



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 membership agreement on connecticare.com for a complete list of benefits.

Personalized for: RSD #14 - Cafeteria

Getting care in our network

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.	
<ul style="list-style-type: none"> • Physical • Well woman visit and pap test • More than 25 screenings, including mammograms and colonoscopies 	<ul style="list-style-type: none"> • Flu shot • Vaccinations • Certain birth control and other prevention medications

Your care costs		
Costs for these services are shared by you and ConnectiCare as follows when you use a doctor or facility in our network.		
	Single Coverage	Family Coverage
In-network deductible	None	None
In-network maximum out-of-pocket	\$6,600 Employee	\$13,200 Employee +1 \$13,200 Family
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	
Baseline routine mammography	\$0	
Routine mammography including tomosynthesis screening	\$0	
Breast ultrasound screening	\$0	
Routine vision exam one exam per year	\$0	
Allergy testing Unlimited	\$20	
Hearing Screenings one exam every year	\$0	

Ongoing Care and Sick Visits	Your cost
Primary care services	\$20
Specialist services	\$20
Gynecologist services	\$20
Maternity and pre-natal care visits	\$0
Allergy injections up to 80 visits every three years	\$0
Telemedicine visit	\$20
Retail clinic	\$20
Nutritional Counseling Limit 3 visits per year	\$0
Infertility (Infertility benefits outlined in the Certificate of Coverage are unlimited, with no age or cycle restrictions)	\$20 (Office visit) \$25 (Ambulatory Services Outpatient) \$25 per admission (Inpatient Hospital)
Lab and Radiology Performed in a hospital, lab or radiology facility (Please refer to the provider directory for facility type)	
Laboratory services	\$0
Non-advanced radiology X-ray, diagnostic	\$0
Advanced radiology MRI, PET and CAT scan and nuclear cardiology	\$0
Sudden and Unexpected Care The In-network cost share applies for both the In-Network and Out-of-Network services	
Walk-in center	\$20
Urgent care center	\$25
Emergency room Copayment waived if admitted	\$25
Ambulance	\$0
Inpatient Hospital Services	
Inpatient hospital services, including room and board	\$25 per admission
Skilled nursing facilities up to 120 days per year	\$25 per admission
Inpatient rehabilitation up to 60 days per year	\$25 per admission
Private Duty Nursing up to \$15,000 per year	\$0

Outpatient Hospital Services and Home Care (Please refer to the provider directory for facility type)	
Hospital outpatient facilities	\$25
Ambulatory surgical center	\$25
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
Outpatient Rehabilitative Services	
Rehabilitative services up to 50 visits per year (includes services combined for physical, speech and occupational therapy and chiropractic services)	\$0
Mental Health and Substance Abuse	
Inpatient mental health services	\$25 per admission
Inpatient alcohol and substance abuse treatment	\$25 per admission
Outpatient mental health, alcohol and substance abuse treatment (office visits and home services)	\$20
Outpatient mental health, alcohol and substance abuse treatment (intensive outpatient treatment and partial hospitalization)	\$0
Supplies	
Durable medical equipment including prosthetics and disposable medical supplies No member cost for 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
Diabetic equipment and supplies	\$0
Modified food products and specialized formula pharmacy tier	\$0

Getting care outside of our network

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.

	Single Coverage	Family Coverage
Out-of-network deductible	\$200 Employee	\$400 Employee +1 \$500 Family
Out-of-network coinsurance	20% after plan deductible	20% after plan deductible
Out-of-network home health care	20% after \$50 benefit deductible	20% after \$50 benefit deductible
Out-of-network durable medical equipment	20% after plan deductible	20% after plan deductible
Out-of-network maximum out-of-pocket	\$400 Employee	\$800 Employee +1 \$1,000 Family

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 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 providers or non-participating providers. A reduction will apply if you do not obtain pre-authorization for these specified services. Refer to your ConnectiCare Insurance Company, Inc. Certificate of Coverage for more information.
- For mental health, alcohol, and substance abuse services call 1-888-946-4658 to obtain pre-authorization.
- Out-of-Network cost shares are reimbursed at 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 mandated benefits.
- Your plan is Insured by ConnectiCare Insurance Company, Inc.

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.		
	Single Coverage	Family Coverage
In-network maximum out-of-pocket (Includes a combination of deductible, copayments and coinsurance for health and pharmacy services)	\$6,600 Employee	\$13,200 Employee +1 \$13,200 per Family
	Your cost retail (up to a 30 day supply per prescription)	Your cost mail order (up to a 100 day supply per prescription)
Generic drugs	\$5	\$10
Preferred brand drugs	\$20	\$40
Non-preferred brand drugs	\$30	\$60
Getting care outside of our network		
You may also get care outside of our network; however, your share of the costs will be higher.		
	Single Coverage	Family Coverage
Out-of-network coinsurance	20%	20%
Out-of-network mail order	100%	100%
Out-of-network maximum out-of-pocket	\$400 Employee	\$800 Employee +1 \$1,000 per Family

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.
- 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.
- Certain prescription drugs and supplies require pre-authorization from us before they will be covered under the prescription drug rider. 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.
- 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
- Always remember to carry your ConnectiCare ID Card.