ConnectiCare

# FlexPOS HSA $2000/$4000 10% CNT Fixed Funding Solutions Open Access Contract Year Benefit Summary (A)

The individual deductible and out-of-pocket maximum applies if you have coverage only for yourself and not for any dependents. The family deductible and out-of-pocket maximum applies if you have coverage for yourself and one or more eligible dependents. In addition, if you have family coverage, any applicable copayments or coinsurance will not apply to services until the total deductible is met for the family, without regard to how much any one family member has met.

Your ConnectiCare health plan helps you get the care you need. Here are the most frequently used services. Refer to your Health Plan Description on connecticare.com for a complete list of benefits.

**In-Network Preventive Services**
These services are no cost to you when you use an **in-network** doctor or facility. Frequency is based on age and gender. For a complete list of preventive services and to find a doctor, refer to connecticare.com.

Getting care within ConnectiCare's network typically costs you less. You may also get care outside of our network; however, your share of the costs will be higher. Out-of-network doctors and facilities do not appear in the "Find a doctor" directory on connecticare.com.

- **Physical**
- **Well woman visit and pap test**
- **More than 25 screenings, including mammograms and colonoscopies**
- **Flu shot**
- **Vaccinations**
- **Certain birth control and other prevention medications**

| | **In-network member pays** | **Out-of-network member pays** |
|---|---|---|
| **Your deductible**<br>Deductible is combined for medical services and prescription drugs | $2,000 Individual<br>$4,000 Family | $4,000 Individual<br>$8,000 Family |
| **Your out-of-pocket maximum**<br>Includes a combination of deductible, copayments and coinsurance for medical and pharmacy services | $3,000 Individual<br>$6,000 Family | $8,000 Individual<br>$16,000 Family |
| **Out-of-network reimbursement** | Not applicable | Plan will reimburse the coinsurance percentage of the maximum allowable amount |
| After you have spent the out-of-pocket maximum amount, ConnectiCare will pay 100% of your covered health care expenses for the remainder of the year. | | |
| **Screenings** | **In-network member pays** | **Out-of-network member pays** |
| **Baseline routine mammography**<br>(ages 35-39) | 10% coinsurance<br>after plan deductible | 50% coinsurance<br>after plan deductible |
| **Annual routine mammography**<br>(age 40 or older) | No charge | 50% coinsurance<br>after plan deductible |

| Screenings | In-network member pays | Out-of-network member pays |
|---|---|---|
| **Breast ultrasound** | 10% coinsurance<br>after plan deductible | 50% coinsurance<br>after plan deductible |
| **Annual routine vision exam** | 10% coinsurance;<br>deductible does not apply | 50% coinsurance<br>after plan deductible |
| **Allergy testing**<br>up to one visit per year | 10% coinsurance<br>after plan deductible | 50% coinsurance<br>after plan deductible |
| **Ongoing Care and Sick Visits** | **In-network member pays** | **Out-of-network member pays** |
| **Primary care services**<br>(includes office and telemedicine services) | 10% coinsurance<br>after plan deductible | 50% coinsurance<br>after plan deductible |
| **Specialist services**<br>(includes office and telemedicine services) | 10% coinsurance<br>after plan deductible | 50% coinsurance<br>after plan deductible |
| **Gynecologist services** | 10% coinsurance<br>after plan deductible | 50% coinsurance<br>after plan deductible |
| **Maternity and prenatal care visits**<br>May not apply to all laboratory and radiology services – refer to your plan documents | No charge | 50% coinsurance<br>after plan deductible |
| **Allergy injections**<br>Unlimited | 10% coinsurance<br>after plan deductible | 50% coinsurance<br>after plan deductible |
| **Telemedicine visit**<br>(services rendered by a Teladoc® provider)<br><br>Primary Care – members must be 18 or older | **Primary Care, Mental Health and General Medical Services:**<br>0% coinsurance<br>after plan deductible<br><br>**Dermatologists:**<br>10% coinsurance<br>after plan deductible | 50% coinsurance<br>after plan deductible |
| **Retail clinic** | 10% coinsurance<br>after plan deductible | 50% coinsurance<br>after plan deductible |
| **Lab and Radiology**<br>**Performed in a hospital, lab or radiology facility** | **In-network member pays** | **Out-of-network member pays** |
| **Laboratory services** | 10% coinsurance<br>after plan deductible | 50% coinsurance<br>after plan deductible |
| **Non-advanced radiology**<br>X-ray, diagnostic | 10% coinsurance<br>after plan deductible | 50% coinsurance<br>after plan deductible |
| **Advanced radiology**<br>**Hospital facility**<br>MRI, PET and CAT scan and nuclear cardiology | 10% coinsurance<br>after plan deductible | 50% coinsurance<br>after plan deductible |

