ConnectiCare

# Small Group Market
# FlexPOS Copay/Coins. $2500
# 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**<br>Individual<br>Family | $2,500 per member<br>$5,000 per family | $8,000 per member<br>$16,000 per family |
| **Separate Prescription Drug Deductible**<br>Individual<br>Family | N/A per member<br>N/A per family | N/A per member<br>N/A per family |
| **Out-of-Pocket Maximum**<br><br>Individual<br>Family<br>(Includes a combination of deductible, copayments and coinsurance for medical and pharmacy services) | $6,500 per member<br>$13,000 per family | $16,000 per member<br>$32,000 per family |
| **Benefits** | **In-Network (INET) Member Pays** | **Out-of-Network (OON) Member Pays** |
| **Provider Office Visits** | | |
| **Adult/Pediatric Preventive Visits** | No charge | 50% coinsurance<br>after plan deductible |
| **Primary Care Provider Office/ Telemedicine Visits**<br>(includes services for illness, injury, follow-up care and consultations) | $20 copayment/visit;<br>deductible does not apply | 50% coinsurance<br>after plan deductible |
| **Telemedicine Services**<br>(services rendered by a Teladoc® provider) | No charge | 50% coinsurance<br>after plan deductible |
| **Specialist Office/Telemedicine Visits** | $50 copayment/visit;<br>deductible does not apply | 50% coinsurance<br>after plan deductible |
| **Mental Health and Substance Abuse Office Visits** | $50 copayment/visit;<br>deductible does not apply | 50% coinsurance<br>after plan deductible |
| **Outpatient Diagnostic Services** | | |

| Benefits | In-Network (INET) Member Pays | Out-of-Network (OON) Member Pays |
|---|---|---|
| **Advanced Radiology** (CT/PET Scan, MRI) | Hospital Facility: 20% coinsurance after plan deductible<br><br>Freestanding Facility: $75 copayment/service; deductible does not apply up to five copayments per year, then copayment waived | 50% coinsurance after plan deductible |
| **Laboratory Services** | $10 copayment/service; deductible does not apply | 50% coinsurance after plan deductible |
| **Non-Advanced Radiology** (X-ray, Diagnostic) | Hospital Facility: 20% coinsurance after plan deductible<br><br>Freestanding Facility: $25 copayment/service; deductible does not apply | 50% coinsurance after plan deductible |
| **Mammography Ultrasound** | Hospital Facility: 20% coinsurance after plan deductible<br><br>Freestanding Facility: $25 copayment/service; deductible does not apply | 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 | 50% coinsurance; deductible does not apply |

| Benefits | In-Network (INET) Member Pays | Out-of-Network (OON) Member Pays |
|---|---|---|
| **Non-Preferred Specialty** Tier 6 | 50% coinsurance up to a maximum of $750 per prescription; deductible does not apply | 50% coinsurance; deductible does not apply |
| **Prescription – 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** | $50 copayment/visit; deductible does not apply | 50% coinsurance after plan deductible |
| **Physical and Occupational Therapy** | $30 copayment/visit; deductible does not apply | 50% coinsurance after plan deductible |
| **Other Services** | | |
| **Chiropractic Services** (up to 20 visits per contract year) | $50 copayment/visit; deductible does not apply | 50% coinsurance after plan deductible |
| **Diabetic Equipment and Supplies** | 20% 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) | Outpatient Hospital Facility: 20% coinsurance after plan deductible<br><br>Ambulatory Facility: $250 copayment/visit after plan deductible | 50% coinsurance after plan deductible |
| **Inpatient Services** | | |

| Benefits | In-Network (INET) Member Pays | Out-of-Network (OON) Member Pays |
|---|---|---|
| **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 |
| **Emergency and Urgent Care** | | |
| **Ambulance Services** | 20% coinsurance after plan deductible | Same as In-network benefit |
| **Emergency Room** | 20% coinsurance after plan deductible | Same as In-network benefit |
| **Walk-In Center** | $50 copayment/visit; deductible does not apply | Same as In-network benefit |
| **Pediatric Dental Care (for children under age 26 )** | | |
| **Diagnostic & Preventive** | No charge | 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 |
| **Pediatric Vision Care (for children under age 26)** | | |
| **Prescription Eye Glasses** (one pair of frames and lenses per contract year) | Lenses: 50% after plan deductible<br>Collection frames: 50% after plan deductible<br>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) | $25 copayment/visit; deductible does not apply | 50% coinsurance after plan deductible |
| **Additional Covered Services** | | |
| **Adult Routine Eye Exam by a Specialist - over age 26** (one exam per contract year) | $25 copayment/visit; deductible does not apply | 50% coinsurance after plan deductible |
| **Allergy Injections** (up to 20 visits per contract year) | See primary care or specialist visits | 50% coinsurance after plan deductible |

| Benefits | In-Network (INET)<br>Member Pays | Out-of-Network (OON)<br>Member Pays |
|---|---|---|
| **Allergy Testing**<br>(up to one visit per contract year) | See primary care or specialist office visits | 50% coinsurance<br>after plan deductible |
| **Artificial Limbs**<br>(includes associated supplies and equipment) | 20% coinsurance<br>after plan deductible | 50% coinsurance<br>after plan deductible |
| **Inpatient Physician Services** | 20% coinsurance<br>after plan deductible | 50% coinsurance<br>after plan deductible |
| **Modified Food Products and Specialized Formula** | 50% coinsurance<br>after plan deductible | 50% coinsurance<br>after plan deductible |
| **Outpatient mental health, alcohol and substance abuse treatment**<br>(intensive outpatient treatment and partial hospitalization) | 20% coinsurance;<br>deductible does not apply | 50% coinsurance<br>after plan deductible |
| **Retail Clinic** | $20 copayment/visit;<br>deductible does not apply | 50% coinsurance<br>after plan deductible |

## Important information

- 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.
- Insulin and noninsulin drugs are covered up to a cost share maximum of $25 for each 30-day supply.
- Diabetes Devices and Diabetic Ketoacidosis Devices are covered up to a cost share maximum $100 per 30-day supply.
- Please refer to the certificate of coverage 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).
- 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.
- 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.
- 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