ConnectiCare

Choice EPO-OA-CNT-HSA-1500I/3000F-03 Contract Year Benefit Summary (A)

The individual deductible and out-of-pocket maximum applies if you have coverage only for yourself and not for any dependents. The family deductible and out-of-pocket maximum applies if you have coverage for yourself and one or more eligible dependents. In addition, if you have family coverage, any applicable copayments or coinsurance will not apply to services until the total deductible is met for the family, without regard to how much any one family member has met.

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 - Police, IUOE & AFSCME

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 directory 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
Your deductible Deductible is combined for medical services and prescription drugs	$1,500 Individual $3,000 Family
Your out-of-pocket maximum Includes a combination of deductible, copayments and coinsurance for medical and pharmacy services	$3,000 Individual $6,000 Family
Lifetime maximum benefit	Unlimited

After you have spent the in-network 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**
Baseline routine mammography (ages 35-39)	No charge
Annual routine mammography including tomosynthesis screening (age 40 or older)	No charge

Screenings	In-network member pays
Annual routine vision exam one exam per year	No charge
Allergy testing up to one visit per year	0% coinsurance after plan deductible
Ongoing Care and Sick Visits	**In-network member pays**
Primary care services	0% coinsurance after plan deductible
Specialist services	0% coinsurance after plan deductible
Gynecologist services	0% coinsurance after plan deductible
Maternity and prenatal care visits	No charge
Allergy injections	0% coinsurance after plan deductible
Telemedicine visit	0% coinsurance after plan deductible
Retail clinic	0% coinsurance after plan deductible
Lab and Radiology Performed in a hospital, lab or radiology facility	**In-network member pays**
Laboratory services	0% coinsurance after plan deductible
Non-advanced radiology X-ray, diagnostic	0% coinsurance after plan deductible
Advanced radiology **Hospital facility** MRI, PET and CAT scan and nuclear cardiology	0% coinsurance after plan deductible
Advanced radiology **Stand-alone facility** MRI, PET and CAT scan and nuclear cardiology	0% coinsurance after plan deductible
Sudden and Unexpected Care The same cost share applies for both in-network and out-of-network services	**In-network member pays**
Urgent care or other walk-in clinic	0% coinsurance after plan deductible
Emergency room	0% coinsurance after plan deductible
Ambulance	0% coinsurance after plan deductible

Inpatient Hospital Services	In-network member pays
Inpatient hospital services, including room and board	0% coinsurance after plan deductible
Skilled nursing and rehabilitation facilities up to 60 days per year	0% coinsurance after plan deductible
Outpatient Hospital services and Home Care	**In-network member pays**
Hospital outpatient facilities	0% coinsurance after plan deductible
Ambulatory surgical center	0% coinsurance after plan deductible
Home health services up to 100 visits per year	0% coinsurance after plan deductible
Outpatient Rehabilitative Services	**In-network member pays**
Rehabilitative Services up to 40 visits per year includes services combined for physical, speech and occupational therapy	0% coinsurance after plan deductible
Chiropractic services up to 20 visits per year	0% coinsurance after plan deductible
Mental Health and Substance Abuse	**In-network member pays**
Inpatient mental health services	0% coinsurance after plan deductible
Inpatient alcohol and substance abuse treatment	0% coinsurance after plan deductible
Outpatient mental health, alcohol and substance abuse treatment office visits and home services	0% coinsurance after plan deductible
Outpatient mental health, alcohol and substance abuse treatment intensive outpatient treatment and partial hospitalization	0% coinsurance after plan deductible
Supplies	**In-network**
Durable medical equipment including prosthetics and disposable medical supplies	20% coinsurance after plan deductible
Diabetic equipment and supplies	20% coinsurance after plan deductible

Getting care outside of our network

Generally your plan does not cover service rendered outside of our network. Please refer to your member documents for additional plan information.
To ensure that you use services within our network, please visit www.connecticare.com and use the "Find a doctor" option to search for doctors and facilities.

Important Information

- 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 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.
- If you are a Massachusetts resident, this plan along with pharmacy services meets Massachusetts Minimum Creditable Coverage standard for 2018.
- Your plan is administered by ConnectiCare Insurance Company, Inc.

ConnectiCare

Prescription Drug Copayment Plan - HMO Open Access High Deductible Health Plan (HDHP) for Use with Health Savings Account (HSA) Benefit Summary

This is a brief summary of your prescription drug 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 Contract year.

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Covered prescription drugs through retail Participating Pharmacies or our mail order service. Generics are dispensed unless the Member pays the **Generic** Cost-Share plus the difference in price between the Generic Equivalent and the Brand Name Drug.

Your Plan includes the following: Mandatory Drug Substitution, Generic Substitution Program, Tiered Cost-Share Program, and Voluntary Mail Order Program.

	In-network member pays
Your deductible (Deductible is combined for medical services and prescription drugs)	$1,500 Individual $3,000 Family
Your out-of-pocket maximum (Includes a combination of deductible, copayments and coinsurance for medical and pharmacy services)	$3,000 Individual $6,000 Family
Retail Pharmacy (up to a 30 day supply per prescription)	**In-network member pays**
Generic drugs (Tier 1)	0% coinsurance after plan deductible
Preferred brand drugs (Tier 2)	0% coinsurance after plan deductible
Non-preferred brand drugs (Tier 3)	0% coinsurance after plan deductible
Mail Order Pharmacy (up to a 90 day supply per prescription)	**In-network member pays**
Generic drugs (Tier 1)	0% coinsurance after plan deductible
Preferred brand drugs (Tier 2)	0% coinsurance after plan deductible
Non-preferred brand drugs (Tier 3)	0% coinsurance after plan deductible
Getting care outside of our network	
• Your plan does not cover services rendered outside of our network	

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 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, or cost share maximum.
- 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.