ConnectiCare

FlexPOS-CNT-HSA-2000I/4000F-02-Combined Open Access 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 - Non Affiliated and Housing Authority

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	Out-of-network member pays
Your deductible Deductible is combined for medical services and prescription drugs Deductible is combined for in and out-of-network	$2,000 Individual $4,000 Family	$2,000 Individual $4,000 Family
Your out-of-pocket maximum Includes a combination of deductible, copayments and coinsurance for medical and pharmacy services Out-of-pocket maximum is combined for in and out-of-network	$3,000 Individual $6,000 Family	$3,000 Individual $6,000 Family
Out-of-network reimbursement	Not applicable	Plan will reimburse the coinsurance percentage of the maximum allowable amount
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

Screenings	In-network member pays	Out-of-network member pays
Annual routine mammography including tomosynthesis screening (age 40 or older)	No charge	20% coinsurance after plan deductible
Annual routine vision exam	No charge	20% coinsurance after plan deductible
Allergy testing up to one visit every year	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Ongoing Care and Sick Visits	**In-network member pays**	**Out-of-network member pays**
Primary care services	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Specialist services	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Gynecologist services	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Maternity and prenatal care visits	No charge	20% coinsurance after plan deductible
Allergy injections	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Telemedicine visit	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Retail clinic	0% coinsurance after plan deductible	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	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Non-advanced radiology X-ray, diagnostic	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Advanced radiology **Hospital facility** MRI, PET and CAT scan and nuclear cardiology	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Advanced radiology **Stand-alone facility** MRI, PET and CAT scan and nuclear cardiology	0% coinsurance after plan deductible	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	0% coinsurance after plan deductible	Same as In-network benefit

Sudden and Unexpected Care	In-network member pays	Out-of-network member pays
Emergency room	0% coinsurance after plan deductible	Same as In-network benefit
Ambulance	0% coinsurance after plan deductible	Same as In-network benefit
Inpatient Hospital Services	**In-network member pays**	**Out-of-network member pays**
Inpatient hospital services, including room and board	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Skilled nursing and rehabilitation facilities up to 60 days per year	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Outpatient Hospital Services and Home Care	**In-network member pays**	**Out-of-network member pays**
Hospital outpatient facilities	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Ambulatory surgical center	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Home health services up to 100 visits per year	0% coinsurance after plan deductible	20% coinsurance after plan 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	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Chiropractic services up to 20 visits per year	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Mental Health and Substance Abuse	**In-network member pays**	**Out-of-network member pays**
Inpatient mental health services	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Inpatient alcohol and substance abuse treatment	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Outpatient mental health, alcohol and substance abuse treatment office visits and home services	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Outpatient mental health, alcohol and substance abuse treatment intensive outpatient treatment and partial hospitalization	0% coinsurance after plan deductible	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 after plan deductible	20% coinsurance after plan deductible

Supplies	In-network member pays	Out-of-network member pays
Diabetic equipment and supplies	20% coinsurance after plan deductible	20% coinsurance after plan deductible

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.
- 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 Insured by ConnectiCare Insurance Company, Inc.

ConnectiCare

FlexPOS Combined Deductible Prescription Drug Plan 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	**Out-of-network member pays**
Your deductible (Deductible is combined for medical services and prescription drugs) (Deductible is combined for In and out-of-network)	$2,000 Individual $4,000 Family	$2,000 Individual $4,000 Family
Your out-of-pocket maximum (Includes a combination of deductible, copayments and coinsurance for medical and pharmacy services) (Out-of-pocket maximum is combined for In and out-of-network)	$3,000 Individual $6,000 Family	$3,000 Individual $6,000 Family
Retail Pharmacy (up to a 30 day supply per prescription)	**In-network member pays**	**Out-of-network member pays**
Generic drugs (Tier 1)	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Preferred brand drugs (Tier 2)	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Non-preferred brand drugs (Tier 3)	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Mail Order Pharmacy (up to a 90 day supply per prescription)	**In-network member pays**	**Out-of-network member pays**
Generic drugs (Tier 1)	0% coinsurance after plan deductible	Not covered
Preferred brand drugs (Tier 2)	0% coinsurance after plan deductible	Not covered
Non-preferred brand drugs (Tier 3)	0% coinsurance after plan deductible	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