ConnectiCare®

FlexPOS-CAL-20-25-100-100D-02 Open Access Calendar Year 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 MEMBER PAYS	**OUT-OF-NETWORK MEMBER PAYS**
Calendar Year Plan Deductible	None	$500 per Member $1,500 per Family
Coinsurance Maximum *(Maximum does not include Plan deductible or Benefit Deductible)*	None	$2,500 per Member $7,500 per Family
Out-of-Pocket Maximum *(Maximum includes Plan Deductibles and Coinsurance Maximum only. Benefit Deductibles are not included)*	None	$3,000 per Member $9,000 per Family
Out-of-Network Reimbursement	None	**Plan will reimburse the coinsurance percentage of the Maximum Allowable Amount.**
Lifetime Maximum Benefit	Unlimited	Unlimited
PREVENTIVE SERVICES (Refer to "Prevention and Wellness" section found at the end of this summary)	**IN-NETWORK MEMBER PAYS**	**OUT-OF-NETWORK MEMBER PAYS**
Adult Physical Exam (one exam per year when provided by a PCP)	No Member cost	20% after Plan Deductible
Infant / Pediatric Physical Exam (frequency limits apply and the exam must be provided by a PCP)	No Member cost	20% after Plan Deductible
Gynecological Preventive Exam	No Member cost	20% after Plan Deductible
Preventive Laboratory Services (Complete blood count and urinalysis, one test per year)	No Member cost	20% after Plan Deductible
Baseline Routine Mammography (ages 35-40)	No Member cost	20% after Plan Deductible
Annual Routine Mammography (over age 40)	No Member cost	20% after Plan Deductible
Annual Routine Vision Exam (one exam per year when provided by an Optometrist or Ophthalmologist)	$10 Copayment per visit	Additional cost in excess of $30

OUTPATIENT SERVICES	IN-NETWORK MEMBER PAYS	OUT-OF-NETWORK MEMBER PAYS
Primary Care Provider Office Services (includes services for illness, injury, sickness, follow-up care and consultations)	$20 Copayment per visit	20% after Plan Deductible
Specialist Office Services (includes services for illness, injury, sickness, follow-up care and consultations)	$25 Copayment per visit	20% after Plan Deductible
Gynecological Office Services	$20 Copayment per visit	20% after Plan Deductible
Maternity Care Office Visits	No Member cost	20% after Plan Deductible
Allergy Testing up to $315 every two years	Applicable office visit Copayment	20% after Plan Deductible
Laboratory Services (includes services performed in a Hospital or laboratory facility)	No Member cost	20% after Plan Deductible
Non-Advanced Radiology (includes services performed in a Hospital or radiology facility)	No Member cost	20% after Plan Deductible
Advanced Radiology (includes services for MRI, PET and CAT scan and nuclear cardiology performed in a Hospital or radiology facility)	No Member cost	20% after Plan Deductible
Outpatient Rehabilitative Therapy up to 40 visits per year (includes services combined for physical, speech, and occupational therapy)	$25 Copayment per visit	20% after Plan Deductible
Chiropractic Services up to 20 visits per year	$25 Copayment per visit	20% after Plan Deductible
Retail Clinic	$20 Copayment per visit	20% after Plan Deductible
EMERGENCY / URGENT CARE	**IN-NETWORK MEMBER PAYS**	**OUT-OF-NETWORK MEMBER PAYS**
Walk-In/Urgent Care Centers	$25 Copayment per visit	$25 Copayment per visit
Emergency Room (Copayments waived if admitted)	$100 Copayment per visit	$100 Copayment per visit
Ambulance Services	No Member cost	No Member cost
HOSPITAL SERVICES	**IN-NETWORK MEMBER PAYS**	**OUT-OF-NETWORK MEMBER PAYS**
Inpatient Hospital Services, Including Room & Board	$100 Copayment per day up to $500 per year	20% after Plan Deductible
Ambulatory Services (Outpatient) (includes services performed in a Hospital or ambulatory facility)	$100 Copayment per visit	20% after Plan Deductible

HOSPITAL SERVICES	IN-NETWORK MEMBER PAYS	OUT-OF-NETWORK MEMBER PAYS
Skilled Nursing and Rehabilitation Facilities up to 90 days per year	No Member cost	20% after Plan Deductible
MENTAL HEALTH SERVICES	**IN-NETWORK MEMBER PAYS**	**OUT-OF-NETWORK MEMBER PAYS**
Inpatient Mental Health Services (including inpatient acute, residential and partial hospitalization programs)	$100 Copayment per day up to $500 per year	20% after Plan Deductible
Inpatient Alcohol and Substance Abuse Treatment (including inpatient acute, residential and partial hospitalization programs)	$100 Copayment per day up to $500 per year	20% after Plan Deductible
Outpatient Mental Health, Alcohol and Substance Abuse Treatment (including office visits, professional services provided in the home and intensive outpatient treatment programs)	$20 Copayment per visit	20% after Plan Deductible
OTHER SERVICES	**IN-NETWORK MEMBER PAYS**	**OUT-OF-NETWORK MEMBER PAYS**
Durable Medical Equipment Including Prosthetics and Disposable Medical Supplies	20%	20% after Plan Deductible
Diabetic Equipment and Supplies	20%	20% after Plan Deductible
Home Health Services up to 100 visits per year	No Member cost	20% after $50 Benefit Deductible

PREVENTION AND WELLNESS

In-Network prevention and wellness services as defined by the United States Preventive Service Task Force (listed below) are exempt from all member cost share (deductible, copayment and coinsurance) under the Patient Protection and Affordable Care Act (PPACA). Services that are exempt from cost share must be identified by the specific codes. The codes your health care provider submits must match ConnectiCare's coding list to be exempt from all cost share.

