



# SOLO Individual Plans

2025

ConnectiCare<sup>®</sup>



# Creating Healthier Futures

Your health is your greatest strength. Helping you maintain it is ours. That's why at ConnectiCare, we go beyond coverage to connect you to conveniently located doctors and health and wellness resources that can help keep you healthy.

This guide has information on 2025 ConnectiCare Choice SOLO health plans for individuals and families.

## Get the Benefits and Services You Need

**ConnectiCare Choice SOLO plans** include many benefits that help you and your family stay healthy including preventive care and care when you're sick or hurt.

- Preventive care at \$0 cost-share for services like annual checkups, screenings, flu shots, and other vaccinations.\*
- Prescription drug coverage, including drugs that are available at \$0 cost-share, like birth control and medicine to prevent heart disease.
- Mental health care for substance use disorder, anxiety, depression, and other behavioral health conditions.
- Specialist care, diagnostic testing, and hospital treatment.
- Pediatric dental and vision coverage for members through age 26.
- Emergency and urgent care wherever you travel.\*\*



### Teladoc® Primary360

Most SOLO plans offer convenient telemedicine with a **\$0** copay and **\$0** deductible\* for virtual primary care, mental health, and 24/7 on-demand, nonemergency care through phone, video, or mobile app messaging.\*\*\* Plus, dermatology is available with a specialist cost-share. See the same primary care provider (PCP) with no limit on visits.

\*Preventive care means that you will not have a copay or have to pay 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.

\*\*Subject to limitations.

\*\*\*Telemedicine is not appropriate for all covered services, and restrictions apply. Not all services available 24/7. For primary care, members must be 18 or older; for Teladoc mental health services, members must be 13 or older. HSA-compatible plans are subject to deductible.



# The ConnectiCare Difference



### BenefitHub Discount Program

Save on clothing, electronics, gift certificates, cars, vacations, and more.

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### Health Assessment Gift Card

Get a **\$20** gift card for answering health assessment questions.

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### HUSK Marketplace Wellness Discounts

- Gym and fitness center memberships.
  - On-demand fitness.
  - Wellness products.
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### Vision Discount Program

Get **25%** to **30%** off frames, lenses, and prescription contacts when using a participating optician.



# Optional Preventive Dental Coverage

We offer optional adult dental coverage for preventive services — cleanings and checkups — and some comprehensive services, such as fillings. Orthodontic treatment is not included. Plans cover both in- and out-of-network services, although you may pay less by using in-network dentists.

You can purchase preventive dental coverage with your SOLO medical plan or look for our dental plans on Access Health CT with or without the purchase of an on-exchange medical plan.

Use “Find a Doctor” on **connecticare.com** to find participating dentists in the ConnectiCare dental network.

## Member Choice Pharmacy Benefit

Members on maintenance medicines (drugs you take every day, month after month) get convenient, 90-day supplies with a choice of filling these prescriptions at either CVS or Walgreens, or through Express Scripts (ESI) mail order.

Other prescriptions can be filled at any in-network pharmacy.\* You have the option to switch your pharmacy chain once per plan year.

\*Please note, if you choose to fill maintenance medicines at CVS, Walgreens will become out-of-network for you. If you select Walgreens, CVS will become out-of-network. ESI mail order for maintenance drugs will continue to be an option at any time, even after you choose a retail network. Copayments for 90-day supplies will be the same whether filling through home delivery or the participating pharmacy.

## ConnectiCare SOLO Is Guaranteed Issue

Guaranteed issue means that your SOLO health insurance policy will be issued regardless of your health status. There is no underwriting, and there are no medical questions on the application.

### Eligibility

You may apply for ConnectiCare SOLO if you are:

- A legal resident of Connecticut.
- Under age 65.
- Not eligible to enroll in Medicare.
- Single or married, or one of the following:
  - Dependent spouse.
  - Civil union/domestic partner.\*\*
  - Dependent child up to age 26 who is not covered under a group health plan.

\*\*Domestic partners must meet eligibility criteria and submit the Domestic Partner Verification Form or other satisfactory certification as we determine. CAUTION: Domestic partners are not recognized by the IRS as legal dependents for HSA funding. You should consult with your broker and your tax advisor before establishing an HSA.

