ConnectiCare

Choice EPO-OA-CAL-25-40-100-100D-01 EPO Open Access Calendar Year Plan 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

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	$0 Individual $0 Family
Your out-of-pocket maximum Includes a combination of deductible, copayments and coinsurance for medical and pharmacy services	$6,350 Individual $12,700 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
Annual routine vision exam one exam per year	$10 copayment/visit

Screenings	In-network member pays
Allergy testing up to one visit per year	Applicable primary care or specialist cost share
Ongoing Care and Sick Visits	**In-network member pays**
Primary care services	$25 copayment/visit
Specialist services	$40 copayment/visit
Gynecologist services	$25 copayment/visit
Maternity and prenatal care visits	No charge
Allergy injections	No charge
Telemedicine visit	Applicable primary care or specialist cost share
Retail clinic	$25 copayment/visit
Lab and Radiology Performed in a hospital, lab or radiology facility	**In-network member pays**
Laboratory services	No charge
Non-advanced radiology X-ray, diagnostic	No charge
Advanced radiology **Hospital facility** MRI, PET and CAT scan and nuclear cardiology	No charge
Advanced radiology **Stand-alone facility** MRI, PET and CAT scan and nuclear cardiology	No charge
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	$25 copayment/visit
Emergency room copayment waived if admitted	$100 copayment/visit
Ambulance	No charge
Inpatient Hospital Services	**In-network member pays**
Inpatient hospital services, including room and board	$100 copayment per day up to $500 per year
Skilled nursing and rehabilitation facilities up to 90 days per year	No charge

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

Getting care outside of our network

Generally your plan does not cover services rendered outside of our network. Please refer to you 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 Calendar 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 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 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.

	In-network member pays
Your out-of-pocket maximum (Includes a combination of deductible, copayments and coinsurance for medical and pharmacy services)	$6,350 Individual $12,700 Family
Retail Pharmacy (up to a 30 day supply per prescription)	**In-network member pays**
Generic drugs (Tier 1)	$15 copayment/prescription
Preferred brand drugs (Tier 2)	$25 copayment/prescription
Non-preferred brand drugs (Tier 3)	$40 copayment/prescription
Mail Order Pharmacy (up to a 90 day supply per prescription)	**In-network member pays**
Generic drugs (Tier 1)	$30 copayment/prescription
Preferred brand drugs (Tier 2)	$50 copayment/prescription
Non-preferred brand drugs (Tier 3)	$80 copayment/prescription

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.
- 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.