



## EPO-OA-CAL-20-25-100-100D-02 EPO Open Access Calendar Year Plan Benefit Summary

This is a brief summary of benefits. Refer to your Summary Plan Description or consult with your benefits manager for more information. The Summary Plan Description will prevail for all benefits, conditions, limitations and exclusions. All benefits described below are per Member per **Calendar year**. All benefit limits/maximums are listed in the Plan pays column of this summary. A Referral from your Primary Care Provider is not required.

**Personalized for: Town of Glastonbury - Non Affiliated and Housing Authority hired prior to 7/1/09 and IUOE**

	IN-NETWORK	
<b>Lifetime Maximum Benefit</b>	Unlimited	
<b>PREVENTIVE SERVICES</b> (Refer to the "Prevention and Wellness" section of this summary for a complete list of services)	<b>IN-NETWORK MEMBER PAYS</b>	<b>IN-NETWORK PLAN PAYS</b>
<b>Adult Physical Exam</b> (one exam per year when provided by a PCP)	No Member cost	100%
<b>Infant / Pediatric Physical Exam</b> (frequency limits apply and the exam must be provided by a PCP)	No Member cost	100%
<b>Gynecological Preventive Exam</b> (one exam per year)	No Member cost	100%
<b>Preventive Laboratory Services</b> (Complete blood count and Urinalysis, one test per year)	No Member cost	100%
<b>Baseline Routine Mammography</b> (ages 35 - 40)	No Member cost	100%
<b>Annual Routine Mammography</b> (over age 40)	No Member cost	100%
<b>Annual Routine Vision Exam</b> (one exam per year when provided by an Optometrist or Ophthalmologist)	\$10 Copayment per visit up to the visit maximum; then no coverage	100% after Copayment up to one visit every year
<b>OUTPATIENT SERVICES</b>		
<b>Primary Care Provider Office Services</b> (includes services for illness, injury, sickness, follow-up care and consultations)	\$20 Copayment per visit	100% after Copayment
<b>Specialist Office Services</b> (includes services for illness, injury, sickness, follow-up care and consultations)	\$25 Copayment per visit	100% after Copayment
<b>Gynecological Office Services</b>	\$20 Copayment per visit	100% after Copayment
<b>Maternity Care Office Services</b>	\$20 Copayment (for initial visit only)	100% after initial Copayment

<b>OUTPATIENT SERVICES</b>		
<b>Allergy Testing</b>	Applicable office visit Copayment up to the benefit maximum; then no coverage	100% after Copayment up to \$315 every two years
<b>Laboratory Services</b> (includes services performed in a Hospital or laboratory facility)	No Member cost	100%
<b>Non-Advanced Radiology</b> (includes services performed in a Hospital or radiology facility)	No Member cost	100%
<b>Advanced Radiology</b> (includes services for MRI, PET and CAT scan, and nuclear cardiology performed in a Hospital or radiology facility)	No Member cost	100%
<b>Outpatient Rehabilitative Therapy</b> (includes services combined for physical, speech, and occupational therapy)	\$20 Copayment per visit up to the visit maximum; then no coverage	100% after Copayment up to 40 visits per year
<b>Chiropractic Services</b>	\$20 Copayment per visit up to the visit maximum; then no coverage	100% after Copayment up to 20 visits per year
<b>Home Health Services</b>	No Member cost up to the visit maximum; then no coverage	100% up to 100 visits per year
<b>Retail Clinic</b>	\$20 Copayment per visit	100% after Copayment
<b>EMERGENCY / URGENT CARE</b>		
<b>Walk-In/Urgent Care Centers</b>	\$25 Copayment per visit	100% after Copayment
<b>Emergency Room</b> (Copayment waived if admitted)	\$100 Copayment per visit	100% after Copayment
<b>Ambulance Services</b>	No Member cost	100%
<b>HOSPITAL SERVICES</b>		
<b>Inpatient Hospital Services, Including Room &amp; Board</b>	\$100 Copayment per day up to \$500 per year	100% after Copayment
<b>Ambulatory Services (Outpatient)</b> (includes services performed in a Hospital or ambulatory facility)	\$100 Copayment per visit	100% after Copayment
<b>Skilled Nursing and Rehabilitation Facilities</b>	No Member cost up to the visit maximum; then no coverage	100% up to 90 days
<b>MENTAL HEALTH SERVICES</b>		
<b>Inpatient Mental Health Services</b> (including inpatient acute, residential and partial hospitalization programs)	\$100 Copayment per day up to \$500 per year	100% after Copayment
<b>Inpatient Alcohol and Substance Abuse Treatment</b> (including inpatient acute, residential and partial hospitalization programs)	\$100 Copayment per day up to \$500 per year	100% after Copayment

