ConnectiCare

FlexPOS-CAL-HSA-2250I/4500F-02-Combined Open Access Calendar Year Benefit

Summary (A)

The sponsor of this group health insurance plan believes that this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to some other plans, for example, the requirement for the provision of certain preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to your employer's benefit administrator. If your plan is subject to ERISA, you may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

The Individual deductible and out-of-pocket maximum applies if you have coverage only for yourself and not for any dependents. The family deductible and out-of-pocket maximum applies if you have coverage for yourself and one or more eligible dependents. In addition, if you have family coverage, any applicable copayments or coinsurance will not apply to services until the total deductible is met for the family, without regard to how much any one family member has met. No one member will exceed an in-network out-of-pocket maximum greater than $6,850.

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

Personalized for: Naugatuck BOE - Teachers

Getting care in our network

In-Network Preventive Services

These services are no cost to you when you use an in-network doctor or facility. Frequency is based on age and gender. For a complete list of preventive services and to find a doctor, refer to connecticare.com.

Getting care within ConnectiCare's network typically costs you less. You may also get care outside of our network; however, your share of the costs will be higher. Out-of-network doctors and facilities do not appear in the "Find a doctor" directory on connecticare.com

- Physical
- Flu shot
- Well woman visit and pap test
- Vaccinations
- More than 25 screenings, including mammograms and
- Certain birth control and other prevention medications
- Colonoscopies

	In-network member pays	Out-of-network member pays
Your deductible **Deductible is combined for medical services and prescription drugs** **Deductible is combined for in and out-of-network**	$2,250 Individual $4,500 Family	$2,250 Individual $4,500 Family
Your out-of-pocket maximum **Includes a combination of deductible, copayments and coinsurance for medical and pharmacy services** **Out-of-pocket is combined for in and out-of-network**	$5,000 Individual $10,000 Family	$5,000 Individual $10,000 Family
Out-of-network reimbursement	Not applicable	Plan will reimburse the coinsurance percentage of the maximum allowable amount

After you have spent the 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 member pays	Out-of-network member pays
Baseline routine mammography	No charge	30% coinsurance after plan deductible
Routine mammography including tomosynthesis screening	No charge	30% coinsurance after plan deductible
Breast ultrasound	0% coinsurance after plan deductible	30% coinsurance after plan deductible

Screenings	In-network member pays	Out-of-network member pays
Annual routine vision exam	No charge	30% coinsurance after plan deductible
Allergy testing **Unlimited**	0% coinsurance after plan deductible	30% coinsurance after plan deductible
Hearing Screenings **one exam every 24 months**	No charge	30% coinsurance after plan deductible

Ongoing Care and Sick Visits	In-network member pays	Out-of-network member pays
Primary care services	0% coinsurance after plan deductible	30% coinsurance after plan deductible
Specialist services	0% coinsurance after plan deductible	30% coinsurance after plan deductible
Gynecologist services	0% coinsurance after plan deductible	30% coinsurance after plan deductible
Maternity and prenatal care visits	No charge	30% coinsurance after plan deductible
Allergy injections **Unlimited**	0% coinsurance after plan deductible	30% coinsurance after plan deductible
Telemedicine visit	0% coinsurance after plan deductible	30% coinsurance after plan deductible
Retail clinic	0% coinsurance after plan deductible	30% coinsurance after plan deductible
Nutritional Counseling **Limit 3 visits per year**	0% coinsurance after plan deductible	30% coinsurance after plan deductible
Infertility **Infertility benefits outlined in the Certificate of Coverage are unlimited, with no age or cycles restrictions**	0% coinsurance (Office visit) after plan deductible 0% coinsurance (Ambulatory Services Outpatient) after plan deductible 0% coinsurance (Inpatient Hospital) after plan deductible	30% coinsurance after plan deductible

Lab and Radiology **Performed in a hospital, lab or radiology facility**	**In-network member pays**	**Out-of-network member pays**
Laboratory services	0% coinsurance after plan deductible	30% coinsurance after plan deductible
Non-advanced radiology **X-ray, diagnostic**	0% coinsurance after plan deductible	30% coinsurance after plan deductible
Advanced radiology	0% coinsurance after plan deductible	30% coinsurance after plan deductible
Hospital facility **MRI, PET and CAT scan and nuclear cardiology**	0% coinsurance after plan deductible	30% coinsurance after plan deductible

Sudden and Unexpected Care	**Out-of-network member pays**	**Out-of-network member pays**
Urgent care or other walk-in	0% coinsurance after plan deductible	Same as In-network benefit
Emergency room	0% coinsurance after plan deductible	Same as In-network benefit
Ambulance	0% coinsurance after plan deductible	Same as In-network benefit