### Guaranteed Renewal

You have the right to renew your plan each year. Your decision to renew your policy has no impact on claims for services you had before your current plan’s end date.

# Choosing Your Plan

You want your health care dollars to work hard for you. So, take some time to review your plan options and choose the one that meets your needs and budget.

**ConnectiCare Choice SOLO plans** let you manage your health your way. You may use any of the doctors, hospitals, labs, and facilities in our large network covering Connecticut, 28 counties of New York, and parts of Massachusetts and Rhode Island.

## Metal Levels

Here's the range of premiums and out-of-pocket costs for all types of plans.

Metal Level	Premiums	Out-of-Pocket Costs	Plan Pays*
Silver	Moderate	Moderate	70%
Bronze	Lowest	Highest	60%

## Networks

Using doctors in your plan's network can help save you money. Go to [connecticare.com](https://connecticare.com) and use "Find a Doctor" to find doctors and facilities in your plan's network.

# What Happens After You Enroll

After you enroll in an individual or family plan, if your plan has a monthly premium, you'll receive a bill. For your coverage to begin, you must pay the bill by the due date on your invoice. Please note that if you don't pay your premium on time, you will not be considered a member of the plan and any services you receive will not be covered.

Soon after you enroll, you'll receive your member ID card. We encourage all members to set up an account on our member portal, [my.connecticare.com](https://my.connecticare.com), and select a primary care provider (PCP).

\*Average amount plan pays for covered services.

# Health Plan ABCs

Three letters that can explain a lot about your health plan.

**HMO** – Select a plan with “HMO” (health maintenance organization) in the name, and you must visit in-network doctors to have those services covered.

**POS** – Choosing a plan with “POS” (point of service) in its name means you’ll be able to visit out-of-network doctors, but you’ll pay more.

**HSA** – Stands for “health savings account.” HSA plans allow you to save by using pre-tax money for qualified health care expenses. HSA plans may have higher deductibles than others.

## Guide to Important Terms

You pay a premium every month for your health insurance. There are other costs you may pay, too. The plan grids on the next few pages use the terms defined below.

**Deductible** – a specific amount that you pay each year before ConnectiCare starts to pay covered expenses.

**Maximum out-of-pocket costs** – the most you’d have to pay (in addition to premium) in the plan year for covered services.

**In-network** – refers to doctors, hospitals, pharmacies, facilities, and other health care professionals that have negotiated rates for services with ConnectiCare.

**Copayment or copay** – a fixed amount you pay for a service covered by your plan.

**Medical benefits or covered services** – the benefits or services that your ConnectiCare plan pays some or all of the costs of.

**Out-of-network** – doctors, hospitals, pharmacies, facilities, and other health care professionals that do not have contracts with ConnectiCare. You’ll often pay more or not have any coverage if you visit out-of-network doctors, hospitals, pharmacies, facilities, or other health care professionals.

**Deductible waived** – means your deductible does not apply to the service, and you have a copay or coinsurance.

**Coinsurance** – describes how you and ConnectiCare will share the costs of covered services and prescription medicines.

**Prescription drug benefit** – describes how much you’ll pay for prescription drugs that are on your plan’s drug list.

**Primary care provider (PCP)** – a health care professional that gets to know you and your medical history to help keep you healthy. You visit a PCP to help manage chronic conditions and receive preventive care such as annual checkups, screenings, and vaccinations.

**Tiers** – a way of categorizing prescription drugs covered by your plan. Generally, drugs in tiers with lower numbers cost you less than drugs in tiers with higher numbers.

## Compare plans and enroll

Visit [chooseconnecticare.com](https://www.chooseconnecticare.com) to compare plan features, premiums, and out-of-pocket costs. Then enroll online.

