ConnectiCare

Small Group Market
Compass HMO Copay/Coins. $2000 with Dental
Benefit Summary
Tiered Network Plan

Deductible and Out-of-Pocket Maximum	Preferred Provider In-Network (INET) Member Pays	Participating Provider In-Network (INET) Member Pays	Out-of-network (OON) Member Pays
Plan deductible Individual Family	$2,000 per member $4,000 per family	$3,500 per member $7,000 per family	N/A per member N/A 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 a combination of deductible, copayments and coinsurance for medical and pharmacy services)	$8,500 per member $17,000 per family		N/A per member N/A per family
Benefits	**Preferred Provider In-Network (INET) Member Pays**	**Participating Provider In-Network (INET) Member Pays**	**Out-of-network (OON) Member Pays**
Provider Office Visits			
Adult/Pediatric Preventive Visits	No charge	Same as Preferred Provider cost share	N/A
Primary Care Provider Office/ Telemedicine Visits (includes services for illness, injury, follow-up care and consultations)	$20 copayment/visit; deductible does not apply	50% coinsurance after plan deductible	N/A
Telemedicine Services (services rendered by a Teladoc® provider)	No charge	See primary care or specialist office visits	N/A
Specialist Office/Telemedicine Visits	$50 copayment/visit; deductible does not apply	See primary care or specialist office visits	N/A
Mental Health and Substance Abuse Office Visits	$50 copayment/visit; deductible does not apply	Same as Preferred Provider cost share	N/A

Benefits	Preferred Provider In-Network (INET) Member Pays	Participating Provider In-Network (INET) Member Pays	Out-of-network (OON) Member Pays
Outpatient Diagnostic Services			
Advanced Radiology (CT/PET Scan, MRI)	Freestanding Facility: $75 copayment/ service; deductible does not apply, up to five copayments per year, then copayment waived Hospital Facility: 20% coinsurance after plan deductible	Same as Preferred Provider cost share when done at a Freestanding Facility Hospital Facility: 50% coinsurance after plan deductible	N/A
Laboratory Services	$10 copayment/visit; deductible does not apply	Same as Preferred Provider cost share	N/A
Non-Advanced Radiology (X-ray, Diagnostic)	Freestanding Facility: $10 copayment/ service; deductible does not apply Hospital Facility: 20% coinsurance after plan deductible	Same as Preferred Provider cost share when done at a Freestanding Facility Hospital Facility: 50% coinsurance after plan deductible	N/A
Mammography Ultrasound	Freestanding Facility: $10 copayment/ service; deductible does not apply Hospital Facility: 20% coinsurance after plan deductible	Same as Preferred Provider cost share when done at a Freestanding Facility Hospital Facility: 50% coinsurance after plan deductible	N/A
Prescription Drugs – Retail Pharmacy (cost share based on 30 day supply per prescription)			
Preferred Generic Tier 1	$5 copayment/ prescription; deductible does not apply	Same as Preferred Provider cost share	N/A
Non-preferred Generic Tier 2	50% coinsurance up to a maximum of $250 per prescription; deductible does not apply	Same as Preferred Provider cost share	N/A

Benefits	Preferred Provider In-Network (INET) Member Pays	Participating Provider In-Network (INET) Member Pays	Out-of-network (OON) Member Pays
Preferred Brand Tier 3	$50 copayment/ prescription; deductible does not apply	Same as Preferred Provider cost share	N/A
Non-Preferred Brand Tier 4	50% coinsurance up to a maximum of $500 per prescription; deductible does not apply	Same as Preferred Provider cost share	N/A
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	Same as Preferred Provider cost share	N/A
Non-Preferred Specialty Tier 6	50% coinsurance up to a maximum of $750 per prescription; deductible does not apply	Same as Preferred Provider cost share	N/A
Prescription – Mail Order Pharmacy (up to a 90 day supply per prescription)			
Preferred Generic Tier 1	$10 copayment/ prescription; deductible does not apply	Same as Preferred Provider cost share	N/A
Non-preferred Generic Tier 2	50% coinsurance up to a maximum of $500 per prescription; deductible does not apply	Same as Preferred Provider cost share	N/A
Preferred Brand Tier 3	$100 copayment/ prescription; deductible does not apply	Same as Preferred Provider cost share	N/A
Non-Preferred Brand Tier 4	50% coinsurance up to a maximum of $1,000 per prescription; deductible does not apply	Same as Preferred Provider cost share	N/A

