

## Benefit Comparison by Insurance Company

(Reflects benefits for HC2)

		<b>In-Network</b> <i>Applies to HMO and POS plans</i>	<b>Out-of-Network</b> <i>Applies to POS plans only</i>
Routine Physical Exams		Covered in full. Schedule varies by carrier.	Varies by carrier.
	ConnectiCare	Routine Physical Exam Schedule: One visit annually.	Not covered.
	Oxford	No schedule. PCP is guided by good medical practice and individual circumstances.	Covered subject to deductible and coinsurance.
Well Baby Visits		Covered in full. Schedule varies by carrier.	Covered subject to applicable out-of-network deductible and coinsurance. Schedule varies by carrier.
	ConnectiCare	No schedule. PCP is guided by good medical practice and individual circumstances.	Preventive care is available only to members age 6 and under.
	Oxford	No schedule. PCP is guided by good medical practice and individual circumstances.	No schedule.
Routine Mammography		Covered in full. Age limitations vary by carrier.	Varies by carrier. Associated well-woman exam not covered.
	ConnectiCare	No age limitations.	Not covered.
	Oxford	Age limitations: • Ages 35-39, one baseline exam • Ages 40 and over, one exam per year  Provider is guided by good medical practice and individual circumstances, and additional services are covered as deemed necessary.	Covered subject to applicable out-of-network deductible and coinsurance.
Routine Vision Exam		Varies by carrier.	Varies by carrier.
	ConnectiCare	Covered in full after applicable copay or deductible; one exam per 24 months.	Not covered.
	Oxford	One exam per 24 months, covered to a maximum of \$50, on a reimbursement basis.	One exam per 24 months, covered to a maximum of \$50, on a reimbursement basis.

		<b>In-Network</b> <i>Applies to HMO and POS plans</i>	<b>Out-of-Network</b> <i>Applies to POS plans only</i>
Diagnostic X-Ray and Lab		Refer to individual Plan Summaries for Diagnostic X-Ray and Lab benefits by plan. See definition of Advanced Imaging services for each carrier.	Refer to individual Plan Summaries for Diagnostic X-Ray and Lab benefits by plan.
	<b>ConnectiCare</b>	ConnectiCare's Advanced Radiology Imaging services include: MRIs, MRAs, CAT Scans, and PET Scans. Bone Density is exempt from copays.	
	<b>Oxford</b>	Oxford's Advanced Radiology Imaging services include: MRI, MRA, CAT Scans, PET, Bone Density screenings, Nuclear Medicine and Surgical Endoscopic procedures.	
Outpatient Rehab – Physical, Speech and Occupational Therapy*		Covered in full after applicable copay or deductible. Allowable number of treatments varies by carrier. Speech therapy is covered only when it is necessary to correct a condition that is the result of a disease or injury. Coverage for speech therapy requires pre-authorization. In-network and out-of-network services are combined for maximum.	Covered subject to applicable out-of-network deductible and coinsurance. Allowable number of treatments varies by carrier. In-network and out-of-network services are combined for maximum.
	<b>ConnectiCare</b>	Covered up to 30 visits per member per contract year.	Covered up to 30 visits per member per contract year.
	<b>Oxford</b>	Covered up to 30 visits per condition per calendar year.	Covered up to 30 visits per condition per calendar year.
Diabetes Services		Varies by carrier.	Varies by carrier.
	<b>ConnectiCare</b>	Equipment (such as pumps, insulin cartridges, tubing, etc.) is covered subject to 20% co-insurance. Some supplies (lancets, syringes, test kits, and glucose monitoring medications) and prescription drugs are covered under the prescription drug benefit and subject to Rx deductibles/co-pays.	Covered subject to applicable out-of-network deductible and coinsurance.
	<b>Oxford</b>	Diabetic supplies – covered under base medical (which can also be purchased at the pharmacy) and subject to applicable office visit copay or deductible. Oral diabetic medications are covered under the pharmacy plan, at the lowest medical office visit copay/deductible. The charge will not exceed the amount of the item. Insulin pumps require precertification.	Covered subject to applicable out-of-network deductible and coinsurance. Insulin pumps require precertification.

\* Visit limitations also apply to HSA plans.

		<b>In-Network</b> <i>Applies to HMO and POS plans</i>	<b>Out-of-Network</b> <i>Applies to POS plans only</i>
<b>Durable Medical Equipment (DME)</b>	<b>ConnectiCare</b>	Varies by carrier.  HMO and POS co-pay and hospital/facility deductible plans: Covered subject to 50% co-insurance. HMO 30/45 2500 plan: Subject to deductible, then 50% co-insurance. POS 30/45 2500 20% plan: Subject to deductible, then 20% co-insurance. Hearing aids are excluded except when CT State Mandate applies.	Varies by carrier.  Covered subject to applicable out-of-network deductible and coinsurance. (Hearing aids are excluded except when CT state mandate applies.)
	<b>Oxford</b>	All HMO and POS plans (except POS 2000): Covered in full; no deductible or co-insurance. POS 2000: Subject to deductible then covered in full.	Covered subject to deductible and coinsurance.
<b>Chiropractic Therapy*</b>	<b>ConnectiCare</b>	Covered subject to applicable office visit copay or deductible. Allowable number of visits varies by carrier, and is combined for in- and out-of-network.  Covered for up to 10 visits per member per contract year.	Covered subject to applicable out-of-network deductible and coinsurance. Allowable number of visits varies by carrier, and is combined for in- and out-of-network.  Covered for up to 10 visits per member per contract year.
	<b>Oxford</b>	Covered for up to 30 visits per member per calendar year.	Covered for up to 30 visits per member per calendar year.
<b>Home Health Care*</b>	<b>ConnectiCare</b>	Benefit meets the CT state mandate. Covered in full. Allowable number of visits varies by carrier, and is combined for in- and out-of-network. Precertification is required.  100 visits per year.	Benefit meets the CT state mandate. Allowable number of visits varies by carrier, and is combined for in- and out-of-network. Precertification is required.  Covered subject deductible and coinsurance, up to 100 visits per year
	<b>Oxford</b>	80 visits per year.	Covered subject to deductible and coinsurance, up to 80 visits per year

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	<b>In-Network</b> <i>Applies to HMO and POS plans</i>	<b>Out-of-Network</b> <i>Applies to POS plans only</i>
<b>Skilled Nursing Facility*</b>	<b>Allowable number of days varies by carrier, and is combined for in- and out-of-network.</b>  <b>ConnectiCare</b> Up to 90 days per contract year when authorized. Applicable hospital copay or deductible applies.  <b>Oxford</b> Up to 60 days per calendar year when authorized. Applicable hospital copay or deductible applies.	<b>Covered subject to applicable out-of-network deductible and coinsurance. Allowable number of days varies by carrier, and is combined for in- and out-of-network.</b>  Up to 90 days per contract year when authorized.  Up to 60 days per calendar year when authorized.

\* Visit limitations also apply to HSA plans.

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.)