

## Small Business Health Options Program (SHOP) Choice Bronze POS HSA Benefit Summary Non-Tiered Network Plan

The individual deductible and out-of-pocket maximum applies if you have coverage only for yourself. The family deductible and out-of-pocket maximum applies if you have coverage for yourself and one or more eligible dependents. Each individual on the family plan will only need to satisfy the individual deductible and out-of-pocket maximum, not the full family amount. Each individual's charges will accrue towards the family amounts.

Deductible and Out-of-Pocket Maximum	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Plan deductible Individual Family	\$5,750 per member \$11,500 per family	\$20,000 per member \$40,000 per family
Separate Prescription Drug Deductible Individual Family	Included in Plan Deductible per member/per family	Included in Plan Deductible per member / per family
Out-of-Pocket Maximum Individual Family (Includes deductible, copayments and coinsurance)	\$7,050 per member \$14,100 per family	\$30,000 per member \$60,000 per family
Benefits	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
<b>Provider Office Visits</b>		
Adult/Pediatric Preventive Visits	No cost	50% coinsurance per visit
Primary Care Provider Office/ Telemedicine Visits (includes services for illness, injury, follow-up care and consultations)	50% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met
Telemedicine Services (services rendered by a Teladoc® provider)	0% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met
Specialist Office/Telemedicine Visits	50% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met
Mental Health and Substance Abuse Office Visits	50% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met
Outpatient Diagnostic Services		-

Benefits	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays		
<b>Advanced Radiology</b> (CT/PET Scan, MRI)	50% coinsurance per service after INET plan deductible is met	50% coinsurance per service after OON plan deductible is met		
Laboratory Services	50% coinsurance per service after INET plan deductible is met	50% coinsurance per service after OON plan deductible is met		
Non-Advanced Radiology (X-ray, Diagnostic)	50% coinsurance per service after INET plan deductible is met	50% coinsurance per service after OON plan deductible is met		
Mammography Ultrasound	50% coinsurance per service after INET plan deductible is met	50% coinsurance per service after OON plan deductible is met		
Prescription Drugs - Retail Pharmacy (cost share based on 30 day supply per prescription)				
<b>Generic Drugs</b> Tier 1	\$10 copayment per prescription after INET plan deductible is met	50% coinsurance per prescription after OON plan deductible is met		
Preferred Brand Drugs Tier 2	\$60 copayment per prescription after INET plan deductible is met	50% coinsurance per prescription after OON plan deductible is met		
Non-Preferred Brand Tier 3	50% coinsurance up to a maximum of \$300 per prescription after INET plan deductible is met	50% coinsurance per prescription after OON plan deductible is met		
<b>Specialty Drugs</b> Tier 4	50% coinsurance up to a maximum of \$500 per prescription after INET plan deductible is met	50% coinsurance per prescription after OON plan deductible is met		
Prescription - Mail Order Pharm	acy (up to a 90 day supply per pre	scription)		
Generic Drugs Tier 1	\$20 copayment per prescription after INET plan deductible is met	50% coinsurance per prescription after OON plan deductible is met		
<b>Preferred Brand Drugs</b> Tier 2	\$120 copayment per prescription after INET plan deductible is met	50% coinsurance per prescription after OON plan deductible is met		
Non-Preferred Brand Tier 3	50% coinsurance up to a maximum of \$600 per prescription after INET plan deductible is met	50% coinsurance per prescription after OON plan deductible is met		
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% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met		
Physical and Occupational Therapy	50% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met		
Other Services	•			
Chiropractic Services (up to 20 visits per contract year)	50% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met		

