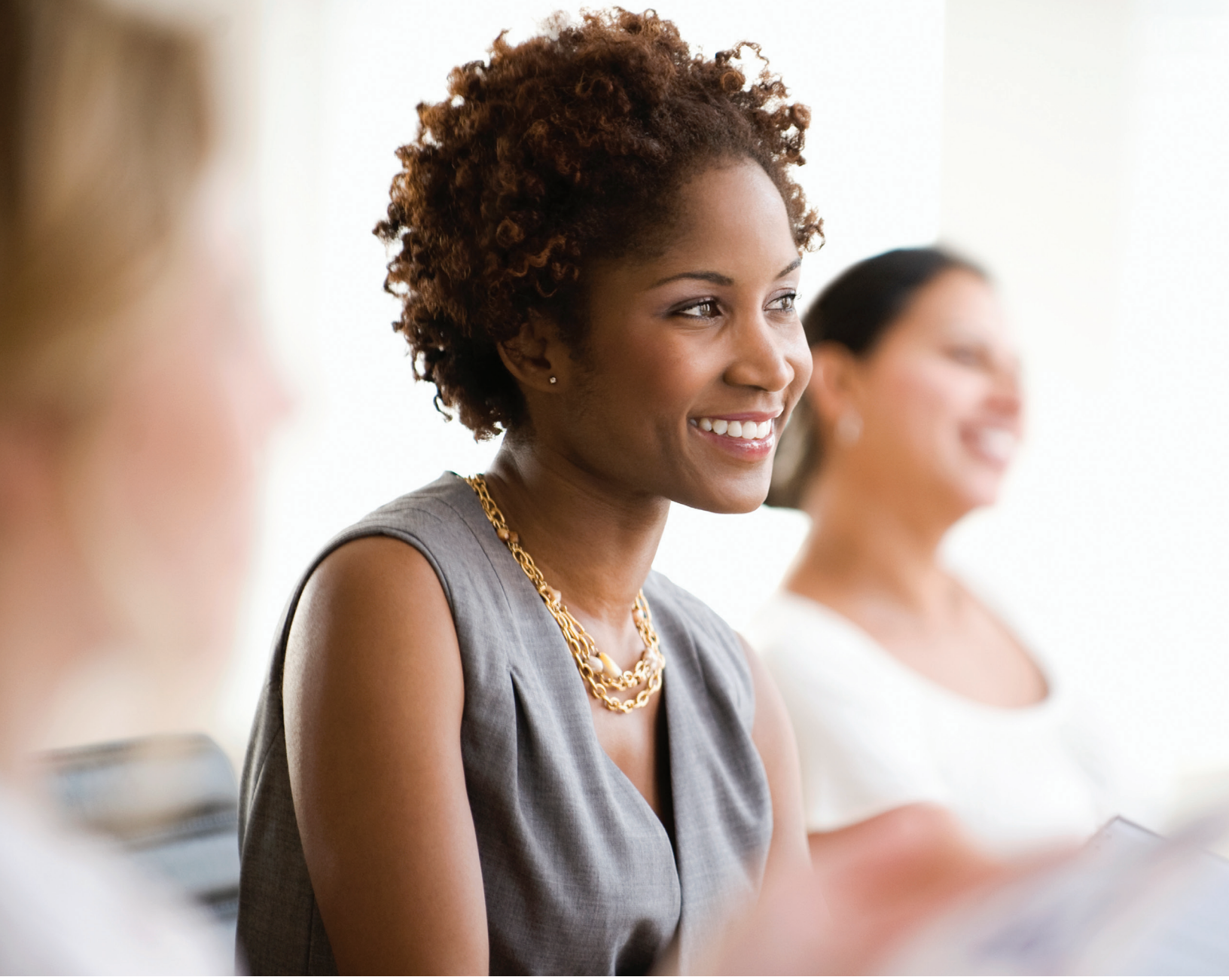


Plans Through Access Health CT

2024

ConnectiCare

You'll know the difference in customer service with ConnectiCare

Once you're a member, you can reach Member Services right here in Connecticut by calling **800-251-7722** (TTY: **711**). Find hours at **connecticare.com/contact**.

We also have ConnectiCare Centers where you can get help in person. Go to **visitconnecticare.com** to make an appointment.

We Mean Health

Your health is your greatest strength. Helping you maintain it is ours. That's why at ConnectiCare, when we say we mean health, we mean we go beyond coverage to connect you to conveniently located doctors and health and wellness resources that can help keep you healthy.

This guide has information on 2024 plans sold through Access Health CT, Connecticut's official health insurance marketplace.

Benefits and Services for 2024

We're pleased to offer more plan choices and services to give our members coverage that fits their busy lifestyles.

- **New! Member Choice**, a pharmacy benefit, requires members on maintenance medicines (drugs you take every day, month after month) to get convenient, 90-day supplies with a choice of filling these prescriptions at either CVS or Walgreens, or through Express Scripts (ESI) mail order. Other prescriptions can be filled at any in-network pharmacy.* You have the option to switch your pharmacy chain once per plan year.
- **Teladoc® Primary360** offers virtual primary care, behavioral health, dermatology, and 24/7 on-demand, non-emergency care through phone, video, or mobile app messaging.** Members can see the same primary care provider (PCP) virtually with no limit on the number of visits.
- **Dental plans** offer coverage for basic services like exams, cleanings, x-rays, and fillings as well as for major services like root canals, crowns, and dentures. These plans offer coverage to adults and children, even if you don't have ConnectiCare medical coverage.
- **WellSpark Health** can help you create healthy habits, feel happier, and reduce your risk of preventable chronic diseases. Members can use habit-tracking tools, connect an activity tracker and device, and view a robust health resource library.

