ConnectiCare

Passage SOLO HMO Copay/Coins. $6,000 ded. Calendar year Benefit Summary

Your ConnectiCare health plan helps you get the care you need. Here are the most frequently used services. Refer to your policy on connecticare.com for a complete list of benefits.

Passage plans require the selection of an in-network primary care provider upon enrollment.

A referral from your primary care provider is required to see a specialist.

Free* Preventive Services

These services are free with your premium when you use an **in-network** doctor or facility. 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**

*Free preventive care means that you will not have a copayment or have to pay money toward your deductible or coinsurance for the services. Sometimes a preventive care visit leads to other medical care or tests, even at the same appointment. You should check with your doctor or doctor's staff during your visit to see if there are services you may be billed for.

Your care costs

	In-network
Your deductible Deductible is combined for health services and prescription drugs	$6,000 Individual $12,000 Family
Your out-of-pocket maximum	$7,350 Individual $14,700 Family

Your plan requires that you use doctors and other care providers that are in ConnectiCare's network. Check to see if your doctor is in our network, or find a new one, at connecticare.com/findadoctor.

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

Screenings	**In-network**
Breast ultrasound	$20 copayment/visit after plan deductible
Routine vision exam	$50 copayment/visit deductible does not apply
Allergy testing one visit per year	See primary care or specialist services
Ongoing Care and Sick Visits	**In-network**
Primary care services	$40 copayment/visit deductible does not apply

Ongoing Care and Sick Visits	In-network
Specialist services	$50 copayment/visit after plan deductible
Gynecologist services	$50 copayment/visit after plan deductible
Maternity and prenatal care visits	No charge
Allergy injections up to 20 visits per year	See primary care or specialist services
Telemedicine visit	See primary care or specialist services
Retail clinic	$40 copayment/visit deductible does not apply
Lab and Radiology Performed in a hospital, lab or radiology facility	**In-network**
Laboratory services	$5 copayment/visit after plan deductible
Non-advanced radiology X-ray, diagnostic, baseline mammography, screening tomosynthesis	$30 copayment/visit after plan deductible
Advanced radiology **Hospital facility** MRI, PET and CAT scan and nuclear cardiology	50% coinsurance after plan deductible
Advanced radiology **Stand-alone facility** up to five copayments per year, then copayments waived MRI, PET and CAT scan and nuclear cardiology	$75 copayment/visit after plan deductible
Sudden or Unexpected Care The same cost share applies for both in-network and out-of-network services	**In-network**
Urgent care or other walk-in clinic	$75 copayment/visit deductible does not apply
Emergency room	50% coinsurance after plan deductible
Ambulance	50% coinsurance after plan deductible
Hospital Stays	**In-network**
Inpatient hospital services, including room and board	50% coinsurance after plan deductible

Hospital Stays	In-network
Skilled nursing and rehabilitation facilities up to 90 days per year	50% coinsurance after plan deductible
Outpatient and Home Care	**In-network**
Hospital outpatient facilities	50% coinsurance after plan deductible
Ambulatory surgical center	50% coinsurance after plan deductible
Home health services up to 100 visits per year	25% coinsurance deductible does not apply
Chiropractic services up to 20 visits per year	$50 copayment/visit after plan deductible
Outpatient Rehabilitative and Habilitative Services	**In-network**
Physical and occupational therapy up to 40 visits per year combined for physical, speech and occupational therapy (habilitative services have a separate 40 visit maximum)	$30 copayment/visit after plan deductible
Speech therapy up to 40 visits per year combined for physical, speech and occupational therapy (habilitative services have a separate 40 visit maximum)	$50 copayment/visit after plan deductible
Mental Health and Substance Abuse	**In-network**
Inpatient mental health services	50% coinsurance after plan deductible
Inpatient alcohol and substance abuse treatment	50% coinsurance after plan deductible
Outpatient mental health, alcohol and substance abuse treatment (office visits and home services)	$50 copayment/visit deductible does not apply
Outpatient mental health, alcohol and substance abuse treatment (intensive outpatient treatment and partial hospitalization)	50% coinsurance after plan deductible
Supplies	**In-network**
Breastfeeding supplies	No charge
Durable medical equipment including prosthetics and disposable medical supplies	50% coinsurance after plan deductible

Supplies	In-network
Diabetic equipment and supplies	50% coinsurance after plan deductible
Modified food products and specialized formula pharmacy tier	50% coinsurance after plan deductible
Pediatric Only Services (for members under age 20)	**In-network**
Pediatric dental diagnostic & preventive	No charge
Pediatric dental services Basic restorative, major restorative and orthodontia services (medically necessary only)	50% coinsurance after plan deductible
Pediatric vision routine eye exam one exam per year	$50 copayment/visit deductible does not apply
Pediatric prescription eye glasses one pair of frames and lenses per year	Lenses: 50% after plan deductible Collection frames: 50% after plan deductible Non-collection frames: 50% after Plan Deductible up to the collection frame allowance; any amount over is payable by the member minus a 20% discount
Prescription Drugs **Retail Pharmacy** - up to 30 day supply per prescription **Mail order Pharmacy** - up to 90 day supply per prescription	**In-network**
Preferred generic drugs (Tier 1)	$5 copayment/prescription deductible does not apply (retail) $10 copayment/prescription deductible does not apply (mail order)
Non-preferred generic drugs (Tier 2)	50% coinsurance up to a maximum of $200 per prescription after plan deductible (retail) 50% coinsurance up to a maximum of $400 per prescription after plan deductible (mail order)
Preferred brand drugs (Tier 3)	$40 copayment/prescription after plan deductible (retail) $80 copayment/prescription after plan deductible (mail order)
Non-preferred brand drugs (Tier 4)	50% coinsurance up to a maximum of $200 per prescription after plan deductible (retail) 50% coinsurance up to a maximum of $400 per prescription after plan deductible (mail order)

Prescription Drugs **Retail Pharmacy** - up to 30 day supply per prescription **Mail order Pharmacy** - up to 90 day supply per prescription	**In-network**
You can choose to get a brand-name drug instead of a generic, but you will pay more: the cost of the generic drug plus the difference in the price for the brand name. What you pay for the difference of the brand-name drug will also not count toward your plan's deductible or out-of-pocket costs. Refer to the drug list on connecticare.com to find the tier for your drug.	
Specialty Drugs (up to a 30 day supply per prescription) These drugs generally require pre-authorization and may require special handling	**In-network**
Preferred specialty drugs (Tier 5)	50% coinsurance up to a maximum of $500 per prescription after plan deductible (specialty retail only)
Non-preferred specialty drugs (Tier 6)	50% coinsurance up to a maximum of $750 per prescription after plan deductible (specialty retail only)

Getting care outside of our network
Generally your plan does not cover services rendered outside of our network. Please refer to your member documents for additional plan information. To ensure that you use services within our network, please visit www.connecticare.com and use the "Find a doctor" option to search for doctors and facilities.

Important Information
• This is a brief summary of benefits. Refer to your Membership Agreement for complete details on benefits, conditions, limitations and exclusions, or consult with your benefits manager. 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. • 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. • 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.