<b>MENTAL HEALTH SERVICES</b>		
<b>Outpatient Mental Health, Alcohol and Substance Abuse Treatment</b> (including office visits, professional services provided in the home and intensive outpatient treatment programs)	\$20 Copayment per visit	100% after Copayment
<b>OTHER SERVICES</b>		
<b>Durable Medical Equipment Including Prosthetics and Disposable Medical Supplies</b>	20%	80%
<b>Diabetic Equipment and Supplies</b>	20%	80%
<b>PREVENTION AND WELLNESS</b>		
<p>In-Network Prevention and wellness services as defined by the United States Preventive Service Task Force (listed below) are exempt from all member cost shares (deductible, copayment and coinsurance) under the Patient Protection and Affordable Care Act (PPACA). These services are identified by the specific coding your Provider submits to ConnectiCare. Service coding must match ConnectiCare's coding list to be exempt from all cost sharing.</p> <ul style="list-style-type: none"> <li>• Routine Physical Exam and appropriate screening and counseling for adults, one per year</li> <li>• Preventive Care and screenings for infants, children and adolescents supported by the Health Resources and Services Administration</li> <li>• Preventive Care and screenings for women supported by the Health Resources and Services Administration</li> <li>• Bone Density Screenings, age 60 or older, one every 23 months</li> <li>• Screening for colorectal cancer using fecal occult blood testing, sigmoidoscopy, or colonoscopy; age 50 or older, one per year</li> <li>• Routine Mammography Screening, age 40 or older, one per year</li> <li>• Immunizations recommended by the Advisory Committee on Immunization Practices of the CDC</li> <li>• Outpatient Laboratory Services, one per year: <ul style="list-style-type: none"> <li>◦ Cervical Cancer and Cervical Dysplasia Screening - Pap Smear</li> <li>◦ Lipid Cholesterol Screening for adults and children at risk</li> <li>◦ Fasting Plasma Glucose or Hemoglobin A1c, age 18 or older for people at risk for diabetes</li> <li>◦ Hematocrit and Hemoglobin, for children up to age 21</li> <li>◦ Lead screening, for children up to age 6</li> <li>◦ Tuberculin testing, for children up to age 21</li> <li>◦ Chlamydia, Syphilis and Gonorrhea screening for females all ages</li> <li>◦ Human immunodeficiency virus screening - HIV testing, no limit</li> <li>◦ Screening for phenylketonuria (PKU) in newborns, under 3 months of age</li> <li>◦ Screening for sickle cell disease in newborns, under 3 months of age</li> </ul> </li> <li>• Routine Vision Screening, up to age 21, one per year when services are rendered by a Primary Care Provider</li> <li>• Routine hearing screening up to age 21 when rendered by a Primary Care Provider</li> <li>• Developmental, Autism, and Psychosocial/behavioral assessments when rendered by a Primary Care Provider</li> <li>• Dietary counseling for adults with hyperlipidemia or obesity</li> <li>• Tobacco Cessation interventions</li> <li>• Screening for Hepatitis B, Iron Deficient Anemia, Rh (D) Blood Typing and Asymptomatic Bacteriuria in women who are pregnant</li> <li>• Screening for Abdominal Aortic Aneurysm in men age 65 - 75 who have ever smoked</li> <li>• BRCA counseling and genetic screening for women at risk</li> </ul>		

### Important Information

- If you have questions regarding your Plan, visit our website at [www.connecticare.com](http://www.connecticare.com) or call us at (860) 674-2075 or 1-800-846-8578.
- For mental health, alcohol, and substance abuse services call 1-888-946-4658 to obtain Pre-Authorization.
- We track benefits internally and do not provide Members with a regular update of benefits that have been used. Members should keep a record of benefits they use to determine when they reached their benefit limit. Members will be responsible for paying in full any services rendered after the limit is reached.
- If you are a Massachusetts resident, this plan along with Pharmacy services meets Massachusetts Minimum Creditable standards for 2011.
- Your plan is administered 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 or consult with your benefits manager for more information. The Prescription Drug Rider and the Summary Plan Description will prevail for all benefits, conditions, limitations and exclusions. All Benefits described below are per Member per **Calendar year**.

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<b>PRESCRIPTION DRUGS</b>		
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.		
<b>RETAIL PHARMACY (up to a 30-day supply per prescription)</b>	<b>MEMBER PAYS</b>	<b>PLAN PAYS</b>
<b>Tier 1 drugs</b>	\$10 Copayment per 30 day supply	100% after Copayment
<b>Tier 2 drugs</b>	\$20 Copayment per 30 day supply	100% after Copayment
<b>Tier 3 drugs</b>	\$35 Copayment per 30 day supply	100% after Copayment
<b>MAIL ORDER PHARMACY (up to a 90-day supply per prescription)</b>	<b>MEMBER PAYS</b>	<b>PLAN PAYS</b>
<b>Tier 1 drugs</b>	\$20 Copayment per 90 day supply	100% after Copayment
<b>Tier 2 drugs</b>	\$40 Copayment per 90 day supply	100% after Copayment
<b>Tier 3 drugs</b>	\$70 Copayment per 90 day supply	100% after Copayment
<b>Additional Information</b>		
<ul style="list-style-type: none"> <li>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 Members 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 &amp; 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.</li> <li>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 <a href="http://www.connecticare.com">www.connecticare.com</a> or call our Member Services Department at 860-674-2075 or 1-800-846-8578.</li> <li>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 <a href="http://www.connecticare.com">www.connecticare.com</a> or call our Member Services Department at 860-674-2075 or 1-800-846-8578 to find out if a prescription drug or supply requires Pre-Authorization.</li> <li>Always remember to carry your ConnectiCare ID Card.</li> </ul>		