cbia health connections

ConnectiCare

HSA $6,500/10%

ACA Metal:* Bronze

All plans are open access and contract year.
ConnectiCare offers POS plans.

	In-Network	Out-of-Network
Medical Office Visits *Routine/Preventive visits covered in full*	PCP: 10% after deductible Specialist: 10% after deductible	50% after deductible
General X-Ray	10% after deductible	50% after deductible
Advanced Imaging	10% after deductible	50% after deductible
Laboratory	10% after deductible	50% after deductible
Hospital Inpatient	10% after deductible	50% after deductible
Outpatient Surgery	10% after deductible	50% after deductible
Telemedicine	10% after deductible	50% after deductible
Retail Clinic	10% after deductible	50% after deductible
Walk-in/Urgent Care Centers	10% after deductible	Same as in-network
Emergency Room Services	10% after deductible	Same as in-network
Emergency Ambulance Services	10% after deductible	Same as in-network
Physical Therapy *Includes physical, speech and occupational. (40 visits per year)*	10% after deductible	50% after deductible
Annual Routine Vision Exam *(one exam per year when provided by an Optometrist or Ophtalmologist)*	10% coinsurance (deductible waived)	50% after deductible
Durable Medical Equipment	10% after deductible	50% after deductible
Deductible	$6,500 individual; $13,000 family	$13,000 individual; $26,000 family
Coinsurance	10% after deductible	50% after deductible
Maximum Out-of-Pocket *Includes deductible, coinsurance, & copays for all covered services*	$6,750 individual; $13,500 family	$27,000 individual; $54,000 family

* Reflects actuarial value certified by insurance carrier

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cbia health connections

ConnectiCare

HSA $6,500/10%

ACA Metal: Bronze

All plans are open access and contract year. ConnectiCare offers POS plans.

	IN-NETWORK	OUT-OF-NETWORK
Diabetic Supplies	10% after deductible	50% after deductible
Pediatric Dental For children under age 19	Diagnostic & preventive: Covered in full Basic, major, and orthodontia services (medically necessary only): 50% after deductible	50% after deductible
Pediatric Rx glasses For children under age 19 (one pair of frames or lenses per plan year)	Lenses & collection frames: No charge after plan deductible Non-collection frames: No charge after plan deductible up to collection frame allowance; any amount over is payable by the member minus a 20% discount	50% after deductible
Allergy Injections* (up to 20 visits per year)	10% after deductible	50% after deductible
Chiropractic Therapy* (up to 20 visits per year)	10% after deductible	50% after deductible
Home Health Care* (up to 100 visits per year)	10% after deductible	25% after deductible
Skilled Nursing Facility* (up to 90 visits per year)	10% after deductible	50% after deductible
Maternity Services	Single deductible for mother and baby for routine services. Separate deductible for mother and baby for non-routine services including baby staying beyond mother's discharge date.	50% after deductible

*Allowable number of visits are combined for in- and out-of-network.

Prescription Drugs

Prescription Drugs (retail) (MAC-A: mandatory generic) Generic substitution is required when available. If member purchases a brand drug when a generic is available, the member pays the co-pay plus the difference in cost between the brand and generic. The prescription costs listed below apply when a prescription is filled at a participating pharmacy. Go to our prescription drug page at cbia.com/insurance to access ConnectiCare's drug list.

HSA benefit for preventive drugs

All HSA-compatible plans include a pharmacy benefit that encourages the use of certain preventive medications to manage chronic conditions. This means that many covered preventive drugs are not subject to the plan deductible. Copays and coinsurance still apply.

	TIER DEFINITION	COST-SHARE**
Tier 1	Preferred generic	$5
Tier 2	Non-preferred generic	50% up to $250/script
Tier 3	Preferred brand	$50
Tier 4	Non-preferred brand	50% up to $500/script
Tier 5	Preferred specialty drugs	50% up to $500/script
Tier 6	Non-preferred specialty drugs	50% up to $750/script

Mail Order Prescriptions

Mail order drugs are dispensed at 2x the retail prescription co-pay or cost share.

**For HSA plans, deductible must be met first, excluding certain preventive drugs.

cbia health connections

ConnectiCare

HSA $5,000/50%

ACA Metal:* Bronze

All plans are open access and contract year.
ConnectiCare offers POS plans.

	In-Network	Out-of-Network
Medical Office Visits *Routine/Preventive visits covered in full*	PCP: 50% after deductible Specialist: 50% after deductible	50% after deductible
General X-Ray	50% after deductible	50% after deductible
Advanced Imaging	50% after deductible	50% after deductible
Laboratory	50% after deductible	50% after deductible
Hospital Inpatient	50% after deductible	50% after deductible
Outpatient Surgery	50% after deductible	50% after deductible
Telemedicine	50% after deductible	50% after deductible
Retail Clinic	50% after deductible	50% after deductible
Walk-in/Urgent Care Centers	50% after deductible	Same as in-network
Emergency Room Services	50% after deductible	Same as in-network
Emergency Ambulance Services	50% after deductible	Same as in-network
Physical Therapy *Includes physical, speech and occupational. (40 visits per year)*	50% after deductible	50% after deductible
Annual Routine Vision Exam *(one exam per year when provided by an Optometrist or Ophtalmologist)*	50% (deductible waived)	50% after deductible
Durable Medical Equipment	50% after deductible	50% after deductible
Deductible	$5,000 individual; $10,000 family	$10,000 individual; $20,000 family
Coinsurance	50% after deductible	50% after deductible
Maximum Out-of-Pocket *Includes deductible, coinsurance, & copays for all covered services*	$6,550 individual; $13,100 family	$13,100 individual; $26,200 family

* Reflects actuarial value certified by insurance carrier

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ConnectiCare

HSA $5,000/50%

ACA Metal: Bronze

All plans are open access and contract year. ConnectiCare offers POS plans.

