



## FlexPOS \$30/\$45 \$500 \$500Day CNT Fixed Funding Solutions Open Access Contract Year Benefit Summary

Your ConnectiCare health plan helps you get the care you need. Here are the most frequently used services. Refer to your employer's Health Plan Description for a complete list of benefits. All benefits described below are per member per plan year.

<b>In-Network Preventive Services</b>		
<p>These services are no cost to you when you use an <b>in-network</b> 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.</p> <p>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.</p>		
<ul style="list-style-type: none"> <li>• Physical</li> <li>• Well woman visit and pap test</li> <li>• More than 25 screenings, including mammograms and colonoscopies</li> <li>• Flu shot</li> <li>• Vaccinations</li> <li>• Certain birth control and other prevention medications</li> </ul>		
	<b>In-network member pays</b>	<b>Out-of-network member pays</b>
<b>Your deductible</b>	\$0 Individual \$0 Family	\$4,000 Individual \$8,000 Family
<b>Your out-of-pocket maximum</b> Includes a combination of deductible, copayments and coinsurance for medical and pharmacy services	\$5,000 Individual \$10,000 Family	\$10,000 Individual \$20,000 Family
<b>Out-of-network reimbursement</b>	Not applicable	Plan will reimburse the coinsurance percentage of the maximum allowable amount
<p>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.</p>		
<b>Screenings</b>	<b>In-network member pays</b>	<b>Out-of-network member pays</b>
<b>Baseline routine mammography</b> (ages 35-39)	\$10 copayment/visit	50% coinsurance after plan deductible
<b>Annual routine mammography</b> (age 40 or older)	No charge	50% coinsurance after plan deductible
<b>Breast ultrasound</b>	\$10 copayment/visit	50% coinsurance after plan deductible
<b>Annual routine vision exam</b>	\$45 copayment/visit	50% coinsurance after plan deductible

<b>Screenings</b>	<b>In-network member pays</b>	<b>Out-of-network member pays</b>
<b>Allergy testing</b> up to one visits per year	Refer to your applicable primary care or specialist cost share	50% coinsurance after plan deductible
<b>Ongoing Care and Sick Visits</b>	<b>In-network member pays</b>	<b>Out-of-network member pays</b>
<b>Primary care services</b> (includes office and telemedicine services)	\$30 copayment/visit	50% coinsurance after plan deductible
<b>Specialist services</b> (includes office and telemedicine services)	\$45 copayment/visit	50% coinsurance after plan deductible
<b>Gynecologist services</b>	\$45 copayment/visit	50% coinsurance after plan deductible
<b>Maternity and prenatal care visits</b> May not apply to all laboratory and radiology services - refer to your plan documents	No charge	50% coinsurance after plan deductible
<b>Allergy injections</b> Unlimited	Refer to your applicable primary care or specialist cost share	50% coinsurance after plan deductible
<b>Telemedicine visit</b> (services rendered by a Teladoc® provider)  Primary Care - members must be 18 or older	<b>Primary Care, Mental Health and General Medical Services:</b> No charge  <b>Dermatologists:</b> \$45 copayment/visit	50% coinsurance after plan deductible
<b>Retail clinic</b>	\$30 copayment/visit	50% coinsurance after plan deductible
<b>Lab and Radiology Performed in a hospital, lab or radiology facility</b>	<b>In-network member pays</b>	<b>Out-of-network member pays</b>
<b>Laboratory services</b>	No charge	50% coinsurance after plan deductible
<b>Non-advanced radiology</b> X-ray, diagnostic	\$10 copayment/visit	50% coinsurance after plan deductible
<b>Advanced radiology Hospital facility</b> MRI, PET and CAT scan and nuclear cardiology up to five copayments per year	\$75 copayment/service	50% coinsurance after plan deductible
<b>Advanced radiology Stand-alone facility</b> MRI, PET and CAT scan and nuclear cardiology up to five copayments per year	\$75 copayment/service	50% coinsurance after plan deductible

<b>Sudden and Unexpected Care</b>	<b>In-network member pays</b>	<b>Out-of-network member pays</b>
<b>Urgent care or other walk-in clinic</b>	\$75 copayment/visit	Same as In-network benefit
<b>Emergency room</b> copayment waived if admitted	\$150 copayment/visit	Same as In-network benefit
<b>Ambulance</b>	No charge	Same as In-network benefit
<b>Inpatient Hospital Services</b>	<b>In-network member pays</b>	<b>Out-of-network member pays</b>
<b>Inpatient hospital services, including room and board</b> (copayment maximum is combined with Skilled nursing and rehabilitation services)	\$500 copayment/day up to \$2,000 per admission	50% coinsurance after plan deductible
<b>Skilled nursing and rehabilitation facilities</b> (copayment maximum is combined with Inpatient hospital services) up to 90 days per year	\$500 copayment/day up to \$2,000 per admission	50% coinsurance after plan deductible
<b>Outpatient Hospital Services and Home Care</b>	<b>In-network member pays</b>	<b>Out-of-network member pays</b>
<b>Hospital outpatient facilities</b>	\$500 copayment/visit	50% coinsurance after plan deductible
<b>Ambulatory surgical center</b>	\$500 copayment/visit	50% coinsurance after plan deductible
<b>Home health services</b> up to 100 visits per year	No charge	50% coinsurance after plan deductible
<b>Outpatient Rehabilitative Services</b>	<b>In-network member pays</b>	<b>Out-of-network member pays</b>
<b>Rehabilitative Services</b> up to 40 visits per year includes services combined for physical, speech and occupational therapy	\$45 copayment/visit	50% coinsurance after plan deductible
<b>Chiropractic services</b> up to 20 visits per year	\$45 copayment/visit	50% coinsurance after plan deductible
<b>Mental Health and Substance Abuse</b>	<b>In-network member pays</b>	<b>Out-of-network member pays</b>
<b>Inpatient mental health services</b>	\$500 copayment/day up to \$2,000 per admission	50% coinsurance after plan deductible
<b>Inpatient alcohol and substance abuse treatment</b>	\$500 copayment/day up to \$2,000 per admission	50% coinsurance after plan deductible

