ConnectiCare®

FlexPOS-CNT-30-45-500-500D-31 Open Access Contract Year Benefit Summary

This is a brief summary of benefits. Refer to your ConnectiCare Insurance Company, Inc. Certificate of Coverage for complete details on benefits, conditions, limitations and exclusions, or consult with your benefits manager. All benefits described below are per Member per Contract year. A referral from your primary care provider is not required.

Personalized for: Dattco

	IN-NETWORK MEMBER PAYS	**OUT-OF-NETWORK MEMBER PAYS**
Contract Year Plan Deductible	None	$2,000 per Member $6,000 per Family
Out-of-Pocket Maximum *(Includes a combination of deductible, copayments and coinsurance for health and pharmacy services)*	$6,350 per Member $12,700 per Family	$6,350 per Member $12,700 per Family
Out-of-Network Reimbursement	None	**Plan will reimburse the coinsurance percentage of the Maximum Allowable Amount.**
Lifetime Maximum Benefit	Unlimited	Unlimited
PREVENTIVE SERVICES *(Refer to "Prevention and Wellness" section found at the end of this summary)*	**IN-NETWORK MEMBER PAYS**	**OUT-OF-NETWORK MEMBER PAYS**
Physical Exam *(frequency limits apply and the exam must be provided by a PCP)*	No Member cost	30% after Plan Deductible
Gynecological Preventive Exam	No Member cost	30% after Plan Deductible
Preventive Laboratory Services *(Complete blood count and urinalysis, one test per ye*ar)	No Member cost	30% after Plan Deductible
Baseline Routine Mammography *(ages 35 - 39)*	$10 Copayment per visit	30% after Plan Deductible
Annual Routine Mammography *(age 40 or older*)	No Member cost	30% after Plan Deductible
Breast Ultrasound Screening	$10 Copayment per visit	30% after Plan Deductible
Annual Routine Vision Exam *(one exam per year when provided by an Optometrist or Ophthalmologist)*	$45 Copayment per visit	30% after Plan Deductible

OUTPATIENT SERVICES	IN-NETWORK MEMBER PAYS	OUT-OF-NETWORK MEMBER PAYS
On-Line Visit *(telemedicine consultation)*	$30 Copayment per visit	30% after Plan Deductible
Primary Care Services *(includes services for illness, injury, sickness, follow-up care and consultations)*	$30 Copayment per visit	30% after Plan Deductible
Specialist Services *(includes services for illness, injury, sickness, follow-up care and consultations)*	$45 Copayment per visit	30% after Plan Deductible
Gynecological Services	$30 Copayment per visit	30% after Plan Deductible
Maternity Care Office Visits *(prenatal care)*	No Member cost	30% after Plan Deductible
Allergy Testing *up to one visit every year*	Applicable office visit Copayment	30% after Plan Deductible
Allergy Injections *up to 20 visits every year*	Applicable office visit Copayment	30% after Plan Deductible
Laboratory Services *(includes services performed in a Hospital or laboratory facility)* *(Please refer to the provider directory for facility type)*	No Member cost	30% after Plan Deductible
Non-Advanced Radiology *(includes services performed in a Hospital or radiology facility)*	$10 Copayment per visit	30% after Plan Deductible
Advanced Radiology *up to five Copayments per year (includes services for MRI, PET and CAT scan and nuclear cardiology performed in a Hospital or radiology facility)* *(Please refer to the provider directory for facility type)*	$75 Copayment per service	30% after Plan Deductible
Outpatient Rehabilitative Therapy *up to 40 visits per year (includes services combined for physical, speech, and occupational therapy)*	$30 Copayment per visit	30% after Plan Deductible
Chiropractic Services *up to 20 visits per year*	$45 Copayment per visit	30% after Plan Deductible
Retail Clinic	$30 Copayment per visit	30% after Plan Deductible
EMERGENCY / URGENT CARE	**IN-NETWORK MEMBER PAYS**	**OUT-OF-NETWORK MEMBER PAYS**
Walk-In/Urgent Care Centers	$75 Copayment per visit	$75 Copayment per visit