	IN-NETWORK	OUT-OF-NETWORK
Diabetic Supplies	50% after deductible	50% after deductible
Pediatric Dental For children under age 19	Diagnostic & preventive: Covered in full Basic, major, and orthodontia services (medically necessary only): 50% after deductible	50% after deductible
Pediatric Rx glasses For children under age 19 (one pair of frames or lenses per plan year)	Lenses & collection frames: No charge after plan deductible Non-collection frames: No charge after plan deductible up to collection frame allowance; any amount over is payable by the member minus a 20% discount	50% after deductible
Allergy Injections* (up to 20 visits per year)	50% after deductible	50% after deductible
Chiropractic Therapy* (up to 20 visits per year)	50% after deductible	50% after deductible
Home Health Care* (up to 100 visits per year)	25% after deductible	25% after deductible
Skilled Nursing Facility* (up to 90 visits per year)	50% after deductible	50% after deductible
Maternity Services	Single deductible for mother and baby for routine services. Separate deductible for mother and baby for non-routine services including baby staying beyond mother's discharge date.	50% after deductible

*Allowable number of visits are combined for in- and out-of-network.

Prescription Drugs

Prescription Drugs (retail) (MAC-A: mandatory generic) Generic substitution is required when available. If member purchases a brand drug when a generic is available, the member pays the co-pay plus the difference in cost between the brand and generic. The prescription costs listed below apply when a prescription is filled at a participating pharmacy. Go to our prescription drug page at cbia.com/insurance to access ConnectiCare's drug list.

HSA benefit for preventive drugs

All HSA-compatible plans include a pharmacy benefit that encourages the use of certain preventive medications to manage chronic conditions. This means that many covered preventive drugs are not subject to the plan deductible. Copays and coinsurance still apply.

	TIER DEFINITION	COST-SHARE**
Tier 1	Preferred generic	$5
Tier 2	Non-preferred generic	50% up to $250/script
Tier 3	Preferred brand	$50
Tier 4	Non-preferred brand	50% up to $500/script
Tier 5	Preferred specialty drugs	50% up to $500/script
Tier 6	Non-preferred specialty drugs	50% up to $750/script

Mail Order Prescriptions

Mail order drugs are dispensed at 2x the retail prescription co-pay or cost share.

**For HSA plans, deductible must be met first, excluding certain preventive drugs.

cbia health connections

ConnectiCare

HSA $3,500/30%

ACA Metal:* Silver

All plans are open access and contract year.
ConnectiCare offers POS plans.

	In-Network	Out-of-Network
Medical Office Visits *Routine/Preventive visits covered in full*	PCP: 30% after deductible Specialist: 30% after deductible	50% after deductible
General X-Ray	30% after deductible	50% after deductible
Advanced Imaging	30% after deductible	50% after deductible
Laboratory	30% after deductible	50% after deductible
Hospital Inpatient	30% after deductible	50% after deductible
Outpatient Surgery	30% after deductible	50% after deductible
Telemedicine	30% after deductible	50% after deductible
Retail Clinic	30% after deductible	50% after deductible
Walk-in/Urgent Care Centers	30% after deductible	Same as in-network
Emergency Room Services	30% after deductible	Same as in-network
Emergency Ambulance Services	30% after deductible	Same as in-network
Physical Therapy *Includes physical, speech and occupational. (40 visits per year)*	30% after deductible	50% after deductible
Annual Routine Vision Exam *(one exam per year when provided by an Optometrist or Ophtalmologist)*	30% (deductible waived)	50% after deductible
Durable Medical Equipment	30% after deductible	50% after deductible
Deductible	$3,500 individual; $7,000 family	$7,000 individual; $14,000 family
Coinsurance	30% after deductible	50% after deductible
Maximum Out-of-Pocket *Includes deductible, coinsurance, & copays for all covered services*	$5,500 individual; $11,000 family	$11,000 individual; $22,000 family

* Reflects actuarial value certified by insurance carrier

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ConnectiCare

HSA $3,500/30%

ACA Metal: Silver

All plans are open access and contract year. ConnectiCare offers POS plans.

	in-network	out-of-network
Diabetic Supplies	30% after deductible	50% after deductible
Pediatric Dental For children under age 19	Diagnostic & preventive: Covered in full Basic, major, and orthodontia services (medically necessary only): 50% after deductible	50% after deductible
Pediatric Rx glasses For children under age 19 (one pair of frames or lenses per plan year)	Lenses & collection frames: No charge after plan deductible Non-collection frames: No charge after plan deductible up to collection frame allowance; any amount over is payable by the member minus a 20% discount	50% after deductible
Allergy Injections* (up to 20 visits per year)	30% after deductible	50% after deductible
Chiropractic Therapy* (up to 20 visits per year)	30% after deductible	50% after deductible
Home Health Care* (up to 100 visits per year)	25% after deductible	25% after deductible
Skilled Nursing Facility* (up to 90 visits per year)	30% after deductible	50% after deductible
Maternity Services	Single deductible for mother and baby for routine services. Separate deductible for mother and baby for non-routine services including baby staying beyond mother's discharge date.	50% after deductible

*Allowable number of visits are combined for in- and out-of-network.