- Routine physical exam and appropriate screening and counseling, one per year
- Preventive care and screenings for infants, children and adolescents supported by the Health Resources and Services Administration
- Preventive care and screenings for women supported by the Health Resources and Services Administration:
  - At least one well-woman preventive care visit annually to obtain the recommended preventive services
  - Screening for diabetes during pregnancy, two per pregnancy
  - Human Papillomavirus (HPV) testing, age 30 or older, one per year
  - Counseling on sexually transmitted infections for all sexually active women, two per year
  - Counseling and screening for human immune-deficiency virus (HIV) for all sexually active women
  - Contraceptive methods approved by the Food and Drug administration, sterilization procedures and contraceptive patient education and counseling
  - Comprehensive lactation support, counseling, a manual breast pump, and breastfeeding supplies
  - Screening and counseling for interpersonal and domestic violence for all women and adolescents
- Bone density screenings, age 60 or older, one every 23 months
- Screening for colorectal cancer using fecal occult blood testing, sigmoidoscopy, or colonoscopy, age 50 or older, one per year
- Routine mammography screening, age 40 or older, one per year
- Immunizations recommended by the Advisory Committee on Immunization Practices of the CDC
- Outpatient laboratory services, one per year:
  - Cervical cancer and cervical dysplasia screening – pap smear
  - Lipid cholesterol screening for adults and children at risk
  - Fasting plasma glucose or hemoglobin A1c, age 18 and older for people at risk for diabetes
  - Hematocrit and Hemoglobin, for children up to age 21.
  - Lead screening, for children up to age 6
  - Tuberculin testing, for children up to age 21
  - Chlamydia, syphilis and gonorrhea screening for females all ages
  - Human immunodeficiency virus screening – HIV testing (no limit)
  - Screening for phenylketonuria (PKU) in newborns, under 3 months of age
  - Screening for sickle cell disease in newborns, under 3 months of age
- Routine vision screening up to age 21, one per year when services are rendered by a primary care provider
- Routine hearing screening up to age 21 when rendered by a primary care provider
- Developmental, autism, and psychosocial/behavioral assessments when rendered by a primary care provider.
- Dietary counseling for adults with hyperlipidemia or obesity
- Tobacco cessation interventions
- Screening for hepatitis B, iron deficient anemia, Rh (D) blood typing and asymptomatic bacteriuria in women who are pregnant.
- Screening for abdominal aortic aneurysm in men age 65 – 75 who have ever smoked
- BRCA counseling and genetic screening for women at risk

Important Information

- 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.
- Many services require that you obtain our pre-certification or pre-authorization prior to obtaining care prescribed or rendered by network providers or non-participating providers. A reduction will apply if you do not obtain pre-authorization for these specified services. Refer to your ConnectiCare Insurance Company, Inc. Summary Plan Description for more information.
- For mental health, alcohol, and substance abuse services call 1-888-946-4658 to obtain pre-authorization.
- Out-of-Network cost shares are reimbursed at the maximum allowable amount. Members are responsible to pay any charges in excess of this amount. Please refer to your ConnectiCare Insurance Company, Inc. Summary Plan Description for more information.
- If you are a Massachusetts resident, please refer to your a*mendatory rider for Massachusetts mandated benefits* for additional details of your mandated benefits.
- If you are a Massachusetts resident, this plan along with pharmacy services meets Massachusetts Minimum Creditable Coverage standards for 2013.
- Your plan is insured by ConnectiCare Insurance Company, Inc.

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Prescription Drug Copayment Plan Benefit Summary

This is a brief summary of your prescription drug benefits. Refer to your Prescription Drug Rider or 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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PRESCRIPTION DRUGS		
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**
Benefit Deductible	None	None
Out-of-Network Reimbursement	Not Applicable	**Plan will reimburse the coinsurance percentage of the Maximum Allowable Amount.**
RETAIL PHARMACY (up to a 30 day supply per prescription)	**IN-NETWORK MEMBER PAYS**	**OUT-OF-NETWORK MEMBER PAYS**
Tier 1 drugs	$10 Copayment	50% Coinsurance
Tier 2 drugs	$20 Copayment	50% Coinsurance
Tier 3 drugs	$35 Copayment	50% Coinsurance
MAIL ORDER PHARMACY (up to a 90 day supply per prescription)	**IN-NETWORK MEMBER PAYS**	**OUT-OF-NETWORK MEMBER PAYS**
Tier 1 drugs	$20 Copayment	100%
Tier 2 drugs	$40 Copayment	100%
Tier 3 drugs	$70 Copayment	100%

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.
- 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 www.connecticare.com or call our Member Services Department at 1-800-846-8578.
- 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 www.connecticare.com or call our Member Service Department at 1-800-846-8578 to find out if a prescription drug or supply requires pre-authorization.
- Always remember to carry your ConnectiCare ID Card.