

**Individual Market  
Choice Gold Alternative POS  
Benefit Summary  
Non-Tiered Network Plan**

Choice Network - Includes Providers in Connecticut only

<b>Deductible and Out-of-Pocket Maximum</b>	<b>In-Network (INET) Member Pays</b>	<b>Out-of-network (OON) Member Pays</b>
<b>Plan deductible</b> Individual Family	\$2,000 per member \$4,000 per family	\$7,000 per member \$14,000 per family
<b>Separate Prescription Drug Deductible</b> Individual Family	\$75 per member \$150 per family	\$500 per member \$1,000 per family
<b>Out-of-Pocket Maximum</b> Individual Family (Includes deductible, copayments and coinsurance for medical and pharmacy services)	\$7,900 per member \$15,800 per family	\$12,000 per member \$24,000 per family
<b>Benefits</b>	<b>In-Network (INET) Member Pays</b>	<b>Out-of-network (OON) Member Pays</b>
<b>Provider Office Visits</b>		
<b>Adult/Pediatric Preventive Visits</b>	No cost	50% coinsurance per visit; deductible does not apply
<b>Primary Care Provider Office/ Telemedicine Visits</b> (includes services for illness, injury, follow-up care and consultations)	\$40 copayment per visit; deductible does not apply	50% coinsurance per visit after OON plan deductible is met
<b>Telemedicine Services</b> (services rendered by a Teladoc® provider)  Primary Care - members must be 18 or older	<b>Primary Care, Mental Health and General Medical Services:</b> No cost  <b>Dermatologists:</b> \$50 copayment per visit; deductible does not apply	50% coinsurance per visit after OON plan deductible is met
<b>Specialist Office/Telemedicine Visits</b>	\$50 copayment per visit; deductible does not apply	50% coinsurance per visit after OON plan deductible is met
<b>Mental Health and Substance Abuse Office Visits</b>	\$40 copayment per visit; deductible does not apply	50% coinsurance per visit after OON plan deductible is met
<b>Outpatient Diagnostic Services</b>		

<b>Benefits</b>	<b>In-Network (INET) Member Pays</b>	<b>Out-of-network (OON) Member Pays</b>
<b>Advanced Radiology</b> (CT/PET Scan, MRI)	30% coinsurance per service after INET plan deductible is met at a Hospital Facility  \$75 copayment per service up to a combined annual maximum of \$375 for MRI and CAT scans; \$400 for PET scans at an Independent Facility; deductible does not apply	50% coinsurance per service after OON plan deductible is met
<b>Laboratory Services</b>	\$10 copayment per service; deductible does not apply	50% coinsurance per service after OON plan deductible is met
<b>Non-Advanced Radiology</b> (X-ray, Diagnostic)	30% coinsurance per service after INET plan deductible is met at a Hospital Facility  \$50 copayment per service; deductible does not apply at an Independent Facility	50% coinsurance per service after OON plan deductible is met
<b>Mammography Ultrasound/MRI</b> (No cost for Screening and Diagnostic if within Federal and/or State regulations)	30% coinsurance per service after INET plan deductible is met at a Hospital Facility  \$50 copayment per service; deductible does not apply at a Freestanding Facility	50% coinsurance per service after OON plan deductible is met
<b>Prescription Drugs - Retail Pharmacy (cost share based on 30 day supply per prescription)</b>		
<b>Generic Drugs</b> Tier 1	\$10 copayment per prescription; deductible does not apply	50% coinsurance per prescription after OON prescription drug deductible is met
<b>Preferred Brand Drugs</b> Tier 2	\$40 copayment per prescription; deductible does not apply	50% coinsurance per prescription after OON prescription drug deductible is met
<b>Non-Preferred Brand</b> Tier 3	\$60 copayment per prescription after INET prescription drug deductible is met	50% coinsurance per prescription after OON prescription drug deductible is met
<b>Specialty Drugs</b> Tier 4	20% coinsurance up to a maximum of \$150 per prescription after INET prescription drug deductible is met	50% coinsurance per prescription after OON prescription drug deductible is met
<b>Prescription - Mail Order Pharmacy (up to a 90 day supply per prescription)</b>		
<b>Generic Drugs</b> Tier 1	\$20 copayment per prescription; deductible does not apply	50% coinsurance per prescription after OON prescription drug deductible is met
<b>Preferred Brand Drugs</b> Tier 2	\$80 copayment per prescription; deductible does not apply	50% coinsurance per prescription after OON prescription drug deductible is met