Prescription Drugs

Prescription Drugs (retail) (MAC-A: mandatory generic) Generic substitution is required when available. If member purchases a brand drug when a generic is available, the member pays the co-pay plus the difference in cost between the brand and generic. The prescription costs listed below apply when a prescription is filled at a participating pharmacy. Go to our prescription drug page at cbia.com/insurance to access ConnectiCare's drug list.

HSA benefit for preventive drugs

All HSA-compatible plans include a pharmacy benefit that encourages the use of certain preventive medications to manage chronic conditions. This means that many covered preventive drugs are not subject to the plan deductible. Copays and coinsurance still apply.

	TIER DEFINITION	COST-SHARE**
Tier 1	Preferred generic	$5
Tier 2	Non-preferred generic	50% up to $250/script
Tier 3	Preferred brand	$50
Tier 4	Non-preferred brand	50% up to $500/script
Tier 5	Preferred specialty drugs	50% up to $500/script
Tier 6	Non-preferred specialty drugs	50% up to $750/script

Mail Order Prescriptions

Mail order drugs are dispensed at 2x the retail prescription co-pay or cost share.

**For HSA plans, deductible must be met first, excluding certain preventive drugs.

cbia health connections

ConnectiCare

HSA $2,800/20%

ACA Metal:* Silver

All plans are open access and contract year
ConnectiCare offers POS plans.

	In-Network	Out-of-Network
Medical Office Visits *Routine/Preventive visits covered in full*	PCP: 20% after deductible Specialist: 20% after deductible	50% after deductible
General X-Ray	20% after deductible	50% after deductible
Advanced Imaging	20% after deductible	50% after deductible
Laboratory	20% after deductible	50% after deductible
Hospital Inpatient	20% after deductible	50% after deductible
Outpatient Surgery	20% after deductible	50% after deductible
Telemedicine	20% after deductible	50% after deductible
Retail Clinic	20% after deductible	50% after deductible
Walk-in/Urgent Care Centers	20% after deductible	Same as in-network
Emergency Room Services	20% after deductible	Same as in-network
Emergency Ambulance Services	20% after deductible	Same as in-network
Physical Therapy *Includes physical, speech and occupational. (40 visits per year)*	20% after deductible	50% after deductible
Annual Routine Vision Exam *(one exam per year when provided by an Optometrist or Ophtalmologist)*	20% (deductible waived)	50% after deductible
Durable Medical Equipment	20% after deductible	50% after deductible
Deductible	$2,800 individual; $5,600 family	$5,600 individual; $11,200 family
Coinsurance	20% after deductible	50% after deductible
Maximum Out-of-Pocket *Includes deductible, coinsurance, & copays for all covered services*	$4,500 individual; $9,000 family	$9,000 individual; $18,000 family

* Reflects actuarial value certified by insurance carrier

All plans subject to CT Ins. Dept. approval. The services described are only an overview of the entire benefit package. Cost-share is determined by the carrier at the time of claim processing. For a more detailed description of benefits and terms, including any limitations and exclusions, refer to the carrier documents that will be provided to the member upon enrollment.

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ConnectiCare

HSA $2,800/20%

ACA Metal: Silver

All plans are open access and contract year. ConnectiCare offers POS plans.

	IN-NETWORK	OUT-OF-NETWORK
Diabetic Supplies	20% after deductible	50% after deductible
Pediatric Dental For children under age 19	Diagnostic & preventive: Covered in full Basic, major, and orthodontia services (medically necessary only): 50% after deductible	50% after deductible
Pediatric Rx glasses For children under age 19 (one pair of frames or lenses per plan year)	Lenses & collection frames: No charge after plan deductible Non-collection frames: No charge after plan deductible up to collection frame allowance; any amount over is payable by the member minus a 20% discount	50% after deductible
Allergy Injections* (up to 20 visits per year)	20% after deductible	50% after deductible
Chiropractic Therapy* (up to 20 visits per year)	20% after deductible	50% after deductible
Home Health Care* (up to 100 visits per year)	20% after deductible	25% after deductible
Skilled Nursing Facility* (up to 90 visits per year)	20% after deductible	50% after deductible
Maternity Services	Single deductible for mother and baby for routine services. Separate deductible for mother and baby for non-routine services including baby staying beyond mother's discharge date.	50% after deductible

*Allowable number of visits are combined for in- and out-of-network.

Prescription Drugs

Prescription Drugs (retail) (MAC-A: mandatory generic) Generic substitution is required when available. If member purchases a brand drug when a generic is available, the member pays the co-pay plus the difference in cost between the brand and generic. The prescription costs listed below apply when a prescription is filled at a participating pharmacy. Go to our prescription drug page at cbia.com/insurance to access ConnectiCare's drug list.

HSA benefit for preventive drugs

All HSA-compatible plans include a pharmacy benefit that encourages the use of certain preventive medications to manage chronic conditions. This means that many covered preventive drugs are not subject to the plan deductible. Copays and coinsurance still apply.

	TIER DEFINITION	COST-SHARE**
Tier 1	Preferred generic	$5
Tier 2	Non-preferred generic	50% up to $250/script
Tier 3	Preferred brand	$50
Tier 4	Non-preferred brand	50% up to $500/script
Tier 5	Preferred specialty drugs	50% up to $500/script
Tier 6	Non-preferred specialty drugs	50% up to $750/script

Mail Order Prescriptions

Mail order drugs are dispensed at 2x the retail prescription co-pay or cost share.

**For HSA plans, deductible must be met first, excluding certain preventive drugs.

cbia health connections

ConnectiCare

POS $35/$50–$4,000/50%

ACA Metal:* Silver

All plans are open access and contract year.
ConnectiCare offers POS plans.

