

Enrollment information for groups with **3-50** employees



CBIA
HEALTH
CONNECTIONS **2**
THE POWER OF CHOICE

The doctors you want and the coverage you need.



January 2011

All plans are offered by **ConnectiCare** and **Oxford** unless otherwise noted.

		POS \$2,000	HMO \$30/\$45-\$2,500	POS \$30/\$45-\$2,500/20%	POS \$30/\$45-\$5,000	POS \$30/\$45-\$3,000
Benefit Year		Contract Year**	Contract Year**	Contract Year**	Contract Year**	Contract Year**
Medical Office Visits* <i>Includes office visits associated with mental/nervous and substance abuse</i>	IN-NETWORK	Routine/preventive services covered in full. All other services subject to deductible then covered in full.	\$30 PCP/\$45 specialist per visit	\$30 PCP/\$45 specialist per visit	\$30 PCP/\$45 specialist per visit	\$30 PCP/\$45 specialist per visit
	OUT-OF-NETWORK	70/30% after deductible		60/40% after deductible	70/30% after deductible	70/30% after deductible
Hospital Inpatient	IN-NETWORK	Subject to deductible, then covered in full.	Covered in full after plan deductible	80/20% after deductible	Covered in full after Hospital & Facility-based services deductible of \$5,000 individual/\$10,000 family	Covered in full after Hospital & Facility-based services deductible of \$3,000 individual/\$6,000 family
	OUT-OF-NETWORK	70/30% after deductible		60/40% after deductible	70/30% after deductible	70/30% after deductible
Outpatient Surgery* <i>Doctor's office or other facility</i>	IN-NETWORK	Subject to deductible, then covered in full.	\$30 PCP office; \$45 specialist office; outpatient facility—covered in full after plan deductible	80/20% after deductible	\$30 PCP/\$45 specialist; Outpatient facility: Subject to Hospital & Facility-based deductible of \$5,000 individual/\$10,000 family	\$30 PCP; \$45 specialist; Outpatient facility: subject to Hospital & Facility-based deductible of \$3,000 individual/\$6,000 family
	OUT-OF-NETWORK	70/30% after deductible		60/40% after deductible	70/30% after deductible	70/30% after deductible
Diagnostic X-ray and Laboratory* <i>(Advanced imaging services may vary by carrier and are defined in an employee's certificate of coverage)</i>	IN-NETWORK	Diagnostic X-ray: Subject to deductible then covered in full. Lab: Covered in full as part of routine physical exam, otherwise subject to deductible.	Diagnostic X-ray: Subject to deductible then covered in full. Lab: Covered in full.	80/20% after deductible	Advanced imaging: \$75 co-pay per service to a co-pay max. of \$375 per benefit year. All other services covered in full. Lab: Covered in full at participating labs.	Advanced imaging: \$75 co-pay per service to a co-pay max. of \$375 per benefit year. All other services covered in full. Lab: Covered in full at participating labs.
	OUT-OF-NETWORK	70/30% after deductible		60/40% after deductible	70/30% after deductible	70/30% after deductible
Urgent Care <i>(includes walk-in centers)</i>	IN-NETWORK	Subject to deductible, then covered in full.	\$75 per visit	\$75 per visit	\$75 per visit	\$75 per visit
	OUT-OF-NETWORK	70/30% after deductible		\$75 per visit	70/30% after deductible	70/30% after deductible
Emergency Room Services	IN-NETWORK	Subject to in-network deductible, then covered in full.	\$150 if not admitted to hospital	\$150 if not admitted to hospital	\$150 if not admitted to hospital	\$150 if not admitted to hospital
	OUT-OF-NETWORK	Subject to in-network deductible, then covered in full.	\$150 if not admitted to hospital	\$150 if not admitted to hospital	\$150 if not admitted to hospital	\$150 if not admitted to hospital
Prescription Drugs <i>(Retail) (MAC-A: Mandatory Generic****) See formularies for each health plan company.</i>	IN-NETWORK	\$100 pharmacy deductible on tiers 2 and 3 only, then co-pays apply. 3X deductible max. per family. Three-tier co-pay \$15/\$30/\$40	\$100 pharmacy deductible on tiers 2 and 3 only, then co-pays apply. 3X deductible max. per family. Three-tier co-pay \$15/\$30/\$40	\$200 pharmacy deductible on tiers 2 and 3 only, then co-pays apply. 3x deductible max. per family. Three tier co-pay \$10/30/40	\$100 pharmacy deductible on tiers 2 and 3 only, then co-pays apply. 3X deductible max. per family. Three-tier co-pay \$15/\$30/\$40	Three-tier co-pay \$15/\$30/\$40
	OUT-OF-NETWORK	Not covered. Members must use participating pharmacy.		Not covered. Members must use participating pharmacy.	Not covered. Members must use participating pharmacy.	Not covered. Members must use participating pharmacy.
Deductible	IN-NETWORK	\$2,000 individual/\$4,000 family	\$2,500 individual/\$5,000 family	\$2,500 individual/\$5,000 family	Front End N/A; Hospital/Facility \$5,000	Front End N/A; Hospital/Facility \$3,000
	OUT-OF-NETWORK	\$3,000 individual/\$6,000 family		\$5,000 individual/\$10,000 family	\$5,000 individual/\$10,000 family	\$5,000 individual; \$10,000 family
Coinsurance	IN-NETWORK	100%	N/A	80/20% after deductible	N/A	N/A
	OUT-OF-NETWORK	70/30% after deductible		60/40% after deductible	70/30% after deductible	70/30% after deductible
Maximum Out-of-Pocket Limit <i>Based on approved charges (including deductible)</i>	IN-NETWORK	N/A	N/A	\$5,000 individual/\$10,000 family	N/A	N/A
	OUT-OF-NETWORK	\$5,000 individual/\$10,000 family		\$10,000 individual/\$20,000 family	\$10,000 individual/\$20,000 family	\$10,000 individual; \$20,000 family
Coinsurance Limit <i>(not including deductible or in-network co-payments)</i>	IN-NETWORK	N/A	N/A	\$2,500 individual/\$5,000 family	N/A	N/A
	OUT-OF-NETWORK	\$2,000 individual/\$4,000 family		\$5,000 individual/\$10,000 family	\$5,000 individual/\$10,000 family	\$5,000 individual; \$10,000 family
Access		All carriers Open Access	All carriers Open Access	All carriers Open Access	All carriers Open Access	All carriers Open Access