<b>Benefits</b>	<b>In-Network (INET) Member Pays</b>	<b>Out-of-network (OON) Member Pays</b>
<b>Non-Preferred Brand Tier 3</b>	\$120 copayment per prescription after INET prescription drug deductible is met	50% coinsurance per prescription after OON prescription drug deductible is met
<b>Outpatient Rehabilitative and Habilitative Services (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.)</b>		
<b>Speech Therapy</b>	30% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met
<b>Physical and Occupational Therapy</b>	30% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met
<b>Other Services</b>		
<b>Chiropractic Services</b> (up to 20 visits per calendar year)	30% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met
<b>Diabetic Equipment and Supplies</b>	30% coinsurance per equipment/supply after INET plan deductible is met	50% coinsurance per equipment/supply after OON plan deductible is met
<b>Durable Medical Equipment (DME)</b>	30% coinsurance per equipment/supply after INET plan deductible is met	50% coinsurance per equipment/supply after OON plan deductible is met
<b>Home Health Care Services</b> (up to 100 visits per calendar year)	25% coinsurance per visit after separate \$50 deductible is met	25% coinsurance per visit after separate \$50 deductible is met
<b>Outpatient Services</b> (in a hospital or ambulatory facility)	30% coinsurance per visit after INET plan deductible is met at an Outpatient Hospital Facility  \$250 copayment per visit; deductible does not apply at an Ambulatory Surgery Center	50% coinsurance per visit after OON plan deductible is met
<b>Inpatient Services</b>		
<b>Inpatient hospital services include mental health, substance abuse, maternity, hospice, skilled nursing facility* and all IP settings.</b> (*skilled nursing facility stay is limited to 90 days per calendar year)	30% coinsurance per admission after INET plan deductible is met	50% coinsurance per admission after OON plan deductible is met
<b>Emergency and Urgent Care</b>		
<b>Ambulance Services</b>	30% coinsurance per service after INET plan deductible is met	30% coinsurance per service after INET plan deductible is met
<b>Emergency Room</b>	30% coinsurance per visit after INET plan deductible is met	30% coinsurance per visit after INET plan deductible is met
<b>Urgent Care Centers</b>	30% coinsurance per visit; deductible does not apply	50% coinsurance per visit after OON plan deductible is met

<b>Benefits</b>	<b>In-Network (INET) Member Pays</b>	<b>Out-of-network (OON) Member Pays</b>
<b>Pediatric Dental Care (for members under age 26)</b>		
<b>Diagnostic &amp; Preventive</b>	No cost	50% coinsurance per visit after OON plan deductible is met
<b>Basic Services</b>	50% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met
<b>Major Services</b>	50% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met
<b>Orthodontia Services</b> (medically necessary only)	50% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met
<b>Pediatric Vision Care (for members under age 26)</b>		
<b>Prescription Eye Glasses</b> (one pair of frames and lenses or contact lens per calendar year)	Lenses: 50% coinsurance after INET plan deductible is met Collection frame: 50% coinsurance after INET plan deductible is met 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	50% coinsurance per visit after OON plan deductible is met
<b>Routine Eye Exam by a Specialist</b> (one exam per calendar year)	\$50 copayment per visit; deductible does not apply	50% coinsurance per visit after OON plan deductible is met
<b>Additional Covered Services</b>		
<b>Adult Routine Eye Exam by a Specialist</b> (for members over age 26 - one exam per calendar year)	\$50 copayment per visit; deductible does not apply	50% coinsurance per visit after OON plan deductible is met
<b>Allergy Injections</b> (Unlimited)	See primary care or specialist office visits	50% coinsurance per visit after OON plan deductible is met
<b>Allergy Testing</b> (one visit per calendar year)	See primary care or specialist office visits	50% coinsurance per visit after OON plan deductible is met
<b>Artificial Limbs</b> (includes associated supplies and equipment)	20% coinsurance after INET plan deductible is met	50% coinsurance after OON plan deductible is met
<b>Infusion therapy</b> (when services are rendered in a Specialist office or Freestanding Infusion Center)	\$50 copayment per visit; deductible does not apply	50% coinsurance per visit after OON plan deductible is met