| **Lab and Radiology**<br>**Performed in a hospital, lab or radiology facility** | **In-network member pays** | **Out-of-network member pays** |
|---|---|---|
| **Advanced radiology**<br>**Stand-alone facility**<br>MRI, PET and CAT scan and nuclear cardiology | 10% coinsurance<br>after plan deductible | 50% coinsurance<br>after plan deductible |
| **Sudden and Unexpected Care** | **In-network member pays** | **Out-of-network member pays** |
| **Urgent care or other walk-in clinic** | 10% coinsurance<br>after plan deductible | Same as In-network benefit |
| **Emergency room** | 10% coinsurance<br>after plan deductible | Same as In-network benefit |
| **Ambulance** | 10% coinsurance<br>after plan deductible | Same as In-network benefit |
| **Inpatient Hospital Services** | **In-network member pays** | **Out-of-network member pays** |
| **Inpatient hospital services, including room and board** | 10% coinsurance<br>after plan deductible | 50% coinsurance<br>after plan deductible |
| **Skilled nursing and rehabilitation facilities**<br>up to 90 days per year | 10% coinsurance<br>after plan deductible | 50% coinsurance<br>after plan deductible |
| **Outpatient Hospital Services and Home Care** | **In-network member pays** | **Out-of-network member pays** |
| **Hospital outpatient facilities** | 10% coinsurance<br>after plan deductible | 50% coinsurance<br>after plan deductible |
| **Ambulatory surgical center** | 10% coinsurance<br>after plan deductible | 50% coinsurance<br>after plan deductible |
| **Home health services**<br>up to 100 visits per year | 10% coinsurance<br>after plan deductible | 50% coinsurance<br>after plan deductible |
| **Outpatient Rehabilitative Services** | **In-network member pays** | **Out-of-network member pays** |
| **Rehabilitative Services**<br>up to 40 visits per year<br>includes services combined for physical, speech and occupational therapy | 10% coinsurance<br>after plan deductible | 50% coinsurance<br>after plan deductible |
| **Chiropractic services**<br>up to 20 visits per year | 10% coinsurance<br>after plan deductible | 50% coinsurance<br>after plan deductible |
| **Mental Health and Substance Abuse** | **In-network member pays** | **Out-of-network member pays** |
| **Inpatient mental health services** | 10% coinsurance<br>after plan deductible | 50% coinsurance<br>after plan deductible |
| **Inpatient alcohol and substance abuse treatment** | 10% coinsurance<br>after plan deductible | 50% coinsurance<br>after plan deductible |

| Mental Health and Substance Abuse | In-network member pays | Out-of-network member pays |
|---|---|---|
| **Outpatient mental health, alcohol and substance abuse treatment**<br>office visits and home services | 10% 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 | 10% coinsurance<br>after plan deductible | 50% coinsurance<br>after plan deductible |
| **Supplies** | **In-network member pays** | **Out-of-network member pays** |
| **Durable medical equipment including prosthetics and disposable medical supplies** | 10% coinsurance<br>after plan deductible | 50% coinsurance<br>after plan deductible |
| **Diabetic equipment and supplies** | 10% coinsurance<br>after plan deductible | 50% coinsurance<br>after plan deductible |

**Important information**

- This is a brief summary of benefits.  Refer to your employer's Health Plan Description for complete details on benefits, conditions, limitations and exclusions, or consult with your benefits manager. All benefits described are per member per plan year.
- To learn more about your Teladoc® provider benefits contact Teladoc® at teladoc.com/connecticare or call 1-800-835-2362 (TTY: 711).
- 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 Health Plan Description for additional cost share maximums regarding diabetic services. Some diabetic services fall under preventive care and cost share may be waived.
- Certain services require Prior Authorization, please refer to your Health Plan Description for a detailed list of services or call member service at 1-800-251-7722.
- 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.
- 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 employer's Health Plan Description for more information.
- If you are a Massachusetts resident, this plan along with pharmacy services meets Massachusetts Minimum Creditable Coverage standards for 2023.
- Your plan is administered by ConnectiCare Insurance Company, Inc.