EMERGENCY / URGENT CARE	IN-NETWORK MEMBER PAYS	OUT-OF-NETWORK MEMBER PAYS
Emergency Room *(Copayments waived if admitted)*	$150 Copayment per visit	$150 Copayment per visit
Ambulance Services	No Member cost	No Member cost
HOSPITAL SERVICES	**IN-NETWORK MEMBER PAYS**	**OUT-OF-NETWORK MEMBER PAYS**
Inpatient Hospital Services, Including Room & Board	$500 Copayment per day up to $2,000 per year	30% after Plan Deductible
Hospital Outpatient Facilities *(includes services performed in a Hospital facility)* *(Please refer to the provider directory for facility type)*	$500 Copayment per visit	30% after Plan Deductible
Ambulatory Surgical Center *(includes services performed in a stand-alone ambulatory facility)* *(Please refer to the provider directory for facility type)*	$500 Copayment per visit	30% after Plan Deductible
Skilled Nursing and Rehabilitation Facilities *up to 90 days per year*	No Member cost	30% after Plan Deductible
MENTAL HEALTH SERVICES	**IN-NETWORK MEMBER PAYS**	**OUT-OF-NETWORK MEMBER PAYS**
Inpatient Mental Health Services *(including inpatient acute and residential programs)*	$500 Copayment per day up to $2,000 per year	30% after Plan Deductible
Inpatient Alcohol and Substance Abuse Treatment *(including inpatient acute and residential programs)*	$500 Copayment per day up to $2,000 per year	30% after Plan Deductible
Outpatient Mental Health, Alcohol and Substance Abuse Treatment *(including office visits and professional services provided in the home)*	$30 Copayment per visit	30% after Plan Deductible
Outpatient Mental Health, Alcohol and Substance Abuse Treatment *(intensive outpatient treatment and partial hospitalization programs)*	$30 Copayment per visit	30% after Plan Deductible
OTHER SERVICES	**IN-NETWORK MEMBER PAYS**	**OUT-OF-NETWORK MEMBER PAYS**
Durable Medical Equipment Including Prosthetics and Disposable Medical Supplies	50%	50% after Plan Deductible
Diabetic Equipment and Supplies	20%	30% after Plan Deductible

OTHER SERVICES	IN-NETWORK MEMBER PAYS	OUT-OF-NETWORK MEMBER PAYS
Home Health Services *up to 100 visits per year*	No Member cost	25% after $50 Benefit Deductible

PREVENTION AND WELLNESS

In-Network prevention and wellness services as defined by the United States Preventive Service Task Force (listed below) are exempt from all member cost share (deductible, copayment and coinsurance) under the Patient Protection and Affordable Care Act (PPACA). Services that are exempt from cost share must be identified by the specific code(s). The codes your health care provider submits must match ConnectiCare's coding list to be exempt from all cost share. Please note that not all preventive services are listed below and that some diagnostic services provided in relation to preventive and wellness services require member cost share. Go to www.connecticare.com/preventive for more information on coverage of preventive care or services.

- Routine physical exam and appropriate screening and counseling for adults (including but not limited to cardiovascular disease, depression, obesity and sexually transmitted infections) one per year
- Preventive care and screening for infants, children and adolescents supported by the Health Resources and Services Administration (including but not limited to depression, obesity and sexually transmitted infections)
- Preventive care and screenings for women supported by the Health Resources and Services Administration:
    - o At least one well-woman preventive care visit annually to obtain the recommended preventive services
    - o Screening for diabetes during pregnancy, two per pregnancy
    - o Human Papillomavirus (HPV) testing, age 30 or older, one per year
    - o Counseling on sexually transmitted infections for all sexually active women, two per year
    - o Counseling and screening for human immune-deficiency virus (HIV) for all sexually active women
    - o Contraceptive methods approved by the Food and Drug administration, sterilization procedures and contraceptive patient education and counseling
    - o Comprehensive lactation support, counseling, a manual breast pump (either manual or non-hospital grade electric), and breast feeding supplies
    - o Screening and counseling for interpersonal and domestic violence for all women and adolescents
- Bone density screenings, age 60 or older, one every 23 months
- Screening for colorectal cancer using fecal occult blood testing, sigmoidoscopy, or colonoscopy, ages 50 - 75, one per year
- Routine mammography screening, age 40 or older, one per year
- Immunizations recommended by the Advisory Committee on Immunization Practices of the CDC
- Outpatient laboratory services, one per year:
    - o Cervical cancer and cervical dysplasia screening – pap smear
    - o Lipid cholesterol screening for adults and children at risk
    - o Fasting plasma glucose or hemoglobin A1c, age 18 and older for people at risk for diabetes
    - o Hematocrit and Hemoglobin, for children up to age 21
    - o Lead screening, for children up to age 6
    - o Tuberculin testing, for children up to age 21
    - o Chlamydia, syphilis and gonorrhea screening for females all ages
    - o Human immunodeficiency virus screening – HIV testing (no limit)
    - o Hypothyroidism screening in newborns, under 3 months of age
    - o Screening for phenylketonuria (PKU) in newborns, under 3 months of age
    - o Screening for sickle cell disease in newborns, under 3 months of age
    - o Hepatitis B screening for adolescents and adults at risk
    - o Hepatitis C screening for adults at risk
    - o Lung Cancer screening for adults ages 55 - 80 who have smoked
- Routine vision screening up to age 21, one per year when services are rendered by a primary care provider
- Routine hearing screening up to age 21 when rendered by a primary care provider
- Dental caries prevention up to age 5 when rendered by a primary care provider
- Developmental, autism, and psychosocial/behavioral assessments up to age 21 when rendered by a primary care provider
- Dietary counseling for adults with cardiovascular disease, hyperlipidemia or obesity
- Alcohol misuse screening and counseling
- Tobacco cessation interventions
- Screening for hepatitis B, iron deficient anemia, Rh (D) blood typing and asymptomatic bacteriuria in women who are pregnant
- Screening for abdominal aortic aneurysm in men age 65 – 75 who have ever smoked
- BRCA screening, genetic counseling and if indicated genetic testing
- Physical therapy to prevent falls in adults ages 65 and older