# Choice SOLO Plans

Plan name/Metal level

Choice SOLO POS  
Coins. \$4,000 ded.  
Silver

Choice SOLO POS  
Copay/Coins. \$5,500 30% ded.  
Silver

NETWORK ACCESS	CT, parts of MA, RI, and NY through EmblemHealth Prime Network	CT, parts of MA, RI, and NY through EmblemHealth Prime Network
<b>PLAN/MEDICAL DEDUCTIBLE</b>		
Deductible (individual/family)	\$4,000/\$8,000*	\$5,500/\$11,000*
Maximum out-of-pocket limit (individual/family)	\$8,400/\$16,800	\$8,000/\$16,000
<b>IN-NETWORK MEDICAL BENEFITS</b>		
Preventive care/screenings/immunizations	\$0	\$0
Primary care provider (PCP) services	\$50 copay (deductible waived)	\$40 copay (deductible waived)
Telemedicine visits through Teladoc**	<b>Primary care, mental health and general medical services: \$0 (deductible waived)</b> <b>Dermatologist: 50% coinsurance after deductible</b>	<b>Primary care, mental health, and general medical services: \$0 (deductible waived)</b> <b>Dermatologist: \$70 copay after deductible</b>
Specialist services	50% coinsurance after deductible	\$70 copay after deductible
Mental health and substance use office visits	\$50 copay (deductible waived)	\$40 copay (deductible waived)
Vision	50% coinsurance after deductible	\$50 copay (deductible waived)
Walk-in/urgent care center	50% coinsurance after deductible	\$100 copay (deductible waived)
Worldwide emergency coverage***	50% coinsurance after deductible	30% coinsurance after deductible
Hospital – inpatient treatment	50% coinsurance after deductible	30% coinsurance after deductible
Hospital – outpatient treatment	50% coinsurance after deductible	30% coinsurance after deductible
Outpatient surgery in independent locations	50% coinsurance after deductible	\$500 copay after deductible
Lab services	50% coinsurance after deductible	<b>Independent facility: \$10 copay after deductible</b> <b>Hospital setting: 30% coinsurance after deductible</b>
X-rays	50% coinsurance after deductible	<b>Independent facility: \$35 copay after deductible</b> <b>Hospital setting: 30% coinsurance after deductible</b>
Advanced imaging (CT scans and MRI)	50% coinsurance after deductible	<b>Independent facility: \$75 copay up to \$375 after deductible</b> <b>Hospital setting: 30% coinsurance after deductible</b>
<b>OUT-OF-NETWORK MEDICAL BENEFITS</b>		
Deductible (individual/family)	\$15,000/\$30,000	\$15,000/\$30,000
Coinsurance	50%	50%
Maximum out-of-pocket limit (individual/family)	\$30,000/\$60,000	\$30,000/\$60,000
<b>PRESCRIPTION DRUG BENEFITS</b>		
Prescription drug deductible (individual/family)	Plan has integrated deductible with medical (see above)*	Plan has integrated deductible with medical (see above)*
Tier 1 – Preferred generic drugs	\$10 copay (deductible waived)	\$10 copay (deductible waived)
Tier 2 – Non-preferred generic drugs	50% coinsurance; \$250 maximum per prescription after deductible	50% coinsurance; \$250 maximum per prescription after deductible
Tier 3 – Preferred brand drugs	\$50 copay (deductible waived)	\$60 copay (deductible waived)
Tier 4 – Non-preferred brand drugs	50% coinsurance; \$500 maximum per prescription after deductible	50% coinsurance; \$500 maximum per prescription after deductible
Tier 5 – Preferred specialty drugs	50% coinsurance; \$500 maximum per prescription after deductible	50% coinsurance; \$500 maximum per prescription after deductible
Tier 6 – Non-preferred specialty drugs	50% coinsurance; \$750 maximum per prescription after deductible	50% coinsurance; \$750 maximum per prescription after deductible

\*Integrated medical and prescription drug deductible.

\*\*Telemedicine is not appropriate for all covered services, and restrictions apply. For primary care, members must be 18 or older; for Teladoc mental health services, members must be 13 or older.

\*\*\*Subject to limitations.



