



FlexPOS-CNT-HSA-2000I/4000F-05-Combined Open Access Contract Year Benefit Summary

Open Access High Deductible Health Plan (HDHP) for use with a Health Savings Account (HSA)

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

The individual deductible applies if you have coverage only for yourself and not for any dependents. The family deductible applies if you have coverage for yourself and one or more eligible dependents. In addition, if you have family coverage, any applicable copayment, coinsurance or cost share maximums will apply until the total is met for the family, without regard to how much any one family member has met.

Personalized for: Town of Vernon - Union Employees

	IN-NETWORK MEMBER PAYS	OUT-OF-NETWORK MEMBER PAYS
Contract Year Plan Deductible <i>(Deductible is combined for In- and out-of-network health services and prescription drugs)</i>	\$2,000 per Individual \$4,000 per Family	\$2,000 per Member \$4,000 per Family
Out-of-Pocket Maximum <i>(Includes a combination of deductible, copayments and coinsurance for health services and pharmacy services)</i> <i>(Out-of-Pocket Maximum is combined for In- and out-of-network health services and prescription drugs)</i>	\$2,500 per Individual \$5,000 per Family	\$4,000 per Member \$8,000 per Family
Out-of-Network Reimbursement	Not Applicable	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 <i>(Plan Deductible waived)</i>	20% after Plan Deductible
Gynecological Preventive Exam	No Member cost <i>(Plan Deductible waived)</i>	20% after Plan Deductible
Preventive Laboratory Services <i>(Complete blood count and urinalysis)</i>	No Member cost <i>(Plan Deductible waived)</i>	20% after Plan Deductible
Baseline Routine Mammography	No Member cost <i>(Plan Deductible waived)</i>	20% after Plan Deductible
Routine Mammography	No Member cost <i>(Plan Deductible waived)</i>	20% after Plan Deductible
Breast Ultrasound Screening	No Member cost after Plan Deductible	20% after Plan Deductible
Routine Vision Exam <i>(one exam per year when provided by an Optometrist or Ophthalmologist)</i>	No Member cost <i>(Plan Deductible waived)</i>	20% after Plan Deductible

PREVENTIVE SERVICES (Refer to "Prevention and Wellness" section found at the end of this summary)	IN-NETWORK MEMBER PAYS	OUT-OF-NETWORK MEMBER PAYS
Hearing Screenings (one exam every 24 months)	No Member cost (<i>Plan Deductible waived</i>)	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)	No Member cost after Plan Deductible	20% after Plan Deductible
Specialist Services (includes services for illness, injury, sickness, follow-up care and consultations)	No Member cost after Plan Deductible	20% after Plan Deductible
Gynecological Office Services	No Member cost after Plan Deductible	20% after Plan Deductible
Maternity Care Office Visits (<i>Prenatal Care</i>)	No Member cost	20% after Plan Deductible
Allergy Testing (Unlimited)	No Member cost after Plan Deductible	20% after Plan Deductible
Allergy Injections (Unlimited)	No Member cost after Plan Deductible	20% after Plan Deductible
Laboratory Services (includes services performed in a Hospital or laboratory facility) (<i>Please refer to the provider directory for facility type</i>)	No Member cost after Plan Deductible	20% after Plan Deductible
Non-Advanced Radiology (includes services performed in a Hospital or radiology facility)	No Member cost after Plan Deductible	20% after Plan Deductible
Advanced Radiology (includes services for MRI, PET and CAT scan and nuclear cardiology performed in a Hospital or radiology facility) (<i>Please refer to the provider directory for facility type</i>)	No Member cost after Plan Deductible	20% after Plan Deductible
Outpatient Rehabilitative Therapy (includes services combined for physical, speech, and occupational therapy and chiropractic services) (Unlimited)	No Member cost after Plan Deductible	20% after Plan Deductible
Retail Clinic	No Member cost after Plan Deductible	20% after Plan Deductible
EMERGENCY / URGENT CARE	IN-NETWORK MEMBER PAYS	OUT-OF-NETWORK MEMBER PAYS
Walk-In Centers	No Member cost after Plan Deductible	Same as In-Network Benefit
Emergency Room	No Member cost after Plan Deductible	Same as In-Network Benefit

EMERGENCY / URGENT CARE	IN-NETWORK MEMBER PAYS	OUT-OF-NETWORK MEMBER PAYS
Ambulance Services	No Member cost after Plan Deductible	Same as In-Network Benefit
HOSPITAL SERVICES	IN-NETWORK MEMBER PAYS	OUT-OF-NETWORK MEMBER PAYS
Inpatient Hospital Services, Including Room & Board	No Member cost after Plan Deductible	20% after Plan Deductible
Hospital Outpatient Surgical Facilities (includes services performed in a Hospital facility) <i>(Please refer to the provider directory for facility type)</i>	No Member cost after Plan Deductible	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 after Plan Deductible	20% after Plan Deductible
Skilled Nursing and Rehabilitation Facilities up to 120 days per year	No Member cost after Plan Deductible	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)	No Member cost after Plan Deductible	20% after Plan Deductible
Inpatient Alcohol and Substance Abuse Treatment (including inpatient acute and residential programs)	No Member cost after Plan Deductible	20% after Plan Deductible
Outpatient Mental Health, Alcohol and Substance Abuse Treatment (including office visits and professional services provided in the home)	No Member cost after Plan Deductible	20% after Plan Deductible
Outpatient Mental Health, Alcohol and Substance Abuse Treatment (intensive outpatient treatment and partial hospitalization programs)	No Member cost after Plan Deductible	20% after Plan Deductible

