

PRESCRIPTION DRUG OPTIONS

Prescription drug coverage is optional under the Point of Service plans. If selected, In-network benefits are provided for covered prescription drugs purchased through participating retail pharmacies, or through our mail-order program. There is a three-tier benefit design for covered prescription drugs: tier one drugs have the lowest copayment level; tier two drugs have an intermediate copayment level; and tier three drugs have the highest copayment level.

In-Network Prescription Drug Options

| Option I | Tier One | Tier Two | Tier Three | Benefit Limit |
|---|----------------|----------|------------|---------------|
| 30-Day supply through participating retail pharmacies | \$10 Copayment | 50% | 50% | \$1,000 |
| 90-Day supply through participating Mail Order Vendor | \$20 Copayment | 50% | 50% | |
| Option II | Tier One | Tier Two | Tier Three | Benefit Limit |
| 30-Day supply through participating retail pharmacies | \$10 Copayment | 50% | 50% | \$5,000 |
| 90-Day supply through participating Mail Order Vendor | \$20 Copayment | 50% | 50% | |

The Benefit Limit is a combined in-network and out-of-network Benefit Limit up to which ConnectiCare will provide coverage in a contract year. The member is responsible for prescription drug costs that exceed the Benefit Limit.

Benefit Limits are per member per contract year limits.

Out-of-network pharmacy costs is a 50% member cost share.

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For help or questions call 1-866-508-0618



Individual health plans
the ConnectiCare way.

Prescription Drug Copayment Plan Benefit Summary

This is a brief summary of your prescription drug benefits. Refer to the appropriate ConnectiCare Insurance Company, Inc. Policy for more information. The Policy will prevail for all benefits, conditions, limitations and exclusions. It is important that you read your Policy. All Benefits described below are per Member per **Contract year**.

| 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. | | | | |
| | IN-NETWORK | | OUT-OF-NETWORK | |
| Contract Year Plan Deductible | None | | None | |
| Prescription Drug Benefit Limit | \$1,000 per Member The Prescription Drug Benefit Limit is a combined in-network and out-of-network Benefit Limit up to which ConnectiCare will provide coverage in a contract year. The Member is responsible for prescription drug costs that exceed the Benefit Limit. | | | |
| Out-of-Network Reimbursement | None | | Plan will reimburse the coinsurance percentage of the Maximum Allowable Amount. | |
| RETAIL PHARMACY (up to a 30-day supply per prescription) | MEMBER PAYS | PLAN PAYS | MEMBER PAYS | PLAN PAYS |
| Tier 1 drugs | \$10 Copayment per 30 day supply up to Benefit Limit, then no coverage | 100% after Copayment up to Benefit Limit | 50% Coinsurance up to Benefit Limit, then no coverage | 50% Coinsurance up to Benefit Limit |
| Tier 2 drugs | 50% Coinsurance up to Benefit Limit, then no coverage | 50% Coinsurance up to Benefit Limit | 50% Coinsurance up to Benefit Limit, then no coverage | 50% Coinsurance up to Benefit Limit |
| Tier 3 drugs | 50% Coinsurance up to Benefit Limit, then no coverage | 50% Coinsurance up to Benefit Limit | 50% Coinsurance up to Benefit Limit, then no coverage | 50% Coinsurance up to Benefit Limit |

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| MAIL ORDER PHARMACY (up to a 90-day supply per prescription) | MEMBER PAYS | PLAN PAYS | MEMBER PAYS | PLAN PAYS |
|---|--|--|-----------------------|-----------------------|
| Tier 1 drugs | \$20 Copayment per 90 day supply up to Benefit Limit, then no coverage | 100% after Copayment up to Benefit Limit | Not a covered benefit | Not a covered benefit |
| Tier 2 drugs | 50% Coinsurance up to Benefit Limit, then no coverage | 50% Coinsurance up to Benefit Limit | Not a covered benefit | Not a covered benefit |
| Tier 3 drugs | 50% Coinsurance up to Benefit Limit, then no coverage | 50% Coinsurance up to Benefit Limit | Not a covered benefit | Not a covered benefit |
| Additional Information | | | | |
| <ul style="list-style-type: none"> • 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 Members 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 1-800-251-7722. • 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 1-800-251-7722 to find out if a prescription drug or supply requires Pre-Authorization. • Always remember to carry your ConnectiCare ID Card. | | | | |

Benefits are Pending Department of Insurance Approval

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| Your Plan includes the following: Mandatory Drug Substitution, Generic Substitution Program, Tiered Cost-Share Program, and Voluntary Mail Order Program. | | | | |
| | IN-NETWORK | | OUT-OF-NETWORK | |
| Contract Year Plan Deductible | None | | None | |
| Prescription Drug Benefit Limit | \$5,000 per Member The Prescription Drug Benefit Limit is a combined in-network and out-of-network Benefit Limit up to which ConnectiCare will provide coverage in a contract year. The Member is responsible for prescription drug costs that exceed the Benefit Limit. | | | |
| Out-of-Network Reimbursement | None | | Plan will reimburse the coinsurance percentage of the Maximum Allowable Amount. | |
| RETAIL PHARMACY (up to a 30-day supply per prescription) | MEMBER PAYS | PLAN PAYS | MEMBER PAYS | PLAN PAYS |
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Additional Information

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- 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 1-800-251-7722 to find out if a prescription drug or supply requires Pre-Authorization.
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