Choice SOLO POS Copay/Coins. \$6,000 ded. Silver	Choice SOLO HMO Copay/Coins. \$7,700 ded. Silver	Choice SOLO POS HSA Coins. \$3,500 ded. Silver
CT, parts of MA, RI, and NY through EmblemHealth Prime Network	CT, parts of MA, RI, and NY through EmblemHealth Prime Network	CT, parts of MA, RI, and NY through EmblemHealth Prime Network
\$6,000/\$12,000*	\$7,700/\$15,400*	\$3,500/\$7,000*
\$9,200/\$18,400	\$9,000/\$18,000	\$7,200/\$14,400
\$0	\$0	\$0
\$40 copay (deductible waived)	\$40 copay (deductible waived)	30% coinsurance after deductible
<b>Primary care, mental health, and general medical services:</b> \$0 (deductible waived) <b>Dermatologist:</b> \$70 copay (deductible waived)	<b>Primary care, mental health, and general medical services:</b> \$0 (deductible waived) <b>Dermatologist:</b> \$60 copay (deductible waived)	<b>Primary care, mental health, and general medical services:</b> 0% coinsurance after deductible <b>Dermatologist:</b> 30% coinsurance after deductible
\$70 copay (deductible waived)	\$60 copay (deductible waived)	30% coinsurance after deductible
\$40 copay (deductible waived)	\$40 copay (deductible waived)	30% coinsurance after deductible
\$50 copay (deductible waived)	\$25 copay (deductible waived)	25% coinsurance (deductible waived)
\$100 copay (deductible waived)	\$100 copay (deductible waived)	30% coinsurance after deductible
30% coinsurance after deductible	50% coinsurance after deductible	30% coinsurance after deductible
30% coinsurance after deductible	50% coinsurance after deductible	30% coinsurance after deductible
30% coinsurance after deductible	50% coinsurance after deductible	30% coinsurance after deductible
\$500 copay after deductible	\$500 copay (deductible waived)	30% coinsurance after deductible
<b>Independent facility:</b> \$10 copay after deductible <b>Hospital setting:</b> 30% coinsurance after deductible	\$25 copay (deductible waived)	30% coinsurance after deductible
<b>Independent facility:</b> \$35 copay (deductible waived) <b>Hospital setting:</b> 30% coinsurance after deductible	<b>Independent facility:</b> \$60 copay (deductible waived) <b>Hospital setting:</b> 50% coinsurance after deductible	30% coinsurance after deductible
<b>Independent facility:</b> \$75 copay up to \$375 after deductible <b>Hospital setting:</b> 30% coinsurance after deductible	<b>Independent facility:</b> 50% coinsurance (deductible waived) <b>Hospital setting:</b> 50% coinsurance after deductible	30% coinsurance after deductible
\$15,000/\$30,000	N/A	\$15,000/\$30,000
50%	N/A	50%
\$30,000/\$60,000	N/A	\$30,000/\$60,000
Plan has integrated deductible with medical (see above)*	Plan has integrated deductible with medical (see above)*	Plan has integrated deductible with medical (see above)*
\$10 copay (deductible waived)	\$15 copay (deductible waived)	\$10 copay after deductible
50% coinsurance; \$250 maximum per prescription after deductible	50% coinsurance; \$250 maximum per prescription after deductible	50% coinsurance; \$250 maximum per prescription after deductible
\$60 copay (deductible waived)	\$50 copay (deductible waived)	\$60 copay after deductible
50% coinsurance; \$500 maximum per prescription after deductible	50% coinsurance; \$500 maximum per prescription after deductible	50% coinsurance; \$500 maximum per prescription after deductible
50% coinsurance; \$500 maximum per prescription after deductible	50% coinsurance; \$500 maximum per prescription after deductible	50% coinsurance; \$500 maximum per prescription after deductible
50% coinsurance; \$750 maximum per prescription after deductible	50% coinsurance; \$750 maximum per prescription after deductible	50% coinsurance; \$750 maximum per prescription after deductible