Financial Help Is Available

We encourage you to visit **accesshealthct.com** and enter your income information to see if you qualify for financial assistance. If you do, you will need to enroll in a plan through Access Health CT to receive financial assistance.***

Complete a Health Assessment

Once you're a member, sign in to **my.connecticare.com** and complete your health assessment by selecting "Health and Wellness" in the top navigation. Members who complete a health assessment will receive a $20 gift card for completing a series of questions about their health that helps ConnectiCare recommend services to keep you well.

*Please note, if you choose to fill maintenance medicines at CVS, Walgreens will become out-of-network for you. If you select Walgreens, CVS will become out-of-network. ESI mail order for maintenance drugs will continue to be an option at any time, even after you choose a retail network. Copayments for 90-day supplies will be the same whether filling through home delivery or the participating pharmacy.

**Telemedicine is not appropriate for all covered services, and restrictions apply. Not all services available 24/7.

***Access Health CT is the only place you can get financial help to pay for your coverage.

Get the Benefits and Services You Need

ConnectiCare plans include many benefits that help you and your family stay healthy and get care when you're sick or hurt.

With a ConnectiCare plan, you get:

- Preventive care coverage at no cost for services like annual checkups, screenings, flu shots, and other vaccinations.†
- Prescription drug coverage, including drugs that are available at no cost to you, like birth control and medicine to prevent heart disease.
- Teladoc telemedicine visits on demand with a mobile app, phone, or computer.
- Mental health care for substance use disorder, anxiety, depression, and other behavioral health conditions.
- Specialist care, diagnostic testing, and hospital treatment.
- Pediatric dental and vision coverage for members through age 26.
- Emergency and urgent care wherever you travel.††

Plans with embedded dental benefits

Two plans include preventive dental coverage for adults – **Choice Catastrophic POS with Dental**, and **Choice Bronze Alternative POS with Dental**. Visit a participating dentist's office for important routine care, including preventive exams and cleanings and periodic x-rays. Use "Find a Doctor" on **connecticare.com** to find dentists in the ConnectiCare dental network. Adult dental plans are available as a buy-up for all other plans.

We're here to help

Your broker is ready to help you enroll in a 2024 plan. If you don't have a broker, please contact us.

BY PHONE

Call us at **800-723-2986** (TTY: **711**)
Monday - Friday, 8 a.m. to 5 p.m.
Extended hours Nov. 1 - Jan. 15:
Monday - Friday, 8 a.m. to 7 p.m.

IN PERSON

Meet with us at a ConnectiCare Center. Go to **visitconnecticare.com** or call **877-523-6837** (TTY: **711**) to find locations and make an appointment.

ONLINE

Visit **chooseconnecticare.com** or **accesshealthct.com** to compare plan benefits, features, and premium rates.

†No-cost preventive care means that you will not have a copay or have to pay toward your deductible or coinsurance for the services. Sometimes, a preventive care visit leads to other medical care or tests, even at the same appointment. You should check with your doctor or doctor's staff during your visit to see if there are services you may be billed for.

††Subject to limitations.

Choosing Your Plan

You want your health care dollars to work hard for you. So, take some time to review your plan options and choose the one that meets your needs and budget. Plan names have information about the **type** of plan, its **metal** level, and other features.

Types of ConnectiCare Plans

Choice	Choice plans let you manage your health your way. You may use any of the doctors, hospitals, labs, and facilities in our large network covering Connecticut.
Value	Our Value plan features a tailored network, which is a subset of our commercial Choice Network. It may be the right solution for individuals who can choose care options within a more localized area. All providers are right here in Connecticut but note that not all hospitals and their affiliated providers are participating in the Value Network.

Metal Levels

Metal levels show the range of premiums and out-of-pocket costs for all types of plans.

Metal Level	Premiums	Out-of-pocket costs	Plan pays*
Gold	Higher	Lower	80%
Silver	Moderate	Moderate	70%
Bronze	Lowest	Highest	60%

Catastrophic plans are also available for eligible individuals under age 30 and for those who qualify for an affordability or hardship exemption through Access Health CT.

*Average amount plan pays for covered services.

