Quality First Select Access Plan

Your costs in this plan vary based on where you receive care. Use the chart below to compare coverage and out-of-pocket costs. **Note: You and your covered dependents must live in Connecticut to enroll in this plan.**

ACTIVE *employees*

Plan year: July 1, 2025 - June 30, 2026

Benefit Features		Quality First Select Access		
		In-Network Value Tier 1	In-Network Tier 2	Out-of-Network[1]
Office/PCP telemedicine visit		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[2]		Individual: $500[2] Family: $1,500[2]
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] *Non-HEP Compliant: Additional $350 per individual; $1,400 maximum per family*

Updated April 2025

All Other Medical Plans

What you pay for covered services depends on your plan and where you get care.

Plan year: July 1, 2025 - June 30, 2026

ACTIVE *employees*

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
LiveHealth Online (telemedicine)		You pay $5	You pay $5	N/A
Preventive care		You pay $0	You pay $0	You pay 20%, plus deductible
Walk-In Clinic/Urgent Care Center		You pay $15	You pay $15	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 (up to 200 visits per year; prior authorization required)		You pay $0	You pay $0	You pay 20%, plus deductible; up to 200 visits per year
Annual deductible		$0[3]		Individual: $300[3] Family: $900[3]
Annual out-of-pocket maximum		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*

Dental Plan Coverage

Plan year: July 1, 2025 - June 30, 2026

ACTIVE *employees*

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

** **Out-of-network coverage for the Basic and Enhanced plans has decreased for many dental procedures.** 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.

*Closed to new enrollments; the Total Care DHMO Plan offers better coverage and lower costs

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

	Total Care DHMO Plan	Enhanced Plan	Basic Plan	Dental Care DHMO Plan*
Annual deductible	None	$0 in-network, $25 & $75 out-of-network	None	None
Annual maximum	None	$5,000; $2,500 out-of-network (excluding orthodontia)	None	None
Exams, cleanings and x-rays	You pay $0	You pay $0, deductible does not apply[1]	You pay $0	You pay $0
Periodontal maintenance[2]	You pay 15%	You pay $0 in-network and out-of-network[1]	You pay 20% in-network and out-of-network, $0 for HEP enrollees	Copay[3]
Periodontal root scaling and planing[2]	You pay 15%	You pay $0 in-network, 50% out-of-network	You pay 40% in-network, 50% out-of-network	Copay[3]
Other periodontal services	You pay 15%	You pay 20% in-network, 50% out-of-network	You pay 50% in-network and out-of-network	Copay[3]
Simple Restoration				
Fillings	You pay 15%	You pay 20% in-network, 30% out-of-network	You pay 20% in-network, 30% out-of-network	Copay[3]
Oral surgery	You pay 15%	You pay 20% in-network, 50% out-of-network	You pay 30% in-network, 50% out-of-network	Copay[3]
Major Restorations				
Crowns	You pay 30%	You pay 33% in-network, 50% out-of-network	You pay 33% in-network, 50% out-of-network	Copay[3]
Dentures, fixed bridges	You pay 45%	You pay 50% in-network and out-of-network	Not covered[4]	Copay[3]
Implants	You pay 45% (one per year)	You pay 50% in-network and out-of-network (up to $500)	Not covered[4]	Copay[3]
Orthodontia	45% (24 month course of treatment — lifetime maximum)	You pay 50% (plan pays maximum of $2,000, $1,000 out-of-network, per person per lifetime)[5]	Not covered[4]	Copay[3]

[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.*