



**Choice Silver POS HSA
Small Business Options Program (SHOP)
Schedule of Benefits**

Deductible and Out-of-Pocket Maximum	IN-NETWORK (INET) MEMBER PAYS	OUT-OF-NETWORK (OON) MEMBER PAYS
Plan Deductible <i>Individual</i> <i>Family</i>	\$3,000 per Member \$6,000 per Family	\$20,000 per Member \$40,000 per Family
Out-of-Pocket Maximum <i>Individual</i> <i>Family</i> <i>(Includes deductible, copayments and coinsurance)</i>	\$5,500 per Member \$11,000 per Family	\$30,000 per Member \$60,000 per Family
Benefits	IN-NETWORK (INET) MEMBER PAYS	OUT-OF-NETWORK (OON) MEMBER PAYS
Provider Office Visits		
Adult Preventive Visit	No cost	50% coinsurance per visit
Infant/Pediatric Preventive Visit	No cost	50% coinsurance per visit
Primary Care Provider Office Visits <i>(includes services for illness, injury, follow-up care and consultations)</i>	20% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met
Specialist Office Visits	20% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met
Mental Health and Substance Abuse Office Visit	20% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met
Outpatient Diagnostic Services	IN-NETWORK (INET) MEMBER PAYS	OUT-OF-NETWORK (OON) MEMBER PAYS
Advanced Radiology <i>(CT/PET Scan, MRI)</i>	20% coinsurance per service after INET plan deductible is met	50% coinsurance per service after OON plan deductible is met
Laboratory Services	20% coinsurance per service after INET plan deductible is met	50% coinsurance per service after OON plan deductible is met

Outpatient Diagnostic Services	IN-NETWORK (INET) MEMBER PAYS	OUT-OF-NETWORK (OON) MEMBER PAYS
Non-Advanced Radiology <i>(X-ray, Diagnostic, Baseline Mammography, Screening Tomosynthesis)</i>	20% coinsurance per service after INET plan deductible is met	50% coinsurance per service after OON plan deductible is met
Mammography Ultrasound	20% coinsurance per service after INET plan deductible is met	50% coinsurance per service after OON plan deductible is met
Prescription Drugs - Retail Pharmacy <i>(30 day supply per prescription)</i>	IN-NETWORK (INET) MEMBER PAYS	OUT-OF-NETWORK (OON) MEMBER PAYS
Tier 1 Prescription Drugs <i>(Generic Drugs)</i>	\$5 copayment per prescription after INET plan deductible is met	50% coinsurance per prescription after OON plan deductible is met
Tier 2 Prescription Drugs <i>(Preferred Brand Drugs)</i>	\$60 copayment per prescription after INET plan deductible is met	50% coinsurance per prescription after OON plan deductible is met
Tier 3 Prescription Drugs <i>(Non-Preferred Brand Drugs)</i>	50% coinsurance up to a maximum of \$200 per prescription after INET plan deductible is met	50% coinsurance per prescription after OON plan deductible is met
Tier 4 Prescription Drugs <i>(Specialty Drugs)</i>	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
Prescription Drugs - Mail Order <i>(90 day supply per prescription)</i>	IN-NETWORK (INET) MEMBER PAYS	OUT-OF-NETWORK (OON) MEMBER PAYS
Tier 1 Prescription Drugs <i>(Generic Drugs)</i>	\$10 copayment per prescription after INET plan deductible is met	Not covered
Tier 2 Prescription Drugs <i>(Preferred Brand Drugs)</i>	\$120 copayment per prescription after INET plan deductible is met	Not covered
Tier 3 Prescription Drugs <i>(Non-Preferred Brand Drugs)</i>	50% coinsurance up to a maximum of \$400 per prescription after INET plan deductible is met	Not covered
Outpatient Rehabilitative and Habilitative Services	IN-NETWORK (INET) MEMBER PAYS	OUT-OF-NETWORK (OON) MEMBER PAYS
Speech Therapy <i>(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)</i>	20% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met
Physical and Occupational Therapy <i>(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)</i>	20% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met

Other Services	IN-NETWORK (INET) MEMBER PAYS	OUT-OF-NETWORK (OON) MEMBER PAYS
Chiropractic Services <i>(up to 20 visits per contract year)</i>	20% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met
Diabetic Equipment and Supplies	20% coinsurance per equipment/supply after INET plan deductible is met	50% coinsurance per equipment/supply after OON plan deductible is met
Durable Medical Equipment (DME)	20% coinsurance per equipment/supply after INET plan deductible is met	50% coinsurance per equipment/supply after OON plan deductible is met
Home Health Care Services <i>(up to 100 visits per contract year)</i>	20% coinsurance per visit after INET plan deductible is met	25% coinsurance per visit after OON plan deductible is met
Outpatient Services <i>(in a hospital or ambulatory facility)</i>	20% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met
Inpatient Hospital Services	IN-NETWORK MEMBER PAYS	OUT-OF-NETWORK MEMBER PAYS
Inpatient Hospital services <i>(including mental health, substance abuse, maternity, hospice and skilled nursing facility*)</i> <i>*(skilled nursing facility stay is limited to 90 days per contract year)</i>	20% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met
Emergency and Urgent Care	IN-NETWORK MEMBER PAYS	OUT-OF-NETWORK MEMBER PAYS
Ambulance Services	20% coinsurance per visit after INET plan deductible is met	20% coinsurance per visit after INET plan deductible is met
Emergency Room	20% coinsurance per visit after INET plan deductible is met	20% coinsurance per visit after INET plan deductible is met
Urgent Care Centers	20% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met
Pediatric Dental Care <i>(for children under age 20)</i>	IN-NETWORK MEMBER PAYS	OUT-OF-NETWORK MEMBER PAYS
Diagnostic & Preventive	No cost	50% coinsurance per visit after OON plan deductible is met
Basic Services	50% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met
Major Services	50% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met
Orthodontia Services <i>(medically necessary only)</i>	50% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met

Pediatric Vision Care <i>(for children under age 20)</i>	IN-NETWORK MEMBER PAYS	OUT-OF-NETWORK MEMBER PAYS
Prescription Eye Glasses <i>(one pair of frames and lenses or contact lens per contract year)</i>	Lenses: 20% after INET plan deductible is met Collection frame: 20% 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	Not covered
Routine Eye Exam by Specialist <i>(one exam per contract year)</i>	20% coinsurance per visit	50% coinsurance per visit after OON plan deductible is met
Adult Vision Care <i>(over age 20)</i>	IN-NETWORK MEMBER PAYS	OUT-OF-NETWORK MEMBER PAYS
Routine Eye Exam by Specialist <i>(one exam per contract year)</i>	20% coinsurance per visit	50% coinsurance per visit after OON plan deductible is met
Important Information		
<ul style="list-style-type: none"> • 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 Contract year. • 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. • ConnectiCare offers a Telemedicine benefit for all members. The type of provider you see will determine the cost share and will follow the PCP or Specialist office visit. • 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. • Refer to ConnectiCare's pharmacy center online at www.connecticare.com for the value list of drugs that are not subject to the member's deductible. • 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. 		