Passage and Compass HMO plans

Plan name/Metal level	Passage HMO PCP Copay/Coins. $2,500 Gold	Passage HMO PCP Copay $6,500/$13,000 ded. Silver	Compass HMO Copay/Coins. $2,000 with Dental* Gold	Passage HMO PCP Coins. $8,500 Bronze
NETWORK ACCESS	**PCPs in CT only with specialists and facilities in CT and bordering parts of MA, RI and EmblemHealth Prime for NY**	**PCPs in CT only with specialists and facilities in CT and bordering parts of MA, RI and EmblemHealth Prime for NY**	**CT only**	**PCPs in CT only with specialists and facilities in CT and bordering parts of MA, RI and EmblemHealth Prime for NY**
PLAN/MEDICAL DEDUCTIBLE				
Deductible (individual/family)	$2,500/$5,000	$6,500/$13,000	**Preferred Providers:** $2,000/$4,000 **Participating Providers:** $3,500/$7,000	$8,500/$17,000**
Maximum out-of-pocket limit (individual/family)	$8,000/$16,000	$8,700/$17,400	$8,500/$17,000	$8,700/$17,400
IN-NETWORK MEDICAL BENEFITS				
Preventive care/screenings/immunizations	$0	$0	$0	$0
Primary care services	$30 copay (deductible waived)	$30 copay (deductible waived)	**Preferred Providers:** $20 (deductible waived) **Participating Providers:** 50% after deductible	50% coinsurance after deductible
Telemedicine visits through Teladoc®	$0	$0	$0	$0
Specialist services	$50 copay (deductible waived)	$50 copay (deductible waived)	$50 copay (deductible waived)	50% coinsurance after deductible
Mental health and substance abuse office visits	$50 copay (deductible waived)	$50 copay (deductible waived)	$50 copay (deductible waived)	50% coinsurance after deductible
Vision	$25 copay (deductible waived)	$30 copay (deductible waived)	$15 copay (deductible waived)	50% coinsurance (deductible waived)
Walk-in/urgent care center	$50 copay (deductible waived)	$50 copay (deductible waived)	$50 copay (deductible waived)	50% coinsurance after deductible
Worldwide emergency coverage***	25% coinsurance after deductible	30% coinsurance after deductible	20% coinsurance after deductible	50% coinsurance after deductible
Hospital – inpatient treatment	25% coinsurance after deductible	30% coinsurance after deductible	**Preferred Providers:** 20% coinsurance after deductible **Participating Providers:** 50% coinsurance after deductible	50% coinsurance after deductible
Hospital – outpatient treatment	25% coinsurance after deductible	30% coinsurance after deductible	**Preferred Providers:** 20% coinsurance after deductible **Participating Providers:** 50% coinsurance after deductible	50% coinsurance after deductible
Outpatient surgery in freestanding locations	$450 copay after deductible	$350 copay (deductible waived)	$350 copay after deductible	50% coinsurance after deductible
Lab services	$10 copay (deductible waived)	$10 copay (deductible waived)	$10 copay (deductible waived)	50% coinsurance after deductible
X-rays	$50 copay (deductible waived)	**Freestanding facility:** $25 copay (deductible waived) **Hospital setting:** 30% coinsurance after deductible	**Preferred Providers:** 20% coinsurance after deductible **Freestanding Facility:** $10 copay (deductible waived) **Participating Providers:** 50% coinsurance after deductible	50% coinsurance after deductible
Advanced imaging (CT scans & MRI)	**Freestanding facility:** $75 copay up to $375 (deductible waived) **Hospital setting:** 25% coinsurance after deductible	**Freestanding facility:** $75 copay up to $375 after deductible **Hospital setting:** 30% coinsurance after deductible	**Preferred Providers:** 20% coinsurance after deductible **Freestanding Facility:** $75 copay up to $375 copay (deductible waived) **Participating Providers:** 50% coinsurance after deductible	50% coinsurance after deductible
OUT-OF-NETWORK MEDICAL BENEFITS				
Deductible (individual/family)	N/A	N/A	N/A	N/A
Coinsurance	N/A	N/A	N/A	N/A
Maximum out-of-pocket limit (individual/family)	N/A	N/A	N/A	N/A
PRESCRIPTION DRUG BENEFIT				
Prescription drug deductible (individual/family)	None	None	None	Plan has integrated deductible with medical (see above)**
Tier 1 – Generic drugs	$10 copay	$10 copay	$5 copay	$15 copay after deductible
Tier 2 – Preferred brand drugs	50% coinsurance $250 maximum per prescription	50% coinsurance $250 maximum per prescription	50% coinsurance $250 maximum per prescription	50% coinsurance $250 maximum per prescription after deductible
Tier 3 – Preferred brand drugs	$50 copay	$50 copay	$50 copay	$60 copay after deductible
Tier 4 – Non-preferred brand drugs	50% coinsurance $500 maximum per prescription	50% coinsurance $500 maximum per prescription	50% coinsurance $500 maximum per prescription	50% coinsurance $500 maximum per prescription after deductible
Tier 5 – Preferred specialty drugs	50% coinsurance $500 maximum per prescription	50% coinsurance $500 maximum per prescription	50% coinsurance $500 maximum per prescription	50% coinsurance $1,000 maximum per prescription after deductible
Tier 6 – Non-preferred specialty drugs	50% coinsurance $750 maximum per prescription	50% coinsurance $750 maximum per prescription	50% coinsurance $750 maximum per prescription	50% coinsurance $1,000 maximum per prescription after deductible