# Choice SOLO Plans

Plan name/Metal level	Choice SOLO HMO HSA \$6,500 ded. Bronze	Choice SOLO POS HSA Coins. \$6,000 ded. Bronze
<b>NETWORK ACCESS</b>	CT, parts of MA, RI, and NY through EmblemHealth Prime Network	CT, parts of MA, RI, and NY through EmblemHealth Prime Network
<b>PLAN/MEDICAL DEDUCTIBLE</b>		
Deductible (individual/family)	\$6,500/\$13,000*	\$6,000/\$12,000*
Maximum out-of-pocket limit (individual/family)	\$7,800/\$15,600	\$7,500/\$15,000
<b>IN-NETWORK MEDICAL BENEFITS</b>		
Preventive care/screenings/immunizations	\$0	\$0
Primary care provider (PCP) services	\$40 copay after deductible	25% coinsurance after deductible
Telemedicine visit through Teladoc**	<b>Primary care, mental health and general medical services:</b> 0% coinsurance after deductible <b>Dermatologist:</b> \$50 copay after deductible	<b>Primary care, mental health and general medical services:</b> 0% coinsurance after deductible <b>Dermatologist:</b> 25% coinsurance after deductible
Specialist services	\$50 copay after deductible	25% coinsurance after deductible
Mental health and substance use office visits	\$40 copay after deductible	25% coinsurance after deductible
Vision	\$50 copay (deductible waived)	25% coinsurance (deductible waived)
Walk-in/urgent care center	\$100 copay after deductible	25% coinsurance after deductible
Worldwide emergency coverage***	30% coinsurance after deductible	25% coinsurance after deductible
Hospital – inpatient treatment	30% coinsurance after deductible	25% coinsurance after deductible
Hospital – outpatient treatment	30% coinsurance after deductible	25% coinsurance after deductible
Outpatient surgery in independent locations	\$500 copay after deductible	25% coinsurance after deductible
Lab services	<b>Independent facility:</b> \$10 copay after deductible <b>Hospital setting:</b> 30% coinsurance after deductible	25% coinsurance after deductible
X-rays	<b>Independent facility:</b> \$35 copay after deductible <b>Hospital setting:</b> 30% coinsurance after deductible	25% coinsurance after deductible
Advanced imaging (CT scans and MRI)	<b>Independent facility:</b> \$75 copay up to \$375 after deductible <b>Hospital setting:</b> 30% coinsurance after deductible	25% coinsurance after deductible
<b>OUT-OF-NETWORK MEDICAL BENEFITS</b>		
Deductible (individual/family)	N/A	\$15,000/\$30,000
Coinsurance	N/A	50%
Maximum out-of-pocket limit (individual/family)	N/A	\$30,000/\$60,000
<b>PRESCRIPTION DRUG BENEFITS</b>		
Prescription drug deductible (individual/family)	Plan has integrated deductible with medical (see above)*	Plan has integrated deductible with medical (see above)*
Tier 1 – Preferred generic drugs	\$10 copay after deductible	\$10 copay after deductible
Tier 2 – Non-preferred generic drugs	50% coinsurance; \$250 maximum per prescription after deductible	50% coinsurance; \$250 maximum per prescription after deductible
Tier 3 – Preferred brand drugs	\$60 copay after deductible	\$60 copay after deductible
Tier 4 – Non-preferred brand drugs	50% coinsurance; \$500 maximum per prescription after deductible	50% coinsurance; \$500 maximum per prescription after deductible
Tier 5 – Preferred specialty drugs	50% coinsurance; \$500 maximum per prescription after deductible	50% coinsurance; \$500 maximum per prescription after deductible
Tier 6 – Non-preferred specialty drugs	50% coinsurance; \$750 maximum per prescription after deductible	50% coinsurance; \$750 maximum per prescription after deductible

\*Integrated medical and prescription drug deductible.

\*\*Telemedicine is not appropriate for all covered services, and restrictions apply. For primary care, members must be 18 or older; for Teladoc mental health services, members must be 13 or older.

\*\*\*Subject to limitations.

# Notes

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Call us at **800-723-2986** (TTY: **711**)  
8 a.m. to 5 p.m., Monday through Friday  
Extended hours Nov. 1 through Dec. 15:  
8 a.m. to 7 p.m., Monday through Friday



Visit **chooseconnecticare.com** to shop for and enroll in a ConnectiCare individual plan. Compare plan benefits, out-of-pocket costs, and premiums. Then, fill out and submit an application.



Meet with us at a ConnectiCare Center. Go to **visitconnecticare.com** or call **877-523-6837** (TTY: **711**) to find locations and make an appointment.



To learn more, scan this QR code with your smartphone.

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