ConnectiCare

# FlexPOS Copayment Prescription Value Drug Plan for Use with Health Savings Account (HSA) Benefit Summary

This is a brief summary of your prescription drug benefits. Refer to your employer's Health Plan Description for complete details on benefits, conditions, limitations and exclusions, or consult with your benefits manager. All benefits described below are per member per plan year.

Covered prescription drugs through retail participating pharmacies or our mail order service. **Generics are dispensed unless the provider writes "Dispense as Written" on the prescription.**

Your Plan includes the following: Mandatory drug substitution, Generic substitution program, Pay the difference waiver, Tiered cost-share program, and Voluntary mail order program.

| | **In-network member pays** | **Out-of-network member pays** |
|---|---|---|
| **Your deductible**<br>Deductible is combined for medical services and prescription drugs | $2,000 Individual<br>$4,000 Family | $4,000 Individual<br>$8,000 Family |
| **Your out-of-pocket maximum**<br>Includes a combination of deductible, copayments and coinsurance for medical and pharmacy services | $3,000 Individual<br>$6,000 Family | $8,000 Individual<br>$16,000 Family |
| **Retail Pharmacy (up to a 30 day supply per prescription)** | **In-network member pays** | **Out-of-network member pays** |
| **Generic drugs**<br>(Tier 1) | $10 copayment/prescription after plan deductible | 50% coinsurance after plan deductible |
| **Preferred brand drugs**<br>(Tier 2) | $50 copayment/prescription after plan deductible | 50% coinsurance after plan deductible |
| **Non-preferred brand drugs**<br>(Tier 3) | 20% coinsurance up to $250 coinsurance maximum per prescription after plan deductible | 50% coinsurance after plan deductible |
| **Mail Order Pharmacy (up to a 90 day supply per prescription)** | **In-network member pays** | **Out-of-network member pays** |
| **Generic drugs**<br>(Tier 1) | $20 copayment/prescription after plan deductible | 50% coinsurance after plan deductible |
| **Preferred brand drugs**<br>(Tier 2) | $100 copayment/prescription after plan deductible | 50% coinsurance after plan deductible |

| **Mail Order Pharmacy (up to a 90 day supply per prescription)** | **In-network member pays** | **Out-of-network member pays** |
|---|---|---|
| **Non-preferred brand drugs** (Tier 3) | 20% coinsurance up to $500 coinsurance maximum per prescription after plan deductible | 50% coinsurance after plan deductible |
| **Specialty drugs (up to a 30 day supply per prescription) These drugs generally require pre-authorization and may require special handling** | **In-network member pays** | **Out-of-network member pays** |
| **Specialty drugs** (Tier 4) | 20% coinsurance up to $500 coinsurance maximum per prescription after plan deductible | 50% coinsurance after plan deductible |

**Additional 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 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.
- Amounts paid by members because they must pay a price difference for a brand name drug do not count towards meeting any deductible, coinsurance and copayment.
- Most specialty drugs are dispensed through specialty pharmacies by mail, up to 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.
- 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 prescription drug rider for additional cost share maximums regarding diabetic services. Some diabetic services fall under preventive care and cost share may be waived.
- Refer to ConnectiCare's Pharmacy Center online at www.connecticare.com for the Value List of drugs that are subject to the member's cost share.
- 90 day supply of maintenance medications must be filled through Express Scripts home delivery or a participating Walgreens pharmacy.
- For a complete list of covered prescription drugs, please refer to the 2023 Large Group National Preferred Formulary at www.connecticare.com