*Plan includes routine adult dental coverage.
**Integrated medical and prescription drug deductible.
***Subject to limitations.

FlexPOS plans and FlexPOS HSA plans

Plan name/Metal level	FlexPOS Copay $20 with Dental* Platinum	FlexPOS HSA Copay/Coins. $3,000/$6,000 ded. with Dental* Silver (E)	FlexPOS HSA Copay/Coins. $3,500 Silver (E)	FlexPOS HSA Coins. $5,800/$11,600 ded. with Dental* Bronze (E)	FlexPOS HSA Copay Copay/Coins. $6,400/$12,800 ded. with Dental* Bronze (E)
NETWORK ACCESS	CT,MA,RI and NY through EmblemHealth Prime and nationally through First Health	CT,MA,RI and NY through EmblemHealth Prime and nationally through First Health	CT,MA,RI and NY through EmblemHealth Prime and nationally through First Health	CT,MA,RI and NY through EmblemHealth Prime and nationally through First Health	CT,MA,RI and NY through EmblemHealth Prime and nationally through First Health
PLAN/MEDICAL DEDUCTIBLE					
Deductible (individual/family)	None	$3,000/$6,000**	$3,500/$7,000**	$5,800/$11,600**	$6,400/$12,800**
Maximum out-of-pocket limit (individual/family)	$5,500/$11,000	$7,000/$14,000	$7,000/$14,000	$7,050/$14,100	$7,000/$14,000
IN-NETWORK MEDICAL BENEFITS					
Preventive care/screenings/immunizations	$0	$0	$0	$0	$0
Primary care services	$20 copay	$25 copay after deductible	$30 copay after deductible	$50 copay after deductible	$40 copay after deductible
Telemedicine visits through Teladoc®	$0	0% coinsurance after plan deductible	0% coinsurance after plan deductible	0% coinsurance after deductible	0% coinsurance after deductible
Specialist services	$45 copay	$50 copay after deductible	$50 copay after deductible	$60 copay after deductible	$50 copay after deductible
Mental health and substance abuse office visits	$45 copay	$50 copay after deductible	$50 copay after deductible	$60 copay after deductible	$50 copay after deductible
Vision	$20 copay	$25 copay (deductible waived)	$30 copay (deductible waived)	$50 copay (deductible waived)	$50 copay (deductible waived)
Walk-in/urgent care center	$50 copay	$50 copay after deductible	$50 copay after deductible	$60 copay after deductible	$50 copay after deductible
Worldwide emergency coverage***	15% coinsurance	20% coinsurance after deductible	25% coinsurance after deductible	50% coinsurance after deductible	10% coinsurance after deductible
Hospital – inpatient treatment	15% coinsurance	20% coinsurance after deductible	25% coinsurance after deductible	50% coinsurance after deductible	10% coinsurance after deductible
Hospital – outpatient treatment	15% coinsurance	20% coinsurance after deductible	25% coinsurance after deductible	50% coinsurance after deductible	10% coinsurance after deductible
Outpatient surgery in freestanding locations	$250 copay	$350 copay after deductible	$450 copay after deductible	$500 copay after deductible	$150 copay after deductible
Lab services	$10 copay	$15 copay after deductible	$10 copay after deductible	$10 copay after deductible	$10 copay after deductible
