

## Quality First Select Access (State BlueCare Prime Network): All Groups

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

Benefit Features	In-Network Value Tier 1	In-Network Tier 2	Out-of-Network <sup>1</sup>
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 <sup>2</sup>	You pay \$0	You pay \$0	N/A
Diagnostic lab: 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 and substance use disorder provider visits	You pay \$0	You pay \$0	You pay 20%, plus deductible

<sup>1</sup> You pay coinsurance plus 100% of any amount your provider bills over the allowable charge (balance billing).

<sup>2</sup> Site of Service doesn't apply to Groups 1-4.

Benefit Features	In-Network Value Tier 1	In-Network Tier 2	Out-of-Network <sup>1</sup>
<b>Family planning: vasectomy or tubal ligation</b> (prior authorization may be required)	You pay \$0	You pay \$0	You pay 20%, plus deductible
<b>Durable medical equipment</b> (prior authorization may be required)	You pay \$0	You pay \$0	You pay 20%, plus deductible
<b>Skilled nursing facility</b> (prior authorization required)	You pay \$0	You pay \$0	You pay 20%, plus deductible
<b>Home health care</b> (up to 200 visits per year; prior authorization required)	You pay \$0	You pay \$0	You pay 20%, plus deductible
<b>Annual deductible</b>	\$0 <sup>3</sup>	\$0 <sup>3</sup>	Individual: \$500 <sup>3</sup> Family: \$1,500 <sup>3</sup>
<b>Annual out-of-pocket maximum</b>	Individual: \$3,000 Family: \$6,000	Individual: \$3,000 Family: \$6,000	Individual: \$6,000 Family: \$12,000

<sup>1</sup> You pay coinsurance plus 100% of any amount your provider bills over the allowable charge (balance billing).

<sup>3</sup> Non-HEP compliant: Additional \$350 per individual; \$1,400 maximum per family



## All Other Medical Plans: In-Network

- Primary Care Access
- Standard Access
- Expanded Access
- State Preferred Point of Service (POS)  
**Closed to new enrollments.**
- Out-of-Area

Benefit Features	Group 1	Group 2	Group 3	Group 4	Groups 5-9
Outpatient physician visit (PCP or specialist): Tier 1 provider <sup>1,2</sup>	You pay \$0	You pay \$0	You pay \$0	You pay \$0	You pay \$0
Outpatient physician visit (PCP or specialist): Tier 2 provider <sup>2</sup>	You pay \$5	You pay \$15	You pay \$15	You pay \$15	You pay \$15
Preventive care	You pay \$0	You pay \$0	You pay \$0	You pay \$0	You pay \$0
Emergency care	You pay \$0	You pay \$0	You pay \$0	You pay \$35 <sup>3</sup>	You pay \$250 <sup>3</sup>
Diagnostic x-ray	You pay \$0	You pay \$0	You pay \$0	You pay \$0	You pay \$0
Diagnostic lab: Site of Service provider	You pay \$0	You pay \$0	You pay \$0	You pay \$0	You pay \$0
Diagnostic lab: Non-Site of Service provider	You pay \$0	You pay \$0	You pay \$0	You pay \$0	You pay 20%, plus deductible
Inpatient hospital care <sup>4</sup>	You pay \$0	You pay \$0	You pay \$0	You pay \$0	You pay \$0
Outpatient surgery <sup>4</sup>	You pay \$0	You pay \$0	You pay \$0	You pay \$0	You pay \$0
Ambulance (if emergency)	You pay \$0	You pay \$0	You pay \$0	You pay \$0	You pay \$0
Physical and occupational therapy <sup>5</sup>	You pay \$0	You pay \$0	You pay \$0	You pay \$0	You pay \$0
Routine vision exam (1 exam per year)	You pay \$15	You pay \$15	You pay \$15	You pay \$15	You pay \$15

<sup>1</sup> You may be eligible for a \$0 copay by using a Tier 1 PCP or specialist.

<sup>2</sup> PCP telemedicine visits are covered the same as office visits.

<sup>3</sup> Emergency room copay waived if admitted; waiver form available for certain circumstances: [carecompass.ct.gov/forms](http://carecompass.ct.gov/forms).

<sup>4</sup> Prior authorization may be required.

<sup>5</sup> Subject to medical necessity review.

