ConnectiCare®

# FlexPOS-CNT-HSA-5000I/10000F-14 Open Access Contract Year Benefit Summary (E)

Point-Of-Service Open Access High Deductible Health Plan (HDHP) for use with a Health Savings Account (HSA)
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.

The Individual Deductible and Maximum Out-of-Pocket applies if you have coverage only for yourself. The Family Deductible and Maximum Out-of-Pocket applies if you have coverage for yourself and one or more eligible dependents. Each Individual on the Family plan will only need to satisfy the Individual Deductible and Maximum Out-of-Pocket, not the full Family amount. Each Individual's charges will accrue towards the Family amounts.

**Personalized for: Dattco**

| | **IN-NETWORK MEMBER PAYS** | **OUT-OF-NETWORK MEMBER PAYS** |
|---|---|---|
| **Contract Year Plan Deductibles** *(Deductible is combined for health services and prescription drugs)* | $5,000 per Individual<br>$10,000 per Family | $6,000 per Member<br>$12,000 per Family |
| **Out-of-Pocket Maximum** *(Includes a combination of deductible, copayments and coinsurance for health and pharmacy services)* | $6,000 per Individual<br>$12,000 per Family | $8,000 per Member<br>$16,000 per Family |
| **Out-of-Network Reimbursement** | Not Applicable | **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 *Plan Deductible waived* | 30% after Plan Deductible |
| **Gynecological Preventive Exam** | No Member cost<br>*(Plan Deductible waived)* | 30% after Plan Deductible |
| **Preventive Laboratory Services** *(Complete blood count and urinalysis, one test per year)* | No Member cost<br>*(Plan Deductible waived)* | 30% after Plan Deductible |
| **Baseline Routine Mammography** *(ages 35 - 39)* | No Member cost after Plan Deductible | 30% after Plan Deductible |
| **Annual Routine Mammography** *(age 40 or older)* | No Member cost<br>*(Plan Deductible waived)* | 30% after Plan Deductible |
| **Breast Ultrasound Screening** | No Member cost after Plan Deductible | 30% after Plan Deductible |

| **PREVENTIVE SERVICES**<br>*(Refer to "Prevention and Wellness" section found at the end of this summary)* | **IN-NETWORK MEMBER PAYS** | **OUT-OF-NETWORK MEMBER PAYS** |
|---|---|---|
| **Annual Routine Vision Exam**<br>*(one exam per year when provided by an Optometrist or Ophthalmologist)* | No Member cost *(Plan Deductible waived)* | 30% after Plan Deductible |
| **OUTPATIENT SERVICES** | **IN-NETWORK MEMBER PAYS** | **OUT-OF-NETWORK MEMBER PAYS** |
| **On-Line Visits**<br>*(telemedicine consultation)* | No Member cost after Plan Deductible | 30% after Plan Deductible |
| **Primary Care Services**<br>*(includes services for illness, injury, sickness, follow-up care and consultations)* | No Member cost after Plan Deductible | 30% after Plan Deductible |
| **Specialist Services**<br>*(includes services for illness, injury, sickness, follow-up care and consultations)* | No Member cost after Plan Deductible | 30% after Plan Deductible |
| **Gynecological Services** | No Member cost after Plan Deductible | 30% after Plan Deductible |
| **Maternity Care Office Visits**<br>*(prenatal care)* | No Member cost | 30% after Plan Deductible |
| **Allergy Testing**<br>*up to one visit every year* | No Member cost after Plan Deductible | 30% after Plan Deductible |
| **Allergy Injections**<br>*up to 20 visits every year* | No Member cost after Plan Deductible | 30% after Plan Deductible |
| **Laboratory Services**<br>*(includes services performed in a Hospital or laboratory facility)*<br>*(Please refer to the provider directory for facility type)* | No Member cost after Plan Deductible | 30% after Plan Deductible |
| **Non-Advanced Radiology**<br>*(includes services performed in a Hospital or radiology facili*ty) | No Member cost after Plan Deductible | 30% after Plan Deductible |
| **Advanced Radiology**<br>*(includes services for MRI, PET and CAT scan and Nuclear Cardiology performed in a Hospital or radiology facility)*<br>*(Please refer to the provider directory for facility type)* | No Member cost after Plan Deductible | 30% after Plan Deductible |
| **Outpatient Rehabilitative Therapy**<br>*up to 40 visits per year*<br>*(includes services combined for physical, speech, and occupational therapy)* | No Member cost after Plan Deductible | 30% after Plan Deductible |
| **Chiropractic Services**<br>*up to 20 visits per year* | No Member cost after Plan Deductible | 30% after Plan Deductible |
| **Retail Clinic** | No Member cost after Plan Deductible | 30% after Plan Deductible |