X-rays	**Freestanding facility:** $15 copay **Hospital setting:** 15% coinsurance	**Freestanding facility:** $25 copay after deductible **Hospital setting:** 20% coinsurance after deductible	**Freestanding facility:** $30 copay after deductible **Hospital setting:** 25% coinsurance after deductible	**Freestanding facility:** $50 copay after deductible **Hospital setting:** 50% coinsurance after deductible	**Freestanding facility:** $10 copay after deductible **Hospital setting:** 10% coinsurance after deductible
Advanced imaging (CT scans & MRI)	**Freestanding facility:** $60 copay up to $300 **Hospital setting:** 15% coinsurance	**Freestanding facility:** $75 copay up to $375 after deductible **Hospital setting:** 20% coinsurance after deductible	**Freestanding facility:** $75 copay up to $375 after deductible **Hospital setting:** 25% coinsurance after deductible	50% coinsurance after deductible	**Freestanding facility:** $40 copay up to $200 after deductible **Hospital setting:** 10% coinsurance after deductible
OUT-OF-NETWORK MEDICAL BENEFITS					
Deductible (individual/family)	$8,000/$16,000	$8,000/$16,000	$8,000/$16,000	$12,500/$25,000	$15,000/$30,000
Coinsurance	50%	50%	50%	50%	50%
Maximum out-of-pocket limit (individual/family)	$15,000/$30,000	$15,000/$30,000	$15,000/$30,000	$17,500/$35,000	$20,000/$40,000
PRESCRIPTION DRUG BENEFIT					
Prescription drug deductible (individual/family)	None	Plan has integrated deductible with medical (see above)**	Plan has integrated deductible with medical (see above)**	Plan has integrated deductible with medical (see above)**	Plan has integrated deductible with medical (see above)**
Tier 1 – Preferred generic drugs	$10 copay	$10 copay after deductible	$15 copay after deductible	$15 copay after deductible	$10 copay after deductible
Tier 2 – Non-preferred generic drugs	50% coinsurance $250 maximum per prescription	50% coinsurance $250 maximum per prescription after deductible	50% coinsurance $250 maximum per prescription after deductible	50% coinsurance $250 maximum per prescription after deductible	50% coinsurance $250 maximum per prescription after deductible
Tier 3 – Preferred brand drugs	$50 copay	$50 copay after deductible	$50 copay after deductible	$60 copay after deductible	$50 copay after deductible
Tier 4 – Non-preferred brand drugs	50% coinsurance $500 maximum per prescription	50% coinsurance $500 maximum per prescription after deductible	50% coinsurance $500 maximum per prescription after deductible	50% coinsurance $500 maximum per prescription after deductible	50% coinsurance $500 maximum per prescription after deductible
Tier 5 – Preferred specialty drugs	50% coinsurance $500 maximum per prescription	50% coinsurance $500 maximum per prescription after deductible	50% coinsurance $500 maximum per prescription after deductible	50% coinsurance $500 maximum per prescription after deductible	50% coinsurance $500 maximum per prescription after deductible
Tier 6 – Non-preferred specialty drugs	50% coinsurance $750 maximum per prescription	50% coinsurance $750 maximum per prescription after deductible	50% coinsurance $750 maximum per prescription after deductible	50% coinsurance $750 maximum per prescription after deductible	50% coinsurance $750 maximum per prescription after deductible

*Plan includes routine adult dental coverage.
**Integrated medical and prescription drug deductible.
***Subject to limitations.

