ConnectiCare

FlexPOS-CAL-25-40-100-100D-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 Summary Plan Description on connecticare.com for a complete list of benefits.

Personalized for: Town of Glastonbury - IUOE

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.

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 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	$0 Individual $0 Family	$500 Individual $1,500 Family
Your out-of-pocket maximum Includes a combination of deductible, copayments and coinsurance for medical and pharmacy services	$3,000 Individual $9,000 Family	$3,000 Individual $9,000 Family
Out-of-network reimbursement	Not applicable	Plan will reimburse the coinsurance percentage of the maximum allowable amount
Lifetime Maximum Benefit	Unlimited	Unlimited

After you have spent the out-of-pocket maximum amount in deductibles, copayments and coinsurance, 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 including tomosynthesis screening (age 40 or older)	No charge	20% coinsurance after plan deductible
Annual routine vision exam one exam per year	$10 copayment/visit	20% coinsurance after plan deductible
Allergy testing up to one visit per year	Applicable primary care or specialist cost share	20% coinsurance after plan deductible

Ongoing Care and Sick Visits	In-network member pays	Out-of-network member pays
Primary care services	$25 copayment/visit	20% coinsurance after plan deductible
Specialist services	$40 copayment/visit	20% coinsurance after plan deductible
Gynecologist services	$25 copayment/visit	20% coinsurance after plan deductible
Maternity and prenatal care visits	No charge	20% coinsurance after plan deductible
Allergy injections	No charge	20% coinsurance after plan deductible
Telemedicine visit	Applicable primary care or specialist cost share	20% coinsurance after plan deductible
Retail clinic	$25 copayment/visit	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	No charge	20% coinsurance after plan deductible
Non-advanced radiology X-ray, diagnostic	No charge	20% coinsurance after plan deductible
Advanced radiology **Hospital facility** MRI, PET and CAT scan and nuclear cardiology	No charge	20% coinsurance after plan deductible
Advanced radiology **Stand-alone facility** MRI, PET and CAT scan and nuclear cardiology	No charge	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	$25 copayment/visit	Same as In-network benefit
Emergency room	$100 copayment/visit	Same as In-network benefit
Ambulance	No charge	Same as In-network benefit
Inpatient Hospital Services	**In-network member pays**	**Out-of-network member pays**
Inpatient hospital services, including room and board	$100 copayment/day up to $500 per year	20% coinsurance after plan deductible
Skilled nursing and rehabilitation facilities up to 90 days per year	No charge	20% coinsurance after plan deductible

Outpatient Hospital Services and Home Care	In-network member pays	Out-of-network member pays
Hospital outpatient facilities	$100 copayment/visit	20% coinsurance after plan deductible
Ambulatory surgical center	$100 copayment/visit	20% coinsurance after plan deductible
Home health services up to 100 visits per year	No charge	20% coinsurance after $50 benefit deductible
Outpatient Rehabilitative Services	**In-network member pays**	**Out-of-network member pays**
Rehabilitative Services up to 40 visits per year includes services combined for physical, speech and occupational therapy	$40 copayment/visit	20% coinsurance after plan deductible
Chiropractic services up to 20 visits per year	$40 copayment/visit	20% coinsurance after plan deductible
Mental Health and Substance Abuse	**In-network member pays**	**Out-of-network member pays**
Inpatient mental health services	$100 copayment/day up to $500 per year	20% coinsurance after plan deductible
Inpatient alcohol and substance abuse treatment	$100 copayment/day up to $500 per year	20% coinsurance after plan deductible
Outpatient mental health, alcohol and substance abuse treatment office visits and home services	$25 copayment/visit	20% coinsurance after plan deductible
Outpatient mental health, alcohol and substance abuse treatment intensive outpatient treatment and partial hospitalization	No charge	20% coinsurance after plan deductible
Supplies	**In-network member pays**	**Out-of-network member pays**
Durable medical equipment including prosthetics and disposable medical supplies	20% coinsurance	20% coinsurance after plan deductible
Diabetic equipment and supplies	20% coinsurance	20% coinsurance after plan deductible

Important Information

- This is a brief summary of benefits. Refer to your Summary Plan description for details on benefits, conditions, limitations and exclusions, or consult with your benefits manager. All benefits described are per member per Contract year.
- If you have questions regarding your plan, visit our website at www.connecticare.com or call us at (860) 674-2075 or 1-800-846-8578.
- 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 Summary Plan Description for more information.
- If you are a Massachusetts resident, this plan along with pharmacy services meets Massachusetts Minimum Creditable Coverage standards for 2018.
- Your plan is administered by ConnectiCare Insurance Company, Inc.

ConnectiCare

Prescription Drug Copayment Plan Benefit Summary

This is a brief summary of benefits. Refer to your Summary Plan Description 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.

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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.		
	In-network member pays	**Out-of-network member pays**
Your out-of-pocket maximum Includes a combination of deductible, copayments and coinsurance for medical and pharmacy services	$3,000 Individual $9,000 Family	$3,000 Individual $9,000 Family
Retail Pharmacy (up to a 30 day supply per prescription)	**In-network member pays**	**Out-of-network member pays**
Generic drugs (Tier 1)	$15 copayment/prescription	50% coinsurance
Preferred brand drugs (Tier 2)	$25 copayment/prescription	50% coinsurance
Non-preferred brand drugs (Tier 3)	$40 copayment/prescription	50% coinsurance
Mail Order Pharmacy (up to a 90 day supply per prescription)	**In-network member pays**	**Out-of-network member pays**
Generic drugs (Tier 1)	$30 copayment/prescription	Not covered
Preferred brand drugs (Tier 2)	$50 copayment/prescription	Not covered
Non-preferred brand drugs (Tier 3)	$80 copayment/prescription	Not covered

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.
- Always remember to carry your ConnectiCare ID card.