

	In-Network	Out-of-Network
Access		Open Access
Benefit Year		Contract Year
Plan Deductible	\$2,500 individual plan deductible \$5,000 family plan deductible*	\$4,000 individual plan deductible \$8,000 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.	
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) Includes plan deductible and pharmacy co-pays.	\$6,000 individual (2X family)
Hospital Inpatient		
Hospital Services: Semi-private room & board, medications, and related hospital services (includes inpatient service for mental/nervous and substance abuse)	100% after plan deductible	30% after plan deductible
Outpatient Medical Services		
Routine Physical Exams (including immunizations)	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)	Routine/preventive services covered in full	30% after plan deductible
Routine Colonoscopy (subject to age limitations)	Routine/preventive services covered in full	30% after plan deductible
Routine Vision Exam	Covered in full. One exam per contract year	Not covered
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
Durable Medical Equipment	Subject to deductible, then covered in full	30% after plan deductible
Prescription Drugs (Retail) (MACA mandatory generic)* 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 to pharmacy co-pay max.	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	Unlimited

* Generic substitution required when available. If member purchases brand drug when a generic is available, the member pays the difference in cost between brand and generic.

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).

	In-Network	Out-of-Network
Access		Open Access
Benefit Year		Contract Year*
Plan Deductible	\$2,000 individual plan deductible \$4,000 family plan deductible Note: For Family coverage, the family plan deductible must be met completely prior to any member of the family becoming eligible for benefits after the deductible.	\$2,000 individual plan deductible \$4,000 family plan deductible*
Coinsurance	100%	30%
Coinsurance Limit (not including deductible or in-network co-payments)	N/A	\$3,000 individual/\$6,000 family (individual coinsurance limit is determined by member paying 30% of approved charges totaling \$10,000)
Maximum Out-of-Pocket —based on approved charges (including deductible)	\$5,000 individual (2X family) Includes plan deductible and pharmacy co-pays.	\$5,000 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 (including immunizations)	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)	Routine/preventive services covered in full	30% after plan deductible
Routine Colonoscopy (subject to age limitations)	Routine/preventive services covered in full	30% after plan deductible
Routine Vision Exam	Not covered unless provided by PCP at time of routine exam	Not covered
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	30% after plan deductible
Durable Medical Equipment	Subject to deductible, then covered in full	30% after plan deductible
Prescription Drugs (Retail) (MAC-C co-pay only. No differential paid between cost of brand and generic.) See formularies for each health plan company.	Subject to plan deductible. Once deductible is met, then \$15/\$25/\$40 (Tier 1/2/3) to a pharmacy co-pay max of \$3,000 individual (2X family) per contract year. Max does not include the plan deductible.	30% after plan deductible
Mail-order Pharmacy	Subject to plan deductible. Then 2X retail co-pay for up to a 90-day supply to pharmacy co-pay max.	30% after plan deductible
Urgent Care (includes walk-in centers)	100% after plan deductible	30% 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	Unlimited

*Contract year effective July 1, 2009 for new business. In-force groups may be contract year or calendar year, determined at a group's renewal. NOTE: For Oxford, deductibles will run on a contract year. All other benefits will operate on a calendar year.

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).

	In-Network	Out-of-Network
Access		Open Access
Benefit Year		Contract Year*
Plan Deductible	\$2,500 individual plan deductible \$5,000 family plan deductible Note: For Family coverage, this 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.	\$3,000 individual plan deductible \$6,000 family plan deductible
Coinsurance	100%	70/30%
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)	\$3,000 individual (2X family) Includes plan deductible and pharmacy co-pays.	\$5,000 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 (including immunizations)	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)	Routine/preventive services covered in full	30% after plan deductible
Routine Colonoscopy (subject to age limitations)	Routine/preventive services covered in full	30% after plan deductible
Routine Vision Exam	ConnectiCare: Covered in full, one exam per contract year; Oxford: Not covered	Not covered
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. (Allowable treatments varies by carrier.)	100% after plan deductible	30% after plan deductible
Durable Medical Equipment	Subject to deductible, then covered in full	30% after plan deductible
Prescription Drugs (Retail) (CtCare: MAC-A mandatory generic)** (Oxford: MAC-C co-pay only. No differential paid between cost of brand and generic) See formularies for each health plan company.	Subject to plan deductible. Once deductible is met, then \$15/\$25/\$40 (Tier 1/2/3) to a pharmacy co-pay max of \$500 individual (2X family) per contract year. Max does not include the plan deductible.	30% after plan deductible
Mail-order Pharmacy	Subject to plan deductible. Then 2X retail co-pay for up to a 90-day supply to pharmacy co-pay max.	30% after plan deductible
Urgent Care (includes walk-in centers)	100% after plan deductible	30% 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	Unlimited