FlexPOS plans

Plan name/Metal level	FlexPOS Coins. $7,500 with Dental* Bronze	FlexPOS Copay/Coins. $3,500 Silver	FlexPOS Copay/Coins. $4,250 with Dental* Silver	FlexPOS Copay/Coins. $5,300 Silver
NETWORK ACCESS	**CT,MA,RI and NY through EmblemHealth Prime and nationally through First Health**	**CT,MA,RI and NY through EmblemHealth Prime and nationally through First Health**	**CT,MA,RI and NY through EmblemHealth Prime and nationally through First Health**	**CT,MA,RI and NY through EmblemHealth Prime and nationally through First Health**
PLAN/MEDICAL DEDUCTIBLE				
Deductible (individual/family)	$7,500/$15,000**	$3,500/$7,000	$4,250/$8,500	$5,300/$10,600
Maximum out-of-pocket limit (individual/family)	$8,700/$17,400	$8,550/$17,100	$8,550/$17,100	$8,550/$17,100
IN-NETWORK MEDICAL BENEFITS				
Preventive care/screenings/immunizations	$0	$0	$0	$0
Primary care services	50% coinsurance after deductible	$45 copay (deductible waived)	$45 copay (deductible waived)	$35 copay (deductible waived)
Telemedicine visits through Teladoc®	$0	$0	$0	$0
Specialist services	50% coinsurance after deductible	$60 copay after deductible	$60 copay (deductible waived)	$50 copay (deductible waived)
Mental health and substance abuse office visits	50% coinsurance after deductible	$60 copay (deductible waived)	$60 copay (deductible waived)	$50 copay (deductible waived)
Vision	50% coinsurance (deductible waived)	$45 copay (deductible waived)	$45 copay (deductible waived)	$35 copay (deductible waived)
Walk-in/urgent care center	50% coinsurance after deductible	$60 copay after deductible	$60 copay (deductible waived)	$75 copay (deductible waived)
Worldwide emergency coverage***	50% coinsurance after deductible	30% coinsurance after deductible	40% coinsurance after deductible	30% coinsurance after deductible
Hospital – inpatient treatment	50% coinsurance after deductible	30% coinsurance after deductible	40% coinsurance after deductible	30% coinsurance after deductible
Hospital – outpatient treatment	50% coinsurance after deductible	30% coinsurance after deductible	40% coinsurance after deductible	30% coinsurance after deductible
Outpatient surgery in freestanding locations	50% coinsurance after deductible	$500 copay after deductible	$500 copay after deductible	$300 copay after deductible
Lab services	50% coinsurance after deductible	$10 copay after deductible	$10 copay (deductible waived)	$10 copay (deductible waived)
X-rays	50% coinsurance after deductible	**Freestanding facility:** $35 copay after deductible **Hospital setting:** 30% coinsurance after deductible	**Freestanding facility:** $50 copay (deductible waived) **Hospital setting:** 40% coinsurance after deductible	**Freestanding facility:** $50 copay (deductible waived) **Hospital setting:** 30% coinsurance after deductible
Advanced imaging (CT scans & MRI)	50% coinsurance after deductible	**Freestanding facility:** $75 copay up to $375 after deductible **Hospital setting:** 30% coinsurance after deductible	**Freestanding facility:** $75 copay up to $375 after deductible **Hospital setting:** 40% coinsurance after deductible	**Freestanding facility:** $75 copay up to $375 after deductible **Hospital setting:** 30% coinsurance after deductible
OUT-OF-NETWORK MEDICAL BENEFITS				
Deductible (individual/family)	$15,000/$30,000	$8,000/$16,000	$10,000/$20,000	$12,000/$24,000
Coinsurance	50%	50%	50%	50%
Maximum out-of-pocket limit (individual/family)	$20,000/$40,000	$16,000/$32,000	$20,000/$40,000	$20,000/$40,000
PRESCRIPTION DRUG BENEFIT				
Prescription drug deductible (individual/family)	Plan has integrated deductible with medical (see above)**	None	None	None
Tier 1 – Preferred generic drugs	$15 copay after deductible	$10 copay	$10 copay	$10 copay
Tier 2 – Non-preferred generic drugs	50% coinsurance $250 maximum per prescription after deductible	50% coinsurance $250 maximum per prescription	50% coinsurance $250 maximum per prescription	50% coinsurance $250 maximum per prescription
Tier 3 – Preferred brand drugs	$60 copay after deductible	$50 copay	$50 copay	$50 copay
Tier 4 – Non-preferred brand drugs	50% coinsurance $500 maximum per prescription after deductible	50% coinsurance $500 maximum per prescription	50% coinsurance $500 maximum per prescription	50% coinsurance $500 maximum per prescription
Tier 5 – Preferred specialty drugs	50% coinsurance $500 maximum per prescription after deductible	50% coinsurance $500 maximum per prescription	50% coinsurance $500 maximum per prescription	50% coinsurance $500 maximum per prescription
Tier 6 – Non-preferred specialty drugs	50% coinsurance $750 maximum per prescription after deductible	50% coinsurance $750 maximum per prescription	50% coinsurance $750 maximum per prescription	50% coinsurance $750 maximum per prescription

