ConnectiCare

Small Group Market
FlexPOS $45/$60 $3,000 30% cnt.
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	$3,000 per member $6,000 per family	$8,000 per member $16,000 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)	$8,150 per member $16,300 per family	$16,000 per member $32,000 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 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:** $45 copayment/visit; deductible does not apply	50% coinsurance after plan deductible
Specialist Office Visits	$60 copayment/visit after plan deductible	50% coinsurance after plan deductible
Mental Health and Substance Abuse Office Visits	$60 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 at a Hospital Facility $75 copayment/service after plan deductible at a Freestanding Facility up to five copayments per year, then copayment waived	50% coinsurance after plan deductible
Laboratory Services	$10 copayment/service after plan deductible	50% coinsurance after plan deductible
Non-Advanced Radiology (X-ray, Diagnostic)	30% coinsurance after plan deductible at a Hospital Facility $60 copayment/service after plan deductible at a Freestanding Facility	50% coinsurance after plan deductible

Benefits	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Mammography Ultrasound	30% coinsurance after plan deductible at a Hospital Facility $60 copayment/service after plan deductible at a Freestanding Facility	50% coinsurance after plan deductible
Prescription Drugs – Retail Pharmacy (cost share based on 30-day supply per prescription)		
Preferred Generic Tier 1	$10 copayment/ prescription; deductible does not apply	50% coinsurance; deductible does not apply
Non-preferred Generic Tier 2	50% coinsurance up to a maximum of $250 per prescription; deductible does not apply	50% coinsurance; deductible does not apply
Preferred Brand Tier 3	$50 copayment/ prescription; deductible does not apply	50% coinsurance; deductible does not apply
Non-Preferred Brand Tier 4	50% coinsurance up to a maximum of $500 per prescription; deductible does not apply	50% coinsurance; deductible does not apply
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; deductible does not apply (specialty retail only)	50% coinsurance; deductible does not apply (specialty retail only)
Non-Preferred Specialty Tier 6	50% coinsurance up to a maximum of $750 per prescription; deductible does not apply (specialty retail only)	50% coinsurance; deductible does not apply (specialty retail only)
Prescription Drugs – Mail Order Pharmacy (up to a 90-day supply per prescription)		
Preferred Generic Tier 1	$20 copayment/ prescription; deductible does not apply	50% coinsurance; deductible does not apply
Non-preferred Generic Tier 2	50% coinsurance up to a maximum of $500 per prescription; deductible does not apply	50% coinsurance; deductible does not apply
Preferred Brand Tier 3	$100 copayment/ prescription; deductible does not apply	50% coinsurance; deductible does not apply
Non-Preferred Brand Tier 4	50% coinsurance up to a maximum of $1,000 per prescription; deductible does not apply	50% coinsurance; deductible does not apply
Outpatient Rehabilitative and Habilitative Services (40 visits per contract year limit combined for Rehabilitative physical, speech and occupational therapies. Separate 40 visits per contract year limit combined for Habilitative speech, physical and occupational therapies.)		
Speech Therapy	$45 copayment/visit after plan deductible	50% coinsurance after plan deductible

Benefits	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Physical and Occupational Therapy	$30 copayment/visit after plan deductible	50% coinsurance after plan deductible
Other Services		
Chiropractic Services (up to 20 visits per contract year)	$45 copayment/visit after plan deductible	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 contract year)	$25 copayment/visit; deductible does not apply	25% coinsurance; deductible does not apply
Outpatient Services (in a hospital or ambulatory facility)	30% coinsurance after plan deductible at an Outpatient Hospital Facility $500 copayment after plan deductible at an Ambulatory Surgery Center	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 contract 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	$100 copayment/visit after plan deductible	Same as In-Network Benefit
Pediatric Dental Care (for children under age 20)		
Diagnostic & Preventive	No cost	50% coinsurance after plan deductible
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

Benefits	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Pediatric Vision Care (for children under age 20)		
Prescription Eye Glasses (one pair of frames and lenses or contact lens per contract 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 contract year)	$60 copayment; 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 contract year)	$60 copayment; deductible does not apply	50% coinsurance after plan deductible
Allergy Injections (up to 20 visits per contract year)	See primary care or specialist office visits	50% coinsurance after plan deductible
Allergy Testing (up to one per contract 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
Modified Food Products and Specialized Formula	50% 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
Telemedicine	See primary care or specialist office visits	50% coinsurance after plan deductible

- This is a brief summary of benefits. Refer to your ConnectiCare Insurance Company, Inc. certificate of coverage for complete details on benefits, conditions, limitations and exclusions. All benefits described are per member per contract year.
- Mammogram screenings, breast ultrasounds, and breast MRIs – Please refer to the certificate of coverage for details.
- 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 Insurance Company, Inc. certificate of coverage for more information.
- If you are a Massachusetts resident, please refer to your amendatory rider for Massachusetts mandated benefits for additional details of your mandated benefits.
- 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 drug's or supply's clinical effectiveness and cost, not on whether it is a generic drug or supply or brand name drug or supply.

- 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 certificate of coverage 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.