	In-Network	Out-of-Network
Medical Office Visits *Routine/Preventive visits covered in full*	PCP: $35 Specialist: $50	50% after deductible
General X-Ray	50% after deductible	50% after deductible
Advanced Imaging	50% after deductible	50% after deductible
Laboratory	50% after deductible	50% after deductible
Hospital Inpatient	50% after deductible	50% after deductible
Outpatient Surgery	50% after deductible	50% after deductible
Telemedicine	$35 copay**	50% after deductible
Retail Clinic	$35	50% after deductible
Walk-in/Urgent Care Centers	50% after deductible	Same as in-network
Emergency Room Services	50% after deductible	Same as in-network
Emergency Ambulance Services	50% after deductible	Same as in-network
Physical & Occupational Therapy *(40 visits per year)****	50% after deductible	50% after deductible
Speech Therapy *(40 visits per year)****	50% after deductible	50% after deductible
Annual Routine Vision Exam *(one exam per year when provided by an Optometrist or Ophthalmologist)*	$50 copay	50% after deductible
Durable Medical Equipment	50% after deductible	50% after deductible
Deductible	$4,000 individual; $8,000 family	$8,000 individual; $16,000 family
Coinsurance	50% after deductible	50% after deductible
Maximum Out-of-Pocket *Includes deductible, coinsurance, & copays for all covered services*	$7,900 individual; $15,800 family	$15,800 individual; $31,600 family

* Reflects actuarial value certified by insurance carrier
** Copay may be higher for specialty providers
*** Max. 40 visits per year combined for physical, occupational, and speech therapies

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ConnectiCare

POS $35/$50–$4,000/50%

ACA Metal: Silver

All plans are open access and contract year. ConnectiCare offers POS plans.

	IN-NETWORK	OUT-OF-NETWORK
Diabetic Supplies	50% after deductible	50% after deductible
Pediatric Dental For children under age 19	Diagnostic & preventive: Covered in full Basic, major, and orthodontia services (medically necessary only): 50% after deductible	50% after deductible
Pediatric Rx glasses For children under age 19 (one pair of frames or lenses per plan year)	Lenses & collection frames: No charge after plan deductible Non-collection frames: No charge after plan deductible up to collection frame allowance; any amount over is payable by the member minus a 20% discount	50% after deductible
Allergy Injections* (up to 20 visits per year)	PCP or specialist copay	50% after deductible
Chiropractic Therapy* (up to 20 visits per year)	$50 copay	50% after deductible
Home Health Care* (up to 100 visits per year)	25% coinsurance (deductible waived)	25% coinsurance (deductible waived)
Skilled Nursing Facility* (up to 90 visits per year)	50% after deductible	50% after deductible
Maternity Services	Single deductible for mother and baby for routine services. Separate deductible for mother and baby for non-routine services including baby staying beyond mother's discharge date.	50% after deductible

*Allowable number of visits are combined for in- and out-of-network.

Prescription Drugs

Prescription Drugs (retail) (MAC-A: mandatory generic) Generic substitution is required when available. If member purchases a brand drug when a generic is available, the member pays the co-pay plus the difference in cost between the brand and generic. The prescription costs listed below apply when a prescription is filled at a participating pharmacy. Go to our prescription drug page at cbia.com/insurance to access ConnectiCare's drug list.

	TIER DEFINITION	COST-SHARE
Tier 1	Preferred generic	$5
Tier 2	Non-preferred generic	50% up to $250/script
Tier 3	Preferred brand	$50
Tier 4	Non-preferred brand	50% up to $500/script
Tier 5	Preferred specialty drugs	50% up to $500/script
Tier 6	Non-preferred specialty drugs	50% up to $750/script

Mail Order Prescriptions

Mail order drugs are dispensed at 2x the retail prescription co-pay or cost share.

cbia health connections

ConnectiCare

POS $40/$50–$3,800/30%

ACA Metal:* Silver

All plans are open access and contract year ConnectiCare offers POS plans.

	In-Network	Out-of-Network
Medical Office Visits *Routine/Preventive visits covered in full*	PCP: $40 Specialist: $50	50% after deductible
General X-Ray	30% after deductible	50% after deductible
Advanced Imaging	30% after deductible	50% after deductible
Laboratory	30% after deductible	50% after deductible
Hospital Inpatient	30% after deductible	50% after deductible
Outpatient Surgery	30% after deductible	50% after deductible
Telemedicine	$40 copay**	50% after deductible
Retail Clinic	$40	50% after deductible
Walk-in/Urgent Care Centers	$75	Same as in-network
Emergency Room Services	30% after deductible	Same as in-network
Emergency Ambulance Services	30% after deductible	Same as in-network
Physical & Occupational Therapy *(40 visits per year)****	$30 copay	50% after deductible
Speech Therapy *(40 visits per year)****	$50 copay	50% after deductible
Annual Routine Vision Exam *(one exam per year when provided by an Optometrist or Ophthalmologist)*	$50 copay	50% after deductible
Durable Medical Equipment	50% after deductible	50% after deductible
Deductible	$3,800 individual; $7,600 family	$7,600 individual; $15,200 family
Coinsurance	30% after deductible	50% after deductible
Maximum Out-of-Pocket *Includes deductible, coinsurance, & copays for all covered services*	$7,900 individual; $15,800 family	$15,800 individual; $31,600 family

* Reflects actuarial value certified by insurance carrier
** Copay may be higher for specialty providers
*** Max. 40 visits per year combined for physical, occupational, and speech therapies

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ConnectiCare

POS $40/$50–$3,800/30%

ACA Metal: Silver

All plans are open access and contract year. ConnectiCare offers POS plans.

