ConnectiCare

Small Group Market
Passage HMO PCP Copay $6500/$13000 ded.
Benefit Summary
Non-Tiered Network Plan

Passage plans require the selection of an in-network primary care provider upon enrollment.

A referral from your primary care provider is required to see a specialist.

Deductible and Out-of-Pocket Maximum	**In-Network (INET) Member Pays**	**Out-of-network (OON) Member Pays**
Plan deductible Individual Family	$6,500 per member $13,000 per family	N/A per member N/A per family
Separate Prescription Drug Deductible Individual Family	N/A per member N/A per family	N/A per member N/A per family
Out-of-Pocket Maximum Individual Family (Includes a combination of deductible, copayments and coinsurance for medical and pharmacy services)	$9,000 per member $18,000 per family	N/A per member N/A per family
Benefits	**In-Network (INET) Member Pays**	**Out-of-network (OON) Member Pays**
Provider Office Visits		
Adult/Pediatric Preventive Visits	No charge	N/A
Primary Care Provider Office/ Telemedicine Visits (includes services for illness, injury, follow-up care and consultations)	$30 copayment/visit; deductible does not apply	N/A
Telemedicine Services (services rendered by a Teladoc® provider) Primary Care - members must be 18 or older	**Primary Care, Mental Health and General Medical Services:** No charge **Dermatologist:** $50 copayment/visit; deductible does not apply	N/A
Specialist Office/Telemedicine Visits	$50 copayment/visit; deductible does not apply	N/A

Benefits	In-Network (INET) Member Pays	Out-of-network (OON) Member Pays
Mental Health and Substance Abuse Office Visits	$50 copayment/visit; deductible does not apply	N/A
Outpatient Diagnostic Services		
Advanced Radiology (CT/PET Scan, MRI)	Freestanding Facility: $75 copayment/service after plan deductible up to five copayments per year, then copayments waived Hospital Facility: 30% coinsurance after plan deductible	N/A
Laboratory Services	$20 copayment/service after plan deductible	N/A
Non-Advanced Radiology (X-ray, Diagnostic)	Freestanding Facility: $25 copayment/service; deductible does not apply Hospital Facility: 30% coinsurance after plan deductible	N/A
Mammography Ultrasound	Freestanding Facility: $25 copayment/service; deductible does not apply Hospital Facility: 30% coinsurance after plan deductible	N/A
Prescription Drugs – Retail Pharmacy (cost share based on 30 day supply per prescription)		
Preferred Generic Tier 1	$10 copayment/prescription; deductible does not apply	N/A
Non-preferred Generic Tier 2	50% coinsurance up to a maximum of $250 per prescription; deductible does not apply	N/A
Preferred Brand Tier 3	$50 copayment/prescription; deductible does not apply	N/A
Non-Preferred Brand Tier 4	50% coinsurance up to a maximum of $500 per prescription; deductible does not apply	N/A
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	N/A

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	N/A
Prescription – Mail Order Pharmacy (up to a 90 day supply per prescription)		
Preferred Generic Tier 1	$20 copayment/prescription; deductible does not apply	N/A
Non-preferred Generic Tier 2	50% coinsurance up to a maximum of $500 per prescription; deductible does not apply	N/A
Preferred Brand Tier 3	$100 copayment/prescription; deductible does not apply	N/A
Non-Preferred Brand Tier 4	50% coinsurance up to a maximum of $1,000 per prescription; deductible does not apply	N/A
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 after plan deductible	N/A
Physical and Occupational Therapy	$30 copayment/visit after plan deductible	N/A
Other Services		
Chiropractic Services (up to 20 visits per contract year)	$50 copayment/visit after plan deductible	N/A
Diabetic Equipment and Supplies	20% coinsurance after plan deductible	N/A
Durable Medical Equipment (DME)	50% coinsurance after plan deductible	N/A
Home Health Care Services (up to 100 visits per contract year)	$25 copayment/visit; deductible does not apply	N/A
Outpatient Services (in a hospital or ambulatory facility)	Ambulatory Facility: $350 copayment/visit; deductible does not apply Outpatient Hospital: 30% coinsurance after plan deductible	N/A
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)	30% coinsurance after plan deductible	N/A
Emergency and Urgent Care		
Ambulance Services	30% coinsurance after plan deductible	Same as In-network benefit
Emergency Room	30% coinsurance after plan deductible	Same as In-network benefit
Urgent Care Centers	$50 copayment/visit; deductible does not apply	Same as In-network benefit
Pediatric Dental Care (for members under age 26)		
Diagnostic & Preventive	No charge	N/A
Basic Services	50% coinsurance after plan deductible	N/A
Major Services	50% coinsurance after plan deductible	N/A
Orthodontia Services (medically necessary only)	50% coinsurance after plan deductible	N/A
Pediatric Vision Care (for members under age 26)		
Prescription Eye Glasses (one pair of frames and lenses per contract year)	Lenses: 50% coinsurance after plan deductible Collection frames: 50% coinsurance after plan deductible Non-collection frames: 50% coinsurance after plan deductible up to the collection frame allowance; any amount over is payable by the member minus a 20% discount	N/A
Routine Eye Exam by a Specialist (one exam per contract year)	$30 copayment/visit; deductible does not apply	N/A
Additional Covered Services		
Adult Routine Eye Exam by a Specialist - for members over age 26 (one exam per contract year)	$30 copayment/visit; deductible does not apply	N/A
Allergy Injections (Unlimited)	See primary care or specialist office visits	N/A

Benefits	In-Network (INET) Member Pays	Out-of-network (OON) Member Pays
Allergy Testing (up to one visit per contract year)	See primary care or specialist office visits	N/A
Artificial Limbs (includes associated supplies and equipment)	20% coinsurance after plan deductible	N/A
Modified Food Products and Specialized Formula	50% coinsurance after plan deductible	N/A
Outpatient mental health, alcohol and substance abuse treatment (intensive outpatient treatment and partial hospitalization)	30% coinsurance; deductible does not apply	N/A
Retail Clinic	$30 copayment/visit; deductible does not apply	N/A

Important information

- This is a brief summary of benefits. Refer to your ConnectiCare, Inc. membership agreement for complete details on benefits, conditions, limitations and exclusions. All benefits described are per member per Contract year.
- Ovarian cancer screening and monitoring services coverage and cost share details are available in your membership agreement.
- Mammogram screenings, breast ultrasounds, and breast MRIs – Please refer to the membership agreement 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 membership agreement for additional cost share maximums regarding diabetic services. Some diabetic services fall under preventive care and cost share may be waived.
- For a complete list of covered prescription drugs, please refer to the 2023 Small Group National Preferred Formulary at www.connecticare.com.
- 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.
- To learn more about your **Teladoc®** benefits contact **Teladoc®** at teladoc.com/connecticare or call 1-800-835-2362 (TTY: 711).
- 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.
- Many services require that you obtain written Pre-Authorization from us in order for the treatment to be covered under this plan, including services rendered by non-participating providers. Refer to the "Managed Care Rules and Guidelines" section in your membership agreement for more details or call member service at 1-800-251-7722. Without pre-authorization you may be responsible for the total cost of the service.
- 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.