CBIA HEALTH CONNECTIONS 2
THE POWER OF CHOICE

51 plus

HSA-Compatible

ConnectiCare POS $2500 B

51-100 EMPLOYEES

	In-Network	Out-of-Network
Access	Open Access	
Benefit Year	Contract Year	
Deductible	$2,500 individual plan deductible $5,000 family plan deductible* *Note: For Family coverage, the ConnectiCare plan requires that the family plan deductible must be met completely prior to any member of the family becoming eligible for benefits after the deductible.	$4,000 individual plan deductible $8,000 family plan deductible*
Coinsurance	100%	30%
Coinsurance Limit (not including deductible or in-network co-payments)	N/A	$2,000 individual plan/$4,000 family plan (individual plan coinsurance limit is determined by member paying 30% of approved charges totaling $6,667)
Maximum Out-of-Pocket—based on approved charges (including deductible)	$3,500 individual (2X family)	$6,000 individual (2X family)
Hospital Inpatient		
Hospital Services: Semi-private room & board, medications, and related hospital services (includes inpatient services for mental/nervous and substance abuse)	100% after plan deductible	30% after plan deductible
Outpatient Medical Services		
Routine Physical Exams (adults and children based on schedules)	Covered in full	30% after plan deductible
Medical Office Visits—includes office visits associated with mental/nervous and substance abuse	100% after plan deductible	30% after plan deductible
Routine OB/GYN Exam—1 visit annually	Covered in full	30% after plan deductible
Routine Mammography (subject to age limitations)	Covered in full	30% after plan deductible
Routine Vision Exam	Covered in full; One exam per contract year	Not covered
Immunizations	Covered in full (based on schedules)	30% after plan deductible
Diagnostic X-ray	100% after plan deductible	30% after plan deductible
Laboratory	Covered in full as part of routine physical exam; otherwise subject to deductible	30% after plan deductible
Outpatient Surgery (doctor's office or other facility)	100% after plan deductible	30% after plan deductible
Other Services		
Physical Therapy: Includes physical, speech and occupational. Prior authorization required.	100% after plan deductible (up to 20 visits combined)	30% after plan deductible
Prescription Drugs (Retail) See formularies for each health plan company.	Subject to plan deductible. Once deductible is met, then $15/$25/$40 (Tier 1/2/3) up to a pharmacy co-pay maximum of $1,000 individual plan/$2,000 family plan per contract year. Maximum does not include the plan deductible.	Not Covered
Mail-order Pharmacy	Subject to plan deductible. Then 2X retail co-pay for up to a 90-day supply.	Not Covered
Urgent Care (includes walk-in centers)	100% after plan deductible	100% after plan deductible
Emergency Room Services	100% after plan deductible	100% after in-network plan deductible
Ambulance Services	100% after plan deductible	100% after in-network plan deductible
Lifetime Maximum	Unlimited	$1,000,000

The services described are only an overview of the entire benefit package. For a more detailed plan description prior to enrolling, please contact the health plan company that interests you. Health plan company phone numbers can be obtained from your employer. Services provided by the health plan company under the benefit plan you select will be fully described in the proof of coverage document you'll receive once you are enrolled in the program. The benefits are subject to various limitations, exclusions and conditions as fully described in each health plan company's Certificate of Coverage. The services identified are covered as described only when they are provided based on the guidelines of the program; in other words, when they are provided, prescribed or directed by the health plan company you have selected (except in cases of emergencies).