	IN-NETWORK	OUT-OF-NETWORK
Diabetic Supplies	50% after deductible	50% after deductible
Pediatric Dental For children under age 19	Diagnostic & preventive: Covered in full Basic, major, and orthodontia services (medically necessary only): 50% after deductible	50% after deductible
Pediatric Rx glasses For children under age 19 (one pair of frames or lenses per plan year)	Lenses & collection frames: No charge after plan deductible Non-collection frames: No charge after plan deductible up to collection frame allowance; any amount over is payable by the member minus a 20% discount	50% after deductible
Allergy Injections* (up to 20 visits per year)	PCP or specialist copay	50% after deductible
Chiropractic Therapy* (up to 20 visits per year)	$50 copay	50% after deductible
Home Health Care* (up to 100 visits per year)	25% coinsurance (deductible waived)	25% coinsurance (deductible waived)
Skilled Nursing Facility* (up to 90 visits per year)	30% after deductible	50% after deductible
Maternity Services	Single deductible for mother and baby for routine services. Separate deductible for mother and baby for non-routine services including baby staying beyond mother's discharge date.	50% after deductible

*Allowable number of visits are combined for in- and out-of-network.

Prescription Drugs

Prescription Drugs (retail) (MAC-A: mandatory generic) Generic substitution is required when available. If member purchases a brand drug when a generic is available, the member pays the co-pay plus the difference in cost between the brand and generic. The prescription costs listed below apply when a prescription is filled at a participating pharmacy. Go to our prescription drug page at cbia.com/insurance to access ConnectiCare's drug list.

	TIER DEFINITION	COST-SHARE
Tier 1	Preferred generic	$5
Tier 2	Non-preferred generic	50% up to $250/script
Tier 3	Preferred brand	$50
Tier 4	Non-preferred brand	50% up to $500/script
Tier 5	Preferred specialty drugs	50% up to $500/script
Tier 6	Non-preferred specialty drugs	50% up to $750/script

Mail Order Prescriptions

Mail order drugs are dispensed at 2x the retail prescription co-pay or cost share.

cbia health connections

ConnectiCare

POS $40/$50–$3,500/35%

ACA Metal:* Silver

All plans are open access and contract year ConnectiCare offers POS plans.

	In-Network	Out-of-Network
Medical Office Visits *Routine/Preventive visits covered in full*	PCP: $40 Specialist: $50	50% after deductible
General X-Ray	35% after deductible	50% after deductible
Advanced Imaging	Hospital Setting: 35% after deductible Preferred Facility: $75 copay	50% after deductible
Laboratory	35% after deductible	50% after deductible
Hospital Inpatient	35% after deductible	50% after deductible
Outpatient Surgery	Hospital Setting: 35% after deductible Preferred Facility: $500 copay	50% after deductible
Telemedicine	$40 copay**	50% after deductible
Retail Clinic	$40	50% after deductible
Walk-in/Urgent Care Centers	35% after deductible	Same as in-network
Emergency Room Services	35% after deductible	Same as in-network
Emergency Ambulance Services	35% after deductible	Same as in-network
Physical & Occupational Therapy *(40 visits per year)****	$30 copay	50% after deductible
Speech Therapy *(40 visits per year)****	$50 copay	50% after deductible
Annual Routine Vision Exam *(one exam per year when provided by an Optometrist or Ophtalmologist)*	$50 copay	50% after deductible
Durable Medical Equipment	50% after deductible	50% after deductible
Deductible	$3,500 individual; $7,000 family	$7,000 individual; $14,000 family
Coinsurance	35% after deductible	50% after deductible
Maximum Out-of-Pocket *Includes deductible, coinsurance, & copays for all covered services*	$7,900 individual; $15,800 family	$15,800 individual; $31,600 family

* Reflects actuarial value certified by insurance carrier
** Copay may be higher for specialty providers
*** Max. 40 visits per year combined for physical, occupational, and speech therapies

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ConnectiCare

POS $40/$50–$3,500/35%

ACA Metal: Silver

All plans are open access and contract year. ConnectiCare offers POS plans.

	IN-NETWORK	OUT-OF-NETWORK
Diabetic Supplies	50% after deductible	50% after deductible
Pediatric Dental For children under age 19	Diagnostic & preventive: Covered in full Basic, major, and orthodontia services (medically necessary only): 50% after deductible	50% after deductible
Pediatric Rx glasses For children under age 19 (one pair of frames or lenses per plan year)	Lenses & collection frames: No charge after plan deductible Non-collection frames: No charge after plan deductible up to collection frame allowance; any amount over is payable by the member minus a 20% discount	50% after deductible
Allergy Injections* (up to 20 visits per year)	PCP or specialist copay	50% after deductible
Chiropractic Therapy* (up to 20 visits per year)	$50 copay	50% after deductible
Home Health Care* (up to 100 visits per year)	25% coinsurance (deductible waived)	25% coinsurance (deductible waived)
Skilled Nursing Facility* (up to 90 visits per year)	35% after deductible	50% after deductible
Maternity Services	Single deductible for mother and baby for routine services. Separate deductible for mother and baby for non-routine services including baby staying beyond mother's discharge date.	50% after deductible

*Allowable number of visits are combined for in- and out-of-network.

Prescription Drugs

Prescription Drugs (retail) (MAC-A: mandatory generic) Generic substitution is required when available. If member purchases a brand drug when a generic is available, the member pays the co-pay plus the difference in cost between the brand and generic. The prescription costs listed below apply when a prescription is filled at a participating pharmacy. Go to our prescription drug page at cbia.com/insurance to access ConnectiCare's drug list.

