CARE COMPASS **Active Employees**

Medical Plan Coverage: Plan year July 1, 2024-June 30, 2025

Quality First Select Access Plan

Here's how much you pay for covered services depending on where you choose to receive care. Employees and their covered dependents must reside in Connecticut to choose this plan.

Benefit Features		Quality First Select Access		
		In-Network Value Tier 1	In-Network Tier 2	Out-of-Network[1]
Office visit[2]		You pay $0	PCP: You pay $50 Specialist: You pay $100	You pay 20%, plus deductible
LiveHealth Online (telemedicine)		You pay $0	N/A	N/A
Preventive care		You pay $0	You pay $0	You pay 20%, plus deductible
Walk-In Clinic/Urgent Care Center		You pay $35	You pay $35	You pay 20%, plus deductible
Emergency care (waived if admitted)		You pay $250	You pay $250	You pay $250
Diagnostic lab	Site of Service	You pay $0	You pay $0	N/A
	Non-Site of Service	You pay 20%	You pay 20%	You pay 40%, plus deductible
Diagnostic x-ray (prior authorization required for diagnostic imaging)		You pay $0	You pay $0	You pay 20%, plus deductible
Inpatient physician/hospital (prior authorization required)		You pay $0	You pay $0	You pay 20%, plus deductible
Outpatient surgical facility (prior authorization required)		You pay $0	You pay $0	You pay 20%, plus deductible
Ambulance (if emergency)		You pay $0	You pay $0	You pay $0
Short-term rehabilitation and physical therapy (prior authorization may be required)		You pay $0	You pay $0	You pay 20%, plus deductible
Routine eye exam (one exam per year)		You pay $0	You pay $50	You pay 50%, plus deductible
Audiology screening (one exam per year)		You pay $0	You pay $50	You pay 20%, plus deductible
Inpatient Mental Health/Substance Abuse (prior authorization required)		You pay $0	You pay $0	You pay 20%, plus deductible
Outpatient Mental Health/ Substance Abuse		You pay $0	You pay $0	You pay 20%, plus deductible
Family planning: vasectomy or tubal ligation (prior authorization may be required)		You pay $0	You pay $0	You pay 20%, plus deductible
Durable medical equipment (prior authorization may be required)		You pay $0	You pay $0	You pay 20%, plus deductible
Skilled nursing facility (prior authorization required)		You pay $0	You pay $0	You pay 20%, plus deductible
Home health care (up to 200 visits per year; prior authorization required)		You pay $0	You pay $0	You pay 20%, plus deductible
Annual deductible		$0[3]		Individual: $500[3] Family: $1,500[3]
Annual out-of-pocket maximum		Individual: $3,000 Family: $6,000		Individual: $6,000 Family: $12,000

[1] You pay coinsurance plus 100% of any amount your provider bills over the allowable charge (balance billing).

[2] PCP telemedicine visits are covered the same as office visits.

[3] Non-HEP Compliant: Additional $350 per individual; $1,400 maximum per family

Updated November 2024

CARE COMPASS **Active Employees**

Medical Plan Coverage: Plan year July 1, 2024-June 30, 2025

All Other Medical Plans

Here's how much you pay for covered services depending on the plan you're enrolled in and where you choose to receive care.