More Information To Help You Compare and Choose

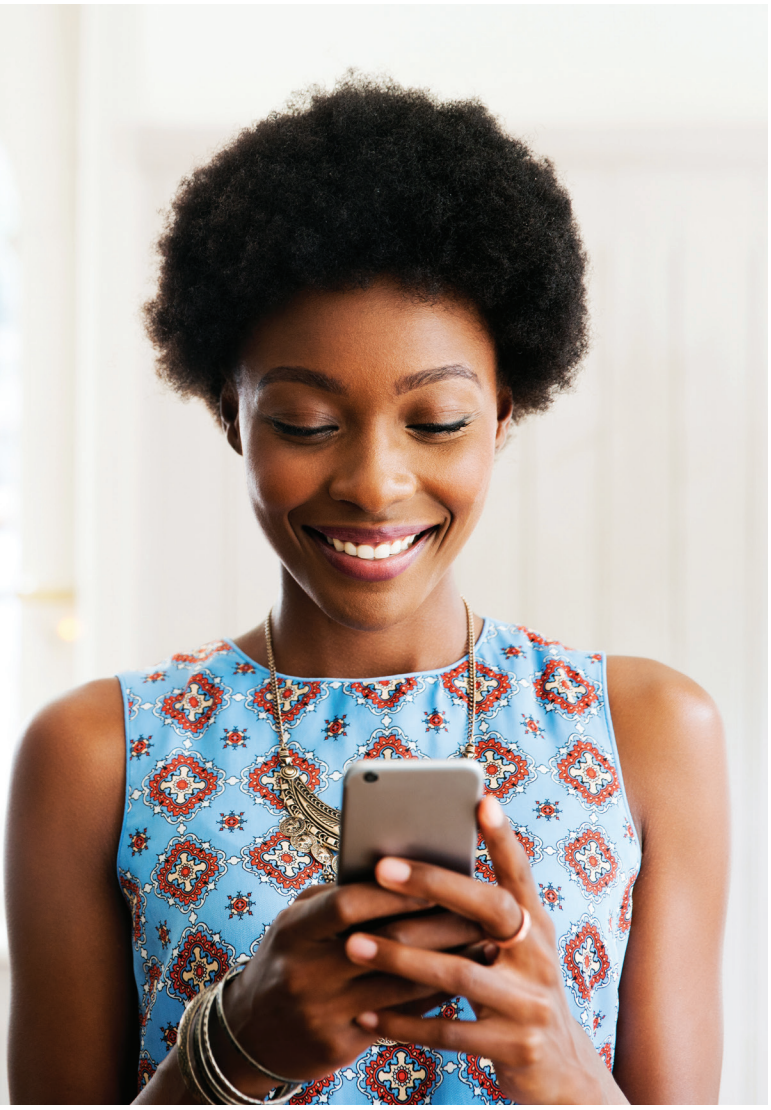
Three letters that can explain a lot about your health plan.

POS – Choosing a plan with "POS" (point of service) in its name means you'll be able to visit out-of-network doctors, but you'll pay more.

HSA – Stands for "health savings account." HSA plans allow you to save money tax-free to use for qualified health care expenses.

Search Before You Choose

Using doctors in your plan's network can help save you money. Go to **connecticare.com** and use "Find a Doctor" to find doctors and facilities in your plan's network. Search by network and choose "Through Access Health CT," then choose your plan type.



Guide to Important Terms

You may pay a premium every month for your health insurance. There are other costs you may pay, too. The plan grids on the next few pages use the terms defined below.

Deductible – a specific amount that you pay each year before ConnectiCare starts to pay covered expenses.

Maximum out-of-pocket costs – the most you'd have to pay (in addition to premium) in the plan year for covered services. Once you reach your maximum out-of-pocket, ConnectiCare pays 100% of eligible claims.

In-network – refers to doctors, hospitals, pharmacies, facilities, and other health care professionals that have negotiated rates for services with ConnectiCare.

Copayment or copay – a fixed amount you pay for a service covered by your plan. Not all plans have copays.

Medical benefits or **covered services** – the benefits or services that your ConnectiCare plan pays some or all of the costs of.

Out-of-network – doctors, hospitals, pharmacies, facilities, and other health care professionals that do not have contracts with ConnectiCare. You'll often pay more or not have any coverage if you visit out-of-network doctors, hospitals, pharmacies, facilities, or other health care professionals.

Deductible waived – means your deductible does not apply to the service, and you have a copay or coinsurance.

Coinsurance – describes how you and ConnectiCare will share the costs of covered services and prescription medicines.

Prescription drug benefit – describes how much you'll pay for prescription drugs that are on your plan's drug list.

Tiers – a way of categorizing prescription drugs covered by your plan. Generally, drugs in tiers with lower numbers cost you less than drugs in tiers with higher numbers.

Advanced premium tax credit (APTC) – financial help to pay for health plan premiums (for those who qualify).*

Cost-share reductions (CSRs)** – lower copays, deductibles, and coinsurance for those who qualify for these extra savings.

Primary care provider (PCP) – a health care professional that gets to know you and your medical history to help keep you healthy. You visit a PCP to help manage chronic conditions and receive preventive care such as annual checkups, preventive screenings, and vaccinations.

*APTC is only available through Access Health CT.

**Standard Silver plans have cost-share reduction versions for those who have certain income levels. These plans are only available through Access Health CT.

