ConnectiCare

P.O. Box 4058, Farmington, CT 06032-4058
www.connecticare.com ■ 1-800-251-7722

Enrollment / Change Form

Please print clearly, complete in full using ballpoint pen.

EMPLOYEE: Complete the following two sections, sign at bottom and read information on reverse side.

Please check appropriate item: ☐ New Enrollment ☐ Terminate Enrollment ☐ Add Dependent ☐ Remove Dependent ☐ Change Provider ☐ Change Division
☐ COBRA Election ☐ Other (Name change, address change, etc. Indicate reason for change.) _____

Plan type: ☐ HMO ☐ Point-of-Service (POS) ☐ FlexPOS ☐ Passage* ☐ Compass EPO
Plan Name: (from Benefit Summary) _____
*Selection of a PCP from the Passage network is required. Find participating Passage network PCPs with the "Find a Doctor" tool on connecticare.com

ConnectiCare, Inc. = HMO, HDHP, POS Benefit Plans and ConnectiCare Insurance Company, Inc. = PPO and FlexPOS Benefit Plans. MA employers cannot purchase CCI or CICI products.

Marital Status: ☐ Single ☐ Married/Civil Union ☐ Domestic Partner ☐ Legally Separated ☐ Separated ☐ Widowed ☐ Divorced

First Name | Middle Name | Last Name

Street Address | City | State | ZIP Code

Primary Phone Number ☐ Home ☐ Cell ☐ Work | Secondary Phone Number ☐ Home ☐ Cell ☐ Work | Email Address | Primary Language (optional)

MEMBER(S): First Name/Middle Initial/Last Name	Add	Delete	Social Security Number (required)	Sex	Date of Birth (mm/dd/yy)	Primary Care Provider	ConnectiCare Provider ID Number (optional)	Existing Patient
Employee				☐ M ☐ F				☐ Yes ☐ No
Spouse/Civil Union/Domestic Partner				☐ M ☐ F				☐ Yes ☐ No
Dependent 1				☐ M ☐ F				☐ Yes ☐ No
Dependent 2				☐ M ☐ F				☐ Yes ☐ No
Dependent 3				☐ M ☐ F				☐ Yes ☐ No

Are you currently using tobacco?
Employee ☐ Yes ☐ No Spouse/Civil Union/Dom. Partner ☐ Yes ☐ No Dependent 1 ☐ Yes ☐ No Dependent 2 ☐ Yes ☐ No Dependent 3 ☐ Yes ☐ No

Race/Ethnicity (optional): This information is designed for the purpose of data collection and will not be used to determine eligibility, rating or claim payment.

Employee:
☐ White ☐ Black/African American ☐ Hispanic/Latino ☐ Asian ☐ Amer. Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander ☐ Other _____ ☐ Unknown

Spouse/Civil Union/Domestic Partner:
☐ White ☐ Black/African American ☐ Hispanic/Latino ☐ Asian ☐ Amer. Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander ☐ Other _____ ☐ Unknown

Dependent 1:
☐ White ☐ Black/African American ☐ Hispanic/Latino ☐ Asian ☐ Amer. Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander ☐ Other _____ ☐ Unknown

Dependent 2:
☐ White ☐ Black/African American ☐ Hispanic/Latino ☐ Asian ☐ Amer. Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander ☐ Other _____ ☐ Unknown

Dependent 3:
☐ White ☐ Black/African American ☐ Hispanic/Latino ☐ Asian ☐ Amer. Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander ☐ Other _____ ☐ Unknown

☐ Check if enrolling a disabled dependent age 26 or over and contact ConnectiCare to obtain a form for submitting proof of disability.

Other health care coverage: Will you have other health insurance in addition to this ConnectiCare plan, under a Group, HMO or Medicare plan? ☐ Yes ☐ No

If yes, name of person covered | Employer

Insurance Co. Name and Address (Please attach a copy of your group medical insurance card.) | Policy Number | Medicare (Please attach a copy of your Medicare card.) ☐ Part A ☐ Part B ☐ Retired

EMPLOYER: Complete this section. Form cannot be processed without this information.

Cobra ☐ Yes ☐ No
Cobra Start Date

Length of coverage: ☐ 30 months ☐ 36 months ☐ Other_____

Date of Hire (mm/dd/yy)

Hours per week _____

Coverage Effective Date (mm/dd/yy)

Coverage End Date (mm/dd/yy)

Employee Work Location | Group Name | Plan Name | Group Number/Subdivision/Class

Requested Effective Date: Medical: _____ Dental: _____

Subgroup ID _____ Class ID _____ Plan ID _____

Employer Signature ▶ | Title | Date

Important: By signing here you are indicating that you have read and understand the information on the front **and back** of this form. This authorization is valid as long as you are enrolled in a ConnectiCare health plan, and for one year after enrollment if the plan ends. I certify to the best of my knowledge and belief that the information supplied in the form is correct. I agree to the consent on the reverse side of this form. I understand that the phone numbers I provided on this application may be used by ConnectiCare or any of its contracted parties to contact me about my account, the provision of services to me or my health benefit plan or related programs.

