



**Small Business Health Options Program (SHOP)**  
**Choice Silver POS**  
**Benefit Summary**  
**Non-Tiered Network Plan**

<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 (Deductible is combined for medical services and prescription drugs)	\$4,000 per member \$8,000 per family	\$20,000 per member \$40,000 per family
<b>Separate Prescription Drug Deductible</b> Individual Family	Included in Plan Deductible per member / per family	Included in Plan Deductible per member / per family
<b>Out-of-Pocket Maximum</b> Individual Family (Includes deductible, copayments and coinsurance for medical and pharmacy services)	\$9,100 per member \$18,200 per family	\$30,000 per member \$60,000 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
<b>Primary Care Provider Office/ Telemedicine Visits</b> (includes services for illness, injury, follow-up care and consultations)	\$50 copayment per visit	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>Dermatologist:</b> \$75 copayment per visit	50% coinsurance per visit after OON plan deductible is met
<b>Specialist Office/Telemedicine Visits</b>	\$75 copayment per visit	50% coinsurance per visit after OON plan deductible is met
<b>Mental Health and Substance Abuse Office Visits</b>	\$50 copayment per visit	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>Outpatient Diagnostic Services</b>		
<b>Advanced Radiology</b> (CT/PET Scan, MRI)	40% coinsurance per service after INET plan deductible is met	50% coinsurance per service after OON plan deductible is met
<b>Laboratory Services</b>	40% coinsurance per service after INET plan deductible is met	50% coinsurance per service after OON plan deductible is met
<b>Non-Advanced Radiology</b> (X-ray, Diagnostic)	40% coinsurance per service after INET plan deductible is met	50% coinsurance per service after OON plan deductible is met
<b>Mammography Ultrasound</b>	40% coinsurance per service after INET plan deductible is met	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	\$20 copayment per prescription	50% coinsurance per prescription after OON plan deductible is met
<b>Preferred Brand Drugs</b> Tier 2	\$60 copayment per prescription	50% coinsurance per prescription after OON plan deductible is met
<b>Non-Preferred Brand</b> Tier 3	50% coinsurance up to a maximum of \$300 per prescription after INET plan deductible is met	50% coinsurance per prescription after OON plan deductible is met
<b>Specialty Drugs</b> Tier 4	50% coinsurance up to a maximum of \$500 per prescription after INET plan deductible is met	50% coinsurance per prescription after OON plan deductible is met
<b>Prescription - Mail Order Pharmacy (up to a 90 day supply per prescription)</b>		
<b>Generic Drugs</b> Tier 1	\$40 copayment per prescription	50% coinsurance per prescription after OON plan deductible is met
<b>Preferred Brand Drugs</b> Tier 2	\$120 copayment per prescription	50% coinsurance per prescription after OON plan deductible is met
<b>Non-Preferred Brand</b> Tier 3	50% coinsurance up to a maximum of \$600 per prescription after INET plan deductible is met	50% coinsurance per prescription after OON plan deductible is met
<b>Outpatient Rehabilitative and Habilitative Services (40 visits per contract year limit combined for Rehabilitative physical, speech and occupational therapies. Separate 40 visits per contract year limit combined for Habilitative speech, physical and occupational therapies.)</b>		
<b>Speech Therapy</b>	\$50 copayment 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 copayment 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 contract year)	40% 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>	40% coinsurance per equipment/supply after INET plan deductible is met	50% coinsurance per equipment/supply 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>Durable Medical Equipment (DME)</b>	40% 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 contract year)	25% coinsurance per visit	25% coinsurance per visit after separate \$50 deductible is met
<b>Outpatient Services</b> (in a hospital or ambulatory facility)	40% coinsurance per visit after INET plan deductible is met	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 contract year)	40% 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>	40% coinsurance per service after INET plan deductible is met	40% coinsurance per service after INET plan deductible is met
<b>Emergency Room</b>	40% coinsurance per visit after INET plan deductible is met	40% coinsurance per visit after INET plan deductible is met
<b>Urgent Care Centers</b>	\$100 copayment per visit	50% coinsurance per visit after OON plan deductible is met
<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>Benefits</b>	<b>In-Network (INET) Member Pays</b>	<b>Out-of-network (OON) Member Pays</b>
<b>Prescription Eye Glasses</b> (one pair of frames and lenses or contact lens per contract year)	Lenses: 50% after INET plan deductible is met Collection frame: 50% 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 after OON plan deductible is met
<b>Routine Eye Exam by a Specialist</b> (one exam per contract year)	\$75 copayment per visit	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 contract year)	\$75 copayment per visit	50% coinsurance per visit after OON plan deductible is met
<b>Allergy Injections</b> (Unlimited)	Applicable office visit cost share	50% coinsurance per visit after OON plan deductible is met
<b>Allergy Testing</b> (one visit per contract year)	Applicable office visit cost share	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>Inpatient Physician Services</b>	40% coinsurance after INET plan deductible is met	50% coinsurance after OON plan deductible is met
<b>Modified Food Products and Specialized Formula</b>	40% 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)	\$75 copayment per visit	50% coinsurance per visit after OON plan deductible is met
<b>Retail Clinic</b>	\$50 copayment per visit	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. certificate of coverage for complete details on benefits, conditions, limitations and exclusions, or consult with your benefits manager.
- Mammogram screenings, breast ultrasounds, and breast MRIs – Please refer to the certificate of coverage 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 the certificate of coverage 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®** provider 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. 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.
- 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 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.
- 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 certificate of coverage for a detailed list of services or call member service 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.

Benefits are pending Connecticut Insurance Department approval