FlexPOS Copay $20 with Dental

This chart explains changes in cost-sharing between your 2021 plan and the option we're presenting for 2022. **You will be automatically enrolled in the 2022 plan below unless you take action.** If you want to shop for a different plan or cancel coverage, contact your ConnectiCare or CBIA Account Manager.

Plan Overview	2021 Plan Year	2022 Plan Year
Plan Name	FlexPOS Copay $20 with Dental	FlexPOS Copay $20 with Dental
Plan Metal Level	Platinum	Platinum
Product Type	POS	POS
Deductible		
Individual In-Network	N/A per Member	No change
Family In-Network	N/A per Family	No change
Individual Out-of-Network	$8,000 per Member	No change
Family Out-of-Network	$16,000 per Family	No change
Prescription Drug Deductible		
Individual In-Network	N/A per Member	No change
Family In-Network	N/A per Family	No change
Individual Out-of-Network	N/A per Member	No change
Family Out-of-Network	N/A per Family	No change
Out-of-Pocket Maximum		
Individual In-Network	$5,500 per Member	No change
Family In-Network	$11,000 per Family	No change
Individual Out-of-Network	$15,000 per Member	No change
Family Out-of-Network	$30,000 per Family	No change
Physician Office Visits		
Preventive Care/Screenings/ Immunizations	In-Network: No cost	No change
	Out-of-Network: 50% coinsurance after plan deductible	No change
Primary Care (injury or illness)	In-Network: $20 copay per visit	No change
	Out-of-Network: 50% coinsurance after plan deductible	No change
Telemedicine visit through Teladoc®	In-Network: $20 copay per visit	No cost
	Out-of-Network: 50% coinsurance after plan deductible	Out-of-Network: N/A
Specialist	In-Network: $45 copay per visit	No change
	Out-of-Network: 50% coinsurance after plan deductible	No change

ConnectiCare

Plan Overview	2021 Plan Year	2022 Plan Year
Mental Health and Substance Abuse	In-Network: $45 copay per visit	No change
	Out-of-Network: 50% coinsurance after plan deductible	No change
Emergency/Urgent Care		
Urgent Care Center or Facility	In-Network: $50 copay per visit	No change
	Out-of-Network: Same as in-network benefit	No change
Emergency Room	In-Network: 15% coinsurance	No change
	Out-of-Network: Same as in-network benefit	No change
Pediatric Dental Care (for those covered in plan under the age of 26)		
Diagnostic & Preventive	In-Network: No cost	No change
	Out-of-Network: 50% coinsurance after plan deductible	No change
Basic Services, Major Services, Orthodontia Services (medically necessary only)	In-Network: 50% coinsurance	No change
	Out-of-Network: 50% coinsurance after plan deductible	No change
Adult Routine and Preventive Dental Care		
One dental exam and cleaning per 6-month period	In-Network: No cost	No change
	Out-of-Network: 50% coinsurance after plan deductible	No change
Pediatric Vision Care (for those covered in plan under the age of 26)		
Routine Eye Exam by Specialist (one exam per contract year)	In-Network: $20 copay per visit	No change
	Out-of-Network: 50% coinsurance after plan deductible	No change
Prescription Eye Glasses (one pair of frames and lenses or contact lenses per contract year)	In-Network: Lenses: 50% Collection frames: 50% Non- collection frames: 50% up to the collection frame allowance; any amount over is payable by the member minus a 20% discount	No change
	Out-of-Network: 50% coinsurance after plan deductible	No change
Hospital Services		
Inpatient (including mental health, substance abuse, maternity, hospice and skilled nursing facility*) *(skilled nursing facility stay is limited to 90 days per calendar year)	In-Network: 15% coinsurance	No change
	Out-of-Network: 50% coinsurance after plan deductible	No change

Plan Overview	2021 Plan Year	2022 Plan Year
Outpatient (performed at an outpatient hospital facility)	In-Network: 15% coinsurance	No change
	Out-of-Network: 50% coinsurance after plan deductible	No change
Outpatient (performed at an ambulatory surgery center)	In-Network: $250 copay per visit	No change
	Out-of-Network: 50% coinsurance after plan deductible	No change
Outpatient Services		
Home Health Care (up to 100 visits per contract year)	In-Network: $25 copay per visit	No change
	Out-of-Network: 25% coinsurance; deductible does not apply	No change
Advanced Radiology (CT/PET Scan, MRI)	In-Network: Freestanding Facility: $60 copay per service up to five copays per year, then copay waived Hospital Facility: 15% coisurance	No change
	Out-of-Network: 50% coinsurance after plan deductible	No change
Non-Advanced Radiology (X-ray, Diagnostic)	In-Network: Freestanding Facility: $15 copay per service Hospital Facility: 15% coinsurance	No change
	Out-of-Network: 50% coinsurance after plan deductible	No change
Laboratory Services	In-Network: $10 copay per service	No change
	Out-of-Network: 50% coinsurance after plan deductible	No change
Physical and Occupational Therapy (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)	In-Network: $30 copay per visit	No change
	Out-of-Network: 50% coinsurance after plan deductible	No change

Plan Overview	2021 Plan Year	2022 Plan Year
Speech Therapy (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)	In-Network: $45 copay per visit	No change
	Out-of-Network: 50% coinsurance after plan deductible	No change
Prescription Drugs		
Tier 1	In-Network: $10 copay per prescription	No change
	Out-of-Network: 50% coinsurance; deductible does not apply	No change
Tier 2	In-Network: 50% coinsurance up to a maximum of $250 per prescription	No change
	Out-of-Network: 50% coinsurance; deductible does not apply	No change
Tier 3	In-Network: $50 copay per prescription	No change
	Out-of-Network: 50% coinsurance; deductible does not apply	No change
Tier 4	In-Network: 50% coinsurance up to a maximum of $500 per prescription after	No change
	Out-of-Network: 50% coinsurance; deductible does not apply	No change
Tier 5	In-Network: 50% coinsurance up to a maximum of $500 per prescription; deductible does not apply	No change
	Out-of-Network: 50% coinsurance after plan deductible	No change
Tier 6	In-Network: 50% coinsurance up to a maximum of $750 per prescription; deductible does not apply	No change
	Out-of-Network: 50% coinsurance; deductible does not apply	No change