| EMERGENCY / URGENT CARE | IN-NETWORK<br>MEMBER PAYS | OUT-OF-NETWORK<br>MEMBER PAYS |
|---|---|---|
| **Walk-In/Urgent Care Centers** | No Member cost after Plan Deductible | Same as In-Network Benefit |
| **Emergency Room**<br>Copayment waived if admitted | $150 Copayment per visit after Plan Deductible | Same as In-Network Benefit |
| **Ambulance Services** | No Member cost after Plan Deductible | Same as In-Network Benefit |
| **HOSPITAL SERVICES** | **IN-NETWORK<br>MEMBER PAYS** | **OUT-OF-NETWORK<br>MEMBER PAYS** |
| **Inpatient Hospital Services, Including Room & Board** | No Member cost after Plan Deductible | 30% after Plan Deductible |
| **Hospital Outpatient Facilities**<br>*(includes services performed in a Hospital facility)*<br>*(Please refer to the provider directory for facility type)* | No Member cost after Plan Deductible | 30% after Plan Deductible |
| **Ambulatory Surgical Center**<br>*(includes services performed in a stand-alone ambulatory facility)*<br>*(Please refer to the provider directory for facility type)* | No Member cost after Plan Deductible | 30% after Plan Deductible |
| **Skilled Nursing and Rehabilitation Facilities**<br>*up to 90 days per year* | No Member cost after Plan Deductible | 30% after Plan Deductible |
| **MENTAL HEALTH SERVICES** | **IN-NETWORK<br>MEMBER PAYS** | **OUT-OF-NETWORK<br>MEMBER PAYS** |
| **Inpatient Mental Health Services**<br>*(including inpatient acute and residential programs)* | No Member cost after Plan Deductible | 30% after Plan Deductible |
| **Inpatient Alcohol and Substance Abuse Treatment**<br>*(including inpatient acute and residential programs)* | No Member cost after Plan Deductible | 30% after Plan Deductible |
| **Outpatient Mental Health, Alcohol and Substance Abuse Treatment**<br>*(including office visits and professional services provided in the home)* | No Member cost after Plan Deductible | 30% after Plan Deductible |
| **Outpatient Mental Health, Alcohol and Substance Abuse Treatment**<br>*(intensive outpatient treatment and partial hospitalization programs)* | No Member cost after Plan Deductible | 30% after Plan Deductible |

| OTHER SERVICES | IN-NETWORK<br>MEMBER PAYS | OUT-OF-NETWORK<br>MEMBER PAYS |
|---|---|---|
| **Durable Medical Equipment Including Prosthetics and Disposable Medical Supplies** | No Member cost after Plan Deductible | 30% after Plan Deductible |
| **Diabetic Equipment and Supplies** | No Member cost after Plan Deductible | 30% after Plan Deductible |
| **Home Health Services**<br>*up to 100 visits per year* | No Member cost after Plan Deductible | 25% after Plan 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 codes. 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 screenings 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:
  - At least one well-woman preventive care visit annually to obtain the recommended preventive services
  - Screening for diabetes during pregnancy, two per pregnancy
  - Human Papillomavirus (HPV) testing, age 30 or older, one per year
  - Counseling on sexually transmitted infections for all sexually active women, two per year
  - Counseling and screening for human immune-deficiency virus (HIV) for all sexually active women
  - Contraceptive methods approved by the Food and Drug administration, sterilization procedures and contraceptive patient education and counseling
  - Comprehensive lactation support, counseling, a breast pump (either manual or non-hospital grade electric), and breastfeeding supplies
  - 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:
  - Cervical cancer and cervical dysplasia screening – pap smear
  - Lipid cholesterol screening for adults and children at risk
  - Fasting plasma glucose or hemoglobin A1c, age 18 and older for people at risk for diabetes
  - Hematocrit and Hemoglobin, for children up to age 21
  - Lead screening, for children up to age 6
  - Tuberculin testing, for children up to age 21
  - Chlamydia, syphilis and gonorrhea screening for females all ages
  - Human immunodeficiency virus screening – HIV testing (no limit)
  - Hypothyroidism screening in newborns, under 3 months of age
  - Screening for phenylketonuria (PKU) in newborns, under 3 months of age
  - Screening for sickle cell disease in newborns, under 3 months of age
  - Hepatitis B screening for adolescents and adults at risk
  - Hepatitis C screening for adults at risk
  - 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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# FlexPOS Copayment Prescription Drug Plan for Use with Health Savings Account (HSA) 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.<br><br>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** |
| **Contract Year Plan Deductible** *(Plan Deductible is combined for health services and prescription drugs)* | $5,000 Individual<br>$10,000 Family<br><br>. | $6,000 Individual<br>$12,000 Family |
| **Out-of-Pocket Maximum** *(Includes a combination of deductible, copayments and coinsurance for health and pharmacy services)* | $6,000 Individual<br>$12,000 Family | $8,000 Individual<br>$16,000 Family |
| **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 Plan Deductible | 50% after Plan Deductible |
| **Tier 2 drugs** *(Preferred Brand Drugs)* | $25 Copayment after Plan Deductible | 50% after Plan Deductible |
| **Tier 3 drugs** *(Non-Preferred Brand Drugs)* | $40 Copayment after Plan Deductible | 50% after Plan Deductible |
| **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 Plan Deductible | 100% |
| **Tier 2 drugs** *(Preferred Brand Drugs)* | $50 Copayment after Plan Deductible | 100% |
| **Tier 3 drugs** *(Non-Preferred Brand Drugs)* | $80 Copayment after Plan 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.
- 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, or cost share maximum.
- 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 Services 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 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 amendatory rider for Massachusetts mandated benefits for additional details of your benefits.

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