ConnectiCare

FlexPOS-CNT-HSA-2000I/4000F-94-Combined Open Access Contract Year Benefit Summary (A)

The Individual Deductible and Maximum Out-of-Pocket applies if you have coverage only for yourself and not for any dependents. The Family Deductible and Maximum Out-of-Pocket 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 certificate of coverage on connecticare.com for a complete list of benefits.

Personalized for: Cooperative Educational Services

Getting care in our network

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.

- **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**

Your care costs
Costs for these services are shared by you and ConnectiCare as follows when you use a doctor or facility in our network.

	Single Coverage	Family Coverage
In-network deductible Plan deductible is combined for in and out-of-network	$2,000	$4,000
In-network maximum out-of-pocket Out-of-pocket maximum is combined for in and out-of-network	$3,000	$6,000

After you've spent the in-network maximum out-of-pocket amount in deductibles, copays and coinsurance, ConnectiCare will pay 100% of your covered health care expenses for the remainder of that year.

Screenings	Your cost
Baseline routine mammography	$0 plan deductible waived
Routine mammography including tomosynthesis screening	$0 plan deductible waived

Screenings	Your cost
Breast ultrasound screening	$0 after plan deductible
Annual routine vision exam	$0 plan deductible waived
Allergy testing Unlimited	$0 after plan deductible
Hearing Screenings one screening per year	$0 plan deductible waived
Ongoing Care and Sick Visits	**Your cost**
Primary care services	$0 after plan deductible
Specialist services	$0 after plan deductible
Gynecologist services	$0 after plan deductible
Maternity and pre-natal care visits	$0 plan deductible waived
Allergy injections Unlimited	$0 after plan deductible
Telemedicine visit	$0 after plan deductible
Retail clinic	$0 after plan deductible
Nutritional Counseling Limit 3 visits per year	$0 after plan deductible
Infertility (Infertility benefits outlined in the Certificate of Coverage are unlimited, with no age or cycle restrictions)	$0 (Office visit) after plan deductible $0 (Ambulatory Services Outpatient) after plan deductible $0 (Inpatient Hospital) after plan deductible
Lab and Radiology Performed in a hospital, lab or radiology facility (Please refer to the provider directory for facility type)	
Laboratory services	$0 after plan deductible
Non-advanced radiology X-ray, diagnostic	$0 after plan deductible
Advanced radiology MRI, PET and CAT scan and nuclear cardiology	$0 after plan deductible
Sudden and Unexpected Care The In-network cost share applies for both the In-Network and Out-of-Network services	
Urgent care or other walk-in clinic	$0 after plan deductible
Emergency room	$0 after plan deductible

Sudden and Unexpected Care The In-network cost share applies for both the In-Network and Out-of-Network services	
Ambulance	$0 after plan deductible
Inpatient Hospital Services	
Inpatient hospital services, including room and board	$0 after plan deductible
Skilled nursing facilities up to 120 days per year	$0 after plan deductible
Inpatient rehabilitation up to 100 days per year	$0 after plan deductible
Private duty nursing up to $15,000 per year	$0 after plan deductible
Outpatient Hospital Services and Home Care (Please refer to the provider directory for facility type)	
Hospital outpatient facilities	$0 after plan deductible
Ambulatory surgical center	$0 after plan deductible
Home health services Nursing and therapeutic services limited to 200 visits Home Health aide services limited to 80 visits that are applicable to the 200 visit limit	$0 after plan deductible
Outpatient Rehabilitative Services	
Rehabilitative services up to 60 visits per year (includes services combined for physical, speech and occupational therapy and chiropractic services)	$0 after plan deductible
Mental Health and Substance Abuse	
Inpatient mental health services	$0 after plan deductible
Inpatient alcohol and substance abuse treatment	$0 after plan deductible
Outpatient mental health, alcohol and substance abuse treatment (office visits and home services)	$0 after plan deductible
Outpatient mental health, alcohol and substance abuse treatment (intensive outpatient treatment and partial hospitalization)	$0 after plan deductible

Supplies	
Durable medical equipment including prosthetics and disposable medical supplies (Includes Wigs prescribed by an oncologist for Member suffering hair loss as a result of chemotherapy or radiation therapy up to one wig per year)	$0 after plan deductible
Diabetic equipment and supplies	$0 after plan deductible
Modified food products and specialized formula pharmacy tier	$0 after plan deductible

Getting care outside of our network

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.		
	Single Coverage	**Family Coverage**
Out-of-network deductible Plan deductible is combined for in and out-of-network	$2,000	$4,000
Out-of-network coinsurance	20% after plan deductible	20% after plan deductible
Out-of-network home health care	20% after plan deductible	20% after plan deductible
Out-of-network durable medical equipment	20% after plan deductible	20% after plan deductible
Out-of-network maximum out-of-pocket Out-of-pocket maximum is combined for in and out-of-network	$3,000	$6,000

Important Information

- This is a brief summary of benefits. Refer to your ConnectiCare Insurance Company, Inc. Certificate of Coverage for complete details on benefits, conditions, limitations and exclusions, or consult with your benefits manager. All benefits described are per member per Contract year.
- A Referral from your Primary Care Provider is not required.
- If you have questions regarding your plan, visit our website at **www.connecticare.com** or call us at (860) 674-5757 or 1-800-251-7722.
- 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. Certificate of Coverage 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. Certificate of Coverage for more information.
- If you are a Massachusetts resident, please refer to your *amendatory 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 2017.
- 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 Prescription Drug Rider 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.

Personalized for: Cooperative Educational Services

Covered prescription drugs through retail Participating Pharmacies or our mail order service. **Generics are dispensed unless the provider writes Dispense as Written on the prescription.** Your Plan includes the following: Mandatory Drug Substitution, Generic Substitution Program, Tiered Cost-Share Program, and Voluntary Mail Order Program.		
	Single Coverage	**Family Coverage**
In-network Contract Year plan deductible (Deductible is combined for In and out-of-network)	$2,000	$4,000
In-network maximum out-of-pocket (Maximum is combined for In and out-of-network)	$3,000	$6,000
	Your cost retail (up to a 34 day supply per prescription)	**Your cost mail order** (up to a 90 day supply per prescription)
Generic drugs	$5 after plan deductible	$10 after plan deductible
Preferred brand drugs	$20 after plan deductible	$40 after plan deductible
Non-preferred brand drugs	$35 after plan deductible	$70 after plan deductible
Getting care outside of our network		
You may also get care outside of our network; however, your share of the costs will be higher.		
	Single Coverage	**Family Coverage**
Out-of-network deductible (Deductible is combined for In and out-of-network)	$2,000	$4,000
Out-of-network coinsurance	20% after plan deductible	20% after plan deductible
Out-of-network mail order	100%	100%
Out-of-network maximum out-of-pocket (Maximum is combined for In and out-of-network)	$3,000	$6,000

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 1-800-251-7722.
- Amounts paid by members because they must pay a price difference for a brand name drug do not count towards meeting any deductible, coinsurance, copayment, or cost share maximum.
- 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 1-800-251-7722 to find out if a prescription drug or supply requires pre-authorization.
- Most Specialty drugs are dispensed through Specialty Pharmacies by mail, up to 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.
- If you are a Massachusetts resident, please refer to your amendatory rider for Massachusetts mandated benefits for additional details of your benefits.