Benefit Features		Primary Care Access | Standard Access	Expanded Access | State Preferred POS[1] | Out-of-Area	
		In-Network ONLY	In-Network	Out-of-Network[2]
Office/PCP telemedicine visit		$15***	You pay $15***	You pay 20%, plus deductible
Walk-In/ Urgent Care Center		You pay $15	You pay $15	You pay 20%, plus deductible
LiveHealth Online (telemedicine)		You pay $5	You pay $5	N/A
Preventive care		You pay $0	You pay $0	You pay 20%, plus deductible
Emergency care (waived if admitted)		You pay $250	You pay $250	You pay $250
Diagnostic lab	Site of Service	You pay $0	You pay $0	N/A
	Non-Site of Service	You pay 20%	You pay 20%	You pay 40%, plus deductible
Diagnostic x-ray (prior authorization required for diagnostic imaging)		You pay $0	You pay $0	You pay 20%, plus deductible
Inpatient physician/hospital (prior authorization required)		You pay $0	You pay $0	You pay 20%, plus deductible
Outpatient surgical facility (prior authorization required)		You pay $0	You pay $0	You pay 20%, plus deductible
Ambulance (if emergency)		You pay $0	You pay $0	You pay $0
Short-term rehabilitation and physical therapy (prior authorization may be required)		You pay $0	You pay $0	You pay 20%, plus deductible; up to 60 inpatient days, 30 outpatient days per condition per year
Routine eye exam (one exam per year)		You pay $15	You pay $15	You pay 50%, plus deductible
Audiology screening (one exam per year)		You pay $15	You pay $15	You pay 20%, plus deductible
Inpatient Mental Health/Substance Abuse (prior authorization required)		You pay $0	You pay $0	You pay 20%, plus deductible
Outpatient Mental Health/ Substance Abuse		You pay $15	You pay $15	You pay 20%, plus deductible
Family planning: vasectomy or tubal ligation (prior authorization may be required)		You pay $0	You pay $0	You pay 20%, plus deductible
Durable medical equipment (prior authorization may be required)		You pay $0	You pay $0	You pay 20%, plus deductible
Skilled nursing facility (prior authorization required)		You pay $0	You pay $0	You pay 20%, plus deductible; up to 60 days per year
Home health care (prior authorization required)		You pay $0	You pay $0	You pay 20%, plus deductible; up to 200 visits per year
Annual deductible		$0[3]	$0[3]	Individual: $300[3] Family: $900[3]
Annual out-of-pocket maximum		Individual: $2,000 Family: $4,000	Individual: $2,000 Family: $4,000	Individual: $2,000, plus deductible Family: $4,000, plus deductible

[1] Closed to new enrollments

[2] You pay coinsurance plus 100% of any amount your provider bills over the allowable charge.

[3] Non-HEP Compliant: Additional $350 per individual; $1,400 maximum per family

**** $0 copay for a HEP Chronic Condition visit*

CARE COMPASS **Active Employees**

Dental Plan Coverage: Plan year July 1, 2024 - June 30, 2025

	Dental Care DHMO Plan	Total Care DHMO Plan	Enhanced Plan	Basic Plan
Primary Care Dentist	Required	Required	Not Required	Not Required
Referred from Primary Care Dentist	Required	Required	Not Required	Not Required
In- and Out-of-Network Coverage*	No	No	Yes	Yes
What you pay when you get care	Copays	Coinsurance	Coinsurance	Coinsurance

**When you visit an out-of-network dentist, you are responsible for all charges above the maximum allowable charge—the amount the plan would have paid if you had visited an in-network dentist.*

Here's what you'll pay for covered dental services, depending on the plan you elect.

	Dental Care DHMO Plan	Total Care DHMO Plan	Enhanced Plan	Basic Plan
Annual deductible	None	None	Individual: $25 Family: $75	None
Annual maximum	None	None	$3,000 per person (excluding orthodontia)	None
Exams, cleanings and x-rays	Plan pays 100%	Plan pays 100%	Plan pays 100%, deductible does not apply[1]	Plan pays 100%
Periodontal maintenance[2]	Copay[3]	15% coinsurance, plan pays 85%	Plan pays 100%[1]	20% (if enrolled in HEP, plan pays 100%)
Periodontal root scaling and planing[2]	Copay[3]	15% coinsurance, plan pays 85%	20%	50%
Other periodontal services	Copay[3]	15% coinsurance, plan pays 85%	20%	50%
Simple Restoration				
Fillings	Copay[3]	15% coinsurance, plan pays 85%	20%	20%
Oral surgery	Copay[3]	15% coinsurance, plan pays 85%	20%	33%
Major Restorations				
Crowns	Copay[3]	30% coinsurance, plan pays 70%	33%	33%
Dentures, fixed bridges	Copay[3]	45% coinsurance, plan pays 55%	50%	Not covered[4]
Implants	Copay[3]	45% coinsurance, plan pays 55% (one per year)	50% (plan pays benefits up to $500)	Not covered[4]
Orthodontia	Copay[3]	45% coinsurance, plan pays 55%	50%, plan pays maximum of $1,500 per person per lifetime[5]	Not covered[4]

[1] In the Enhanced plan, use an in-network dentist to ensure your care is covered 100%; with out-of-network dentists, you will be subject to balance billing if your dentist charges more than the maximum allowable charge.

[2] If you're enrolled in the Health Enhancement Program (HEP), frequency limits and cost share are applicable.

[3] Contact Cigna at 800-244-6224 for patient copay amounts.

[4] While not covered, you will get the discounted rate on these services if you visit a network dentist, unless prohibited by state law (see page 13 for details).

[5] Benefits are prorated over the course of treatment.