ConnectiCare

Individual Market

Choice SOLO POS Copay/Coins. $4,500 ded. cal.

Benefit Summary
Non-Tiered Network Plan

Benefits	IN-NETWORK (INET) MEMBER PAYS	OUT-OF-NETWORK (OON) MEMBER PAYS
Plan Deductible Individual Family	$4,500 per Member $9,000 per Family	$15,000 per Member $30,000 per Family
Separate Prescription Drug Deductible Individual Family	N/A per Member N/A per Family	N/A per Member N/A per Family
Out-of-Pocket Maximum Individual Family (Includes deductibles, copayments and coinsurance)	$7,900 per Member $15,800 per Family	$30,000 per Member $60,000 per Family
Benefits	**IN-NETWORK (INET) MEMBER PAYS**	**OUT-OF-NETWORK (OON) MEMBER PAYS**
Adult/Pediatric Preventive Visits	No cost	50% coinsurance after plan deductible
Primary Care Provider Office Visits (includes services for illness, injury, follow-up care and consultations)	**At a Sanitas Medical Center:** No cost **All other in-network:** $40 copayment/visit deductible does not apply	50% coinsurance after plan deductible
Specialist Office Visits	$50 copayment/visit deductible does not apply	50% coinsurance after plan deductible
Mental Health and Substance Abuse Office Visits	$50 copayment/visit deductible does not apply	50% coinsurance after plan deductible
Outpatient Diagnostic Services		
Advanced Radiology (CT/PET Scan, MRI)	30% coinsurance after plan deductible	50% coinsurance after plan deductible

Benefits	IN-NETWORK (INET) MEMBER PAYS	OUT-OF-NETWORK (OON) MEMBER PAYS
Laboratory Services	30% coinsurance after plan deductible	50% coinsurance after plan deductible
Non-Advanced Radiology (X-ray, Diagnostic)	30% coinsurance after plan deductible	50% coinsurance after plan deductible
Mammography Ultrasound	30% coinsurance after plan deductible	50% coinsurance after plan deductible
Prescription Drugs - Retail Pharmacy (cost share based on 30 day supply per prescription)		
Preferred Generic Tier 1	$5 copayment/prescription deductible does not apply	50% coinsurance after plan deductible
Non-preferred Generic Tier 2	50% coinsurance up to a maximum of $250 per prescription after plan deductible	50% coinsurance after plan deductible
Preferred Brand Tier 3	$60 copayment/prescription deductible does not apply	50% coinsurance after plan deductible
Non-preferred Brand Tier 4	50% coinsurance up to a maximum of $500 per prescription after plan deductible	50% coinsurance after plan deductible
Specialty Drugs (cost share up to 30 day supply per prescription - These drugs generally require pre-authorization and may require special handling)		
Preferred Specialty 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)
Non-preferred Specialty 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)
Prescription Drugs - Mail Order Pharmacy (up to a 90 day supply per prescription)		
Preferred Generic Tier 1	$10 copayment/prescription deductible does not apply	Not covered
Non-preferred Generic Tier 2	50% coinsurance up to a maximum of $500 per prescription after plan deductible	Not covered
Preferred Brand Tier 3	$120 copayment/prescription; deductible does not apply	Not covered

Benefits	IN-NETWORK (INET) MEMBER PAYS	OUT-OF-NETWORK (OON) MEMBER PAYS
Non-preferred Brand Tier 4	50% coinsurance up to a maximum of $1,000 per prescription after plan deductible	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	$50 copayment/visit deductible does not apply	50% coinsurance after plan deductible
Physical and Occupational Therapy	$30 copayment/visit deductible does not apply	50% coinsurance after plan deductible
Other Services		
Chiropractic Services (up to 20 visits per calendar year)	$50 copayment/visit deductible does not apply	50% coinsurance after plan deductible
Diabetic Equipment and Supplies	50% coinsurance after plan deductible	50% coinsurance after plan deductible
Durable Medical Equipment (DME)	50% coinsurance after plan deductible	50% coinsurance after plan deductible
Home Health Care Services (up to 100 visits per calendar year)	25% coinsurance deductible does not apply	25% coinsurance deductible does not apply
Outpatient Services	30% coinsurance after plan deductible	50% coinsurance after plan deductible
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)	30% coinsurance after plan deductible	50% coinsurance after plan deductible
Emergency and Urgent Care		
Ambulance Services	30% coinsurance after plan deductible	Same as In-network benefit
Emergency Room	30% coinsurance after plan deductible	Same as in-network benefit
Urgent Care Centers	$75 copayment/visit deductible does not apply	Same as in-network benefit
Pediatric Dental Care (for children under age 20)		
Diagnostic & Preventive	No cost	50% coinsurance after plan deductible

Benefits	IN-NETWORK (INET) MEMBER PAYS	OUT-OF-NETWORK (OON) MEMBER PAYS
Basic Services	50% coinsurance after plan deductible	50% coinsurance after plan deductible
Major Services	50% coinsurance after plan deductible	50% coinsurance after plan deductible
Orthodontia Services (medically necessary only)	50% coinsurance after plan deductible	50% coinsurance after plan deductible
Pediatric Vision Care (for children under age 20)		
Prescription Eye Glasses (one pair of frames and lenses per calendar year)	Lenses: 50% after plan deductible Collection frames: 50% after plan deductible Non-collection frames: 50% 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
Routine Eye Exam by a Specialist (one exam per calendar year)	$50 copayment/visit deductible does not apply	50% coinsurance after plan deductible
Additional Covered Services		
Adult Routine Eye Exam by a Specialist (over age 20) (one exam per calendar year)	$50 copayment/visit deductible does not apply	50% coinsurance after plan deductible
Allergy Injections (up to 20 visits per calendar year)	See primary care or specialist office visits	50% coinsurance after plan deductible
Artificial Limbs (includes associated supplies and equipment)	20% coinsurance after plan deductible	50% coinsurance after plan deductible
Inpatient Physician Services	30% coinsurance after plan deductible	50% coinsurance after plan deductible
Outpatient mental health, alcohol and substance abuse treatment (intensive outpatient treatment and partial hospitalization)	30% coinsurance after plan deductible	50% coinsurance after plan deductible

Important Information

- This is a brief summary of benefits. Refer to your ConnectiCare Insurance Company 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 Insurance Company, 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.
- Your modified food products and specialized formula drug cost share for in-network is 50% after plan deductible and out-of-network services will apply the applicable plan deductible and coinsurance.