



Small Business Health Options Program (SHOP)

Choice Silver POS

Benefit Summary

Non-Tiered Network Plan

Deductible and Out-of-Pocket Maximum	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
<b>Plan Deductible</b> Individual Family	\$4,250 per member \$8,500 per family	\$20,000 per member \$40,000 per family
<b>Separate Prescription Drug Deductible</b> Individual Family	N/A per member N/A per family	Included in Plan Deductible per member / per family
<b>Out-of-Pocket Maximum</b> Individual Family (Includes deductibles, copayments and coinsurance)	\$8,150 per member \$16,300 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 Visits</b> (includes services for illness, injury, follow-up care and consultations)	\$40 copayment per visit	50% coinsurance per visit after OON plan deductible is met
<b>Specialist Office Visits</b>	\$60 copayment per visit	50% coinsurance per visit after OON plan deductible is met
<b>Mental Health and Substance Abuse Office Visits</b>	\$60 copayment per visit	50% coinsurance per visit after OON plan deductible is met
<b>Outpatient Diagnostic Services</b>		
<b>Advanced Radiology</b> (CT/PET Scan, MRI)	30% coinsurance per service after INET plan deductible is met	50% coinsurance per service after OON plan deductible is met
<b>Laboratory Services</b>	30% 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)	30% coinsurance per service after INET plan deductible is met	50% coinsurance per service 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>Mammography Ultrasound</b>	30% 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	\$10 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	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	50% coinsurance per prescription after OON plan deductible is met
<b>Prescription Drugs – Mail Order Pharmacy (up to a 90-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	\$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	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	50% coinsurance per visit after OON plan deductible is met
<b>Physical and Occupational Therapy</b>	\$30 copayment per visit	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)	\$50 copayment per visit	50% coinsurance per visit after OON plan deductible is met
<b>Diabetic Equipment and Supplies</b>	50% coinsurance per equipment/supply after INET plan deductible is met	50% coinsurance per equipment/supply after OON plan deductible is met
<b>Durable Medical Equipment (DME)</b>	50% 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 copayment per visit	25% coinsurance per visit after separate \$50 deductible is met

<b>Benefits</b>	<b>In-Network (INET) Member Pays</b>	<b>Out-of-Network (OON) Member Pays</b>
<b>Outpatient Services</b> (in a hospital or ambulatory facility)	30% 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 (including 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)	30% 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>	30% coinsurance per service after INET plan deductible is met	30% coinsurance per service after INET plan deductible is met
<b>Emergency Room</b>	30% coinsurance per visit after INET plan deductible is met	30% 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</b> (for children under age 20)		
<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</b> (for children under age 20)		
<b>Prescription Eye Glasses</b> (one pair of frames and lenses or contact lens per contract year)	<b>Lenses:</b> 0% after INET plan deductible is met <b>Collection frames:</b> 0% after INET plan deductible is met <b>Non-collection frames:</b> 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

<b>Benefits</b>	<b>In-Network (INET) Member Pays</b>	<b>Out-of-Network (OON) Member Pays</b>
<b>Routine Eye Exam by a Specialist</b> (one exam per contract year)	\$50 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 – over age 20</b> (one exam per contract year)	\$50 copayment per visit	50% coinsurance per visit after OON plan deductible is met
<b>Allergy Injections</b> (up to 20 visits per contract year)	See primary care or specialist office visit	50% coinsurance per visit after OON plan deductible is met
<b>Allergy Testing</b> (one visit per contract year)	See primary care or specialist office visit	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>Outpatient mental health, alcohol and substance abuse treatment</b> (intensive outpatient treatment and partial hospitalization)	30% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met
<b>Telemedicine</b>	See primary care or specialist office visit	50% coinsurance per visit after OON plan deductible is met

- 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.
- Mammogram screenings, breast ultrasounds, and breast MRIs – Please refer to the certificate of coverage for details.
- 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.
- 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 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 prescribed or rendered by Non-Participating providers or a benefit reduction may apply. Without pre-authorization you may be responsible for the total cost of the service or benefits may be reduced by the lesser of \$500 or 50%. Refer to the "Pre-authorization and Pre-certification Addendum" in your policy for more details.
- 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.