* in compliance with federal mandate, routine/preventive services will be covered in full for all plans. All other services are subject to applicable co-pay or deductible. For information on routine/preventive services, visit cbia.com/ins.
 ** Oxford: Contract year effective July 1, 2009 for new business. In-force groups may be contract year or calendar year, determined at a group's renewal. For Oxford, only deductibles run on a contract year. All other benefits operate on a calendar year.
 *** Generic substitution is required when available. If member purchases a brand drug when a generic is available, the member pays the co-pay plus the difference in cost between the brand and generic.
 All p emp plan

POS \$30/\$45	POS \$20/\$40-\$2,500	POS \$20/\$40-\$1,500	POS \$20 and \$20 OA	HMO \$30/\$45	HMO \$20
ConnectiCare: Contract Year; Oxford: Calendar Year	Contract Year**	Contract Year**	ConnectiCare: Contract Year; Oxford: Calendar Year	ConnectiCare: Contract Year; Oxford: Calendar Year	ConnectiCare: Contract Year; Oxford: Calendar Year
\$30 PCP/\$45 specialist per visit	\$20 PCP/\$40 specialist per visit	\$20 PCP/\$40 specialist per visit	\$20 per visit	\$30 PCP/\$45 specialist per visit	\$20 per visit
70/30% after deductible	70/30% after deductible	70/30% after deductible	70/30% after deductible		
Covered in full after \$500 per day to a max. of \$2,000 per year	Covered in full after Hospital & Facility-based services deductible of \$2,500 individual/\$5,000 family	Covered in full after Hospital & Facility-based services deductible of \$1,500 individual/\$3,000 family	Covered in full after \$500 per admission co-pay	Covered in full after \$500 per day to a max. of \$2,000 per year	Covered in full after \$500 per admission co-pay
70/30% after deductible	70/30% after deductible	70/30% after deductible	70/30% after deductible		
\$30 PCP; \$45 specialist; \$500 outpatient facility	\$20 PCP; \$40 specialist; Outpatient facility; subject to Hospital & Facility-based deductible of \$2,500 individual/\$5,000 family	\$20 PCP; \$40 specialist; Outpatient facility; subject to Hospital & Facility-based deductible of \$1,500 individual/\$3,000 family	\$20 doctor's office; \$100 outpatient facility	\$30 PCP; \$45 specialist; \$500 outpatient facility	\$20 doctor's office; \$100 outpatient facility
70/30% after deductible	70/30% after deductible	70/30% after deductible	70/30% after deductible		
Advanced imaging: \$75 co-pay per service to a co-pay max. of \$375 per benefit year. All other services covered in full. Lab: Covered in full at participating labs.	Advanced imaging: \$75 co-pay per service to a co-pay max. of \$375 per benefit year. All other services covered in full. Lab: Covered in full at participating labs.	Advanced imaging: \$75 co-pay per service to a co-pay max. of \$375 per benefit year. All other services covered in full. Lab: Covered in full at participating labs.	Advanced imaging: \$75 co-pay per service to a co-pay max. of \$375 per benefit year. All other services covered in full. Lab: Covered in full at participating labs.	Advanced imaging: \$75 co-pay per service to a co-pay max. of \$375 per benefit year. All other services covered in full. Lab: Covered in full at participating labs.	Advanced imaging: \$75 co-pay per service to a co-pay max. of \$375 per benefit year. All other services covered in full. Lab: Covered in full at participating labs.
70/30% after deductible	70/30% after deductible	70/30% after deductible	70/30% after deductible		
\$75 per visit	\$75 per visit	\$75 per visit	\$50 per visit	\$75 per visit	\$50 per visit
70/30% after deductible	70/30% after deductible	70/30% after deductible	70/30% after deductible		
\$150 if not admitted to hospital	\$150 if not admitted to hospital	\$150 if not admitted to hospital	\$100 if not admitted to hospital	\$150 if not admitted to hospital	\$100 if not admitted to hospital
\$150 if not admitted to hospital	\$150 if not admitted to hospital	\$150 if not admitted to hospital	\$100 if not admitted to hospital		
Three-tier co-pay \$15/\$30/\$40	Three-tier co-pay \$15/\$30/\$40	Three-tier co-pay \$15/\$30/\$40	Three-tier co-pay \$15/\$30/\$40	Three-tier co-pay \$15/\$30/\$40	Three-tier co-pay \$15/\$30/\$40
Not covered. Members must use participating pharmacy.	Not covered. Members must use participating pharmacy.	Not covered. Members must use participating pharmacy.	Not covered. Members must use participating pharmacy.		
N/A	Front End N/A; Hospital/Facility \$2,500	Front End N/A; Hospital/Facility \$1,500	N/A	N/A	N/A
\$2,500 individual; \$5,000 family	\$5,000 individual; \$10,000 family	\$2,500 individual; \$5,000 family	\$750 individual; \$2,250 family		
N/A	N/A	N/A	N/A	N/A	N/A
70/30% after deductible	70/30% after deductible	70/30% after deductible	70/30% after deductible		
N/A	N/A	N/A	N/A	N/A	N/A
\$7,500 individual; \$15,000 family	\$10,000 individual; \$20,000 family	\$7,500 individual; \$15,000 family	\$3,750 individual; \$11,250 family		
N/A	N/A	N/A	N/A	N/A	N/A
\$5,000 individual; \$10,000 family	\$5,000 individual; \$10,000 family	\$5,000 individual; \$10,000 family	\$3,000 individual; \$9,000 family		
Oxford: Gated; ConnectiCare: Open Access	All carriers Open Access	All carriers Open Access	Available as Gated or Open Access	Oxford: Gated; ConnectiCare: Open Access	Oxford: Gated; ConnectiCare: Open Access

