

Quality First Select Access Plan

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 covered dependents must live in Connecticut to enroll in this plan.**

Benefit Features	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
Diagnostic lab: Non-Site of Service	You pay 20%	You pay 20%	You pay 40% plus deductible
Diagnostic x-ray (prior authorization required for high-cost 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
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	\$0 ²	Individual: \$500 ² Family: \$1,500 ²
Annual out-of-pocket maximum	Individual: \$3,000 Family: \$6,000 In-network Tier 1 and Tier 2 combined	Individual: \$3,000 Family: \$6,000 In-network Tier 1 and Tier 2 combined	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

All Other Medical Plans

What you pay for covered services depends on your plan and where you get 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 ³	You pay \$15 ³	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
Diagnostic lab: Non-Site of Service	You pay 20%	You pay 20%	You pay 40% plus deductible
Diagnostic x-ray (prior authorization required for high-cost 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
Physical and occupational therapy (prior authorization may be required)	You pay \$0	You pay \$0	You pay 20% plus deductible; 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 and substance use disorder provider visits	You pay \$15 ⁴	You pay \$15 ⁴	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 ⁵	\$0 ⁵	Individual: \$300 ⁵ Family: \$900 ⁵
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 enrollment

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

³ \$0 copay for a HEP chronic condition visit

⁴ Lyra Health virtual and in-person providers and services are a \$0 copay per visit.

⁵ Non-HEP Compliant: Additional \$350 per individual; \$1,400 maximum per family

Dental Plan Coverage

The State of Connecticut fully covers the cost of employee dental coverage. This means that if you have Employee Only coverage, you'll pay \$0 in dental premiums! You'll pay to cover any dependents. Cigna is the administrator for all State of Connecticut dental plans.

	Total Care DHMO Plan	Enhanced Plan	Basic Plan	Dental Care DHMO Plan ¹
Primary care dentist	Required	Not required	Not required	Required
Specialist referral 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 ¹	No	Yes	Yes	No

¹ Closed to new enrollment; 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. Note: Balance billing applies with out-of-network dentists.

	Total Care DHMO Plan	Enhanced Plan ²	Basic Plan ²	Dental Care DHMO Plan ³
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	You pay \$0	You pay \$0
Periodontal maintenance ⁴	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 ⁵
Periodontal root scaling and planing ⁴	You pay 15%	You pay \$0 in-network, 50% out-of-network	You pay 40% in-network, 50% out-of-network	Copay ⁵
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 ⁵
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 ⁵
Oral surgery	You pay 15%	You pay 20% in-network, 50% out-of-network	You pay 30% in-network, 50% out-of-network	Copay ⁵
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 ⁵
Dentures, fixed bridges	You pay 45%	You pay 50% in-network and out-of-network	Not covered ⁶	Copay ⁵
Implants	You pay 45% (one per year)	You pay 50% in-network and out-of-network (up to \$500)	Not covered ⁶	Copay ⁵
Orthodontia (braces)	45% (24-month course of treatment – lifetime maximum)	You pay 50% (plan pays maximum of \$2,000 in-network, \$1,000 out-of-network, per person per lifetime) ⁷	Not covered ⁶	Copay ⁵

² 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.

³ 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.

⁴ If you're enrolled in the Health Enhancement Program (HEP), frequency limits and cost share are applicable.

⁵ Contact Cigna at 800-244-6224 for patient copay amounts.

⁶ Although orthodontia is not covered, you will get the discounted rate on these services if you visit a network dentist, unless prohibited by state law.

⁷ Benefits are prorated over the course of treatment.