ConnectiCare

Small Group Market
FlexPOS $40/$80 $2,750 20%
Fixed Funding Solutions
Open Access Contract Plan Year
Benefit Summary
Non-Tiered Network Plan

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.

Deductible and Out-of-Pocket Maximum	**In-Network (INET) Member Pays**	**Out-of-network (OON) Member Pays**
Plan deductible	$2,750 per member $5,500 per family	$7,000 per member $14,000 per family
Separate Prescription Drug Deductible	None	None
Out-of-Pocket Maximum Includes a combination of deductible, copayments and coinsurance for medical and pharmacy services	$6,000 per member $12,000 per family	$15,800 per member $31,600 per family
Benefits	**In-Network (INET) Member Pays**	**Out-of-network (OON) Member Pays**
Provider Office Visits		
Adult/Pediatric Preventive Visits	No charge (frequency is based on age/ gender)	50% coinsurance after plan deductible
Primary Care Provider Office/ Telemedicine Visits includes services for illness, injury, follow-up care and consultations	$40 copayment/visit; deductible does not apply	50% coinsurance after plan deductible
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:** $80 copayment/visit; deductible does not apply	50% coinsurance after plan deductible
Specialist Office/Telemedicine Visits	$80 copayment/visit; deductible does not apply	50% coinsurance after plan deductible

Benefits	In-Network (INET) Member Pays	Out-of-network (OON) Member Pays
Mental Health and Substance Abuse Office Visits	$80 copayment/visit; deductible does not apply	50% coinsurance after plan deductible
Outpatient Diagnostic Services		
Advanced Radiology CT/PET Scan, MRI	**Independent Facility:** $100 copayment/service; deductible does not apply, up to five copayments per year then copayment waived **Hospital Facility:** 20% coinsurance after plan deductible	50% coinsurance after plan deductible
Laboratory Services	20% coinsurance after plan deductible	50% coinsurance after plan deductible
Non-Advanced Radiology X-ray, Diagnostic	**Independent Facility:** $50 copayment/service; deductible does not apply **Hospital Facility:** 20% coinsurance after plan deductible	50% coinsurance after plan deductible
Mammography Ultrasound	**Independent Facility:** $50 copayment/service; deductible does not apply **Hospital Facility:** 20% coinsurance after plan deductible	50% coinsurance after plan deductible
Prescription Drugs – Retail Pharmacy (cost share based on 30 day supply per prescription)		
Preferred Generic Tier 1	$10 copayment/prescription; deductible does not apply	50% coinsurance
Non-preferred Generic Tier 2	50% coinsurance up to a maximum of $250 per prescription; deductible does not apply	50% coinsurance
Preferred Brand Tier 3	$50 copayment/prescription; deductible does not apply	50% coinsurance
Non-Preferred Brand Tier 4	50% coinsurance up to a maximum of $500 per prescription; deductible does not apply	50% coinsurance
Specialty Drugs – (cost share up to 30 day supply per prescription - These drugs generally require pre-authorization and may require special handling)		

Benefits	In-Network (INET) Member Pays	Out-of-network (OON) Member Pays
Preferred Specialty Tier 5	50% coinsurance up to a maximum of $500 per prescription; deductible does not apply	Not covered
Non-Preferred Specialty Tier 6	50% coinsurance up to a maximum of $750 per prescription; deductible does not apply	Not covered
Prescription – Mail Order Pharmacy (up to a 90 day supply per prescription)		
Preferred Generic Tier 1	$20 copayment/prescription; deductible does not apply	Not covered
Non-preferred Generic Tier 2	50% coinsurance up to a maximum of $500 per prescription; deductible does not apply	Not covered
Preferred Brand Tier 3	$100 copayment/prescription; deductible does not apply	Not covered
Non-Preferred Brand Tier 4	50% coinsurance up to a maximum of $1,000 per prescription; deductible does not apply	Not covered
Outpatient Rehabilitative (40 visits per contract year limit combined for Rehabilitative physical, speech and occupational therapies.)		
Speech Therapy	$80 copayment/visit; deductible does not apply	50% coinsurance after plan deductible
Physical and Occupational Therapy	$80 copayment/visit; deductible does not apply	50% coinsurance after plan deductible
Other Services		
Chiropractic Services up to 20 visits per contract year	$80 copayment/visit; deductible does not apply	50% coinsurance after plan deductible
Diabetic Equipment and Supplies	20% coinsurance after plan deductible	50% coinsurance after plan deductible
Durable Medical Equipment (DME) including prosthetics and disposable medical supplies	20% coinsurance after plan deductible	50% coinsurance after plan deductible
Home Health Care Services up to 100 visits per contract year	20% coinsurance after plan deductible	50% coinsurance after plan deductible

Benefits	In-Network (INET) Member Pays	Out-of-network (OON) Member Pays
Outpatient Services in a hospital or ambulatory facility	**Ambulatory Facility:** $400 copayment/visit; deductible does not apply **Hospital Facility:** 20% coinsurance after plan deductible	50% coinsurance after plan deductible
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	20% coinsurance after plan deductible	50% coinsurance after plan deductible
Emergency and Urgent Care		
Ambulance Services	$350 copayment per trip; deductible does not apply	Same as In-network benefit
Emergency Room copayment waived if admitted	$350 copayment/visit; deductible does not apply	Same as In-network benefit
Walk-In Center	$75 copayment/visit; deductible does not apply	Same as In-network benefit
Additional Covered Services		
Routine Eye Exam by a Specialist one exam per contract year	$80 copayment/visit; deductible does not apply	50% coinsurance after plan deductible
Allergy Injections up to 20 visits per contract year	Refer to your applicable primary care or specialist cost share	50% coinsurance after plan deductible
Allergy Testing up to one visit per contract year	Refer to your applicable primary care or specialist cost share	50% coinsurance after plan deductible
Baseline Routine Mammography ages 35-39	**Independent Facility:** $50 copayment/service; deductible does not apply **Hospital Facility:** 20% coinsurance after plan deductible	50% coinsurance after plan deductible
Annual routine mammography age 40 or older	No charge	50% coinsurance after plan deductible
Gynecologist Services	$80 copayment/visit; deductible does not apply	50% coinsurance after plan deductible

Benefits	In-Network (INET) Member Pays	Out-of-network (OON) Member Pays
Outpatient mental health, alcohol and substance abuse treatment intensive outpatient treatment and partial hospitalization	$80 copayment/visit; deductible does not apply	50% coinsurance after plan deductible
Prenatal Office Visits May not apply to all laboratory and radiology services – refer to your plan documents	No charge	50% coinsurance after plan deductible
Retail Clinic	$40 copayment/visit; deductible does not apply	50% coinsurance 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.
- 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 2024.
- To learn more about your Teladoc® benefits contact Teladoc® a teladoc.com/connecticare or call 1-800-835-2362 (TTY:711).
- 90-day supply of maintenance medications must be filled through Express Scripts home delivery or at either a participating CVS or Walgreens pharmacy. Each member has a choice of the pharmacy used.
- 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.
- 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 Mandatory mail order program. The member cost share for specialty pharmacy is different from the cost share for ConnectiCare's mail order program.
- Your plan is administered by ConnectiCare Insurance Company, Inc.