Important Information

- 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.
- Many services require that you obtain our pre-certification or pre-authorization prior to obtaining care prescribed or rendered by network providers or non-participating providers. A reduction will apply if you do not obtain pre-authorization for these specified services. Refer to your ConnectiCare Insurance Company, Inc. Certificate of Coverage for more information.
- For mental health, alcohol, and substance abuse services call 1-888-946-4658 to obtain pre-authorization.
- Out-of-Network cost shares are reimbursed at the maximum allowable amount. Members are responsible to pay any charges in excess of this amount. Please refer to your ConnectiCare Insurance Company, Inc. Certificate of Coverage for more information.
- If you are a Massachusetts resident, please refer to your *amendatory rider for Massachusetts mandated benefits* for additional details of your mandated benefits.
- If you are a Massachusetts resident, this plan along with pharmacy services meets Massachusetts Minimum Creditable Coverage standards for 2016.
- Your plan is Insured by ConnectiCare Insurance Company, Inc.

Benefits are Pending Department of Insurance Approval

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Prescription Drug Copayment with Deductible Plan Benefit Summary

This is a brief summary of your prescription drug benefits. Refer to your prescription drug rider for complete details on benefits, conditions, limitations and exclusions, or consult with your benefits manager. All benefits described below are per member per Contract year.

Personalized for: Dattco

PRESCRIPTION DRUGS		
Covered prescription drugs through retail Participating Pharmacies or our mail order service. Generics are dispensed unless the Member pays the Generic Cost-Share plus the difference in price between the Generic Equivalent and the Brand Name Drug. Your Plan includes the following: Mandatory Drug Substitution, Generic Substitution Program, Tiered Cost-Share Program, and Voluntary Mail Order Program.		
	IN-NETWORK MEMBER PAYS	**OUT-OF-NETWORK MEMBER PAYS**
Benefit Deductible	$200 per Member $400 per Family	None
Out-of-Pocket Maximum *(Includes a combination of deductible, copayment and coinsurance for health and pharmacy services)*	$6,350 per Member $12,700 per Family	$6,350 per Member $12,700 per Family
Out-of-Network Reimbursement	Not Applicable	**Plan will reimburse the coinsurance percentage of the Maximum Allowable Amount.**
RETAIL PHARMACY (up to a 30 day supply per prescription, including Specialty Drugs generally delivered by mail)	**IN-NETWORK MEMBER PAYS**	**OUT-OF-NETWORK MEMBER PAYS**
Tier 1 drugs *(Generic Drugs)*	$5 Copayment after Benefit Deductible	50%
Tier 2 drugs *(Preferred Brand Drugs)*	$30 Copayment after Benefit Deductible	50%
Tier 3 drugs *(Non-Preferred Brand Drugs)*	$40 Copayment after Benefit Deductible	50%
MAIL ORDER PHARMACY (up to a 90 day supply per prescription, does not apply to Specialty Drugs)	**IN-NETWORK MEMBER PAYS**	**OUT-OF-NETWORK MEMBER PAYS**
Tier 1 drugs *(Generic Drugs)*	$10 Copayment after Benefit Deductible	100%
Tier 2 drugs *(Preferred Brand Drugs)*	$60 Copayment after Benefit Deductible	100%
Tier 3 drugs *(Non-Preferred Brand Drugs)*	$80 Copayment after Benefit Deductible	100%

Additional 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 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.
- Generic drugs can reduce your out-of-pocket prescription costs. Generics have the same active ingredients as brand name drugs, but usually cost much less. So, ask your doctor or pharmacist if a generic alternative is available for your prescription. Also, remember to use a participating pharmacy. Most pharmacies in the United States participate in our network. To find one, visit our Web site at www.connecticare.com or call our Member Services Department at 1-800-251-7722.
- Certain prescription drugs and supplies require pre-authorization from us before they will be covered under the prescription drug rider. You should visit our Web site at www.connecticare.com or call our Member Service Department at 1-800-251-7722 to find out if a prescription drug or supply requires pre-authorization.
- 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.
- Always remember to carry your ConnectiCare ID Card.
- If you are a Massachusetts resident, please refer to your a*mendatory rider for Massachusetts mandated benefits* for additional details of your benefits.

Benefits are Pending Department of Insurance Approval