



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 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. 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
Lifetime Maximum Benefit	Unlimited
PREVENTIVE SERVICES (Refer to "Prevention and Wellness" section found at the end of this summary)	IN-NETWORK MEMBER PAYS
Adult Physical Exam (one exam per year when provided by a PCP)	No Member cost
Infant / Pediatric Physical Exam (frequency limits apply and the exam must be provided by a PCP)	No Member cost
Gynecological Preventive Exam	No Member cost
Preventive Laboratory Services (Complete blood count and urinalysis, one test per year)	No Member cost
Baseline Routine Mammography (ages 35 - 40)	No Member cost
Annual Routine Mammography (over age 40)	No Member cost
Annual Routine Vision Exam (one exam per year when provided by an Optometrist or Ophthalmologist)	\$10 Copayment per visit
OUTPATIENT SERVICES	IN-NETWORK MEMBER PAYS
Primary Care Provider Office Services (includes services for illness, injury, sickness, follow-up care and consultations)	\$20 Copayment per visit
Specialist Office Services (includes services for illness, injury, sickness, follow-up care and consultations)	\$25 Copayment per visit
Gynecological Office Services	\$20 Copayment per visit
Maternity Care Office Visits	No Member cost
Allergy Testing up to \$315 every two years	Applicable office visit Copayment

OUTPATIENT SERVICES	IN-NETWORK MEMBER PAYS
Laboratory Services (includes services performed in a Hospital or laboratory facility)	No Member cost
Non-Advanced Radiology (includes services performed in a Hospital or radiology facility)	No Member cost
Advanced Radiology (includes services for MRI, PET and CAT scan, and nuclear cardiology performed in a Hospital or radiology facility)	No Member cost
Outpatient Rehabilitative Therapy up to 40 visits per year (includes services combined for physical, speech, and occupational therapy)	\$25 Copayment per visit
Chiropractic Services up to 20 visits per year	\$25 Copayment per visit
Home Health Services up to 100 visits per year	No Member cost
Retail Clinic	\$20 Copayment per visit
EMERGENCY / URGENT CARE	IN-NETWORK MEMBER PAYS
Walk-In/Urgent Care Centers	\$25 Copayment per visit
Emergency Room (Copayment waived if admitted)	\$100 Copayment per visit
Ambulance Services	No Member cost
HOSPITAL SERVICES	IN-NETWORK MEMBER PAYS
Inpatient Hospital Services, Including Room & Board	\$100 Copayment per day up to \$500 per year
Ambulatory Services (Outpatient) (includes services performed in a Hospital or ambulatory facility)	\$100 Copayment per visit
Skilled Nursing and Rehabilitation Facilities up to 90 days per year	No Member cost
MENTAL HEALTH SERVICES	IN-NETWORK MEMBER PAYS
Inpatient Mental Health Services (including inpatient acute, residential and partial hospitalization programs)	\$100 Copayment per day up to \$500 per year

MENTAL HEALTH SERVICES	IN-NETWORK MEMBER PAYS
Inpatient Alcohol and Substance Abuse Treatment (including inpatient acute, residential and partial hospitalization programs)	\$100 Copayment per day up to \$500 per year
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
OTHER SERVICES	IN-NETWORK MEMBER PAYS
Durable Medical Equipment Including Prosthetics and Disposable Medical Supplies	20%
Diabetic Equipment and Supplies	20%

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.
- For mental health, alcohol, and substance abuse services call 1-888-946-4658 to obtain pre-authorization.
- If you are a Massachusetts resident, this plan along with pharmacy services meets Massachusetts Minimum Creditable Coverage standards for 2013.
- 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 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.

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

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.	
RETAIL PHARMACY (up to a 30 day supply per prescription)	IN-NETWORK MEMBER PAYS
Tier 1 drugs	\$10 Copayment
Tier 2 drugs	\$20 Copayment
Tier 3 drugs	\$35 Copayment
MAIL ORDER PHARMACY (up to a 90 day supply per prescription)	IN-NETWORK MEMBER PAYS
Tier 1 drugs	\$20 Copayment
Tier 2 drugs	\$40 Copayment
Tier 3 drugs	\$70 Copayment
Additional Information	
<ul style="list-style-type: none"> • 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. • 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 Services 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. 	