ConnectiCare Benefits, Inc.

Choice Silver Standard POS
Individual Market
Schedule of Benefits

Deductible and Out-of-Pocket Maximum	IN-NETWORK (INET) MEMBER PAYS	OUT-OF-NETWORK (OON) MEMBER PAYS
Plan Deductible *Individual* *Family*	$3,700 per Member $7,400 per Family	$7,400 per Member $14,800 per Family
Separate Prescription Drug Deductible *Individual* *Family*	$250 per Member $500 per Family	$500 per Member $1,000 per Family
Out-of-Pocket Maximum *(Includes deductible, copayments and coinsurance)*	$7,350 per Member $14,700 per Family	$14,700 per Member $29,400 per Family
Benefits	**IN-NETWORK (INET) MEMBER PAYS**	**OUT-OF-NETWORK (OON) MEMBER PAYS**
Provider Office Visits		
Adult Preventive Visit	No cost	40% coinsurance per visit
Infant/Pediatric Preventive Visit	No cost	40% coinsurance per visit
Primary Care Provider Office Visits *(includes services for illness, injury, follow-up care and consultations)*	$40 copayment per visit	40% coinsurance per visit after OON plan deductible is met
Specialist Office Visits	$50 copayment per visit	40% coinsurance per visit after OON plan deductible is met
Mental Health and Substance Abuse Office Visit	$40 copayment per visit	40% coinsurance per visit after OON plan deductible is met

Outpatient Diagnostic Services	IN-NETWORK (INET) MEMBER PAYS	OUT-OF-NETWORK (OON) MEMBER PAYS
Advanced Radiology *(CT/PET Scan, MRI)*	$75 copayment per service up to a combined annual maximum of $375 for MRI and CAT scans; $400 for PET scans	40% coinsurance per service after OON plan deductible is met
Laboratory Services	$10 copayment per service after INET plan deductible is met	40% coinsurance per service after OON plan deductible is met
Non-Advanced Radiology *(X-ray, Diagnostic, Baseline Mammography, Screening Tomosynthesis)*	$40 copayment per service after INET plan deductible is met	40% coinsurance per service after OON plan deductible is met
Mammography Ultrasound	$20 copayment per service	40% coinsurance per service after OON plan deductible is met
Prescription Drugs - Retail Pharmacy *(30 day supply per prescription)*	**IN-NETWORK (INET) MEMBER PAYS**	**OUT-OF-NETWORK (OON) MEMBER PAYS**
Tier 1 Prescription Drugs *(Generic Drugs)*	$5 copayment per prescription	40% coinsurance per prescription after OON prescription drug deductible is met
Tier 2 Prescription Drugs *(Preferred Brand Drugs)*	$35 copayment per prescription after INET prescription drug deductible is met	40% coinsurance per prescription after OON prescription drug deductible is met
Tier 3 Prescription Drugs *(Non-Preferred Brand Drugs)*	$60 copayment per prescription after INET prescription drug deductible is met	40% coinsurance per prescription after OON prescription drug deductible is met
Tier 4 Prescription Drugs *(Specialty Drugs)*	20% coinsurance up to a maximum of $200 per prescription after INET prescription drug deductible is met	40% coinsurance per prescription after OON prescription drug deductible is met
Prescription Drugs - Mail Order *(90 day supply per prescription)*	**IN-NETWORK (INET) MEMBER PAYS**	**OUT-OF-NETWORK (OON) MEMBER PAYS**
Tier 1 Prescription Drugs *(Generic Drugs)*	$10 copayment per prescription	Not covered
Tier 2 Prescription Drugs *(Preferred Brand Drugs)*	$70 copayment per prescription after INET prescription drug deductible is met	Not covered
Tier 3 Prescription Drugs *(Non-Preferred Brand Drugs)*	$120 copayment per prescription after INET prescription drug deductible is met	Not covered