*Oxford: Contract year effective July 1, 2009 for new business. In-force groups may be contract year or calendar year, determined at a group's renewal. NOTE: For Oxford, deductibles run on a contract year. All other benefits operate on a calendar year.

** Generic substitution required when available. If member purchases brand drug when a generic is available, the member pays the difference in cost between brand and generic.

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	In-Network	Out-of-Network
Access		Open Access
Benefit Year		Contract Year*
Plan Deductible	\$3,500 individual plan deductible \$7,000 family plan deductible Note: For Family coverage, this 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.	\$10,000 individual plan deductible \$20,000 family plan deductible
Coinsurance	100% (Some services subject to co-pay)	50%
Coinsurance/Co-pay Limit (not including deductible)	Co-pay limit: \$1,500 individual (2X family) (health services only)	\$6,000 individual plan/\$12,000 family plan (individual plan coinsurance limit is determined by member paying 50% of approved charges totaling \$12,000)
Maximum Out-of-Pocket —based on approved charges	\$5,750 individual (2X family); Includes plan deductible and copays for health services and pharmacy, to specified maximums	\$16,000 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)	Subject to plan deductible then \$100 copay per day (\$500 copay max per year)	50% after plan deductible
Outpatient Medical Services		
Routine Physical Exams (including immunizations)	Covered in full	50% after plan deductible
Medical Office Visits—includes office visits associated with mental/nervous and substance abuse	Copay applies after plan deductible: \$15 PCP; \$30 specialist	50% after plan deductible
Routine OB/GYN Exam—1 visit annually	Covered in full	50% after plan deductible
Routine Mammography (subject to age limitations)	Routine/preventive services covered in full	50% after plan deductible
Routine Colonoscopy (subject to age limitations)	Routine/preventive services covered in full	50% after plan deductible
Routine Vision Exam	One exam every 24 months; \$30 specialist copay applies after deductible	50% after plan deductible
Diagnostic X-ray	Co-pay applies after plan deductible: \$45 non-advanced; \$75 advanced imaging (\$375 copay max per year)	50% after plan deductible
Laboratory	Covered in full after deductible	50% after plan deductible
Outpatient Surgery (doctor's office or other facility)	\$100 copay after plan deductible	50% after plan deductible
Other Services		
Physical Therapy: Includes physical, speech and occupational. Prior authorization required. (Allowable treatments varies by carrier.)	\$30 copay (per visit) after plan deductible	50% after plan deductible
Durable Medical Equipment	Subject to deductible, then covered in full	50% after plan deductible
Prescription Drugs (Retail) (CtCare: MAC-A mandatory generic)** (Oxford: MAC-C co-pay only. No differential paid between cost of brand and generic) 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 \$750 co-pay max (2X family). Pharmacy max does not include plan deductible.	50% after plan deductible
Mail-order Pharmacy	Subject to plan deductible. Then 2X retail co-pay for up to a 90-day supply. Up to \$750 co-pay max (2X family)	Not covered
Urgent Care (includes walk-in centers)	\$75 copay after plan deductible	\$75 copay after plan deductible
Emergency Room Services	\$150 copay after plan deductible	\$150 copay after plan deductible
Ambulance Services	100% after plan deductible	100% after plan deductible
Lifetime Maximum	Unlimited	Unlimited

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