EPO-OA-15-15-ABPA-17 EPO Open Access Calendar Year Plan Benefit Summary

The sponsor of this group health insurance plan believes that this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to some other plans, for example, the requirement for the provision of certain preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to your employer's benefit administrator. If your plan is subject to ERISA, you may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

This is a brief summary of benefits. Refer to your Summary Plan Description for complete details on benefits, conditions, limitations and exclusions, or consult with your benefits manager. All benefits described below are per member per Calendar year. A referral from your primary care provider is not required.

Personalized for: Simsbury BOE - CT Teachers & Administrators

	IN-NETWORK MEMBER PAYS
Lifetime Maximum Benefit	Unlimited
PREVENTIVE SERVICES	**IN-NETWORK MEMBER PAYS**
Adult Physical Exam (one exam per year when provided by a PCP)	$15 Copayment per visit
Infant / Pediatric Physical Exam (frequency limits apply and the exam must be provided by a PCP)	$15 Copayment per visit
Gynecological Preventive Exam	No Member cost
Preventive Laboratory Services (Complete blood count and urinalysis, one test per year)	No Member cost
Baseline Routine Mammography (ages 35 - 40)	No Member cost
Annual Routine Mammography (over age 40)	No Member cost
Annual Routine Vision Exam (one exam per year when provided by an Optometrist or Ophthalmologist)	$10 Copayment per visit
OUTPATIENT SERVICES	**IN-NETWORK MEMBER PAYS**
Primary Care Provider Office Services (includes services for illness, injury, sickness, follow-up care and consultations)	$15 Copayment per visit

OUTPATIENT SERVICES	IN-NETWORK MEMBER PAYS
Specialist Office Services (includes services for illness, injury, sickness, follow-up care and consultations)	$15 Copayment per visit
Gynecological Office Services	$15 Copayment per visit
Maternity Care Office Visits	No Member cost
Allergy Testing up to $315 every two years	Applicable office visit Copayment
Laboratory Services (includes services performed in a Hospital or laboratory facility)	No Member cost
Non-Advanced Radiology (includes services performed in a Hospital or radiology facility)	No Member cost
Advanced Radiology (includes services for MRI, PET and CAT scan, and nuclear cardiology performed in a Hospital or radiology facility)	No Member cost
Outpatient Rehabilitative Therapy up to 40 visits per year (includes services combined for physical, speech, and occupational therapy)	$15 Copayment per visit
Chiropractic Services up to 20 visits per year	$15 Copayment per visit
Home Health Services up to 100 visits per year	No Member cost
Retail Clinic	$15 Copayment per visit
EMERGENCY / URGENT CARE	**IN-NETWORK MEMBER PAYS**
Walk-In/Urgent Care Centers	$30 Copayment per visit
Emergency Room (Copayment waived if admitted)	$50 Copayment per visit
Ambulance Services	No Member cost
HOSPITAL SERVICES	**IN-NETWORK MEMBER PAYS**
Inpatient Hospital Services, Including Room & Board	$75 Copayment per admission
Ambulatory Services (Outpatient) (includes services performed in a Hospital or ambulatory facility)	$50 Copayment per visit

HOSPITAL SERVICES	IN-NETWORK MEMBER PAYS
Skilled Nursing and Rehabilitation Facilities up to 90 days per year	No Member cost
MENTAL HEALTH SERVICES	**IN-NETWORK MEMBER PAYS**
Inpatient Mental Health Services (including inpatient acute, residential and partial hospitalization programs)	$75 Copayment per admission
Inpatient Alcohol and Substance Abuse Treatment (including inpatient acute, residential and partial hospitalization programs)	$75 Copayment per admission
Outpatient Mental Health, Alcohol and Substance Abuse Treatment (including office visits, professional services provided in the home and intensive outpatient treatment programs)	$15 Copayment per visit
OTHER SERVICES	**IN-NETWORK MEMBER PAYS**
Disposable Medical Supplies • Deductible • Coinsurance	 $100 per Member 20% after Benefit Deductible up to $300 per year
Durable Medical Equipment Including Prosthetics • Deductible • Coinsurance	 $100 per Member 20% after Benefit Deductible up to $1,500 per year
Ostomy Supplies and Equipment • Deductible • Coinsurance	 $100 per Member 20% after Benefit Deductible up to $1,000 per year

WOMEN'S HEALTH PREVENTION

- 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 manual breast pump, and breastfeeding supplies
  - Screening and counseling for interpersonal and domestic violence for all women and adolescents

Important Information
• If you have questions regarding your plan, visit our website at **www.connecticare.com** or call us at (860) 674-2075 or 1-800-846-8578. • For mental health, alcohol, and substance abuse services call 1-888-946-4658 to obtain pre-authorization. • If you are a Massachusetts resident, this plan along with pharmacy services meets Massachusetts Minimum Creditable Coverage standards for 2013. • Your plan is administered by ConnectiCare Insurance Company, Inc.

Prescription Drug Copayment Plan Benefit Summary

This is a brief summary of your prescription drug benefits. Refer to your Prescription Drug Rider or Summary Plan Description for complete details on benefits, conditions, limitations and exclusions or consult with your benefits manager. All benefits described below are per Member per Calendar year.

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PRESCRIPTION DRUGS	
Covered prescription drugs through retail Participating Pharmacies or our mail order service. Generics are dispensed unless the Member pays the **Generic** Cost-Share plus the difference in price between the Generic Equivalent and the Brand Name Drug. Your Plan includes the following: Mandatory Drug Substitution, Generic Substitution Program, Tiered Cost-Share Program, and Voluntary Mail Order Program.	
RETAIL PHARMACY (up to a 30 day supply per prescription)	**IN-NETWORK MEMBER PAYS**
Tier 1 drugs	$5 Copayment
Tier 2 drugs	$20 Copayment
Tier 3 drugs	$35 Copayment
MAIL ORDER PHARMACY (up to a 90 day supply per prescription)	**IN-NETWORK MEMBER PAYS**
Tier 1 drugs	$10 Copayment
Tier 2 drugs	$40 Copayment
Tier 3 drugs	$70 Copayment

Additional Information

- 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 drugs or supplies 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 1-800-846-8578.
- 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 1-800-846-8578 to find out if a prescription drug or supply requires pre-authorization.
- Always remember to carry your ConnectiCare ID Card.