*Plan includes routine adult dental coverage.
**Integrated medical and prescription drug deductible.
***Subject to limitations.

FlexPOS plans

Plan name/Metal level	FlexPOS Copay/Coins. $4,000 with Dental* Gold	FlexPOS Copay/Coins. $1,000 with Dental* Gold	FlexPOS Copay/Coins. $2,000 Gold	FlexPOS Copay/Coins. $2,500 Gold	FlexPOS Copay $3,000 Gold
NETWORK ACCESS	**CT,MA,RI and NY through EmblemHealth Prime and nationally through First Health**	**CT,MA,RI and NY through EmblemHealth Prime and nationally through First Health**	**CT,MA,RI and NY through EmblemHealth Prime and nationally through First Health**	**CT,MA,RI and NY through EmblemHealth Prime and nationally through First Health**	**CT,MA,RI and NY through EmblemHealth Prime and nationally through First Health**
PLAN/MEDICAL DEDUCTIBLE					
Deductible (individual/family)	$4,000/$8,000**	$1,000/$2,000**	$2,000/$4,000**	$2,500/$5,000	$3,000/$6,000
Maximum out-of-pocket limit (individual/family)	$7,000/$14,000	$6,000/$12,000	$5,000/$10,000	$6,500/$13,000	$7,000/$14,000
IN-NETWORK MEDICAL BENEFITS					
Preventive care/screenings/immunizations	$0	$0	$0	$0	$0
Primary care services	$20 copay (deductible waived)	$20 copay (deductible waived)	$25 copay (deductible waived)	$20 copay (deductible waived)	$20 copay (deductible waived)
Telemedicine visits through Teladoc®	$0	$0	$0	$0	$0
Specialist services	$50 copay (deductible waived)	$50 copay (deductible waived)	$45 copay (deductible waived)	$50 copay (deductible waived)	$50 copay (deductible waived)
Mental health and substance abuse office visits	$50 copay (deductible waived)	$50 copay (deductible waived)	$45 copay (deductible waived)	$50 copay (deductible waived)	$50 copay (deductible waived)
Vision	$25 copay (deductible waived)	$20 copay (deductible waived)	$25 copay (deductible waived)	$25 copay (deductible waived)	$25 copay (deductible waived)
Walk-in/urgent care center	$50 copay (deductible waived)	$50 copay (deductible waived)	$50 copay (deductible waived)	$50 copay (deductible waived)	$50 copay (deductible waived)
Worldwide emergency coverage***	20% coinsurance after deductible	30% coinsurance after deductible	40% coinsurance after deductible	20% coinsurance after deductible	$350 copay (deductible waived)
Hospital – inpatient treatment	20% coinsurance after deductible	30% coinsurance after deductible	40% coinsurance after deductible	20% coinsurance after deductible	$500 copay/day $2,000 maximum per admission after deductible
Hospital – outpatient treatment	20% coinsurance after deductible	30% coinsurance after deductible	40% coinsurance after deductible	20% coinsurance after deductible	$500 copay after deductible
Outpatient surgery in freestanding locations	$350 copay (deductible waived)	$500 copay after deductible	25% coinsurance after deductible	$250 copay after deductible	$250 copay after deductible
Lab services	$20 copay (deductible waived)	$10 copay after deductible	25% coinsurance (deductible waived)	$10 copay (deductible waived)	$10 copay (deductible waived)