Benefits	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays	
Diabetic Equipment and Supplies	50% coinsurance per equipment/ supply after INET plan deductible is met	50% coinsurance per equipment/ supply after OON plan deductible is met	
<b>Durable Medical Equipment</b> (DME)	50% coinsurance per equipment/ supply after INET plan deductible is met	50% coinsurance per equipment/ supply after OON plan deductible is met	
Home Health Care Services (up to 100 visits per contract year)	25% coinsurance per visit after INET plan deductible is met	25% coinsurance per visit after OON plan deductible is met	
Outpatient Services (in a hospital or ambulatory facility)	50% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met	
Inpatient Services			
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)	50% coinsurance per admission after INET plan deductible is met	50% coinsurance per admission after OON plan deductible is met	
Emergency and Urgent Care			
Ambulance Services	50% coinsurance per service after INET plan deductible	50% coinsurance per service after INET plan deductible	
Emergency Room	50% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after INET plan deductible is met	
<b>Urgent Care Centers</b>	50% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met	
Pediatric Dental Care (for children under age 26)			
Diagnostic & Preventive	No cost	50% coinsurance per visit after OON plan deductible is met	
Basic Services	50% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met	
Major Services	50% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met	
Orthodontia Services (medically necessary only)	50% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met	
Pediatric Vision Care (for children under age 26)			

Benefits	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays		
Prescription Eye Glasses (one pair of frames and lenses or contact lens per contract year)	Lenses: 50% after INET plan deductible is met Collection frame: 50% after INET plan deductible is met 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	Not covered		
Routine Eye Exam by a Specialist (one exam per contract year)	50% coinsurance per visit	50% coinsurance per visit after OON plan deductible is met		
Additional Covered Services				
Adult Routine Eye Exam by a Specialist - over age 26 (one exam per contract year)	50% coinsurance per visit	50% coinsurance per visit after OON plan deductible is met		
Allergy Injections (up to 20 visits per year)	50% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met		
Allergy Testing (up to one visit per year)	50% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met		
Artificial Limbs (includes associated supplies and equipment)	20% coinsurance after INET plan deductible is met	50% coinsurance after OON plan deductible is met		
Outpatient mental health, alcohol and substance abuse treatment (intensive outpatient treatment and partial hospitalization)	50% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met		
Retail Clinic	50% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met		

Benefit ID: 59018

Product ID: MS020194 / MS020196

## **Important information**

- This is a brief summary of benefits. Refer to your ConnectiCare Benefits, Inc. certificate of coverage for complete details on benefits, conditions, limitations and exclusions, or consult with your benefits manager.
- 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 of \$100 per 30-day supply.
- Please refer to the certficate of coverage for additional cost share maximums regarding diabetic services. Some diabetic services fall under preventive care and cost share may be waived.
- An **ambulatory surgery center** is a facility that exclusively provides outpatient surgical services to patients who do not require hospitalization and whose expected stay in the center does not exceed 24 hours. Ambulatory surgery centers are not owned by a hospital.
- An **outpatient hospital facility** offers surgical procedures and related care that, in the opinion of the attending physician, can be safely performed without requiring overnight inpatient hospital care. Outpatient hospital facilities are owned by a hospital or hospital system.
- If you have questions regarding your plan, visit our website at <a href="https://www.connecticare.com">www.connecticare.com</a> or call us at (860) 674-5757 or 1-800-251-7722.
- To learn more about your **Teladoc**® provider benefits contact **Teladoc**® at <u>teladoc.com/connecticare</u> 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 Benefits, Inc. certificate of coverage for more information.
- 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.
- 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 drug's or supply's clinical
  effectiveness and cost, not on whether it is a generic drug or supply or brand name drug or supply.
- Refer to ConnectiCare's pharmacy center online at www.connecticare.com for the Value list of drugs that are not subject to the member'scost share.
- 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.
- Many services require that you obtain our Pre-Certification or Pre-Authorization prior to obtaining care prescribed or rendered by Non-Participating providers or a benefit reduction may apply. Without pre-authorization you may be responsible for the total cost of the service or benefits may be reduced by the lesser of \$500 or 50%. Refer to the "Pre-authorization and Pre-certification Addendum" in your certificate of coverage for complete for more details.
- 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 from all cost shares under the Patient Protection and Affordable Care Act (PPACA). Visit our website at <a href="https://www.connecticare.com">www.connecticare.com</a> to view a list of preventive and wellness services.