	TIER DEFINITION	COST-SHARE
Tier 1	Preferred generic	$5
Tier 2	Non-preferred generic	50% up to $250/script
Tier 3	Preferred brand	$50
Tier 4	Non-preferred brand	50% up to $500/script
Tier 5	Preferred specialty drugs	50% up to $500/script
Tier 6	Non-preferred specialty drugs	50% up to $750/script

Mail Order Prescriptions

Mail order drugs are dispensed at 2x the retail prescription co-pay or cost share.

cbia health connections

ConnectiCare

POS $30/$50–$3,000/25%

ACA Metal:* Gold

All plans are open access and contract year.
ConnectiCare offers POS plans.

	In-Network	Out-of-Network
Medical Office Vists *Routine/Preventive visits covered in full*	PCP: $30 Specialist: $50	50% after deductible
General X-Ray	$40 copay	50% after deductible
Advanced Imaging	Hospital Setting: 25% after deductible Preferred Facility: $75 copay	50% after deductible
Laboratory	$10 copay	50% after deductible
Hospital Inpatient	25% after deductible	50% after deductible
Outpatient Surgery	Hospital Setting: 25% after deductible Preferred Facility: $500 copay	50% after deductible
Telemedicine	$30 copay**	50% after deductible
Retail Clinic	$30	50% after deductible
Walk-in/Urgent Care Centers	25% after deductible	Same as in-network
Emergency Room Services	25% after deductible	Same as in-network
Emergency Ambulance Services	25% after deductible	Same as in-network
Physical & Occupational Therapy *(40 visits per year)****	$30 copay	50% after deductible
Speech Therapy *(40 visits per year)****	$50 copay	50% after deductible
Annual Routine Vision Exam *(one exam per year when provided by an Optometrist or Ophthalmologist)*	$50 copay	50% after deductible
Durable Medical Equipment	50% after deductible	50% after deductible
Deductible	$3,000 individual; $6,000 family	$6,000 individual; $12,000 family
Coinsurance	25% after deductible	50% after deductible
Maximum Out-of-Pocket *Includes deductible, coinsurance, & copays for all covered services*	$6,700 individual; $13,400 family	$13,400 individual; $26,800 family

* Reflects actuarial value certified by insurance carrier
** Copay may be higher for specialty providers
*** Max. 40 visits per year combined for physical, occupational, and speech therapies

CBIA Service Corp.

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Eff. 01/19; Rev. 03/19

cbia health connections

ConnectiCare

POS $30/$50–$3,000/25%

ACA Metal: Gold

All plans are open access and contract year. ConnectiCare offers POS plans.

	IN-NETWORK	OUT-OF-NETWORK
Diabetic Supplies	50% after deductible	50% after deductible
Pediatric Dental For children under age 19	Diagnostic & preventive: Covered in full Basic, major, and orthodontia services (medically necessary only): 50% after deductible	50% after deductible
Pediatric Rx glasses For children under age 19 (one pair of frames or lenses per plan year)	Lenses & collection frames: No charge after plan deductible Non-collection frames: No charge after plan deductible up to collection frame allowance; any amount over is payable by the member minus a 20% discount	50% after deductible
Allergy Injections* (up to 20 visits per year)	PCP or specialist copay	50% after deductible
Chiropractic Therapy* (up to 20 visits per year)	$50 copay	50% after deductible
Home Health Care* (up to 100 visits per year)	25% coinsurance (deductible waived)	25% coinsurance (deductible waived)
Skilled Nursing Facility* (up to 90 visits per year)	25% after deductible	50% after deductible
Maternity Services	Single deductible for mother and baby for routine services. Separate deductible for mother and baby for non-routine services including baby staying beyond mother's discharge date.	50% after deductible

*Allowable number of visits are combined for in- and out-of-network.

Prescription Drugs

Prescription Drugs (retail) (MAC-A: mandatory generic) Generic substitution is required when available. If member purchases a brand drug when a generic is available, the member pays the co-pay plus the difference in cost between the brand and generic. The prescription costs listed below apply when a prescription is filled at a participating pharmacy. Go to our prescription drug page at cbia.com/insurance to access ConnectiCare's drug list.

	TIER DEFINITION	COST-SHARE
Tier 1	Preferred generic	$5
Tier 2	Non-preferred generic	50% up to $250/script
Tier 3	Preferred brand	$50
Tier 4	Non-preferred brand	50% up to $500/script
Tier 5	Preferred specialty drugs	50% up to $500/script
Tier 6	Non-preferred specialty drugs	50% up to $750/script

Mail Order Prescriptions

Mail order drugs are dispensed at 2x the retail prescription co-pay or cost share.

cbia health connections

ConnectiCare

POS $25/$50–$2,500/20%

ACA Metal:* Gold

All plans are open access and contract year.
ConnectiCare offers POS plans.

