



FlexPOS-CAL-25-25-0-500A-02 Open Access Calendar Year Benefit Summary

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 Calendar year. A referral from your primary care provider is not required.

Personalized for: Town of Vernon - \$25

	IN-NETWORK MEMBER PAYS	OUT-OF-NETWORK MEMBER PAYS
Calendar Year Plan Deductible	None	\$250 Employee \$500 Employee + 1 \$750 per Family
Out-of-Pocket Maximum <i>(Includes a combination of deductible, copayments and coinsurance for health and pharmacy services)</i>	\$1,000 Employee \$2,000 Employee + 1 \$2,500 per Family	\$1,000 Employee \$2,000 Employee + 1 \$2,500 per Family
Out-of-Network Reimbursement	None	Plan will reimburse the coinsurance percentage of the Maximum Allowable Amount.
Lifetime Maximum Benefit	Unlimited	Unlimited
PREVENTIVE SERVICES <i>(Refer to "Prevention and Wellness" section found at the end of this summary)</i>	IN-NETWORK MEMBER PAYS	OUT-OF-NETWORK MEMBER PAYS
Physical Exam	No Member cost	20% after Plan Deductible
Gynecological Preventive Exam	No Member cost	20% after Plan Deductible
Preventive Laboratory Services <i>(Complete blood count and urinalysis)</i>	No Member cost	20% after Plan Deductible
Baseline Routine Mammography	No Member cost	20% after Plan Deductible
Routine Mammography	No Member cost	20% after Plan Deductible
Breast Ultrasound Screening	No Member cost	20% after Plan Deductible
Routine Vision Exam <i>(one exam every 12 months when provided by an Optometrist or Ophthalmologist)</i>	\$25 Copayment per visit	20% after Plan Deductible
Hearing Screening <i>(one exam every 24 months)</i>	\$25 Copayment per visit	20% after Plan Deductible
OUTPATIENT SERVICES	IN-NETWORK MEMBER PAYS	OUT-OF-NETWORK MEMBER PAYS
On-Line Visit <i>(telemedicine consultation)</i>	\$25 Copayment per visit	20% after Plan Deductible

OUTPATIENT SERVICES	IN-NETWORK MEMBER PAYS	OUT-OF-NETWORK MEMBER PAYS
Primary Care Services (includes services for illness, injury, sickness, follow-up care and consultations)	\$25 Copayment per visit	20% after Plan Deductible
Specialist Services (includes services for illness, injury, sickness, follow-up care and consultations)	\$25 Copayment per visit	20% after Plan Deductible
Gynecological Services	\$25 Copayment per visit	20% after Plan Deductible
Maternity Care Office Visits (Prenatal Care)	No Member cost	20% after Plan Deductible
Allergy Testing (Unlimited)	No Member cost	20% after Plan Deductible
Allergy Injections (Unlimited)	No Member cost	20% after Plan Deductible
Laboratory Services (includes services performed in a Hospital or laboratory facility) (Please refer to the provider directory for facility type)	No Member cost	20% after Plan Deductible
Non-Advanced Radiology (includes services performed in a Hospital or radiology facility)	No Member cost	20% after Plan Deductible
Advanced Radiology (includes services for MRI, PET and CAT scan and nuclear cardiology performed in a Hospital or radiology facility) (Please refer to the provider directory for facility type)	No Member cost	20% after Plan Deductible
Outpatient Rehabilitative Therapy combined with chiropractic (includes services combined for physical, speech, and occupational therapy and chiropractic services) (Unlimited)	No Member cost	20% after Plan Deductible
Retail Clinic	\$25 Copayment per visit	20% after Plan Deductible
EMERGENCY / URGENT CARE	IN-NETWORK MEMBER PAYS	OUT-OF-NETWORK MEMBER PAYS
Walk-In Centers	\$25 Copayment per visit	\$25 Copayment per visit
Urgent Care Centers	\$25 Copayment per visit	\$25 Copayment per visit
Emergency Room (Copayments waived if admitted)	\$50 Copayment per visit	\$50 Copayment per visit
Ambulance Services	No Member cost	No Member cost

HOSPITAL SERVICES	IN-NETWORK MEMBER PAYS	OUT-OF-NETWORK MEMBER PAYS
Inpatient Hospital Services, Including Room & Board	\$500 Copayment per admission	20% after Plan Deductible
Hospital Outpatient Facilities (includes services performed in a Hospital facility) <i>(Please refer to the provider directory for facility type)</i>	No Member cost	20% after Plan Deductible
Ambulatory Surgical Center (includes services performed in a stand-alone ambulatory facility) <i>(Please refer to the provider directory for facility type)</i>	No Member cost	20% after Plan Deductible
Skilled Nursing and Rehabilitation Facilities up to 120 days per year	No Member cost	20% after Plan Deductible
MENTAL HEALTH SERVICES	IN-NETWORK MEMBER PAYS	OUT-OF-NETWORK MEMBER PAYS
Inpatient Mental Health Services (including inpatient acute and residential programs)	\$500 Copayment per admission	20% after Plan Deductible
Inpatient Alcohol and Substance Abuse Treatment (including inpatient acute and residential programs)	\$500 Copayment per admission	20% after Plan Deductible
Outpatient Mental Health, Alcohol and Substance Abuse Treatment (including office visits and professional services provided in the home)	\$25 Copayment per visit	20% after Plan Deductible
Outpatient Mental Health, Alcohol and Substance Abuse Treatment (intensive outpatient treatment and partial hospitalization programs)	No Member cost	20% after Plan Deductible
OTHER SERVICES	IN-NETWORK MEMBER PAYS	OUT-OF-NETWORK MEMBER PAYS
Durable Medical Equipment Including Prosthetics and Disposable Medical Supplies (No Member cost for 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)	No Member cost	20% after Plan Deductible
Diabetic Equipment and Supplies	No Member cost	20% after Plan Deductible

OTHER SERVICES	IN-NETWORK MEMBER PAYS	OUT-OF-NETWORK MEMBER PAYS
Infertility (Infertility benefits outlined in the Certificate Of Coverage are unlimited, with no age or cycle restrictions)	\$25 Copayment per visit (Office visit) No Member cost (Ambulatory Services Outpatient) \$500 Copayment per admission (Inpatient Hospital)	20% after Plan Deductible
Nutritional Counseling (Limit 3 visits per year)	No Member cost	20% after Plan Deductible
Home Health Services up to 200 visits per year	No Member cost	20% after \$50 Benefit 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)
- 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
- Screening for colorectal cancer using fecal occult blood testing, sigmoidoscopy, or colonoscopy, ages 50 - 75, one per year
- Routine mammography screening
- Immunizations recommended by the Advisory Committee on Immunization Practices of the CDC
- Outpatient Laboratory Services:
 - Cervical cancer and cervical dysplasia screening – pap smear
 - Lipid cholesterol screening for adults and children at risk
 - Fasting plasma glucose or hemoglobin A1c
 - Hematocrit and Hemoglobin for children up to age 21
 - Lead screening for children
 - Tuberculin testing for children
 - Chlamydia, syphilis and gonorrhea screening for females all ages
 - Human immunodeficiency virus screening – HIV testing
 - Hypothyroidism screening in newborns, under 3 months of age
 - Screening for phenylketonuria (PKU) in newborns, 3 months of age
 - Screening for sickle cell disease in newborns, 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 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 age 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 2015.
- Your plan is Insured by ConnectiCare Insurance Company, Inc.