Benefit Features	Group 1	Group 2	Group 3	Group 4	Groups 5-9
<b>Routine hearing exam</b> (1 exam per year)	You pay \$15	You pay \$15	You pay \$15	You pay \$15	You pay \$15
<b>Hearing aids<sup>4</sup></b> (1 set within a 36-month period)	You pay \$0	You pay \$0	You pay \$0	You pay \$0	You pay \$0
<b>Inpatient mental health/substance abuse<sup>4</sup></b>	You pay \$0	You pay \$0	You pay \$0	You pay \$0	You pay \$0
<b>Outpatient mental health and substance use disorder provider visits</b>	You pay \$15 <sup>6</sup>	You pay \$15 <sup>6</sup>	You pay \$15 <sup>6</sup>	You pay \$15 <sup>6</sup>	You pay \$15 <sup>6</sup>
<b>Skilled nursing facility (SNF)<sup>4</sup></b>	You pay \$0	You pay \$0	You pay \$0	You pay \$0	You pay \$0
<b>Durable medical equipment<sup>4</sup></b>	You pay \$0	You pay \$0	You pay \$0	You pay \$0	You pay \$0
<b>Home health care<sup>4</sup></b>	You pay \$0	You pay \$0	You pay \$0	You pay \$0	You pay \$0
<b>Hospice<sup>4</sup></b>	You pay \$0	You pay \$0	You pay \$0	You pay \$0	You pay \$0
<b>Annual deductible</b>	None	None	None	Individual: \$350 <sup>7</sup> Family: \$350 per individual; \$1,400 maximum per family <sup>7</sup>	Individual: \$350 <sup>7</sup> Family: \$350 per individual; \$1,400 maximum per family <sup>7</sup>
<b>Annual medical out-of-pocket maximum</b>	Individual: \$2,000 Family: \$4,000	Individual: \$2,000 Family: \$4,000	Individual: \$2,000 Family: \$4,000	Individual: \$2,000 Family: \$4,000	Individual: \$2,000 Family: \$4,000

<sup>4</sup> Prior authorization may be required.

<sup>6</sup> Lyra Health virtual and in-person providers and services are a \$0 copay per visit.

<sup>7</sup> Waived for HEP-compliant members.

## Out-of-Network

- State Preferred Point of Service (POS)  
**Closed to new enrollments**
- Out-of-Area

Benefit Features	All Groups <sup>1</sup>
Primary care physician office visit <sup>2</sup>	You pay 20%, plus deductible
Specialist office visit <sup>2</sup>	You pay 20%, plus deductible
Preventive services	You pay 20%, plus deductible
Emergency care <sup>3</sup>	Same copay as in-network
Diagnostic x-ray and lab	Groups 1-4: You pay 20%, plus deductible Groups 5-7: You pay 0%, plus deductible
Inpatient hospital care <sup>4</sup>	You pay 20%, plus deductible
Outpatient surgery <sup>4</sup>	You pay 20%, plus deductible
Ambulance (if emergency)	You pay \$0
Physical and occupational therapy <sup>5</sup>	You pay 20%, plus deductible; 30 outpatient days per condition per year
Routine vision exam (1 exam per year)	You pay 50%, plus deductible
Routine hearing exam (1 exam per year)	You pay 20%, plus deductible
Hearing aids <sup>4</sup> (1 set within a 36-month period)	You pay 20%, plus deductible
Mental health and substance use disorder provider visits (inpatient and outpatient) <sup>4</sup>	You pay 20%, plus deductible
Durable medical equipment <sup>4</sup>	You pay 20%, plus deductible
Skilled nursing facility (SNF) <sup>4</sup>	You pay 20%, plus deductible (up to 60 days per year)
Home health care <sup>4</sup>	You pay 20%, plus deductible (up to 200 visits per year)
Hospice <sup>4</sup>	You pay 20%, plus deductible (up to 60 days per lifetime)
Annual deductible	Individual: \$300 Family: \$300 per individual; \$900 maximum per family
Annual medical out-of-pocket maximum	Individual: \$2,300 Family: \$4,900

<sup>1</sup> You pay 20% of the allowable charge after the annual deductible, plus 100% of any amount your provider bills over the allowable charge (balance billing).

<sup>2</sup> You may be eligible for a \$0 copay by using a Tier 1 PCP or specialist.

<sup>3</sup> Emergency room copay waived if admitted; waiver form available for certain circumstances: [carecompass.ct.gov/forms](https://carecompass.ct.gov/forms).

<sup>4</sup> Prior authorization may be required.

<sup>5</sup> Subject to medical necessity review.

# Prescription Drug Coverage

Your prescription drug coverage is administered by CVS Caremark. Prescription benefits are the same no matter which medical plan you choose.

What you pay depends on whether your prescription is a generic, a preferred brand-name (on the CVS Caremark formulary), or a non-preferred brand-name drug.

Here's what you'll pay for covered prescription drugs.

In-Network	Groups 1 & 2		Group 3	
	Acute and Maintenance Drugs (up to a 90-day supply)	Caremark Mail Order/Maintenance Drug Network <sup>1</sup> (90-day supply)	Acute and Maintenance Drugs (up to a 90-day supply)	Caremark Mail Order/Maintenance Drug Network <sup>1</sup> (90-day supply)
Tier 1: Preferred generic	\$3 copay	\$0 copay	\$5 copay	\$0 copay
Tier 2: Generic	\$3 copay	\$0 copay	\$5 copay	\$0 copay
Tier 3: Preferred brand	\$6 copay	\$0 copay	\$10 copay	\$0 copay
Tier 4: Non-preferred brand	\$6 copay	\$0 copay	\$25 copay	\$0 copay

<sup>1</sup> You are not required to fill your maintenance drug prescription using the maintenance drug network or CVS Caremark Mail Order. However, if you do, you will get a 90-day supply of maintenance medication for a \$0 copay.