Choice plans

Plan name/Metal level	Choice Gold Standard POS
NETWORK ACCESS	**CT only**
PLAN/MEDICAL DEDUCTIBLE	
Deductible (individual/family)	$1,300/$2,600
Maximum out-of-pocket limit (individual/family)	$7,375 / $14,750
IN-NETWORK MEDICAL BENEFITS	
Preventive care/screenings/immunizations	$0
Primary care provider (PCP) services	$20 copay (deductible waived)
Telemedicine visits through Teladoc***	**Primary care, mental health, and general medical services:** $0 (deductible waived) **Dermatologist:** $40 copay (deductible waived)
Specialist services	$40 copay (deductible waived)
Mental health and substance use office visits	$20 copay (deductible waived)
Vision	$40 copay (deductible waived)
Walk-in/urgent care center	$50 copay (deductible waived)
Worldwide emergency coverage†	$400 copay (deductible waived)
Hospital – inpatient treatment	$500 copay/day $1,000 maximum per admission after deductible
Hospital – outpatient treatment	$500 copay after deductible
Outpatient surgery in independent locations	$300 copay after deductible
Lab services	$10 copay after deductible
X-rays	$40 copay after deductible
Advanced imaging (CT scans & MRI)	$65 copay $375 maximum (deductible waived)
OUT-OF-NETWORK MEDICAL BENEFITS	
Deductible (individual/family)	$3,000/$6,000
Coinsurance	30%
Maximum out-of-pocket limit (individual/family)	$14,750/$29,500
PRESCRIPTION DRUG BENEFITS	
Prescription drug deductible (individual/family)	$50/$100
Tier 1 – Generic drugs	$5 copay (deductible waived)
Tier 2 – Preferred brand drugs	$35 copay (deductible waived)
Tier 3 – Non-preferred brand drugs	$60 copay (deductible waived)
Tier 4 – Specialty drugs	20% coinsurance $100 maximum per prescription after Rx deductible

*Catastrophic plans are available to those under age 30 and those who qualify for an affordability or hardship exemption through Access Health CT.
**Integrated medical and prescription drug deductible.
***Telemedicine is not appropriate for all covered services, and restrictions apply. Primary care — members must be age 18 or older.
†Subject to limitations.

Choice Catastrophic POS with Dental*	Choice Bronze Standard POS	Choice Gold Alternative POS
CT only	CT only	CT only
$9,450/$18,900**	$6,550/$13,100**	$2,000/$4,000
$9,450/$18,900	$9,100/$18,200	$8,300/$16,600
$0	$0	$0
$30 copay per visit for the first 3 visits Deductible applies for additional visits $0 after deductible	$50 copay (deductible waived)	$40 copay (deductible waived)
Primary care, mental health, and general medical services: $0 after deductible **Dermatologist:** $0 after deductible	**Primary care, mental health, and general medical services:** $0 (deductible waived) **Dermatologist:** $70 copay after deductible	**Primary care, mental health, and general medical services:** $0 (deductible waived) **Dermatologist:** $50 copay (deductible waived)
$0 after deductible	$70 copay after deductible	$50 copay (deductible waived)
$30 copay per visit for the first 3 visits Deductible applies for additional visits $0 after deductible	$50 copay (deductible waived)	$50 copay (deductible waived)
$0 after deductible	$70 copay after deductible	$50 copay (deductible waived)
$0 after deductible	$75 copay (deductible waived)	30% coinsurance (deductible waived)
$0 after deductible	$450 copay after deductible	30% coinsurance after deductible
$0 after deductible	$500 copay/day $1,000 maximum per admission after deductible	30% coinsurance after deductible
$0 after deductible	$500 copay after deductible	30% coinsurance after deductible
$0 after deductible	$300 copay after deductible	$250 copay (deductible waived)
$0 after deductible	$20 copay (deductible waived)	$10 copay (deductible waived)
$0 after deductible	$40 copay after deductible	**Independent facility:** $50 copay (deductible waived) **Hospital facility:** 30% coinsurance after deductible
$0 after deductible	$75 copay $375 maximum after deductible	**Independent facility:** $75 copay (deductible waived) **Hospital facility:** 30% coinsurance after deductible
$15,000/$30,000	$13,100/$26,200	$7,000/$14,000
50%	50%	50%
$20,000/$40,000	$18,200/$36,400	$12,000/$24,000
Plan has integrated deductible with medical (see above)**	Plan has integrated deductible with medical (see above)**	$75/$150
$0 after deductible	$20 copay (deductible waived)	$10 copay (deductible waived)
$0 after deductible	50% coinsurance after deductible	$40 copay (deductible waived)
$0 after deductible	50% coinsurance after deductible	$60 copay after Rx deductible
$0 after deductible	50% coinsurance $500 maximum per prescription after deductible	20% coinsurance $150 maximum per prescription after Rx deductible

