ConnectiCare

Choice SOLO HSA $6,000/$12,000 ded. Calendar year High Deductible Health Plan for use with a Health Savings Account (HSA) (E)

The Individual Deductible and Maximum Out-of-Pocket applies if you have coverage only for yourself. The Family Deductible and Maximum Out-of-Pocket applies if you have coverage for yourself and one or more eligible dependents. Each Individual on the Family plan will only need to satisfy the Individual Deductible and Maximum Out-of-Pocket, not the full Family amount. Each Individual's charges will accrue towards the Family amounts.

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

In-network Preventive Services

These services are **free** with your premium when you use an **in-network** doctor or facility. Find a doctor at c**onnecticare.com**

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

Costs for these services are shared by you and ConnectiCare as follows when you use a doctor or facility in our network. Find a doctor at connecticare.com. Refer to connecticare.com/preventive for a complete list of preventive services.

Your care costs		
	Single Coverage	**Family Coverage**
In-network deductible	$6,000	$12,000
In-network maximum out-of-pocket	$6,550	$13,100

After you've spent the in-network maximum out-of-pocket amount in deductibles, copays and coinsurance, ConnectiCare will pay 100% of your covered health care expenses for the remainder of that year.

Screenings	**Your cost**
Breast ultrasound	$0 after plan deductible
Routine vision exam	$0 *(plan deductible waived)*
Allergy testing one visit per year	$0 after plan deductible
Ongoing Care and Sick Visits	**Your cost**
Primary care services	$0 after plan deductible
Specialist services	$0 after plan deductible

Ongoing Care and Sick Visits	Your cost
Gynecologist services	$0 after plan deductible
Maternity and pre-natal care visits	$0 *(plan deductible waived)*
Allergy Injections up to 20 visits per year	$0 after plan deductible
Telemedicine visit	$0 after plan deductible
Retail clinic	$0 after plan deductible
Lab and Radiology Performed in a hospital, lab or radiology facility	
Laboratory services	$0 after plan deductible
Non-advanced radiology (X-ray, Baseline Mammography, Screening Tomosynthesis, Diagnostic other)	$0 after plan deductible
Advanced radiology **MRI, PET and CAT scan and nuclear cardiology**	$0 after plan deductible
Sudden and Unexpected Care The same cost share applies for both In-Network and Out-of-Network services	
Urgent care or other walk-in clinic	$0 after plan deductible
Emergency room	$0 after plan deductible
Ambulance	$0 after plan deductible
Hospital Stays	
Inpatient hospital services, including room and board	$0 after plan deductible
Skilled nursing and rehabilitation facilities up to 90 days per year	$0 after plan deductible
Outpatient and Home Care	
Hospital outpatient facilities	$0 after plan deductible
Ambulatory surgical center	$0 after plan deductible
Home health services up to 100 visits per year	$0 after plan deductible
Chiropractic services up to 20 visits per year	$0 after plan deductible

Outpatient Rehabilitative and Habilitative Services	
Physical and occupational therapy up to 40 visits per year combined for physical, speech and occupational therapy (habilitative services have a separate 40 visit maximum)	$0 after plan deductible
Speech therapy up to 40 visits per year combined for physical, speech and occupational therapy (habilitative services have a separate 40 visit maximum)	$0 after plan deductible
Mental Health and Substance Abuse	
Inpatient mental health services	$0 after plan deductible
Inpatient alcohol and substance abuse treatment	$0 after plan deductible
Outpatient mental health, alcohol and substance abuse treatment (office visits and home services)	$0 after plan deductible
Outpatient mental health, alcohol and substance abuse treatment (intensive outpatient treatment and partial hospitalization)	$0 after plan deductible
Supplies	
Breastfeeding supplies	$0 *(plan deductible waived)*
Durable medical equipment including prosthetics and disposable medical supplies	$0 after plan deductible
Diabetic equipment and supplies	$0 after plan deductible
Pediatric Only Services (for members under age 20)	
Pediatric Dental Diagnostic & Preventive	$0 *(plan deductible waived)*
Pediatric Dental Services Basic Restorative, Major Restorative and Orthodontia Services (medically necessary only)	$0 after plan deductible
Pediatric Vision Routine Eye Exam one exam per year	$0 *(plan deductible waived)*
Pediatric Prescription Eye Glasses one pair of frames and lenses per year	Lenses: $0 after plan deductible Collection frames: $0 after plan deductible Non-collection frames: $0 after plan deductible up to the collection frame allowance; any amount over is payable by the member minus a 20% discount

Prescription Drugs Retail Pharmacy	Your cost retail (up to a 30 day supply per prescription)	Your cost mail order (up to a 90 day supply per prescription)
Preferred Generic Drugs (Tier 1)	$5 after plan deductible	$10 after plan deductible
Non-Preferred Generic Drugs (Tier 2)	$50% up to maximum of $200 per script after plan deductible	50% up to maximum of $400 per script after plan deductible
Preferred Brand Drugs (Tier 3)	$60 after plan deductible	$120 after plan deductible
Non-Preferred Brand Drugs (Tier 4)	$50% up to maximum of $200 per script after plan deductible	50% up to maximum of $400 per script after plan deductible
You can choose to get a brand-name drug instead of a generic, but you will pay more: the cost of the generic drug plus the difference in the price for the brand name. What you pay for the difference of the brand-name drug will also not count toward your plan's deductible or out-of-pocket costs.		
Specialty Drugs (up to a 30 day supply per prescription) These drugs generally require pre-authorization and may require special handling	**Your cost**	
Preferred Specialty Drugs (Tier 5)	50% up to a maximum of $500 per script after plan deductible	
Non-Preferred Specialty Drugs (Tier 6)	50% up to a maximum of $750 per script after plan deductible	

Out-of-Network Coverage

You may also get care from doctors or facilities outside of ConnectiCare's 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.

	Out-of-Network Single Coverage	Out-of-Network Family Coverage
Out-of-Network Deductible	$10,000	$20,000
Out-of-Network Coinsurance	50%	50%
Out-of-Network Maximum Out-of-Pocket	$20,000	$40,000

Important Information

- This is a brief summary of benefits. Refer to your ConnectiCare Insurance Company, Inc. policy 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. A referral from your primary care provider is not required.
- 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.
- Many services require that you obtain our pre-certification or pre-authorization prior to obtaining care prescribed or rendered by network provider or non-participating providers. A reduction will apply if you do not obtain pre-authorization for these specified services.
- For mental health, alcohol, and substance abuse services call 1-888-946-4658 to obtain pre-authorization.
- 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. policy for more information.
- Your out-of-network home health services cost share is 25% after the plan deductible.
- The prescription costs listed above apply when you fill a prescription at a participating pharmacy or get drugs delivered to your home. Visit **connecticare.com** to find participating pharmacies near you or for more information on home delivery. Home delivery is an optional service that could save you money.
- 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.
- Certain prescription drugs and supplies require pre-authorization from us before they will be covered under the policy. You should visit our Web site at **www.connecticare.com** or call our Member Service Department at 1-800-251-7722 to find out if a prescription drug or supply requires pre-authorization.
- Generic drugs can reduce your out-of-pocket prescription costs. Generics have the same active ingredients as brand name drugs, but usually cost much less. So, ask your doctor or pharmacist if a generic alternative is available for your prescription. Also, remember to use a participating pharmacy. Most pharmacies in the United States participate in our network. To find one, visit our Web site at **www.connecticare.com** or call our Member Services Department at 1-800-251-7722.
- 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.
- Refer to ConnectiCare's Pharmacy Center online at www.connecticare.com for the Value List of drugs that are not subject to the member's deductible.