In-Network	Group 4			Groups 5-9 <sup>1</sup>		
	Acute Drugs (up to a 90-day supply)	Maintenance Drugs <sup>2</sup> (90-day supply)	HEP Enrolled <sup>3</sup>	Acute Drugs (up to a 90-day supply)	Maintenance Drugs <sup>2</sup> (90-day supply)	HEP Enrolled <sup>3</sup>
Tier 1: Preferred generic	\$5 copay	\$5 copay	\$0 copay	\$5 copay	\$5 copay	\$0 copay
Tier 2: Generic	\$5 copay	\$5 copay	\$0 copay	\$10 copay	\$10 copay	\$0 copay
Tier 3: Preferred brand	\$20 copay	\$10 copay	\$5 copay	\$25 copay	\$25 copay	\$5 copay
Tier 4: Non-preferred brand	\$35 copay	\$25 copay	\$12.50 copay	\$40 copay	\$40 copay	\$12.50 copay

<sup>1</sup> Retirees in Groups 5-9 have a different CVS Caremark formulary (that is, the covered drug list) than retirees in the other groups. The CVS Caremark Standard Control Formulary is focused on clinically effective, lower-cost alternatives to high-cost drugs.

<sup>2</sup> You are required to fill your maintenance drugs using the Maintenance Drug Network or the CVS Caremark Mail Service Pharmacy.

<sup>3</sup> Maintenance drugs to treat (1) asthma or COPD; (2) diabetes (type 1 or 2); (3) heart failure/heart disease; (4) hyperlipidemia (high cholesterol); or (5) hypertension (high blood pressure): You are required to fill your Maintenance Drug Network or the CVS Caremark Mail Service Pharmacy.

## Dental Coverage at a Glance

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

	Total Care DHMO Plan	Enhanced Plan <sup>1</sup>	Basic Plan <sup>1</sup>	Dental Care DHMO Plan <sup>2</sup>
<b>Annual deductible</b>	None	\$0 in-network, \$25 & \$75 out-of-network	None	None
<b>Annual maximum</b>	None	\$5,000; \$2,500 out-of-network (excluding orthodontia)	None	None
<b>Exams, cleanings, and x-rays</b>	You pay \$0	You pay \$0, deductible does not apply	You pay \$0	You pay \$0
<b>Periodontal maintenance<sup>3</sup></b>	You pay 15%	You pay \$0 in-network and out-of-network	You pay 20% in-network and out-of-network, \$0 for HEP enrollees	Copay <sup>4</sup>
<b>Periodontal root scaling and planing<sup>3</sup></b>	You pay 15%	You pay \$0 in-network, 50% out-of-network	You pay 40% in-network, 50% out-of-network	Copay <sup>4</sup>
<b>Other periodontal services</b>	You pay 15%	You pay 20% in-network, 50% out-of-network	You pay 50% in-network and out-of-network	Copay <sup>4</sup>
<b>Simple Restoration</b>				
<b>Fillings</b>	You pay 15%	You pay 20% in-network, 30% out-of-network	You pay 20% in-network, 30% out-of-network	Copay <sup>4</sup>
<b>Oral surgery</b>	You pay 15%	You pay 20% in-network, 50% out-of-network	You pay 30% in-network, 50% out-of-network	Copay <sup>4</sup>
<b>Major Restorations</b>				
<b>Crowns</b>	You pay 30%	You pay 33% in-network, 50% out-of-network	You pay 33% in-network, 50% out-of-network	Copay <sup>4</sup>
<b>Dentures, fixed bridges</b>	You pay 45%	You pay 50% in-network and out-of-network	Not covered <sup>5</sup>	Copay <sup>4</sup>
<b>Implants</b>	You pay 45% (1 per year)	You pay 50% in-network and out-of-network (up to \$500)	Not covered <sup>5</sup>	Copay <sup>4</sup>
<b>Orthodontia</b>	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) <sup>6</sup>	Not covered <sup>5</sup>	Copay <sup>4</sup>

<sup>1</sup> In the Basic and Enhanced plans, use in-network dentists 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.

<sup>2</sup> **Closed to new enrollment;** the Total Care DHMO Plan offers better coverage and lower costs.

<sup>3</sup> If you're enrolled in the Health Enhancement Program (HEP), frequency limits and cost share are applicable.

<sup>4</sup> Contact Cigna at 800-244-6224 for patient copay amounts.

<sup>5</sup> While this service is not covered, you will get the discounted rate if you visit a network dentist, unless prohibited by state law.

<sup>6</sup> Benefits are prorated over the course of treatment.