Passage HMO PCP Copay/Coins. $2,500

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	Passage HMO PCP Copay/Coins. $2,500	Passage HMO PCP Copay/Coins. $2,500
Plan Metal Level	Gold	Gold
Product Type	HMO	HMO
Deductible		
Individual In-Network	$2,500 per Member	No change
Family In-Network	$5,000 per Family	No change
Individual Out-of-Network	N/A per Member	No change
Family Out-of-Network	N/A 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	$8,000 per Member	No change
Family In-Network	$16,000 per Family	No change
Individual Out-of-Network	N/A per Member	No change
Family Out-of-Network	N/A per Family	No change
Physician Office Visits		
Preventive Care/Screenings/ Immunizations	In-Network: No cost	No change
	Out-of-Network: N/A	No change
Primary Care (injury or illness)	In-Network: $30 copay per visit; deductible does not apply	No change
	Out-of-Network: N/A	No change
Telemedicine visit through Teladoc®	In-Network: $30 copay per visit; deductible does not apply	No cost
	Out-of-Network: N/A	Out-of-Network: N/A
Specialist	In-Network: $50 copay per visit; deductible does not apply	No change
	Out-of-Network: N/A	No change

ConnectiCare

Plan Overview	2021 Plan Year	2022 Plan Year
Mental Health and Substance Abuse	In-Network: $50 copay per visit; deductible does not apply	No change
	Out-of-Network: N/A	No change
Emergency/Urgent Care		
Urgent Care Center or Facility	In-Network: $50 copay per visit; deductible does not apply	No change
	Out-of-Network: Same as in-network benefit	No change
Emergency Room	In-Network: 25% coinsurance after plan deductible	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: N/A	No change
Basic Services, Major Services, Orthodontia Services (medically necessary only)	In-Network: 50% coinsurance after plan deductible	No change
	Out-of-Network: N/A	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: $25 copay per visit; deductible does not apply	No change
	Out-of-Network: N/A	No change
Prescription Eye Glasses (one pair of frames and lenses or contact lenses per contract year)	In-Network: Lenses: 50% after plan deductible Collection frames: 50% after plan deductible Non-collection frames: 50% after plan dedutible up to the collection frame allowance; any amount over is payable by the member minus a 20% discount	No change
	Out-of-Network: N/A	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: 25% coinsurance after plan deductible	No change
	Out-of-Network: N/A	No change

Plan Overview	2021 Plan Year	2022 Plan Year
Outpatient (performed at an outpatient hospital facility)	In-Network: 25% coinsurance after plan deductible	No change
	Out-of-Network: N/A	No change
Outpatient (performed at an ambulatory surgery center)	In-Network: $450 copay per visit after plan deductible	No change
	Out-of-Network: N/A	No change
Outpatient Services		
Home Health Care (up to 100 visits per contract year)	In-Network: $25 copay per visit; deductible does not apply	No change
	Out-of-Network: N/A	No change
Advanced Radiology (CT/PET Scan, MRI)	In-Network: Hospital Facility: 25% coinsurance after plan deductible Freestanding Facility: $75 copay per service; deductible does not apply up to five copays per year, then copays waived	No change
	Out-of-Network: N/A	No change
Non-Advanced Radiology (X-ray, Diagnostic)	In-Network: $50 copay per service; deductible does not apply	No change
	Out-of-Network: N/A	No change
Laboratory Services	In-Network: $10 copay per service; deductible does not apply	No change
	Out-of-Network: N/A	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; deductible does not apply	No change
	Out-of-Network: N/A	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: $50 copay per visit; deductible does not apply	No change
	Out-of-Network: N/A	No change
Prescription Drugs		
Tier 1	In-Network: $10 copay per prescription; deductible does not apply	No change
	Out-of-Network: N/A	No change
Tier 2	In-Network: 50% coinsurance up to a maximum of $250 per prescription; deductible does not apply	No change
	Out-of-Network: N/A	No change
Tier 3	In-Network: $50 copay per prescription; deductible does not apply	No change
	Out-of-Network: N/A	No change
Tier 4	In-Network: 50% coinsurance up to a maximum of $500 per prescription; deductible does not apply	No change
	Out-of-Network: N/A	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: N/A	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: N/A	No change