X-rays	**Freestanding facility:** $25 copay (deductible waived) **Hospital setting:** 20% coinsurance after deductible	**Freestanding facility:** $35 copay after deductible **Hospital setting:** 30% coinsurance after deductible	**Freestanding facility:** 25% coinsurance (deductible waived) **Hospital setting:** 40% coinsurance after deductible	**Freestanding facility:** $25 copay (deductible waived) **Hospital setting:** 20% coinsurance after deductible	$50 copay (deductible waived)
Advanced imaging (CT scans & MRI)	**Freestanding facility:** $75 copay up to $375 after deductible **Hospital setting:** 20% coinsurance after deductible	**Freestanding facility:** $75 copay up to $375 after deductible **Hospital setting:** 30% coinsurance after deductible	**Freestanding facility:** 25% coinsurance (deductible waived) **Hospital setting:** 40% coinsurance after deductible	**Freestanding facility:** $75 copay up to $375 (deductible waived) **Hospital setting:** 20% coinsurance after deductible	**Freestanding facility:** $75 copay up to $375 (deductible waived) **Hospital setting:** $75 copay up to $375 after deductible
OUT-OF-NETWORK MEDICAL BENEFITS					
Deductible (individual/family)	$8,000/$16,000	$8,000/$16,000	$8,000/$16,000	$8,000/$16,000	$8,000/$16,000
Coinsurance	50%	50%	50%	50%	50%
Maximum out-of-pocket limit (individual/family)	$16,000/$32,000	$15,000/$30,000	$15,000/$30,000	$16,000/$32,000	$16,000/$32,000
PRESCRIPTION DRUG BENEFIT					
Prescription drug deductible (individual/family)	Plan has integrated deductible with medical (see above)**	Plan has integrated deductible with medical (see above)**	Plan has integrated deductible with medical (see above)**	None	None
Tier 1 – Preferred generic drugs	$10 copay	$15 copay	$15 copay	$10 copay	$10 copay
Tier 2 – Non-preferred generic drugs	50% coinsurance $250 maximum per prescription	50% coinsurance $250 maximum per prescription after deductible	50% coinsurance $250 maximum per prescription after deductible	50% coinsurance $250 maximum per prescription	50% coinsurance $250 maximum per prescription
Tier 3 – Preferred brand drugs	$50 copay	$60 copay	$60 copay	$50 copay	$50 copay
Tier 4 – Non-preferred brand drugs	50% coinsurance $500 maximum per prescription after deductible	50% coinsurance $500 maximum per prescription after deductible	50% coinsurance $500 maximum per prescription after deductible	50% coinsurance $500 maximum per prescription	50% coinsurance $500 maximum per prescription
Tier 5 – Preferred specialty drugs	50% coinsurance $500 maximum per prescription after deductible	50% coinsurance $500 maximum per prescription after deductible	50% coinsurance $500 maximum per prescription after deductible	50% coinsurance $500 maximum per prescription	50% coinsurance $500 maximum per prescription
Tier 6 – Non-preferred specialty drugs	50% coinsurance $750 maximum per prescription after deductible	50% coinsurance $750 maximum per prescription after deductible	50% coinsurance $750 maximum per prescription after deductible	50% coinsurance $750 maximum per prescription	50% coinsurance $750 maximum per prescription