	In-Network	Out-of-Network
Medical Office Visits *Routine/Preventive visits covered in full*	PCP $25; Specialist $50	50% after deductible
General X-Ray	$40 copay	50% after deductible
Advanced Imaging	Hospital setting: $75 after deductible Preferred facility: $75 copay	50% after deductible
Laboratory	$10 copay	50% after deductible
Hospital Inpatient	After deductible, $500 copay per day, up to $2,000 per admission	50% after deductible
Outpatient Surgery	$500 copay after deductible	50% after deductible
Telemedicine	$25 copay**	50% after deductible
Retail Clinic	$25	50% after deductible
Walk-in/Urgent Care Centers	$75	Same as in-network
Emergency Room Services	20% to $350 max/visit	Same as in-network
Emergency Ambulance Services	$200 copay	Same as in-network
Physical & Occupational Therapy *(40 visits per year)****	$25 copay	50% after deductible
Speech Therapy *(40 visits per year)****	$50 copay	50% after deductible
Annual Routine Vision Exam *(one exam per year when provided by an Optometrist or Ophthalmologist)*	$50 copay	50% after deductible
Durable Medical Equipment	50% after deductible	50% after deductible
Deductible	$2,500 individual; $5,000 family	$5,000 individual; $10,000 family
Coinsurance	20% after deductible	50% after deductible
Maximum Out-of-Pocket *Includes deductible, coinsurance, & copays for all covered services*	$5,500 individual; $11,000 family	$11,000 individual; $22,000 family

* Reflects actuarial value certified by insurance carrier
** Copay may be higher for specialty providers
*** Max. 40 visits per year combined for physical, occupational, and speech therapies

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ConnectiCare

POS $25/$50–$2,500/20%

ACA Metal: Gold

All plans are open access and contract year. ConnectiCare offers POS plans.

	IN-NETWORK	OUT-OF-NETWORK
Diabetic Supplies	50% after deductible	50% after deductible
Pediatric Dental For children under age 19	Diagnostic & preventive: Covered in full Basic, major, and orthodontia services (medically necessary only): 50% after deductible	50% after deductible
Pediatric Rx glasses For children under age 19 (one pair of frames or lenses per plan year)	Lenses & collection frames: No charge after plan deductible Non-collection frames: No charge after plan deductible up to collection frame allowance; any amount over is payable by the member minus a 20% discount	50% after deductible
Allergy Injections* (up to 20 visits per year)	PCP or specialist copay	50% after deductible
Chiropractic Therapy* (up to 20 visits per year)	$50 copay	50% after deductible
Home Health Care* (up to 100 visits per year)	Covered in full	25% after deductible
Skilled Nursing Facility* (up to 90 visits per year)	$500 copay per day after deductible	50% after deductible
Maternity Services	Single deductible for mother and baby for routine services. Separate deductible for mother and baby for non-routine services including baby staying beyond mother's discharge date.	50% after deductible

*Allowable number of visits are combined for in- and out-of-network.

Prescription Drugs

Prescription Drugs (retail) (MAC-A: mandatory generic) Generic substitution is required when available. If member purchases a brand drug when a generic is available, the member pays the co-pay plus the difference in cost between the brand and generic. The prescription costs listed below apply when a prescription is filled at a participating pharmacy. Go to our prescription drug page at cbia.com/insurance to access ConnectiCare's drug list.

	TIER DEFINITION	COST-SHARE
Tier 1	Preferred generic	$5
Tier 2	Non-preferred generic	50% up to $250/script
Tier 3	Preferred brand	$50
Tier 4	Non-preferred brand	50% up to $500/script
Tier 5	Preferred specialty drugs	50% up to $500/script
Tier 6	Non-preferred specialty drugs	50% up to $750/script

Mail Order Prescriptions

Mail order drugs are dispensed at 2x the retail prescription co-pay or cost share.

cbia health connections

ConnectiCare

POS $30/$45–$1,800

ACA Metal:* Gold

All plans are open access and contract year.
ConnectiCare offers POS plans.

	In-Network	Out-of-Network
Medical Office Vists *Routine/Preventive visits covered in full*	PCP: $30 Specialist: $45	50% after deductible
General X-Ray	$40 copay	50% after deductible
Advanced Imaging	Hospital Setting: $75 after deductible Preferred Facility: $75 copay	50% after deductible
Laboratory	$10 copay	50% after deductible
Hospital Inpatient	After deductible, $500 copay per day, up to $2,000 per admission	50% after deductible
Outpatient Surgery	Hospital Setting: $500 copay after deductible Preferred Facility: $500 copay	50% after deductible
Telemedicine	$30 copay**	50% after deductible
Retail Clinic	$30	50% after deductible
Walk-in/Urgent Care Centers	$75	Same as in-network
Emergency Room Services	$200 copay	Same as in-network
Emergency Ambulance Services	$200 copay	Same as in-network
Physical & Occupational Therapy *(40 visits per year)****	$30 copay	50% after deductible
Speech Therapy *(40 visits per year)****	$45 copay	50% after deductible
Annual Routine Vision Exam *(one exam per year when provided by an Optometrist or Ophthalmologist)*	$45 copay	50% after deductible
Durable Medical Equipment	50% after deductible	50% after deductible
Deductible	$1,800 individual; $3,600 family	$3,600 individual; $7,200 family
Coinsurance	0% after deductible	50% after deductible
Maximum Out-of-Pocket *Includes deductible, coinsurance, & copays for all covered services*	$4,200 individual; $8,400 family	$8,400 individual; $16,800 family

* Reflects actuarial value certified by insurance carrier
** Copay may be higher for specialty providers
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ConnectiCare

POS $30/$45–$1,800

ACA Metal: Gold

All plans are open access and contract year. ConnectiCare offers POS plans.

	IN-NETWORK	OUT-OF-NETWORK
Diabetic Supplies	50% after deductible	50% after deductible
Pediatric Dental For children under age 19	Diagnostic & preventive: Covered in full Basic, major, and orthodontia services (medically necessary only): 50% after deductible	50% after deductible
Pediatric Rx glasses For children under age 19 (one pair of frames or lenses per plan year)	Lenses & collection frames: No charge after plan deductible Non-collection frames: No charge after plan deductible up to collection frame allowance; any amount over is payable by the member minus a 20% discount	50% after deductible
Allergy Injections* (up to 20 visits per year)	PCP or specialist copay	50% after deductible
Chiropractic Therapy* (up to 20 visits per year)	$45 copay	50% after deductible
Home Health Care* (up to 100 visits per year)	Covered in full	25% after deductible
Skilled Nursing Facility* (up to 90 visits per year)	After deductible, $500 copay per day up to $2,000 max. per admission	50% after deductible
Maternity Services	Single deductible for mother and baby for routine services. Separate deductible for mother and baby for non-routine services including baby staying beyond mother's discharge date.	50% after deductible

*Allowable number of visits are combined for in- and out-of-network.