Outpatient Rehabilitative and Habilitative Services	IN-NETWORK (INET) MEMBER PAYS	OUT-OF-NETWORK (OON) MEMBER PAYS
Speech Therapy *(40 visits per calendar year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per calendar year limit combined for Habilitative speech, physical and occupational therapies)*	$30 copayment per visit	40% coinsurance per visit after OON plan deductible is met
Physical and Occupational Therapy *(40 visits per calendar year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per calendar year limit combined for Habilitative speech, physical and occupational therapies)*	$30 copayment per visit	40% coinsurance per visit after OON plan deductible is met
Other Services	**IN-NETWORK (INET) MEMBER PAYS**	**OUT-OF-NETWORK (OON) MEMBER PAYS**
Chiropractic Services *(up to 20 visits per calendar year)*	$50 copayment per visit	40% coinsurance per visit after OON plan deductible is met
Diabetic Equipment & Supplies	40% coinsurance per equipment/supply	40% coinsurance per equipment/supply after OON plan deductible is met
Durable Medical Equipment (DME)	40% coinsurance per equipment/supply	40% coinsurance per equipment/supply after OON plan deductible is met
Home Health Care Services *(up to 100 visits per calendar year)*	No cost	25% coinsurance per visit after separate $50 plan deductible is met
Outpatient Services *(in a hospital or ambulatory facility)*	$500 copayment per visit after INET plan deductible is met	40% coinsurance per visit after OON plan deductible is met
Inpatient Hospital Services	**IN-NETWORK MEMBER PAYS**	**OUT-OF-NETWORK MEMBER PAYS**
Inpatient Hospital services ***(including mental health, substance abuse, maternity, hospice and skilled nursing facility*)*** **(skilled nursing facility stay is limited to 90 days per calendar year)*	$500 copayment per day up to maximum of $2,000 per admission after INET plan deductible is met	40% coinsurance per visit after OON plan deductible is met

Emergency and Urgent Care	IN-NETWORK MEMBER PAYS	OUT-OF-NETWORK MEMBER PAYS
Ambulance Services	No cost	No cost
Emergency Room	$200 copayment per visit after INET plan deductible is met	$200 copayment per visit after INET plan deductible is met
Urgent Care Centers	$75 copayment per visit	40% coinsurance per visit after OON plan deductible is met
Pediatric Dental Care *(for children under age 20)*	**IN-NETWORK** **MEMBER PAYS**	**OUT-OF-NETWORK** **MEMBER PAYS**
Diagnostic & Preventive	No cost	50% coinsurance per visit after OON plan deductible is met
Basic Services	40% coinsurance per visit	50% coinsurance per visit after OON plan deductible is met
Major Services	50% coinsurance per visit	50% coinsurance per visit after OON plan deductible is met
Orthodontia Services *(medically necessary only)*	50% coinsurance per visit	50% coinsurance per visit after OON plan deductible is met
Pediatric Vision Care *(for children under age 20)*	**IN-NETWORK** **MEMBER PAYS**	**OUT-OF-NETWORK** **MEMBER PAYS**
Prescription Eye Glasses *(one pair of frames and lenses or contact lens per calendar year)*	Lenses: $0 Collection frame: $0 Non-collection frame: Members choosing to upgrade from a collection frame to a non-collection frame will be given a credit substantially equal to the cost of the collection frame and will be entitled to any discount negotiated by the carrier with the retailer	Not covered
Routine Eye Exam by Specialist *(one exam per calendar year)*	$50 copayment per visit	40% coinsurance per visit after OON plan deductible is met

Adult Vision Care *(over age 20)*	**IN-NETWORK** **MEMBER PAYS**	**OUT-OF-NETWORK** **MEMBER PAYS**
Routine Eye Exam by Specialist *(one exam per calendar year)*	$50 copayment per visit	40% coinsurance per visit after OON plan deductible is met

Important Information

- This is a brief summary of benefits. Refer to your ConnectiCare Benefits, Inc. Policy for complete details on benefits, conditions, limitations and exclusions. All benefits described are per member per Calendar year.
- 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.
- ConnectiCare offers a Telemedicine benefit for all members. The type of provider you see will determine the cost share and will follow the PCP or Specialist office visit.
- 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 ConnectiCare Benefits, Inc. policy for more 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 drugs or supplies 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.