Passage Gold POS PCP

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 Gold POS PCP	Passage Gold POS PCP
Plan Metal Level	Gold	Gold
Product Type	POS PCP	POS PCP
Deductible		
Individual In-Network	$3,000 per Member	No change
Family In-Network	$6,000 per Family	No change
Individual Out-of-Network	$20,00 per Member	No change
Family Out-of-Network	$40,000 per Family	No change
Prescription Drugs Deductible		
Individual In-Network	Combined with Medical	No change
Family In-Network	Combined with Medical	No change
Individual Out-of-Network	Combined with Medical	No change
Family Out-of-Network	Combined with Medical	No change
Out-of-Pocket-Maximum		
Individual In-Network	$6,800 per Member	No change
Family In-Network	$13,600 per Family	No change
Individual Out-of-Network	$30,000 per Member	No change
Family Out-of-Network	$60,000 per Family	No change
Physician Office Visits		
Preventive Care/ Screenings/ Immunizations	In-Network: No cost	No change
	Out-of-Network: 50% coinsurance per visit	No change
Primary Care (injury or illness)	In-Network: $30 copayment per visit; deductible waived	No change
	Out-of-Network: 50% coinsurance per visit after OON plan deductible is met	No change
Telemedicine visits through Teladoc	In-Network: $30 copayment per visit; deductible waived	No cost
	Out-of-Network: 50% coinsurance per visit after OON plan deductible is met	Out-of-Network: N/A
Specialist (some specialist services require a PCP's referral)	In-Network: $50 copayment per visit; deductible waived	No change
	Out-of-Network: 50% coinsurance per visit after OON plan deductible is met	No change

ConnectiCare

Plan Overview	2021 Plan Year	2022 Plan Year
Mental Health and Substance Abuse	In-Network: $50 copayment per visit; deductible waived	No change
	Out-of-Network: 50% coinsurance per visit after OON plan deductible is met	No change
Emergency/Urgent Care		
Urgent Care Center or Facility	In-Network: $100 copayment per visit; deductible waived	No change
	Out-of-Network: 50% coinsurance per visit after OON plan deductible is met	No change
Emergency Room	In-Network: 20% coinsurance per visit after INET plan deductible is met	No change
	Out-of-Network: Same as In-Network	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 per visit after OON plan deductible is met	No change
Basic Services / Major Services / Orthodontia Services (medically necessary only)	In-Network: 50% coinsurance per visit after INET plan deductible is met	No change
	Out-of-Network: 50% coinsurance per visit after OON plan deductible is met	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: $50 copayment per visit; deductible waived	No change
	Out-of-Network: 50% coinsurance per visit after OON plan deductible is met	No change
Prescription Eye Glasses (one pair of frames and lenses or contact lens per contract year)	In-Network: Lenses: $0 after INET plan deductible, Collection frame: $0 after INET plan deductible	No change
	Non-collection frame: Members choosing to upgrade from a collection frame to a non-collection frame will be given a credit substantially equal to the cost of the collection frame and will be entitled to any discount negotiated by the carrier with the retailer	No change
	Out-of-Network: Not covered	No change

Plan Overview	2021 Plan Year	2022 Plan Year
Hospital Services		
Inpatient (including mental health, substance abuse, maternity, hospice and skilled nursing facility) (skilled nursing facility stay is limited to 90 days per contract year)	In-Network: 20% coinsurance per admission after INET plan deductible is met	No change
	Out-of-Network: 50% coinsurance per admission after OON plan deductible is met	No change
Outpatient (performed at an outpatient facility)	In-Network: 20% coinsurance per visit after INET plan deductible is met	No change
	Out-of-Network: 50% coinsurance per visit after OON plan deductible is met	No change
Outpatient (performed at an ambulatory surgery center)	In-Network: $500 copayment per visit; deductible waived	No change
	Out-of-Network: 50% coinsurance per visit after OON plan deductible is met	No change
Outpatient Services		
Home Health Care (100 visit contract year maximum)	In-Network: $25 copayment per visit; deductible waived	No change
	Out-of-Network: 25% coinsurance per visit after separate $50 deductible is met	No change
Advanced Radiology (CT/PET Scan, MRI) Hospital	In-Network: 20% coinsurance per service after INET plan deductible is met	No change
	Out-of-Network: 50% coinsurance per service after OON plan deductible is met	No change
Advanced Radiology (CT/PET Scan, MRI) Freestanding	In-Network: $75 copayment per service up to five copayments per year; deductible waived	No change
	Out-of-Network: 50% coinsurance per service after OON plan deductible is met	No change
Non-Advanced Radiology (X-ray, Diagnostic) Hospital	In-Network: 20% coinsurance per service after INET plan deductible is met	No change
	Out-of-Network: 50% coinsurance per service after OON plan deductible is met	No change

Plan Overview	2021 Plan Year	2022 Plan Year
Non-Advanced Radiology (X-ray, Diagnostic) Freestanding	In-Network:$50 copayment per service; deductible waived	No change
	Out-of-Network: 50% coinsurance per service after OON plan deductible is met	No change
Laboratory Services	In-Network: $10 copayment per service; deductible waived	No change
	Out-of-Network: 50% coinsurance per service after OON plan deductible is met	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 copayment per visit; deductible waived	No change
	Out-of-Network: 50% coinsurance per visit after OON plan deductible is met	No change
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 copayment per visit; deductible waived	No change
	Out-of-Network: 50% coinsurance per visit after OON plan deductible is met	No change
Prescription Drugs		
Tier 1	In-Network: $10 copayment per prescription; deductible waived	No change
	Out-of-Network: 50% coinsurance per prescription after OON plan deductible is met	No change
Tier 2	In-Network: $50 copayment per prescription; deductible waived	No change
	Out-of-Network: 50% coinsurance per prescription after OON plan deductible is met	No change
Tier 3	In-Network: 50% coinsurance up to a maximum of $250 per prescription; deductible waived	No change
	Out-of-Network: 50% coinsurance per prescription after OON plan deductible is met	No change

Plan Overview	2021 Plan Year	2022 Plan Year
Tier 4	In-Network: 50% coinsurance up to a maximum of $500 per prescription; deductible waived	No change
	Out-of-Network: 50% coinsurance per prescription after OON plan deductible is met	No change