Choice plans

Plan name/Metal level	Choice Bronze Alternative POS With Dental	Choice Bronze Standard POS HSA
NETWORK ACCESS	**CT only**	**CT only**
PLAN/MEDICAL DEDUCTIBLE		
Deductible (individual/family)	$7,000/$14,000*	$6,500/$13,000*
Maximum out-of-pocket limit (individual/family)	$9,450/$18,900	$7,225/$14,450
IN-NETWORK MEDICAL BENEFITS		
Preventive care/screenings/immunizations	$0	$0
Primary care provider (PCP) services	$50 copay (deductible waived)	20% coinsurance after deductible
Telemedicine visits through Teladoc**	**Primary care, mental health, and general medical services:** $0 (deductible waived)/**Dermatologist:** $70 copay after deductible	**Primary care, mental health, and general medical services:** 0% coinsurance after deductible/**Dermatologist:** 20% coinsurance after deductible
Specialist services	$70 copay after deductible	20% coinsurance after deductible
Mental health and substance use office visits	$70 copay (deductible waived)	20% coinsurance after deductible
Vision	$70 copay (deductible waived)	20% coinsurance after deductible
Walk-in/urgent care center	$100 copay (deductible waived)	20% coinsurance after deductible
Worldwide emergency coverage***	45% coinsurance after deductible	20% coinsurance after deductible
Hospital – inpatient treatment	45% coinsurance after deductible	20% coinsurance after deductible
Hospital – outpatient treatment	45% coinsurance after deductible	20% coinsurance after deductible
Outpatient surgery in independent locations	$500 copay after deductible	20% coinsurance after deductible
Lab services	$25 copay after deductible	20% coinsurance after deductible
X-rays	**Independent facility:** $70 copay after deductible **Hospital facility:** 45% coinsurance after deductible	20% coinsurance after deductible
Advanced imaging (CT scans & MRI)	**Independent facility:** $75 copay (deductible waived) **Hospital facility:** 45% coinsurance after deductible	20% coinsurance after deductible
OUT-OF-NETWORK MEDICAL BENEFITS		
Deductible (individual/family)	$15,000/$30,000	$13,000/$26,000
Coinsurance	50%	50%
Maximum out-of-pocket limit (individual/family)	$20,000/$40,000	$14,450/$28,900
PRESCRIPTION DRUG BENEFITS		
Prescription drug deductible (individual/family)	Plan has integrated deductible with medical (see above)*	Plan has integrated deductible with medical (see above)*
Tier 1 – Generic drugs	$30 copay (deductible waived)	20% coinsurance after deductible
Tier 2 – Preferred brand drugs	$100 copay after deductible	25% coinsurance after deductible
Tier 3 – Non-preferred brand drugs	50% coinsurance after deductible	30% coinsurance after deductible
Tier 4 – Specialty drugs	50% coinsurance $500 maximum per prescription after deductible	30% coinsurance $500 maximum per prescription after deductible

*Integrated medical and prescription drug deductible.
**Telemedicine is not appropriate for all covered services, and restrictions apply. Primary care — members must be age 18 or older.
***Subject to limitations.

Choice Silver Standard POS	Choice Silver Standard POS (CSR 73%)	Choice Silver Standard POS (CSR 87%)	Choice Silver Standard POS (CSR 94%)
	Available for individuals and families up to 250% of the federal poverty level.		
CT only	**CT only**	**CT only**	**CT only**
$5,000/$10,000	$4,750/$9,500	$675/$1,350	None
$9,100/$18,200	$7,475/$14,950	$2,925/$5,850	$1,050/$2,100
$0	$0	$0	$0
$40 copay (deductible waived)	$40 copay (deductible waived)	$20 copay (deductible waived)	$10 copay
Primary care, mental health, and general medical services: $0 (deductible waived)/**Dermatologist:** $60 copay (deductible waived)	**Primary care, mental health, and general medical services:** $0 (deductible waived)/**Dermatologist:** $60 copay (deductible waived)	**Primary care, mental health, and general medical services:** $0 (deductible waived)/**Dermatologist:** $45 copay (deductible waived)	**Primary care, mental health, and general medical services:** $0/**Dermatologist:** $30 copay
$60 copay (deductible waived)	$60 copay (deductible waived)	$45 copay (deductible waived)	$30 copay
$40 copay (deductible waived)	$40 copay (deductible waived)	$20 copay (deductible waived)	$10 copay
$60 copay (deductible waived)	$60 copay (deductible waived)	$45 copay (deductible waived)	$30 copay
$75 copay (deductible waived)	$75 copay (deductible waived)	$35 copay (deductible waived)	$25 copay
$450 copay after deductible	$450 copay after deductible	$150 copay after deductible	$50 copay
$500 copay/day $2,000 maximum per admission after deductible	$500 copay/day $2,000 maximum per admission after deductible	$100 copay/day $400 maximum per admission after deductible	$75 copay/day $300 maximum per admission
$500 copay after deductible	$500 copay after deductible	$100 copay after deductible	$75 copay
$300 copay after deductible	$300 copay after deductible	$60 copay after deductible	$45 copay
$20 copay (deductible waived)	$20 copay (deductible waived)	$10 copay (deductible waived)	$10 copay
$40 copay after deductible	$40 copay after deductible	$30 copay after deductible	$25 copay
$75 copay $375 maximum (deductible waived)	$75 copay $375 maximum (deductible waived)	$60 copay $360 maximum (deductible waived)	$50 copay $350 maximum
$10,000/$20,000	$10,000/$20,000	$10,000/$20,000	$10,000/$20,000
40%	40%	40%	40%
$18,200/$36,400	$18,200/$36,400	$18,200/$36,400	$18,200/$36,400
$250/$500	$250/$500	$50/$100	None
$10 copay (deductible waived)	$10 copay (deductible waived)	$10 copay (deductible waived)	$5 copay
$45 copay after Rx deductible	$45 copay after Rx deductible	$25 copay (deductible waived)	$10 copay
$70 copay after Rx deductible	$70 copay after Rx deductible	$40 copay after Rx deductible	$30 copay
20% coinsurance $200 maximum per prescription after Rx deductible	20% coinsurance $100 maximum per prescription after Rx deductible	20% coinsurance $60 maximum per prescription after Rx deductible	20% coinsurance $60 maximum per prescription