OTHER SERVICES	IN-NETWORK MEMBER PAYS	OUT-OF-NETWORK MEMBER PAYS
<p>Durable Medical Equipment Including Prosthetics and Disposable Medical Supplies</p> <p>(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)</p>	No Member cost after Plan Deductible	20% after Plan Deductible
<p>Diabetic Equipment and Supplies</p>	No Member cost after Plan Deductible	20% after Plan Deductible
<p>Infertility (Infertility benefits outlined in the Certificate Of Coverage are unlimited, with no age or cycle restrictions)</p>	<p>No Member cost after Plan Deductible (Office visit)</p> <p>No Member cost after Plan Deductible (Ambulatory Services Outpatient)</p> <p>No Member cost after Plan Deductible (Inpatient Hospital)</p>	20% after Plan Deductible
<p>Nutritional Counseling (Limit 3 visits per year)</p>	No Member cost after Plan Deductible	20% after Plan Deductible
<p>Home Health Services up to 200 visits per year</p>	No Member cost after Plan Deductible	20% after Plan 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, age 50 or older
- 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 counseling and genetic screening for women at risk
- 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.

Benefits are Subject to Department of Insurance Approval



FlexPOS Copayment 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 Contract year.

Personalized for: Town of Vernon - Union Employees

PRESCRIPTION DRUGS		
Covered prescription drugs through retail Participating Pharmacies or our mail order service. Your Plan includes the following: Mandatory Drug Substitution, Tiered Cost-Share Program, and Voluntary Mail Order Program.		
	IN-NETWORK MEMBER PAYS	OUT-OF-NETWORK MEMBER PAYS
Contract Year Plan Deductible (Deductible is combined for In- and Out-Of-Network prescription drug benefits)	\$2,000 Individual \$4,000 Family The Contract Year Deductible can be reached by any combination of covered Health Services or covered prescription drug services. If you have Family coverage, then covered Health Services and covered prescription drugs will be applied to the Family Plan Deductible until the total amount is met without regard to which family member uses the benefits.	\$2,000 Individual \$4,000 Family The Contract Year Deductible can be reached by any combination of covered Health Services or covered prescription drug services. If you have Family coverage, then covered Health Services and covered prescription drugs will be applied to the Family Plan Deductible until the total amount is met without regard to which family member uses the benefits.
Out-of-Pocket Deductible (Includes a combination of deductible, copayments and coinsurance for health and pharmacy services) (The Out-of-Pocket Maximum is combined for In- and Out-of-Network prescription drug benefits)	\$2,500 Individual \$5,000 Family	\$4,000 Individual \$8,000 Family
Out-of-Network Reimbursement	Not Applicable	Plan will reimburse the coinsurance percentage of the Maximum Allowable Amount.
RETAIL PHARMACY (up to a 34 day supply per prescription)	IN-NETWORK MEMBER PAYS	OUT-OF-NETWORK MEMBER PAYS
Tier 1 drugs (<i>Generic Drugs</i>)	\$5 Copayment after Plan Deductible up to Out-of-Pocket Maximum	20% after Plan Deductible up to Out-of-Pocket Maximum
Tier 2 drugs (<i>Preferred Brand Drugs</i>)	\$15 Copayment after Plan Deductible up to Out-of-Pocket Maximum	20% after Plan Deductible up to Out-of-Pocket Maximum
Tier 3 drugs (<i>Non-Preferred Brand Drugs</i>)	\$35 Copayment after Plan Deductible up to Out-of-Pocket Maximum	20% after Plan Deductible up to Out-of-Pocket Maximum

MAIL ORDER PHARMACY (up to a 100 day supply per prescription)	IN-NETWORK MEMBER PAYS	OUT-OF-NETWORK MEMBER PAYS
Tier 1 drugs (Generic Drugs)	\$10 Copayment after Plan Deductible up to Out-of-Pocket Maximum	100%
Tier 2 drugs (Preferred Brand Drugs)	\$30 Copayment after Plan Deductible up to Out-of-Pocket Maximum	100%
Tier 3 drugs (Non-Preferred Brand Drugs)	\$70 Copayment after Plan Deductible up to Out-of-Pocket Maximum	100%
Additional Information		
<ul style="list-style-type: none"> • 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. • Generic drugs can reduce your out-of-pocket prescription costs. Generics have the same active ingredients as brand name drugs, but usually cost much less. So, ask your doctor or pharmacist if a generic alternative is available for your prescription. Also, remember to use a participating pharmacy. Most pharmacies in the United States participate in our network. To find one, visit our Web site at www.connecticare.com or call our Member Services Department at 1-800-251-7722. • 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. • Certain prescription drugs and supplies require pre-authorization from us before they will be covered under the prescription drug rider. You should visit our Web site at www.connecticare.com or call our Member Services Department at 1-800-251-7722 to find out if a prescription drug or supply requires pre-authorization. • 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 <u>are not part</u> of ConnectiCare's Voluntary Mail Order program. The Member Cost Share for Specialty Pharmacy <u>is different</u> from the Cost Share for ConnectiCare's Mail Order program. • Always remember to carry your ConnectiCare ID Card. • If you are a Massachusetts resident, please refer to your amendatory rider for Massachusetts mandated benefits for additional details of your benefits. 		