



**Small Business Health Options Program (SHOP)**  
**[Passage Gold POS PCP]**  
**Benefit Summary**  
**Non-Tiered Network Plan**

Passage plans require the selection of an in-network primary care provider upon enrollment.

A referral from your primary care provider is required to see a specialist.

<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	\$3,000 per member \$6,000 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	N/A per member N/A per family
<b>Out-of-Pocket Maximum</b> Individual Family (Includes deductible, copayments and coinsurance)	\$6,800 per member \$13,600 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)	\$30 copayment per visit	50% coinsurance per visit after OON plan deductible is met
<b>Specialist Office Visits</b>	\$50 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>Outpatient Diagnostic Services</b>		

<b>Benefits</b>	<b>In-Network (INET) Member Pays</b>	<b>Out-of-Network (OON) Member Pays</b>
<b>Advanced Radiology</b> (CT/PET Scan, MRI)	20% coinsurance per service after INET plan deductible is met at a Hospital Facility  \$75 copayment per service up to five copayments per year at a Freestanding Facility, then copayment waived	50% coinsurance per service after OON plan deductible is met
<b>Laboratory Services</b>	\$10 copayment per service	50% coinsurance per service after OON plan deductible is met
<b>Non-Advanced Radiology</b> (X-ray, Diagnostic)	20% coinsurance per service after INET plan deductible is met at a Hospital Facility  \$50 copayment per service at a Freestanding Facility	50% coinsurance per service after OON plan deductible is met
<b>Mammography Ultrasound</b>	20% coinsurance per service after INET plan deductible is met at a Hospital Facility  \$50 copayment per service at a Freestanding Facility	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
<b>Preferred Brand Drugs</b> Tier 2	\$50 copayment per prescription	50% coinsurance per prescription
<b>Non-Preferred Brand</b> Tier 3	50% coinsurance up to a maximum of \$250 per prescription	50% coinsurance per prescription
<b>Specialty Drugs</b> Tier 4	50% coinsurance up to a maximum of \$500 per prescription	50% coinsurance per prescription
<b>Prescription - 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
<b>Preferred Brand Drugs</b> Tier 2	\$100 copayment per prescription	50% coinsurance per prescription
<b>Non-Preferred Brand</b> Tier 3	50% coinsurance up to a maximum of \$500 per prescription	50% coinsurance per prescription
<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>Benefits</b>	<b>In-Network (INET) Member Pays</b>	<b>Out-of-Network (OON) Member Pays</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	50% coinsurance per equipment/supply after OON plan deductible is met
<b>Durable Medical Equipment (DME)</b>	50% coinsurance per equipment/supply	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>Outpatient Services</b> (in a hospital or ambulatory facility)	20% coinsurance after INET plan deductible is met at an Outpatient Hospital Facility  \$500 copayment per visit at an Ambulatory Facility	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)	20% 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>	20% coinsurance per service after INET plan deductible is met	20% coinsurance per service after INET plan deductible is met
<b>Emergency Room</b>	20% coinsurance per visit after INET plan deductible is met	20% 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 children under age 20)</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>Benefits</b>	<b>In-Network (INET) Member Pays</b>	<b>Out-of-Network (OON) Member Pays</b>
<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 children under age 20)</b>		
<b>Prescription Eye Glasses</b> one pair of frames and lenses or contact lens per contract year	Lenses: 0% after INET plan deductible is met Collection frame: 0% 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
<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 year	Applicable office visit cost share	50% coinsurance per visit after OON plan deductible is met
<b>Allergy Testing</b> up to one visit per 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	50% coinsurance after OON plan deductible is met
<b>Outpatient mental health, alcohol and substance abuse treatment</b> intensive outpatient treatment and partial hospitalization	20% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met
<b>Retail Clinic</b>	\$30 copayment per visit	50% coinsurance per visit after OON plan deductible is met
<b>Telemedicine</b>	Applicable office visit cost share	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.
- 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.
- If you are a Massachusetts resident, this plan along with pharmacy services meets Massachusetts Minimum Creditable Coverage standards for 2021.
- 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.
- Mammogram screenings, breast ultrasounds, and breast MRIs – Please refer to the certificate of coverage for details.

Benefits are pending Connecticut Insurance Department approval