<b>Mental Health and Substance Abuse</b>	<b>In-network member pays</b>	<b>Out-of-network member pays</b>
<b>Outpatient mental health, alcohol and substance abuse treatment</b> office visits and home services	\$45 copayment/visit	50% coinsurance after plan deductible
<b>Outpatient mental health, alcohol and substance abuse treatment</b> intensive outpatient treatment and partial hospitalization	\$45 copayment/visit	50% coinsurance after plan deductible
<b>Supplies</b>	<b>In-network member pays</b>	<b>Out-of-network member pays</b>
<b>Durable medical equipment including prosthetics and disposable medical supplies</b>	50% coinsurance	50% coinsurance after plan deductible
<b>Diabetic equipment and supplies</b>	50% coinsurance	50% coinsurance after plan deductible
<b>Important information</b>		
<ul style="list-style-type: none"> <li>• 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.</li> <li>• To learn more about your Teladoc® provider benefits contact Teladoc® at <a href="https://teladoc.com/connecticare">teladoc.com/connecticare</a> or call 1-800-835-2362 (TTY: 711).</li> <li>• Insulin and noninsulin drugs are covered up to a cost share maximum of \$25 for each 30-day supply.</li> <li>• Diabetes Devices and Diabetic Ketoacidosis Devices are covered up to a cost share maximum of \$100 per 30-day supply.</li> <li>• 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.</li> <li>• 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.</li> <li>• 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.</li> <li>• 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.</li> <li>• If you are a Massachusetts resident, this plan along with pharmacy services meets Massachusetts Minimum Creditable Coverage standards for 2023.</li> <li>• Your plan is administered by ConnectiCare Insurance Company, Inc.</li> </ul>		

# Prescription Drug Copayment Coinsurance Plan 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.

<p>Covered prescription drugs through retail participating pharmacies or our mail order service. <b>Generics are dispensed unless the provider writes "Dispense as Written" on the prescription.</b></p> <p>Your Plan includes the following: Mandatory drug substitution, Generic substitution program, Pay the difference waiver, Tiered cost-share program, and Voluntary mail order program.</p>		
	<b>In-network member pays</b>	<b>Out-of-network member pays</b>
<b>Your out-of-pocket maximum</b> Includes a combination of deductible, copayments and coinsurance for medical and pharmacy services	\$5,000 Individual \$10,000 Family	\$10,000 Individual \$20,000 Family
<b>Retail Pharmacy (up to a 30 day supply per prescription)</b>	<b>In-network member pays</b>	<b>Out-of-network member pays</b>
<b>Generic drugs (Tier 1)</b>	\$10 copayment/prescription	50% coinsurance
<b>Preferred brand drugs (Tier 2)</b>	\$50 copayment/prescription	50% coinsurance
<b>Non-preferred brand drugs (Tier 3)</b>	20% coinsurance up to \$250 coinsurance maximum per prescription	50% coinsurance
<b>Mail Order Pharmacy (up to a 90 day supply per prescription)</b>	<b>In-network member pays</b>	<b>Out-of-network member pays</b>
<b>Generic drugs (Tier 1)</b>	\$20 copayment/prescription	50% coinsurance
<b>Preferred brand drugs (Tier 2)</b>	\$100 copayment/prescription	50% coinsurance
<b>Non-preferred brand drugs (Tier 3)</b>	20% coinsurance up to \$500 coinsurance maximum per prescription	50% coinsurance

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	50% coinsurance
<b>Additional Information</b>		
<ul style="list-style-type: none"> <li>• 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 &amp; 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.</li> <li>• 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.</li> <li>• Insulin and noninsulin drugs are covered up to a cost share maximum of \$25 for each 30-day supply.</li> <li>• Diabetes Devices and Diabetic Ketoacidosis Devices are covered up to a cost share maximum of \$100 per 30-day supply.</li> <li>• 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.</li> <li>• 90 day supply of maintenance medications must be filled through Express Scripts home delivery or a participating Walgreens pharmacy.</li> <li>• For a complete list of covered prescription drugs, please refer to the 2023 Large Group National Preferred Formulary at <a href="http://www.connecticare.com">www.connecticare.com</a></li> </ul>		