ConnectiCare

FlexPOS-CNT-HSA-2250I/4500F-21-Combined-A 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 certificare of coverage on connecticare.com for a complete list of benefits.

Personalized for: Cooperative Educational Services

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 Deductible is combined for medical services and prescription drugs Deductible is combined for in and out-of-network	$2,250 Individual $4,500 Family	$2,250 Individual $4,500 Family
Your out-of-pocket maximum Includes a combination of deductible, copayments and coinsurance for medical and pharmacy services Out-of-pocket is combined for in and out-of-network	$3,000 Individual $6,000 Family	$3,000 Individual $6,000 Family
Out-of-network reimbursement	Not applicable	Plan will reimburse the coinsurance percentage of the maximum allowable amount
The deductible and out-of-pocket maximums are aggregate. 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 (ages 35-39)	No charge	20% coinsurance after plan deductible
Annual routine mammography (age 40 or older)	No charge	20% coinsurance after plan deductible
Annual routine vision exam one exam per year	No charge	20% coinsurance after plan deductible
Hearing Screenings one exam every year	No charge	20% coinsurance after plan deductible
Allergy testing Unlimited	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Ongoing Care and Sick Visits	**In-network member pays**	**Out-of-network member pays**
Primary care services (includes office and telemedicine services)	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Specialist services (includes office and telemedicine services)	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Gynecologist services	0% coinsurance after plan deductible	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 Unlimited	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Telemedicine visit (services rendered by a Teladoc® provider) Primary Care – members must be 18 or older	**Primary Care, Mental Health and General Medical Services:** 0% coinsurance after plan deductible **Dermatologists:** 0% coinsurance after plan deductible	20% coinsurance after plan deductible
Retail clinic	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Infusion therapy (when services are rendered in a Specialist office or Freestanding Infusion Center)	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Nutritional Counseling Limit 3 visits per year	0% coinsurance after plan deductible	20% coinsurance after plan deductible

Ongoing Care and Sick Visits	In-network member pays	Out-of-network member pays
Infertility Infertility benefits outlined in the Certificate of Coverage are unlimited, with no age or cycle restrictions	0% coinsurance (Office visit) after plan deductible 0% coinsurance (Ambulatory Services Outpatient) after plan deductible 0% coinsurance (Inpatient Hospital) after plan deductible	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 **Hospital facility**	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Laboratory services **Independent facility**	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Non-advanced radiology **Hospital facility** X-ray, diagnostic	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Non-advanced radiology **Independent facility** X-ray, diagnostic	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Advanced radiology **Hospital facility** MRI, PET and CAT scan and nuclear cardiology	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Advanced radiology **Independent facility** MRI, PET and CAT scan and nuclear cardiology	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Sudden and Unexpected Care	**In-network member pays**	**Out-of-network member pays**
Urgent care or other walk-in clinic	0% coinsurance after plan deductible	Same as In-network benefit
Emergency room	0% coinsurance after plan deductible	Same as In-network benefit
Ambulance	0% coinsurance 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	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Skilled nursing facilities up to 120 days per year	0% coinsurance after plan deductible	20% coinsurance after plan deductible

Inpatient Hospital Services	In-network member pays	Out-of-network member pays
Inpatient Rehabilitation up to 100 days per year	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Private duty nursing up to $15,000 per year	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Outpatient Hospital Services and Home Care	**In-network member pays**	**Out-of-network member pays**
Hospital outpatient facilities	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Ambulatory surgical center	0% coinsurance after plan deductible	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	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Outpatient Rehabilitative Services	**In-network member pays**	**Out-of-network member pays**
Rehabilitative Services up to 60 visits per year includes services combined for physical, speech and occupational therapy and chiropractic services	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Mental Health and Substance Abuse	**In-network member pays**	**Out-of-network member pays**
Inpatient mental health services	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Inpatient alcohol and substance abuse treatment	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Outpatient mental health, alcohol and substance abuse treatment office visits and home services	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Outpatient mental health, alcohol and substance abuse treatment intensive outpatient treatment and partial hospitalization	0% coinsurance after plan deductible	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	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Artificial Limbs includes associated supplies and equipment	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Diabetic equipment and supplies	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Modified food products and specialized formula	0% coinsurance after plan deductible	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.
- Ovarian cancer screening and monitoring services coverage and cost share details are available in your Certificate of Coverage.
- Mammogram screenings, breast ultrasounds, and breast MRIs - Please refer to the Certificate of Coverage for details.
- 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 certificate of coverage 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 Certificate of Coverage 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 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 2024.

ConnectiCare

FlexPOS Combined Deductible Prescription Drug Plan for Use with Health Savings Account (HSA) 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 Contract year.

Personalized for: Cooperative Educational Services

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 Deductible is combined for medical services and prescription drugs Deductible is combined for In and out-of-network	$2,250 Individual $4,500 Family	$2,250 Individual $4,500 Family
Your out-of-pocket maximum Includes a combination of deductible, copayments and coinsurance for medical and pharmacy services Out-of-pocket maximum is combined for In and out-of-network	$3,000 Individual $6,000 Family	$3,000 Individual $6,000 Family
Retail Pharmacy (up to a 34 day supply per prescription)	**In-network member pays**	**Out-of-network member pays**
Generic drugs (Tier 1)	$5 copayment/prescription after plan deductible	20% coinsurance after plan deductible
Preferred brand drugs (Tier 2)	$20 copayment/prescription after plan deductible	20% coinsurance after plan deductible
Non-preferred brand drugs (Tier 3)	$35 copayment/prescription after plan deductible	20% coinsurance after plan deductible

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 after plan deductible	20% coinsurance after plan deductible
Preferred brand drugs (Tier 2)	$40 copayment/prescription after plan deductible	20% coinsurance after plan deductible
Non-preferred brand drugs (Tier 3)	$70 copayment/prescription after plan deductible	20% 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.
- 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.
- 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.
- If you are a Massachusetts resident, please refer to your *amendatory rider for Massachusetts mandated benefits* for additional details of your benefits.