*Plan includes routine adult dental coverage.
**Integrated medical and prescription drug deductible.
***Subject to limitations.

ConnectiCare Benefits, Inc. (CBI) plans

Plan name/Metal level	Choice Bronze POS HSA	Choice Silver POS HSA	Choice Bronze POS
NETWORK ACCESS	**CT only Provider Search — select Access Health CT (group plans)**	**CT only Provider Search — select Access Health CT (group plans)**	**CT only Provider Search — select Access Health CT (group plans)**
PLAN/MEDICAL DEDUCTIBLE			
Deductible (individual/family)	$5,750/$11,500	$3,500/$7,000	$7,000/$14,000
Maximum out-of-pocket limit (individual/family)	$7,050/$14,100	$6,900/$13,800	$8,300/$16,600
IN-NETWORK MEDICAL BENEFITS			
Preventive care/screenings/immunizations	$0	$0	$0
Primary care services	50% coinsurance after deductible	25% coinsurance after deductible	$40 copay (deductibe waived)
Telemedicine visits through Teladoc®	0% coinsurance after deductible	0% coinsurance after deductible	$0
Specialist services	50% coinsurance after deductible	25% coinsurance after deductible	$60 copay after deductible
Mental health and substance abuse office visits	50% coinsurance after deductible	25% coinsurance after deductible	$60 copay (deductible waived)
Vision	50% coinsurance (deductible waived)	25% coinsurance (deductible waived)	$50 copay (deductible waived)
Walk-in/urgent care center	50% coinsurance after deductible	25% coinsurance after deductible	$100 copay after plan deductible
Worldwide emergency coverage*	50% coinsurance after deductible	25% coinsurance after deductible	40% coinsurance after deductible
Hospital – inpatient treatment	50% coinsurance after deductible	25% coinsurance after deductible	40% coinsurance after deductible
Hospital – outpatient treatment	50% coinsurance after deductible	25% coinsurance after deductible	40% coinsurance after deductible
Outpatient surgery in freestanding locations	50% coinsurance after deductible	25% coinsurance after deductible	$500 copay after deductible
Lab services	50% coinsurance after deductible	25% coinsurance after deductible	$10 copay after deductible
X-rays	50% coinsurance after deductible	25% coinsurance after deductible	**Freestanding facility:** $50 copay after deductible **Hospital setting:** 40% coinsurance after deductible
Advanced imaging (CT scans & MRI)	50% coinsurance after deductible	25% coinsurance after deductible	**Freestanding facility:** $75 copay up to $375 after deductible **Hospital setting:** 40% coinsurance after deductible
OUT-OF-NETWORK MEDICAL BENEFITS			
Deductible (individual/family)	$20,000/$40,000	$20,000/$40,000	$20,000/$40,000
Coinsurance	50%	50%	50%
Maximum out-of-pocket limit (individual/family)	$30,000/$60,000	$30,000/$60,000	$30,000/$60,000
PRESCRIPTION DRUG BENEFIT			
Prescription drug deductible (individual/family)	Plan has integrated deductible with medical (see above)	Plan has integrated deductible with medical (see above)	Plan has integrated deductible with medical (see above)
Tier 1 – Generic drugs	$10 copay after deductible	$10 copay after deductible	$10 copay after deductible
Tier 2 – Preferred brand drugs	$60 copay after deductible	$60 copay after deductible	$60 copay after deductible
Tier 3 – Non-preferred brand drugs	50% coinsurance $300 maximum per prescription after deductible	50% coinsurance $300 maximum per prescription after deductible	50% coinsurance $300 maximum per prescription after deductible
Tier 4 – Specialty drugs	50% coinsurance $500 maximum per prescription after deductible	50% coinsurance $500 maximum per prescription after deductible	50% coinsurance $500 maximum per prescription after deductible