Prescription Drugs

Prescription Drugs (retail) (MAC-A: mandatory generic) Generic substitution is required when available. If member purchases a brand drug when a generic is available, the member pays the co-pay plus the difference in cost between the brand and generic. The prescription costs listed below apply when a prescription is filled at a participating pharmacy. Go to our prescription drug page at cbia.com/insurance to access ConnectiCare's drug list.

	TIER DEFINITION	COST-SHARE
Tier 1	Preferred generic	$5
Tier 2	Non-preferred generic	50% up to $250/script
Tier 3	Preferred brand	$50
Tier 4	Non-preferred brand	50% up to $500/script
Tier 5	Preferred specialty drugs	50% up to $500/script
Tier 6	Non-preferred specialty drugs	50% up to $750/script

Mail Order Prescriptions

Mail order drugs are dispensed at 2x the retail prescription co-pay or cost share.

cbia health connections

ConnectiCare

FlexPOS $40/$50–$4,500/40%

ACA Metal:* Silver

Available to employees residing outside Connecticut.

	In-Network	Out-of-Network
Medical Office Visits *Routine/Preventive visits covered in full*	PCP: At a Sanitas Medical Center: No Cost All other in-network: $40 Specialist: $50	50% after deductible
General X-Ray	Hospital setting: 40% after deductible Freestanding facility: $40 copay	50% after deductible
Advanced Imaging	Hospital setting: 40% after deductible Freestanding facility: $75 copay after deductible, up to $375 copay maximum	50% after deductible
Laboratory	$10 copay	50% after deductible
Hospital Inpatient	40% after deductible	50% after deductible
Outpatient Surgery	Hospital setting: 40% after deductible Ambulatory Surgical Center: $500 copay after deductible	50% after deductible
Telemedicine	$40 copay**	50% after deductible
Retail Clinic	$40	50% after deductible
Walk-in/Urgent Care Centers	$75	Same as in-network
Emergency Room Services	40% after deductible	Same as in-network
Emergency Ambulance Services	40% after deductible	Same as in-network
Physical & Occupational Therapy *(40 visits per year)****	$30 copay	50% after deductible
Speech Therapy *(40 visits per year)****	$50 copay	50% after deductible
Annual Routine Vision Exam *(one exam per year when provided by an Optometrist or Ophthalmologist)*	$50 copay	50% after deductible
Durable Medical Equipment	50% after deductible	50% after deductible
Deductible	$4,500 individual; $9,000 family	$10,000 individual; $20,000 family
Coinsurance	40% after deductible	50% after deductible
Maximum Out-of-Pocket *Includes deductible, coinsurance, & copays for all covered services*	$7,900 individual; $15,800 family	$15,000 individual; $30,000 family

* Reflects actuarial value certified by insurance carrier
** Copay may be higher for specialty providers
*** Max. 40 visits per year combined for physical, occupational, and speech therapies

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ConnectiCare

FlexPOS $40/$50–$4,500/40%

ACA Metal: Silver

Available to employees residing outside Connecticut.

	IN-NETWORK	OUT-OF-NETWORK
Diabetic Supplies	50% after deductible	50% after deductible
Pediatric Dental For children under age 19	Diagnostic & preventive: Covered in full Basic, major, and orthodontia services (medically necessary only): 50% after deductible	50% after deductible
Pediatric Rx glasses For children under age 19 (one pair of frames or lenses per plan year)	Lenses & collection frames: 50% after deductible Non-collection frames: 50% after deductible up to collection frame allowance; any amount over is payable by the member minus a 20% discount	50% after deductible
Allergy Injections* (up to 20 visits per year)	PCP or specialist copay	50% after deductible
Chiropractic Therapy* (up to 20 visits per year)	$50 copay	50% after deductible
Home Health Care* (up to 100 visits per year)	$25 copay	25% coinsurance (deductible waived)
Skilled Nursing Facility* (up to 90 visits per year)	40% after deductible	50% after deductible
Maternity Services	Single deductible for mother and baby for routine services. Separate deductible for mother and baby for non-routine services including baby staying beyond mother's discharge date.	50% after deductible

*Allowable number of visits are combined for in- and out-of-network.

Prescription Drugs

Prescription Drugs (retail) (MAC-A: mandatory generic) Generic substitution is required when available. If member purchases a brand drug when a generic is available, the member pays the co-pay plus the difference in cost between the brand and generic. The prescription costs listed below apply when a prescription is filled at a participating pharmacy. Go to our prescription drug page at cbia.com/insurance to access ConnectiCare's drug list.

	TIER DEFINITION	COST-SHARE
Tier 1	Preferred generic	$5
Tier 2	Non-preferred generic	50% up to $250/script
Tier 3	Preferred brand	$60
Tier 4	Non-preferred brand	50% up to $500/script
Tier 5	Preferred specialty drugs	50% up to $500/script
Tier 6	Non-preferred specialty drugs	50% up to $750/script

Mail Order Prescriptions

Mail order drugs are dispensed at 2x the retail prescription co-pay or cost share.