ConnectiCare

FlexPOS-CAL-20-20-25-25A-01 Open Access Calendar Year Benefit Summary

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

Personalized for: RSD #14 - Cafeteria

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 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	$0 Individual $0 Employee +1 $0 Family	$200 Individual $400 Employee +1 $500 Family
Your out-of-pocket maximum Includes a combination of deductible, copayments and coinsurance for medical and pharmacy services	$6,600 Individual $13,200 Employee +1 $13,200 Family	$400 Individual $800 Employee +1 $1,000 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 in deductibles, copayments and coinsurance, 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	No charge	20% coinsurance after plan deductible
Routine mammography	No charge	20% coinsurance after plan deductible
Breast ultrasound	No charge	20% coinsurance after plan deductible
Routine vision exam one exam per year	No charge	20% coinsurance after plan deductible
Allergy testing Unlimited	$20 copayment/visit	20% coinsurance after plan deductible

Screenings	In-network member pays	Out-of-network member pays
Hearing Screenings one exam per year	No charge	20% coinsurance after plan deductible
Ongoing Care and Sick Visits	**In-network member pays**	**Out-of-network member pays**
Primary care services	$20 copayment/visit	20% coinsurance after plan deductible
Specialist services	$20 copayment/visit	20% coinsurance after plan deductible
Gynecologist services	$20 copayment/visit	20% coinsurance after plan deductible
Maternity and prenatal care visits May not apply to all laboratory and radiology services - refer to your plan documents	No charge	20% coinsurance after plan deductible
Allergy injections up to 80 visits every three years	No charge	20% coinsurance after plan deductible
Telemedicine visit	$20 copayment/visit	20% coinsurance after plan deductible
Retail clinic	$20 copayment/visit	20% coinsurance after plan deductible
Nutritional Counseling Limit 3 visits per year	No charge	20% coinsurance after plan deductible
Infertility Infertility benefits outlined in the Certificate of Coverage are unlimited, with no age or cycles restrictions	$20 copayment/visit (Office visit) $25 copayment/visit (Ambulatory Services Outpatient) $25 copayment per admission (Inpatient Hospital)	20% coinsurance after plan deductible
Lab and Radiology Performed in a hospital, lab or radiology facility	**In-network member pays**	**Out-of-network member pays**
Laboratory services	No charge	20% coinsurance after plan deductible
Non-advanced radiology X-ray, diagnostic	No charge	20% coinsurance after plan deductible
Advanced radiology **Hospital facility** MRI, PET and CAT scan and nuclear cardiology	No charge	20% coinsurance after plan deductible
Advanced radiology **Stand-alone facility** MRI, PET and CAT scan and nuclear cardiology	No charge	20% coinsurance after plan deductible

Sudden and Unexpected Care	In-network member pays	Out-of-network member pays
Walk-in center	$20 copayment/visit	Same as In-network benefit
Urgent care center	$25 copayment/visit	Same as In-network benefit
Emergency room Copayment waived if admitted	$25 copayment/visit	Same as In-network benefit
Ambulance	No charge	Same as In-network benefit
Inpatient Hospital Services	**In-network member pays**	**Out-of-network member pays**
Inpatient hospital services, including room and board	$25 copayment per admission	20% coinsurance after plan deductible
Skilled nursing facilities up to 120 days per year	$25 copayment per admission	20% coinsurance after plan deductible
Inpatient rehabilitation up to 60 days per year	$25 copayment per admission	20% coinsurance after plan deductible
Private Duty Nursing up to $15,000 per year	No charge	20% coinsurance after plan deductible
Outpatient Hospital Services and Home Care	**In-network member pays**	**Out-of-network member pays**
Hospital outpatient facilities	$25 copayment/visit	20% coinsurance after plan deductible
Ambulatory surgical center	$25 copayment/visit	20% coinsurance after plan deductible
Home health services Nursing and therapeutic services limited to 200 visits Home Health aide services limited to 80 visits that are applicable to the 200 visit limit	No charge	20% coinsurance after $50 benefit deductible
Outpatient Rehabilitative Services	**In-network member pays**	**Out-of-network member pays**
Rehabilitative Services up to 50 visits per year includes services combined for physical, speech and occupational therapy and chiropractic services	No charge	20% coinsurance after plan deductible
Mental Health and Substance Abuse	**In-network member pays**	**Out-of-network member pays**
Inpatient mental health services	$25 copayment per admission	20% coinsurance after plan deductible
Inpatient alcohol and substance abuse treatment	$25 copayment per admission	20% coinsurance after plan deductible
Outpatient mental health, alcohol and substance abuse treatment office visits and home services	$20 copayment/visit	20% coinsurance 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 intensive outpatient treatment and partial hospitalization	No charge	20% coinsurance after plan deductible
Supplies	**In-network member pays**	**Out-of-network member pays**
Durable medical equipment including prosthetics and disposable medical supplies Includes wigs prescribed by an oncologist for a member suffering hair loss as a result of chemotherapy or radiation therapy up to one wig per year	No charge	20% coinsurance after plan deductible
Artificial Limbs includes associated supplies and equipment	No charge	20% coinsurance after plan deductible
Diabetic equipment and supplies	No charge	20% coinsurance after plan deductible
Modified food products and specialized formula pharmacy tier	No charge	20% coinsurance after plan deductible

Important Information

- This is a brief summary of benefits. Refer to your ConnectiCare Insurance Company, Inc. Certificate of Coverage for complete details on benefits, conditions, limitations and exclusions, or consult with your benefits manager. All benefits described are per member per Contract 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 ConnectiCare Insurance Company, 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 benefits.
- If you are a Massachusetts resident, this plan along with pharmacy services meets Massachusetts Minimum Creditable Coverage standards for 2019.

ConnectiCare

Prescription Drug Copayment Plan Benefit Summary

This is a brief summary of your prescription drug benefits. Refer to your Prescription Drug Rider for complete details on benefits, conditions, limitations and exclusions, or consult with your benefits manager. All benefits described below are per member per Calendar year.

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Covered prescription drugs through retail Participating Pharmacies or our mail order service. Your Plan includes the following: Mandatory Drug Substitution, Tiered Cost-Share Program, and Voluntary Mail Order Program.

	In-network member pays	**Out-of-network member pays**
Your out-of-pocket maximum Includes a combination of deductible, copayments and coinsurance for medical and pharmacy services	$6,600 Individual $13,200 Employee +1 $13,200 Family	$400 Individual $800 Employee+1 $1,000 Family
Retail Pharmacy (up to a 30 day supply per prescription)	**In-network member pays**	**Out-of-network member pays**
Generic drugs (Tier 1)	$5 copayment/prescription	20% coinsurance
Preferred brand drugs (Tier 2)	$20 copayment/prescription	20% coinsurance
Non-preferred brand drugs (Tier 3)	$30 copayment/prescription	20% coinsurance
Mail Order Pharmacy (up to a 100 day supply per prescription)	**In-network member pays**	**Out-of-network member pays**
Generic drugs (Tier 1)	$10 copayment/prescription	Not covered
Preferred brand drugs (Tier 2)	$40 copayment/prescription	Not covered
Non-preferred brand drugs (Tier 3)	$60 copayment/prescription	Not covered

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.
- 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.
- If you are a Massachusetts resident, please refer to your *amendatory rider for Massachusetts mandated benefits* for additional details of your benefits