



MEDICAL PLANS

from ConnectiCare



For a Healthier All of Us

Being well and staying safe from sickness have never been so important to us all. ConnectiCare health plans through CBIA Health Connections help provide your employees and their families with the care they need to stay strong and the peace of mind that comes from having the financial protection of insurance.

Plan improvements and features

Healthcare costs are always on people's minds – how to manage them without skimping on quality or on care. We're pleased to offer these services and options in 2022.

- **NEW! Telemedicine visits through Teladoc®** are included in all plans at no cost. * Teladoc telemedicine delivers 24/7/365 coverage for non-emergency medical needs. Members can use the mobile app to schedule visits with board-certified doctors.
- **ConnectiCare Benefits, Inc. (CBI) plans** are used to support our exchange product offerings and are also available to small-group employers directly through ConnectiCare. CBI plans include network access to Connecticut providers and facilities in addition to prescription drug coverage.
- **First Health®** is the national network for FlexPOS plans, giving your employees coverage where they live, work, and travel.
- **Passage HMO plans** utilize our network of Connecticut providers. Choose a primary care provider (PCP) from those who accept Passage plans and get your PCP to refer you to some types of specialists.
- **Our Compass plans** can help your employees lower their out-of-pocket costs by visiting "preferred" primary care providers (PCPs) and hospitals.
- **HealthEquity** together with ConnectiCare provide integrated health savings account (HSA) and health reimbursement account (HRA) enrollment and administration to promote smart savings. **
- **Preventive dental benefits for adults** included with some plans, or you may add a dental plan with both preventive and comprehensive benefits.



*Telemedicine is no cost after deductible for members in HSA plans

**HSA/HRA integration not available on all plans.

Benefits and Services your Employees Need

ConnectiCare plans include many benefits that help individuals stay healthy and get care when they're sick or hurt.

Included with the ConnectiCare plans in this guide:

- Free preventive care coverage for services like annual checkups, screenings, flu shots, and other vaccinations.*
- Prescription drug coverage, including drugs that are available at no cost, like birth control and medicines to prevent heart disease.
- Doctor visits by phone or video with Teladoc® to help when they can't visit a doctor in person.
- Mental health care for substance use disorder, anxiety, depression, and other behavioral health conditions.
- Pediatric dental and vision coverage for dependents through age 26.
- Emergency and urgent care wherever your employees travel. **
- Specialist care, diagnostic testing, and hospital treatment.

Helping make health care dollars go further

Network discounts for care

Your employees benefit from ConnectiCare-negotiated rates for services of doctors, hospitals, and other facilities. This is important when they share the costs of their care. Members can also sign in to connecticare.com and use the Treatment Cost Calculator to get personalized estimates of their costs and what their plan will pay for many tests and procedures.

Savings on prescriptions

Your employees can get 90-day supplies and free home delivery of many drugs that people take to stay well. Besides the convenience, home delivery helps members stay on track with taking medicines they need to manage health conditions and stay healthy.

Discounts on everyday items and major purchases

Gym memberships, glasses and contacts, acupuncture and massage, vacations, and major purchases. Discounts on these products and services – and many more – are available to ConnectiCare members. Visit connecticare.com/discountprograms to see all discounts.

*“Free” preventive care means that you will not have a copay or have to pay money toward your deductible or coinsurance for the services. Sometimes, a preventive care visit leads to other medical care or tests, even at the same appointment. You should check with your doctor or doctor's staff during your visit to see if there are services you may be billed for.

**Subject to limitations.

Small Group Plans – You Have Options

Here's more information to help you decide which ConnectiCare plan or plans suit your employees' needs best. Plans fall into one of four categories – FlexPOS, Passage, Compass, or Choice.

FlexPOS plans

FlexPOS plans give your employees the most flexibility with state, regional, and national network coverage through First Health.

Passage plans

With a Passage plan, your employees must choose a primary care provider (PCP) from those who accept the plan. And, they need their PCP to refer them to some types of specialists.

Compass plans

With a Compass plan, employees can lower their out-of-pocket costs by visiting “preferred” PCPs and hospitals. They can visit other health care providers (who are “participating”) in their plan's network, but they will pay more.

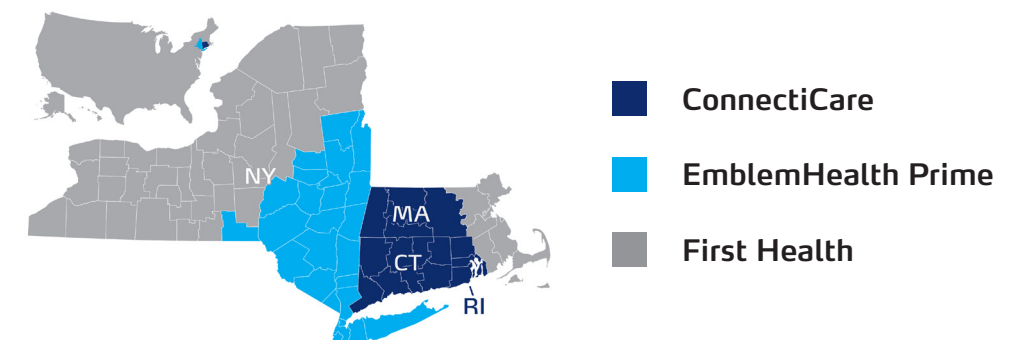
Choice plans

Choice plans let employees see any of the doctors, hospitals, and other health care providers in our Connecticut network. And, they can see specialists without referrals.

Each plan name also includes a “metal level” – platinum, gold, silver, or bronze – that signals how much of average medical costs the plan covers (up to the out-of-pocket maximum).

FlexPOS plan networks

ConnectiCare and its parent company, EmblemHealth, manage networks of doctors and facilities in the areas of Connecticut, New York, Rhode Island, and Massachusetts shaded on this map. Beyond those areas, your employees can choose from doctors and facilities in the First Health network.



Small group plan deductibles

With all of the small group plans described in the following pages, ConnectiCare begins to pay for covered services after one family member meets the individual deductible. This is what's called an embedded deductible. Expenses of covered services for other family members are counted toward the family deductible.

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/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 (deductible 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.

We're here to help.

Call us for questions on Health Connections eligibility and billing:

Phone: 860.525.2242

Monday - Friday, 8 am - 4:30 pm

Send member enrollment, enrollment changes, and other forms to:

CBIA Service Corp.

350 Church Street

Hartford, CT 06103-1126

Email: hcservice@cbia.com

Fax: 860.278.0883

ConnectiCare Member Services

Phone: 800.251.7722 (TTY: 711)

Monday-Friday, 8 am. to 6 pm, Saturday, 9 am to 2 pm

Online: connecticare.com

In-person: Visit connecticare.com for locations, hours, and appointments.



CBIA Service Corp.

CBIA | 350 Church Street, Hartford, CT 06103-1126 | 860.244.1900 | cbia.com/insurance