

Individual Market
Choice Silver Standard POS (CSR 94%)
Benefit Summary
Non-Tiered Network Plan

Choice Network - Includes Providers in Connecticut only

| Deductible and Out-of-Pocket Maximum | In-Network (INET) Member Pays | Out-of-network (OON) Member Pays |
|---|--|--|
| Plan deductible Individual Family | \$0 per member \$0 per family | \$10,000 per member \$20,000 per family |
| Separate Prescription Drug Deductible Individual Family | \$0 per member \$0 per family | \$500 per member \$1,000 per family |
| Out-of-Pocket Maximum Individual Family (Includes deductible, copayments and coinsurance for medical and pharmacy services) | \$950 per member \$1,900 per family | \$18,200 per member \$36,400 per family |
| Benefits | In-Network (INET) Member Pays | Out-of-network (OON) Member Pays |
| Provider Office Visits | | |
| Adult/Pediatric Preventive Visits | No cost | 40% coinsurance per visit |
| Primary Care Provider Office Visits (includes services for illness, injury, follow-up care and consultations) | \$10 copayment per visit | 40% coinsurance per visit after OON plan deductible is met |
| Specialist Office Visits | \$30 copayment per visit | 40% coinsurance per visit after OON plan deductible is met |
| Mental Health and Substance Abuse Office Visits | \$10 copayment per visit | 40% coinsurance per visit after OON plan deductible is met |
| Outpatient Diagnostic Services | | |
| Advanced Radiology (CT/PET Scan, MRI) | \$50 copayment per service up to a combined annual maximum of \$350 for MRI and CAT scans; \$400 for PET scans | 40% coinsurance per service after OON plan deductible is met |
| Laboratory Services | \$10 copayment per service | 40% coinsurance per service after OON plan deductible is met |

| Benefits | In-Network (INET) Member Pays | Out-of-network (OON) Member Pays |
|---|--|--|
| Non-Advanced Radiology (X-ray, Diagnostic) | \$25 copayment per service | 40% coinsurance per service after OON plan deductible is met |
| Mammography Ultrasound | \$20 copayment per service | 40% coinsurance per service after OON plan deductible is met |
| Prescription Drugs - Retail Pharmacy (cost share based on 30 day supply per prescription) | | |
| Generic Drugs Tier 1 | \$5 copayment per prescription | 40% coinsurance per prescription after OON prescription drug deductible is met |
| Preferred Brand Drugs Tier 2 | \$10 copayment per prescription | 40% coinsurance per prescription after OON prescription drug deductible is met |
| Non-Preferred Brand Tier 3 | \$30 copayment per prescription | 40% coinsurance per prescription after OON prescription drug deductible is met |
| Specialty Drugs Tier 4 | 20% coinsurance up to a maximum of \$60 per prescription | 40% coinsurance per prescription after OON prescription drug deductible is met |
| Prescription - Mail Order Pharmacy (up to a 90 day supply per prescription) | | |
| Generic Drugs Tier 1 | \$10 copayment per prescription | 40% coinsurance per prescription after OON prescription drug deductible is met |
| Preferred Brand Drugs Tier 2 | \$20 copayment per prescription | 40% coinsurance per prescription after OON prescription drug deductible is met |
| Non-Preferred Brand Tier 3 | \$60 copayment per prescription | 40% coinsurance per prescription after OON prescription drug deductible is met |
| Outpatient Rehabilitative and Habilitative Services (40 visits per calendar year limit combined for Rehabilitative physical, speech and occupational therapies. Separate 40 visits per calendar year limit combined for Habilitative speech, physical and occupational therapies.) | | |
| Speech Therapy | \$20 copayment per visit | 40% coinsurance per visit after OON plan deductible is met |
| Physical and Occupational Therapy | \$20 copayment per visit | 40% coinsurance per visit after OON plan deductible is met |
| Other Services | | |
| Chiropractic Services (up to 20 visits per calendar year) | \$30 copayment per visit | 40% coinsurance per visit after OON plan deductible is met |
| Diabetic Equipment and Supplies | 40% coinsurance per equipment/supply | 40% coinsurance per equipment/supply after OON plan deductible is met |

| Benefits | In-Network (INET) Member Pays | Out-of-network (OON) Member Pays |
|---|---|---|
| Durable Medical Equipment (DME) | 40% coinsurance per equipment/supply | 40% coinsurance per equipment/supply after OON plan deductible is met |
| Home Health Care Services (up to 100 visits per calendar year) | No cost | 25% coinsurance per visit after separate \$50 deductible is met |
| Outpatient Services (in a hospital or ambulatory facility) | \$75 copayment per visit at an Outpatient Hospital Facility \$45 copayment per visit at an Ambulatory Surgery Center | 40% coinsurance per visit after OON plan deductible is met |
| 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 calendar year) | \$75 copayment per day up to a maximum of \$300 per admission | 40% coinsurance per admission after OON plan deductible is met |
| Emergency and Urgent Care | | |
| Ambulance Services | No cost | No cost |
| Emergency Room | \$50 copayment per visit | \$50 copayment per visit |
| Urgent Care Centers | \$25 copayment per visit | 40% coinsurance per visit after OON plan deductible is met |
| Pediatric Dental Care (for members under age 26) | | |
| Diagnostic & Preventive | No cost | 50% coinsurance per visit after OON plan deductible is met |
| Basic Services | 40% coinsurance per visit | 50% coinsurance per visit after OON plan deductible is met |
| Major Services | 50% coinsurance per visit | 50% coinsurance per visit after OON plan deductible is met |
| Orthodontia Services (medically necessary only) | 50% coinsurance per visit | 50% coinsurance per visit after OON plan deductible is met |
| Pediatric Vision Care (for members under age 26) | | |