Inpatient Hospital Services	In-network member pays	Out-of-network member pays
Inpatient hospital services, including room and board	0% coinsurance after plan deductible	30% coinsurance after plan deductible
Skilled nursing and rehabilitation **up to 220 days per year**	0% coinsurance after plan deductible	30% coinsurance after plan deductible
Private duty nursing **up to $15,000 per year**	0% coinsurance after plan deductible	30% coinsurance after plan deductible

Outpatient Hospital Services and Home Care	In-network member pays	Out-of-network member pays
Hospital outpatient facilities	0% coinsurance after plan deductible	30% coinsurance after plan deductible
Ambulatory surgical center	0% coinsurance after plan deductible	30% coinsurance after plan deductible
Home health services **up to 200 visits per year**	0% coinsurance after plan deductible	25% coinsurance after plan deductible

Outpatient Rehabilitative Services	In-network member pays	Out-of-network member pays
Rehabilitative services **includes services combined for physical, speech and occupational therapy and chiropractic services**	0% coinsurance after plan deductible	30% coinsurance after plan deductible

Mental Health and Substance Abuse	In-network member pay	Out-of-network member pays
Inpatient mental health services	0% coinsurance after plan deductible	30% coinsurance after plan deductible
Inpatient alcohol and substance	0% coinsurance after plan deductible	30% coinsurance after plan deductible
Outpatient mental health, alcohol and substance abuse treatment **office visits and home services**	0% coinsurance after plan deductible	30% coinsurance after plan deductible
Outpatient mental health, alcohol and substance abuse treatment **intensive outpatient treatment and partial hospitalization**	0% coinsurance after plan deductible	30% coinsurance after plan deductible

Supplies	In-network member pays	Out-of-network member pays
Durable medical equipment including prosthetics and disposable medical supplies	0% coinsurance after plan deductible	30% coinsurance after plan deductible

Supplies	In-network member pays	Out-of-network member pays
Includes wigs prescribed by an oncologist for a member suffering hair loss as a result of chemotherapy or radiation therapy up to one wig per year		
Diabetic equipment and supplies	No charge	30% coinsurance after plan deductible
Modified food products and specialized formula pharmacy tier	0% coinsurance after plan deductible	30% coinsurance after plan deductible
Hearing aids	No charge	30% coinsurance after plan deductible

Important Information

- 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 are per member per Calendar year.
- If you have questions regarding your plan, visit our website at connecticare.com or call us at (860) 674-5757 or 1-800-251-7722.
- 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 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 benefits.
- If you are a Massachusetts resident, this plan along with pharmacy services meets Massachusetts Minimum Creditable Coverage standards for 2018.

ConnectiCare

FlexPOS Combined Deductible 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 Calendar year.
Personalized for: Naugatuck BOE - Teachers

Covered prescription drugs through retail Participating Pharmacies or our mail order service. **Generics are dispensed unless the provider writes Dispense as Written on the prescription.**

Your Plan includes the following: Mandatory Drug Substitution, Generic Substitution Program, Tiered Cost-Share Program, and Voluntary Mail Order Program.

	In member network pays	Out of network member pays
Your deductible **(Deductible is combined for medical services and prescription drugs)** **(Deductible is combined for In and out-of-network)**	$2,250 individual $4,500 family	$2,250 individual $4,500 family
Your out-of-pocket maximum **(Includes a combination of deductible, copayments and coinsurance for medical and pharmacy services)** **(Out-of-pocket maximum is combined for In and out-of-network)**	$5,000 individual $10,000 family	$5,000 individual $10,000 family

Retail Pharmacy **(up to a 34 day supply per prescription)**	In-network member pays	Out-of-network member pays
Generic Drugs **(Tier 1)**	$5 copayment/prescription after plan deductible	30% coinsurance after plan deductible
Preferred Brand Drugs	$20 copayment/prescription	30% coinsurance after plan

Retail Pharmacy **(up to a 34 day supply per prescription)**	In-network member pays	Out-of-network member pays
(Tier 2)	after plan deductible	deductible
Non-Preferred Brand Drugs **(Tier 3)**	$35 copayment/prescription after plan deductible	30% coinsurance after plan deductible

Mail Order Pharmacy **(up to a 100 day supply per prescription)**	In-network member pays	Out-of-network member pays
Generic Drugs **(Tier 1)**	$10 copayment/prescription after plan deductible	Not covered
Preferred Brand Drugs **(Tier 2)**	$40 copayment/prescription after plan deductible	Not covered
Non-Preferred Brand Drugs **(Tier 3)**	$70 copayment/prescription after plan deductible	Not covered

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.
- 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.
- 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.
- If you are a Massachusetts resident, please refer to your amendatory rider for Massachusetts mandated benefits for additional details of your benefits.