DOI approval. The services described in this brochure are only an overview of the entire benefit package. For a more detailed plan description prior to enrolling, please contact the health plan company that interests you. Health plan company phone numbers can be obtained from you provided by the health plan company under the benefit plan you select will be fully described in the proof of coverage document you'll receive once you are enrolled in the program. The benefits are subject to various limitations, exclusions and conditions as fully described in each health certificate of Coverage. The services identified are covered as described only when they are provided based on the guidelines of the program; in other words, when they are provided, prescribed or directed by the health plan company you have selected (except in cases of emergencies).

HSA Compatible Plans (Highlights)

	ConnectiCare POS \$2500 B	OXFORD \$2000 D	\$2500 E <i>ConnectiCare and Oxford</i>
Benefit Year	Contract Year	Contract Year*	Contract Year*
Deductible**	\$2,500 individual plan deductible; \$5,000 family plan deductible	\$2,000 individual plan deductible \$4,000 family plan deductible	\$2,500 individual plan deductible \$5,000 family plan deductible
Coinsurance	100%	100%	100%
Coinsurance Limit <i>(not including deductible or in-network co-payments)</i>	N/A	N/A	N/A
Maximum Out-of-Pocket <i>Based on approved charges (including deductible)</i>	\$3,500 individual (2X family)	\$5,000 individual (2X family)	\$3,000 individual (2X family)
Prescription Drugs <i>(Retail)</i>	Subject to plan deductible. Once deductible is met, then \$15/\$25/\$40 (Tier 1/2/3) up to a pharmacy coinsurance maximum of \$1,000 individual plan/\$2,000 family plan per calendar year. Maximum does not include the plan deductible.	Subject to plan deductible. Once deductible is met, then \$15/\$25/\$40 (Tier 1/2/3)	Subject to plan deductible. Once deductible is met, then \$15/\$25/\$40 (Tier 1/2/3)

For more information on each HSA compatible plan, visit cbia.com/plansummaries.

* Oxford: Contract year effective July 1, 2009 for new business. In-force groups may be contract year or calendar year, determined at a group's renewal. For Oxford, only deductibles will run on a contract year. All other benefits will operate on a calendar year.
 ** Note: For Family coverage, all HSA plans require that the family plan deductible be met completely prior to any member of the family becoming eligible for benefits after the deductible.



For more information, please talk to your benefits administrator or your agent.

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350 Church St. • Hartford, CT 06103-1126 • 860-244-1900

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