Value plans

Plan name/Metal level	Value Gold Standard POS
NETWORK ACCESS	**CT only**
PLAN/MEDICAL DEDUCTIBLE	
Deductible (individual/family)	$1,300/$2,600
Maximum out-of-pocket limit (individual/family)	$7,375/$14,750
IN-NETWORK MEDICAL BENEFITS	
Preventive care/screenings/immunizations	$0
Primary care provider (PCP) services	$20 copay (deductible waived)
Telemedicine visits through Teladoc**	**Primary care, mental health, and general medical services:** $0 (deductible waived)/**Dermatologist:** $40 copay (deductible waived)
Specialist services (some specialist services require a PCP's referral.)	$40 copay (deductible waived)
Mental health and substance use office visits	$20 copay (deductible waived)
Vision	$40 copay (deductible waived)
Walk-in/urgent care center	$50 copay (deductible waived)
Worldwide emergency coverage**	$400 copay (deductible waived)
Hospital – inpatient treatment	$500 copay/day $1,000 maximum per admission after deductible
Hospital – outpatient treatment	$500 copay after deductible
Outpatient surgery in independent locations	$300 copay after deductible
Lab services	$10 copay after deductible
X-rays	$40 copay after deductible
Advanced imaging (CT scans & MRI)	$65 copay $375 maximum (deductible waived)
OUT-OF-NETWORK MEDICAL BENEFITS	
Deductible (individual/family)	$3,000/$6,000
Coinsurance	30%
Maximum out-of-pocket limit (individual/family)	$14,750/$29,500
PRESCRIPTION DRUG BENEFITS	
Prescription drug deductible (individual/family)	$50/$100
Tier 1 – Generic drugs	$5 copay (deductible waived)
Tier 2 – Preferred brand drugs	$35 copay (deductible waived)
Tier 3 – Non-preferred brand drugs	$60 copay (deductible waived)
Tier 4 – Specialty drugs	20% coinsurance $100 maximum per prescription after Rx deductible

*Integrated medical and prescription drug deductible.
**Telemedicine is not appropriate for all covered services, and restrictions apply.
***Subject to limitations.

Value Bronze Standard POS	Value Bronze Standard POS HSA
CT only	CT only
$6,550/$13,100*	$6,500/$13,000*
$9,100/$18,200	$7,225/$14,450
$0	$0
$50 copay (deductible waived)	20% coinsurance after deductible
Primary care, mental health, and general medical services: $0 (deductible waived)/**Dermatologist:** $70 copay after deductible	**Primary care, mental health and general medical services:** 0% coinsurance after deductible **Dermatologist:** 20% coinsurance after deductible
$70 copay after deductible	20% coinsurance after deductible
$50 copay (deductible waived)	20% coinsurance after deductible
$70 copay after deductible	20% coinsurance after deductible
$75 copay (deductible waived)	20% coinsurance after deductible
$450 copay after deductible	20% coinsurance after deductible
$500 copay/day $1,000 maximum per admission after deductible	20% coinsurance after deductible
$500 copay after deductible	20% coinsurance after deductible
$300 copay after deductible	20% coinsurance after deductible
$20 copay (deductible waived)	20% coinsurance after deductible
$40 copay after deductible	20% coinsurance after deductible
$75 copay $375 maximum after deductible	20% coinsurance after deductible
$13,100/$26,200	$13,000/$26,000
50%	50%
$18,200/$36,400	$14,450/$28,900
Plan has integrated deductible with medical (see above)*	Plan has integrated deductible with medical (see above)*
$20 copay (deductible waived)	20% coinsurance after deductible
50% coinsurance after deductible	25% coinsurance after deductible
50% coinsurance after deductible	30% coinsurance after deductible
50% coinsurance $500 maximum per prescription after deductible	30% coinsurance $500 maximum per prescription after deductible

Value plans

Plan name/Metal level	Value Silver Standard POS
NETWORK ACCESS	**CT only**
PLAN/MEDICAL DEDUCTIBLE	
Deductible (individual/family)	$5,000/$10,000
Maximum out-of-pocket limit (individual/family)	$9,100/$18,200
IN-NETWORK MEDICAL BENEFITS	
Preventive care/screenings/immunizations	$0
Primary care provider (PCP) services	$40 copay (deductible waived)
Telemedicine visits through Teladoc*	**Primary care, mental health, and general medical services:** $0 (deductible waived) **Dermatologist:** $60 copay (deductible waived)
Specialist services	$60 copay (deductible waived)
Mental health and substance use office visits	$40 copay (deductible waived)
Vision	$60 copay (deductible waived)
Walk-in/urgent care center	$75 copay (deductible waived)
Worldwide emergency coverage**	$450 copay after deductible
Hospital – inpatient treatment	$500 copay/day $2,000 maximum per admission after deductible
Hospital – outpatient treatment	$500 copay after deductible
Outpatient surgery in independent locations	$300 copay after deductible
Lab services	$20 copay (deductible waived)
X-rays	$40 copay after deductible
Advanced imaging (CT scans & MRI)	$75 copay $375 maximum (deductible waived)
OUT-OF-NETWORK MEDICAL BENEFITS	
Deductible (individual/family)	$10,000/$20,000
Coinsurance	40%
Maximum out-of-pocket limit (individual/family)	$18,200/$36,400
PRESCRIPTION DRUG BENEFITS	
Prescription drug deductible (individual/family)	$250/$500
Tier 1 – Generic drugs	$10 copay (deductible waived)
Tier 2 – Preferred brand drugs	$45 copay after Rx deductible
Tier 3 – Non-preferred brand drugs	$70 copay after Rx deductible
Tier 4 – Specialty drugs	20% coinsurance $200 maximum per prescription after Rx deductible