Benefits	In-Network (INET) Member Pays	Out-of-network (OON) Member Pays
<b>Modified Food Products and Specialized Formula</b>	30% coinsurance after INET plan deductible is met	50% coinsurance after OON plan deductible is met
<b>Outpatient mental health, alcohol and substance abuse treatment</b> (intensive outpatient treatment and partial hospitalization)	0% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met
<b>Retail Clinic</b>	\$40 copayment per visit; deductible does not apply	50% 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.
- 90-day supply of maintenance medications must be filled through Express Scripts home delivery or at either a participating CVS or Walgreens pharmacy. Each member has a choice of the pharmacy used.
- Ovarian cancer screening and monitoring services coverage and cost share details are available in your policy.
- Mammogram screenings, breast ultrasounds, and breast MRIs - Please refer to the policy for details.
- Insulin and noninsulin drugs are covered up to a cost share maximum of \$25 for each 30-day supply.
- Diabetes Devices and Diabetic Ketoacidosis Devices are covered up to a cost share maximum of \$100 per 30-day supply.
- Please refer to your policy for additional cost share maximums regarding diabetic services. Some diabetic services fall under preventive care and cost share may be waived.
- An **ambulatory surgery center** is a facility that exclusively provides outpatient surgical services to patients who do not require hospitalization and whose expected stay in the center does not exceed 24 hours. Ambulatory surgery centers are not owned by a hospital.
- An **outpatient hospital facility** offers surgical procedures and related care that, in the opinion of the attending physician, can be safely performed without requiring overnight inpatient hospital care. Outpatient hospital facilities are owned by a hospital or hospital system.
- If you have questions regarding your plan, visit our website at [www.connecticare.com](http://www.connecticare.com) or call us at (860) 674-5757 or 1-800-251-7722.
- To learn more about your **Teladoc®** benefits contact **Teladoc®** at [teladoc.com/connecticare](http://teladoc.com/connecticare) or call 1-800-835-2362 (TTY: 711).
- 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.
- 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, coinsurance or cost share maximum.
- 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 the ConnectiCare's Voluntary Mail Order program.
- Many services require that you obtain our Pre-Certification or Pre-Authorization prior to obtaining care. Please refer to the "Pre-Authorization and Pre-Certification Addendum" in your policy for a detailed list of services or call member services at 1-800-251-7722. Without Pre-Authorization for

services prescribed or rendered by Non-Participating providers, you may be responsible for the total cost of the service or benefits may be reduced by the lesser of \$500 or 50%.

- For mental health, alcohol and substance abuse services call 1-888-946-4658 to obtain Pre-Authorization.
- In-network preventive and wellness services as defined by the United States Preventive Service Task Force (USPSTF), including immunizations recommended by the Advisory Committee on Immunizations Practices at the Centers for Disease Control (CDC), and preventive care and screenings supported by the Health Resources and Services Administration (HRSA) are exempt from all cost shares under the Patient Protection and Affordable Care Act (PPACA). Visit our website at [www.connecticare.com](http://www.connecticare.com) to view a list of preventive and wellness services.