| Benefits | In-Network (INET) Member Pays | Out-of-network (OON) Member Pays |
|--|---|--|
| Prescription Eye Glasses (one pair of frames and lenses or contact lens per calendar year) | Lenses: \$0 Collection frame: \$0 Non-collection frame: Members choosing to upgrade from a collection frame to a non-collection frame will be given a credit substantially equal to the cost of the collection frame and will be entitled to any discount negotiated by the carrier with the retailer | 50% coinsurance per visit after OON plan deductible is met |
| Routine Eye Exam by a Specialist (one exam per calendar year) | \$30 copayment per visit | 40% coinsurance per visit after OON plan deductible is met |
| Additional Covered Services | | |
| Adult Routine Eye Exam by a Specialist (for members over age 26 - one exam per calendar year) | \$30 copayment per visit | 40% coinsurance per visit after OON plan deductible is met |
| Allergy Injections (Unlimited) | See primary care or specialist office visits | 40% coinsurance per visit after OON plan deductible is met |
| Allergy Testing (one visit per calendar year) | See primary care or specialist office visits | 40% coinsurance per visit after OON plan deductible is met |
| Artificial Limbs (includes associated supplies and equipment) | 20% coinsurance | 40% coinsurance after OON plan deductible is met |
| Modified Food Products and Specialized Formula | 40% coinsurance | 40% coinsurance after OON plan deductible is met |
| Outpatient mental health, alcohol and substance abuse treatment (intensive outpatient treatment and partial hospitalization) | \$75 copayment per visit | 40% coinsurance per visit after OON plan deductible is met |
| Retail Clinic | \$10 copayment per visit | 40% coinsurance per visit after OON plan deductible is met |
| 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 cost Dermatologist: \$30 copayment per visit | 40% coinsurance per visit after OON plan deductible is met |

Important information

- This is a brief summary of benefits. Refer to your ConnectiCare Benefits, Inc. policy for complete details on benefits, conditions, limitations and exclusions. All benefits described are per member per calendar year.
- Ovarian cancer screening and monitoring services coverage and cost share details are available in your policy.
- Mammogram screenings, breast ultrasounds, and breast MRIs – Please refer to the policy for details.
- 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 your policy for additional cost share maximums regarding diabetic services. Some diabetic services fall under preventive care and cost share may be waived.
- An **ambulatory surgery center** is a facility that exclusively provides outpatient surgical services to patients who do not require hospitalization and whose expected stay in the center does not exceed 24 hours. Ambulatory surgery centers are not owned by a hospital.
- An **outpatient hospital facility** offers surgical procedures and related care that, in the opinion of the attending physician, can be safely performed without requiring overnight inpatient hospital care. Outpatient hospital facilities are owned by a hospital or hospital system.
- 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.
- To learn more about your **Teladoc**® benefits contact **Teladoc**® at teladoc.com/connecticare or call 1-800-835-2362 (TTY: 711).
- 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 Benefits, Inc. policy for more 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 drugs or supplies clinical effectiveness and cost, not on whether it is a generic drug or supply or brand name drug or supply.
- Amounts paid by members because they must pay a price difference for a brand name drug do not count towards meeting any deductible, coinsurance, copayment, coinsurance or cost share maximum.
- Most specialty drugs are dispensed through specialty pharmacies by mail, up to 30-day supply. Specialty Pharmacies have the same member cost share as all other participating pharmacies and are not part of the ConnectiCare's Voluntary Mail Order program.
- Many services require that you obtain our Pre-Certification or Pre-Authorization prior to obtaining care. Please refer to the "*Pre-Authorization and Pre-Certification Addendum*" in your policy for a detailed list of services or call member service at 1-800-251-7722. Without Pre-Authorization for services prescribed or rendered by Non-Participating providers, you may be responsible for the total cost of the service or benefits may be reduced by the lesser of \$500 or 50%.
- For mental health, alcohol and substance abuse services call 1-888-946-4658 to obtain Pre-Authorization.
- In-network preventive and wellness services as defined by the United States Preventive Service Task Force (USPSTF), including immunizations recommended by the Advisory Committee on Immunizations Practices at the Centers for Disease Control (CDC), and preventive care and screenings supported by the Health Resources and Services Administration (HRSA) are exempt for from all cost shares under the Patient Protection and Affordable Care Act (PPACA). Visit our website at www.connecticare.com to view a list of preventive and wellness services.
- For a complete list of covered prescription drugs, please refer to the 2023 Individual National Preferred Formulary at www.connecticare.com.