*Telemedicine is not appropriate for all covered services, and restrictions apply. Primary care — members must be age 18 or older.
**Subject to limitations.

Value Silver Standard POS (CSR 73%)	Value Silver Standard POS (CSR 87%)	Value Silver Standard POS (CSR 94%)
Available for individuals and families up to 250% of the federal poverty level.		
CT only	**CT only**	**CT only**
$4,750/$9,500	$675/$1,350	None
$7,475/$14,950	$2,925/$5,850	$1,050/$2,100
$0	$0	$0
$40 copay (deductible waived)	$20 copay (deductible waived)	$10 copay
Primary care, mental health, and general medical services: $0 (deductible waived) **Dermatologist:** $60 copay (deductible waived)	**Primary care, mental health, and general medical services:** $0 (deductible waived) **Dermatologist:** $45 copay (deductible waived)	**Primary care, mental health, and general medical services:** $0 **Dermatologist:** $30 copay
$60 copay (deductible waived)	$45 copay (deductible waived)	$30 copay
$40 copay (deductible waived)	$20 copay (deductible waived)	$10 copay
$60 copay (deductible waived)	$45 copay (deductible waived)	$30 copay
$75 copay (deductible waived)	$35 copay (deductible waived)	$25 copay
$450 copay after deductible	$150 copay after deductible	$50 copay
$500 copay/day $2,000 maximum per admission after deductible	$100 copay/day $400 maximum per admission after deductible	$75 copay/day $300 maximum per admission
$500 copay after deductible	$100 copay after deductible	$75 copay
$300 copay after deductible	$60 copay after deductible	$45 copay
$20 copay (deductible waived)	$10 copay (deductible waived)	$10 copay
$40 copay after deductible	$30 copay after deductible	$25 copay
$75 copay $375 maximum (deductible waived)	$60 copay $360 maximum (deductible waived)	$50 copay $350 maximum
$10,000/$20,000	$10,000/$20,000	$10,000/$20,000
40%	40%	40%
$18,200/$36,400	$18,200/$36,400	$18,200/$36,400
$250/$500	$50/$100	None
$10 copay (deductible waived)	$10 copay (deductible waived)	$5 copay
$45 copay after Rx deductible	$25 copay (deductible waived)	$10 copay
$70 copay after Rx deductible	$40 copay after Rx deductible	$30 copay
20% coinsurance $100 maximum per prescription after Rx deductible	20% coinsurance $60 maximum per prescription after Rx deductible	20% coinsurance $60 maximum per prescription

ConnectiCare Basic Dental Plan

Plan Overview		In-Network (INET) Member Pays	Out-of-Network (ONET) Member Pays
Deductible (does not apply to preventive and diagnostic services for in-network services)		$50 per member, up to 3 family members	$50 per member, up to 3 family members
Out-of-Pocket Maximum* For one child For two or more children		$350 $700	None
Diagnostic Services	**Limitations**		
Oral Exams	Two (2) times per year.	$0	30% after ONET deductible is met ($0 for covered persons under age 26)
Periapical Radiographs	Four (4) per year.		
Bitewing Radiographs	Four (4) bitewing x-rays per member per year.		
Panoramic or Complete Series Radiographs	One (1) full-mouth series of x-rays or one (1) panoramic film once every three (3) years.		
Preventive Services			
Cleanings	Two (2) times per year.	$0	30% after ONET deductible is met ($0 for covered persons under age 26)
Periodontal Scaling and Root Planing	Covered one (1) time per 36 months per quadrant.		
Periodontal Maintenance	Once every three (3) months following periodontic surgery.		
Fluoride*	Two (2) times per year.		
Sealants*	One (1) sealant per covered tooth every three (3) calendar years per covered child age 6 until age 14 birthdate.		
Basic Services (for covered persons under age 26 only*)			
Fillings	Fillings, excludes temporary fillings, covered per tooth every six (6) months.	40% after INET deductible is met	40% after ONET deductible is met
Simple Extractions	Routine removal of a tooth or teeth.		
Major Services (for covered persons under age 26 only*)			
Surgical Extractions	Surgery for removal of erupted tooth, fractured jaws, impactions, and lesions are covered. Corrective jaw surgery and surgery relating to accidental injury is not covered.	50% after INET deductible is met	50% after ONET deductible is met
Endodontic Therapy (i.e., Root Canal Treatment)	One (1) pulpotomy per tooth per lifetime. Pulp capping is not covered.		
Periodontal Therapy	Five (5) treatments of diseases of the gums and jaw, including two (2) periodontal maintenance procedure, per member per calendar year.		
Crowns and Cast Restorations	Includes: crowns; inlays; prosthetic services; removable, complete, and partial dentures; fixed bridges; crowns or inlays used as abutments. Replacements covered after five (5) years.		
Prosthodontics (Complete and Partial Dentures; Fixed Bridgework)	Includes: permanent dentures, fixed bridgework, and removable partial dentures; posts if evidence of root canal therapy on the tooth; pins once every six (6) months. Replacements covered after five (5) years from date of service. Insertion of fixed bridge and partial denture in same arch covered after five (5) years from date of service. Adjustment of appliances is covered after one (1) year of insertion.		
Other Services (for covered persons under age 26 only*)			
Medically Necessary Orthodontic Services	Includes office visits, orthodontic appliance, follow-up visits, and retention. Existing appliances are not covered.	50% after INET deductible is met	50% after ONET deductible is met