ConnectiCare Benefits, Inc. (CBI) plans

Plan name/Metal level	Choice Silver A POS	Choice Silver B POS	Passage Gold POS
NETWORK ACCESS	**CT only Provider Search — select Access Health CT (group plans)**	**CT only Provider Search — select Access Health CT (group plans)**	**CT only Provider Search — select Access Health CT (group plans)**
PLAN/MEDICAL DEDUCTIBLE			
Deductible (individual/family)	$4,800/$9,600	$3,000/$6,000	$3,000/$6,000
Maximum out-of-pocket limit (individual/family)	$8,500/$17,000	$8,650/$17,300	$6,800/$13,600
IN-NETWORK MEDICAL BENEFITS			
Preventive care/screenings/immunizations	$0	$0	$0
Primary care services	$45 copay (deductible waived)	$30 copay (deductible waived)	$30 copay (deductible waived)
Telemedicine visits through Teladoc®	$0	$0	$0
Specialist services	$60 copay (deductible waived)	$75 copay (deductible waived)	$50 copay (deductible waived)
Mental health and substance abuse office visits	$60 copay (deductible waived)	$30 copay (deductible waived)	$50 copay (deductible waived)
Vision	$50 copay (deductible waived)	$75 copay (deductible waived)	$50 copay (deductible waived)
Walk-in/urgent care center	$100 copay (deductible waived)	$100 copay (deductible waived)	$100 copay (deductible waived)
Worldwide emergency coverage*	35% coinsurance after deductible	40% coinsurance after deductible	20% coinsurance after deductible
Hospital – inpatient treatment	35% coinsurance after deductible	40% coinsurance after deductible	20% coinsurance after deductible
Hospital – outpatient treatment	35% coinsurance after deductible	40% coinsurance after deductible	20% coinsurance after deductible
Outpatient surgery in freestanding locations	35% coinsurance after deductible	40% coinsurance after deductible	$500 copay (deductible waived)
Lab services	$10 copay (deductible waived)	40% coinsurance after deductible	$10 copay (deductible waived)
X-rays	35% coinsurance after deductible	40% coinsurance after deductible	**Freestanding facility:** $50 copay (deductible waived) **Hospital setting:** 20% coinsurance after deductible
Advanced imaging (CT scans & MRI)	35% coinsurance after deductible	40% coinsurance after deductible	**Freestanding facility:** $75 copay up to $375 (deductible waived) **Hospital setting:** 20% coinsurance after deductible
OUT-OF-NETWORK MEDICAL BENEFITS			
Deductible (individual/family)	$20,000/$40,000	$20,000/$40,000	$20,000/$40,000
Coinsurance	50%	50%	50%
Maximum out-of-pocket limit (individual/family)	$30,000/$60,000	$30,000/$60,000	$30,000/$60,000
PRESCRIPTION DRUG BENEFIT			
Prescription drug deductible (individual/family)	N/A	N/A	N/A
Tier 1 – Generic drugs	$10 copay	$10 copay	$10 copay
Tier 2 – Preferred brand drugs	$60 copay	$50 copay	$50 copay
Tier 3 – Non-preferred brand drugs	50% coinsurance $300 maximum per prescription	50% coinsurance $300 maximum per prescription after deductible	50% coinsurance $250 maximum per prescription
Tier 4 – Specialty drugs	50% coinsurance $500 maximum per prescription	50% coinsurance $500 maximum per prescription after deductible	50% coinsurance $500 maximum per prescription

All plans are contract-year.
The small business plans above are also sold through Access Health CT.
*Subject to limitations.