Benefits	Preferred Provider In-Network (INET) Member Pays	Participating Provider In-Network (INET) Member Pays	Out-of-network (OON) Member Pays
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	$50 copayment/visit after plan deductible	Same as Preferred Provider cost share	N/A
Physical and Occupational Therapy	$30 copayment/visit after plan deductible	Same as Preferred Provider cost share	N/A
Other Services			
Chiropractic Services (up to 20 visits per contract year)	$50 copayment/visit; deductible does not apply	Same as Preferred Provider cost share	N/A
Diabetic Equipment and Supplies	20% coinsurance; deductible does not apply	Same as Preferred Provider cost share	N/A
Durable Medical Equipment (DME)	50% coinsurance; deductible does not apply	Same as Preferred Provider cost share	N/A
Home Health Care Services (up to 100 visits per contract year)	25% coinsurance; deductible does not apply	Same as Preferred Provider cost share	N/A
Outpatient Services (in a hospital or ambulatory facility)	Ambulatory Facility: $350 copayment/visit after plan deductible Outpatient Hospital Facility: 20% coinsurance after plan deductible	Outpatient Hospital Facility: 50% coinsurance after plan deductible Same as Preferred Provider cost share for Outpatient behavioral health, mental health and substance abuse services	N/A
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)	20% coinsurance after plan deductible	50% coinsurance after plan deductible The cost share for Inpatient behavioral health, mental health and substance abuse services is the same as Preferred Provider	N/A
Emergency and Urgent Care			
Ambulance Services	20% coinsurance after plan deductible	Same as Preferred Provider cost share	Same as Preferred Provider cost share

Benefits	Preferred Provider In-Network (INET) Member Pays	Participating Provider In-Network (INET) Member Pays	Out-of-network (OON) Member Pays
Emergency Room	20% coinsurance after plan deductible	Same as Preferred Provider cost share	Same as Preferred Provider cost share
Urgent Care Centers	$50 copayment/visit; deductible does not apply	Same as Preferred Provider cost share	Same as Preferred Provider cost share
Pediatric Dental Care (for children under age 26)			
Diagnostic & Preventive	No charge	Same as Preferred Provider cost share	N/A
Basic Services	50% coinsurance after plan deductible	Same as Preferred Provider cost share	N/A
Major Services	50% coinsurance after plan deductible	Same as Preferred Provider cost share	N/A
Orthodontia Services (medically necessary only)	50% coinsurance after plan deductible	Same as Preferred Provider cost share	N/A
Pediatric Vision Care (for children under age 26)			
Prescription Eye Glasses (one pair of frames and lenses per contract year)	Lenses: 50% coinsurance Collection frames: 50% coinsurance after plan deductible Non-collection frames: 50% coinsurance up to the collection frame allowance; any amount over is payable by the member minus a 20% discount	Same as Preferred Provider cost share	N/A
Routine Eye Exam by a Specialist (one exam per contract year)	$15 copayment/visit; deductible does not apply	Same as Preferred Provider cost share	N/A
Additional Covered Services			
Adult Preventive Dental Care (one dental exam and cleaning per 6-month period)	No charge	Same as Preferred Provider cost share	N/A
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 charge	Same as Preferred Provider cost share	N/A

Benefits	Preferred Provider In-Network (INET) Member Pays	Participating Provider In-Network (INET) Member Pays	Out-of-network (OON) Member Pays
Adult Routine Eye Exam by a Specialist - over age 26 (one exam per contract year)	$15 copayment/visit; deductible does not apply	Same as Preferred Provider cost share	N/A
Allergy Injections (up to 20 visits per contract year)	See primary care or specialist office visits	See primary care or specialist office visits	N/A
Allergy Testing (up to one visit per contract year)	See primary care or specialist office visits	See primary care or specialist office visits	N/A
Artificial Limbs (includes associated supplies and equipment)	20% coinsurance; deductible does not apply	Same as Preferred Provider cost share	N/A
Inpatient Physician Services	20% coinsurance after plan deductible	50% coinsurance after plan deductible	N/A
Modified Food Products and Specialized Formula	20% coinsurance; deductible does not apply	Same as Preferred Provider cost share	N/A
Outpatient mental health, alcohol and substance abuse treatment (intensive outpatient treatment and partial hospitalization)	20% coinsurance; deductible does not apply	Same as Preferred Provider cost share	N/A
Retail Clinic	50% coinsurance after plan deductible	Same as Preferred Provider cost share	N/A

Important information

- This is a brief summary of benefits. Refer to your ConnectiCare, Inc. membership agreement 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 membership agreement for details.
- Insulin and noninsulin drugs are covered up to a maximum of $25 for each 30-day supply.
- Diabetes Devices and Diabetic Ketoacidosis Devices are covered up to $100 per 30-day supply.
- Please refer to the membership agreement for additional cost share maximums regarding diabetic services. Some diabetic services fall under preventive care and cost share may be waived.
- 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.
- If you are a Massachusetts resident, please refer to your amendatory rider for Massachusetts mandated benefits for additional details of your mandated benefits.
- If you are a Massachusetts resident, this plan along with pharmacy services meets Massachusetts Minimum Creditable Coverage standards for 2022.
- To learn more about your **Teladoc®** benefits contact **Teladoc®** at teladoc.com/connecticare or call 1-800-835-2362 (TTY: 711).
- 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 supply's 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 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.
- Services rendered by non-participating providers require that you obtain written Pre-Authorization from us in order for the treatment to be covered under this plan. Without pre-authorization you may be responsible for the total cost of the service. Refer to the “Managed Care Rules and Guidelines” section in your membership agreement 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 for 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.