Annual Plan Maximums	
Plan Maximum (for covered persons under age 26*)	None
Plan Maximum (combined for in-network and out-of-network services for covered persons age 26 and older*)	$1,000 per person

*For child, stepchild, or other dependent child until end of plan year once dependent turns age 26.

Important Information
• This is a brief summary of benefits. Refer to your ConnectiCare Insurance Company, Inc. policy for complete details on coverage and benefits.
• If you have questions regarding your plan, please call Member Services at **855-999-2329** (TTY: **711**).
• Covered services provided by a non-participating dentist will be reimbursed at the maximum allowed amount. Members are responsible to pay the difference between the maximum allowable amount and the amount the provider charges. Please refer to your ConnectiCare Insurance Company, Inc. policy for more information.
• For a list of participating dentists, please call Member Services at **855-999-2329** (TTY: **711**) or visit our website at **connecticare.com.**

ConnectiCare Standard Dental Plan

Plan Overview		In-Network (INET) Member Pays	Out-of-Network (ONET) Member Pays
Deductible (does not apply to preventive and diagnostic services for in-network services)		$60 per member, up to 3 family members	$60 per member, up to 3 family members
Out-of-Pocket Maximum* For one child For two or more children		$350 $700	None
Diagnostic Services	**Limitations**		
Oral Exams	Two (2) times per year.	$0	20% after ONET deductible is met
Periapical Radiographs	Four (4) per year.		
Bitewing Radiographs	Four (4) bitewing x-rays per member per year.		
Panoramic or Complete Series Radiographs	One (1) full-mouth series of x-rays or one (1) panoramic film once every three (3) years.		
Preventive Services			
Cleanings	Two (2) times per year.	$0	20% after ONET deductible is met
Periodontal Scaling and Root Planing	Covered one (1) time per 36 months per quadrant.		
Periodontal Maintenance	Once every three (3) months following periodontic surgery.		
Fluoride*	Two (2) times per year.		
Sealants*	One (1) sealant per covered tooth every three (3) calendar years per covered child age 6 until age 14 birthdate.		
Basic Services (waiting period applies to covered persons over age 26*)			
Fillings	Fillings, excludes temporary fillings, covered per tooth every six (6) months.	20% after INET deductible is met	40% after ONET deductible is met
Simple Extractions	Routine removal of a tooth or teeth.		
Major Services (waiting period applies to covered persons over age 26*)			
Surgical Extractions	Surgery for removal of erupted tooth, fractured jaws, impactions, and lesions are covered. Corrective jaw surgery and surgery relating to accidental injury is not covered.	40% after INET deductible is met	50% after ONET deductible is met
Endodontic Therapy (i.e., Root Canal Treatment)	One (1) pulpotomy per tooth per lifetime. Pulp capping is not covered.		
Periodontal Therapy	Five (5) treatments of diseases of the gums and jaw, including two (2) periodontal maintenance procedure, per member per calendar year.		
Crowns and Cast Restorations	Includes: crowns; inlays; prosthetic services; removable, complete, and partial dentures; fixed bridges; crowns or inlays used as abutments. Replacements covered after five (5) years.		
Prosthodontics (Complete and Partial Dentures; Fixed Bridgework)	Includes: permanent dentures, fixed bridgework; and removable partial dentures; posts if evidence of root canal therapy on the tooth; pins once every six (6) months. Replacements covered after five (5) years from date of service. Insertion of fixed bridge and partial denture in same arch covered after five (5) years from date of service. Adjustment of appliances is covered after one (1) year of insertion.		
Other Services (for covered persons under age 26 only*)			
Medically Necessary Orthodontic Services	Includes office visits, orthodontic appliance, follow-up visits, and retention. Existing appliances are not covered.	50% after INET deductible is met	50% after ONET deductible is met

Waiting Periods (for covered persons over age 26*)	
Applicable Waiting Period for Benefit	
Diagnostic and Preventive Services	No waiting period
Basic Services	6 months ^
Major Services	12 months ^
^Waiver of waiting period available with proof of prior coverage for these services under a dental insurance plan when the termination date was no more than 30 days prior to the effective date of this plan.	
Annual Plan Maximums	
Plan Maximum (for covered persons under age 26*)	None
Plan Maximum (combined for in-network and out-of-network services for covered persons age 26 and older[1])	$2,000 per person

*For child, stepchild, or other dependent child until end of plan year once dependent turns 26.

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