Individual Market

Choice Bronze Alternative POS with Dental

Benefit Summary

Non-Tiered Network Plan

Deductible and Out-of-Pocket Maximum	**In-Network (INET) Member Pays**	**Out-of-Network (OON) Member Pays**
Plan Deductible Individual Family	$5,400 per member $10,800 per family	$15,000 per member $30,000 per family
Separate Prescription Drug Deductible Individual Family	Included in Plan Deductible per member / per family	Included in Plan Deductible per member / per family
Out-of-Pocket Maximum Individual Family (Includes deductibles, copayments and coinsurance)	$8,150 per member $16,300 per family	$20,000 per member $40,000 per family
Benefits	**In-Network (INET) Member Pays**	**Out-of-Network (OON) Member Pays**
Provider Office Visits		
Adult/Pediatric Preventive Visits	No cost	50% coinsurance per visit
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 per visit	50% coinsurance per visit after OON plan deductible is met
Specialist Office Visits	$60 copayment per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met
Mental Health and Substance Abuse Office Visits	$60 copayment per visit	50% coinsurance per visit after OON plan deductible is met
Outpatient Diagnostic Services		
Advanced Radiology (CT/PET Scan, MRI)	45% coinsurance per service after INET plan deductible is met	50% coinsurance per service after OON plan deductible is met
Laboratory Services	$20 copayment per service after INET plan deductible is met	50% coinsurance per service after OON plan deductible is met
Non-Advanced Radiology (X-ray, Diagnostic)	$50 copayment per service after INET plan deductible is met	50% coinsurance per service after OON plan deductible is met

Benefits	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Mammography Ultrasound	$50 copayment per service after INET plan deductible is met	50% 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	$15 copayment per prescription	50% coinsurance per prescription after OON plan deductible is met
Preferred Brand Drugs Tier 2	$50 copayment per prescription after INET plan deductible is met	50% coinsurance per prescription after OON plan deductible is met
Non-Preferred Brand Tier 3	50% coinsurance per prescription after INET plan deductible is met	50% coinsurance per prescription after OON plan deductible is met
Specialty Drugs Tier 4	50% coinsurance up to a maximum of $500 per prescription after INET plan deductible is met	50% coinsurance per prescription after OON plan deductible is met
Prescription Drugs – Mail Order Pharmacy (up to a 90-day supply per prescription)		
Generic Drugs Tier 1	$30 copayment per prescription	50% coinsurance per prescription after OON plan deductible is met
Preferred Brand Drugs Tier 2	$100 copayment per prescription after INET plan deductible is met	50% coinsurance per prescription after OON plan deductible is met
Non-Preferred Brand Tier 3	50% coinsurance per prescription after INET plan deductible is met	50% coinsurance per prescription after OON plan deductible is met
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 per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met
Physical and Occupational Therapy	$30 copayment per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met
Other Services		
Chiropractic Services (up to 20 visits per calendar year)	$50 copayment per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met
Diabetic Equipment and 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 (up to 100 visits per calendar year)	25% coinsurance per visit	25% coinsurance per visit after separate $50 deductible is met
Outpatient Services (in a hospital or ambulatory facility)	45% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met

Benefits	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Inpatient Services		
Inpatient hospital services (including 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)	45% coinsurance per admission after INET plan deductible is met	50% coinsurance per admission after OON plan deductible is met
Emergency and Urgent Care		
Ambulance Services	45% coinsurance per service after INET plan deductible is met	45% coinsurance per service after INET plan deductible is met
Emergency Room	45% coinsurance per visit after INET plan deductible is met	45% coinsurance per visit after INET plan deductible is met
Urgent Care Centers	$100 copayment per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met
Pediatric Dental Care (for children under age 20)		
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 (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 (for children under age 20)		
Prescription Eye Glasses (one pair of frames and lenses or contact lens per calendar year)	**Lenses:** 50% after INET plan deductible is met **Collection frames:** 50% after INET plan deductible is met **Non-collection frames:** 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)	$50 copayment per visit	50% coinsurance per visit after OON plan deductible is met

Benefits	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Additional Covered Services		
Adult Preventive Dental Care (one dental exam and cleaning per 6-month period)	No cost	50% coinsurance per visit after OON plan deductible is met
Adult Routine Dental Care (full mouth x-rays or panoramic x-rays at 36-month intervals and bitewing x-rays at 6-month intervals)	No cost	50% coinsurance per visit after OON plan deductible is met
Adult Routine Eye Exam by a Specialist – over age 20 (one exam per calendar year)	$50 copayment per visit	50% coinsurance per visit after OON plan deductible is met
Allergy Injections (up to 20 visits per calendar year)	See primary care or specialist office visits	50% coinsurance per visit after OON plan deductible is met
Allergy Testing (one visit per calendar year)	See primary care or specialist office visits	50% coinsurance per visit after OON plan deductible is met
Artificial Limbs (includes associated supplies and equipment)	20% coinsurance after INET plan deductible is met	50% coinsurance after OON plan deductible is met
Outpatient mental health, alcohol and substance abuse treatment (intensive outpatient treatment and partial hospitalization)	45% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met
Telemedicine visit	See primary care or specialist office visits	50% coinsurance per visit after OON plan deductible is met

- 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.
- 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 service