapy</b>  | \$30 copayment per visit   | 50% coinsurance per visit after OON plan deductible is met            |
| <b>Other Services</b>   |  |   |
| <b>Chiropractic Services</b><br><i>(up to 20 visits per calendar year)</i>  | \$30 copayment per visit   | 50% coinsurance per visit after OON plan deductible is met            |
| <b>Diabetic Equipment and Supplies</b>  | 50% coinsurance per equipment/supply after INET plan deductible is met | 50% coinsurance per equipment/supply after OON plan deductible is met |
| <b>Durable Medical Equipment (DME)</b>  | 50% coinsurance per equipment/supply after INET plan deductible is met | 50% coinsurance per equipment/supply after OON plan deductible is met |
| <b>Home Health Care Services</b><br><i>(up to 100 visits per calendar year)</i>   | \$25 copayment per visit   | 25% coinsurance per visit   |
| <b>Outpatient Services</b><br><i>in a hospital or ambulatory facility</i>   | 10% coinsurance per visit after INET plan deductible is met            | 50% coinsurance per visit after OON plan deductible is met            |
| <b>Inpatient Services</b>   |  |   |
| <b>Inpatient hospital services include mental health, substance abuse, maternity, hospice, skilled nursing facility*, and all IP settings.</b><br><i>*(skilled nursing facility stay is limited to 90 days per calendar year)</i>   | 10% coinsurance per admission after INET plan deductible is met        | 50% coinsurance per admission after OON plan deductible is met        |
| <b>Emergency and Urgent Care</b>  |  |   |
| <b>Ambulance Services</b>   | 10% coinsurance per visit after INET plan deductible is met            | 10% coinsurance per visit after INET plan deductible is met           |
| <b>Emergency Room</b>   | 10% coinsurance per visit after INET plan deductible is met            | 10% coinsurance per visit after INET plan deductible is met           |
| <b>Urgent Care Centers</b>  | \$50 copayment per visit   | 50% coinsurance per visit after OON plan deductible is met            |
| <b>Pediatric Dental Care</b><br><i>(for children under age 20)</i>  |  |   |

| <b>Benefits</b>   | <b>In-Network (INET)<br/>Member Pays</b>  | <b>Out-of-Network (OON)<br/>Member Pays</b>                    |
|---|---|--|
| <b>Diagnostic &amp; Preventive</b>  | No cost   | 50% coinsurance per visit after OON plan deductible is met     |
| <b>Basic Services</b>   | 50% coinsurance per visit after INET plan deductible is met   | 50% coinsurance per visit after OON plan deductible is met     |
| <b>Major Services</b>   | 50% coinsurance per visit after INET plan deductible is met   | 50% coinsurance per visit after OON plan deductible is met     |
| <b>Orthodontia Services</b><br><i>(medically necessary only)</i>  | 50% coinsurance per visit after INET plan deductible is met   | 50% coinsurance per visit after OON plan deductible is met     |
| <b>Pediatric Vision Care</b><br><i>(for children under age 20)</i>  |   |  |
| <b>Prescription Eye Glasses</b><br><i>(one pair of frames and lenses or contact lens per calendar year)</i> | 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  |
| <b>Routine Eye Exam by a Specialist</b><br><i>(one exam per calendar year)</i>                              | \$30 copayment per visit  | 50% coinsurance per visit after OON plan deductible is met     |
| <b>Other Covered Services</b>   |   |  |
| <b>Adult Routine Eye Exam by a Specialist - over age 20</b><br><i>(one exam per calendar year)</i>          | \$30 copayment per visit  | 50% coinsurance per visit after OON plan deductible is met     |
| <b>Artificial Limbs</b><br><i>(includes associated supplies and equipment)</i>                              | 20% coinsurance per equipment/supply after INET plan deductible is met  | 50% coinsurance per equipment/supply after OON plan deductible |

## 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](http://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](http://www.connecticare.com) to view a list of preventive and wellness services.