▶ _____
Employee's Signature Date

IMPORTANT: EMPLOYEE/MEMBER CONSENT

On my behalf and on behalf of my spouse and/or dependent(s), I hereby authorize any physician, hospital, provider, insurer, ConnectiCare Insurance Company, Inc. (CICI) or a CICI-affiliate, or other organization or person having records, data or information concerning health history or medical insurance for me or my family member(s), including but not limited to information concerning mental health, alcohol/ substance abuse or HIV or AIDS-related conditions, to transfer to any person or company such records, data or information as may be required for the purpose of providing treatment, paying claims, and performing other operations to administer my Benefit Plan. I understand that CICI's privacy notice contains a more complete description of the purposes for which information about me and my dependent(s) may be used or disclosed and that I have a right to review the privacy notice prior to signing this consent. I understand that CICI may change such notice at any time but will provide me a copy of any amended notice. I understand that I have a right to request restrictions on how information about me and my dependent(s) may be used or disclosed to carry out the plan administration purposes and that CICI is not required to agree to the requested restrictions. I understand that this authorization is valid for the term of my and my dependents' coverage under the Plan. I understand that I can revoke this authorization (but will be terminated from the Plan) at any time by giving written notice to CICI as long as CICI or others have not taken action relying on this authorization. I acknowledge that I have retained a copy of this authorization. I authorize payroll deduction, if any, for the coverage I have elected.

I understand that any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime punishable by penalties, imprisonment and restitution depending on applicable laws.

ConnectiCare collects race/ethnicity data solely for the purposes of developing quality improvement programs, education, training, and marketing purposes. This data will not be used for determining eligibility, premium rate or claim payment.

INSTRUCTIONS: DID YOU REMEMBER TO ...

- ☐ **Print clearly, complete all sections and sign at the bottom of page 1?**
- ☐ **Clearly define (write in) the plan name you requested?**
  (It is located at the top left of the Benefit Summary and is included in your enrollment package.)
- ☐ **Select your primary care physician and include the ConnectiCare Provider ID number?**
  (Can be found in the Provider Directory or on Website)
- ☐ **Attach a copy of your Medicare Card if you are Medicare-eligible?**
- ☐ **Attach a copy of your group medical insurance card if you have other coverage?**
- ☐ **Insert Social Security Number for each dependent?**
- ☐ **Retain a copy of this form for your records?**

DISCLOSURE OF MEDICAL LOSS RATIO

The medical loss ratio is defined as the ratio of incurred claims to earned premium for the prior calendar year for managed care plans issued in Connecticut. Claims shall be limited to medical expenses for services and supplies provided to enrollees and shall not include expenses for stop loss, reinsurance, enrollee educational programs, or other cost containment programs or features.

The Federal medical loss ratio has the same meaning as provided in and calculated in accordance with PPACA, PL 111-148, as amended from time to time, and regulations adopted thereunder.

- State Medical Loss Ratio for calendar year 2020 for ConnectiCare, Inc. (CCI): 79.0%
- Federal Medical Loss Ratio for calendar year 2020 for ConnectiCare, Inc. (CCI):
  Individual 91.5%
  Small-Group N/A
  Large-Group 86.7%
- State Medical Loss Ratio for calendar year 2020 for ConnectiCare Insurance Company, Inc. (CICI): 85.8%
- Federal Medical Loss Ratio for calendar year 2020 for ConnectiCare Insurance Company, Inc. (CICI):
  Individual 78.4%
  Small-Group 81.1%
  Large-Group 87.9%

ConnectiCare

Language & Non-Discrimination Notice

ConnectiCare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ConnectiCare does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

ConnectiCare:

- Provides free aids and services to people with disabilities to communicate effectively with us, including qualified interpreters and information in alternate formats.
- Provides free language services to people whose primary language is not English, including translated documents and oral interpretation.

If you need these services, contact The Committee for Civil Rights.

If you believe that ConnectiCare has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

The Committee for Civil Rights, ConnectiCare, 175 Scott Swamp Road, Farmington, CT 06032, Phone: 1-800-251-7722, and TTY: 711. You can file a grievance in person or by mail. If you need help filing a grievance, The Committee for Civil Rights is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Continued →

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-251-7722 (TTY: 711).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-251-7722 (TTY: 711).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-251-7722 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-800-251-7722 (TTY: 711）。

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-251-7722 (TTY: 711).

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-251-7722 (ATS: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-251-7722 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-251-7722 (телетайп: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-251-7722 (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-251-7722 (رقم هاتف الصم والبكم: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-251-7722 (TTY: 711)번으로 전화해 주십시오.

KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-800-251-7722 (TTY: 711).

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-251-7722 (TTY: 711) पर कॉल करें।

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-251-7722 (TTY: 711).

ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-800-251-7722 (TTY: 711).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-251-7722 (TTY: 711)។

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-251-7722 (TTY: 711).

ConnectiCare

FlexPOS-CNT-HSA-3000I/6000F-66 Open Access Contract Year Benefit Summary (A)

The individual deductible and out-of-pocket maximum applies if you have coverage only for yourself and not for any dependents. The family deductible and out-of-pocket maximum applies if you have coverage for yourself and one or more eligible dependents. In addition, if you have family coverage, any applicable copayments or coinsurance will not apply to services until the total deductible is met for the family, without regard to how much any one family member has met. No one member will exceed an in-network out-of-pocket maximum greater than $6,850.

Your ConnectiCare health plan helps you get the care you need. Here are the most frequently used services. Refer to your certificate of coverage on connecticare.com for a complete list of benefits.

Personalized for: Town of Ellington

In-Network Preventive Services
These services are no cost to you when you use an **in-network** doctor or facility. Frequency is based on age and gender. For a complete list of preventive services and to find a doctor, refer to connecticare.com.

Getting care within ConnectiCare's network typically costs you less. You may also get care outside of our network; however, your share of the costs will be higher. Out-of-network doctors and facilities do not appear in the "Find a doctor" directory on connecticare.com.

- **Physical**
- **Well woman visit and pap test**
- **More than 25 screenings, including mammograms and colonoscopies**
- **Flu shot**
- **Vaccinations**
- **Certain birth control and other prevention medications**

	In-network member pays	Out-of-network member pays
Your deductible Deductible is combined for medical services and prescription drugs	$3,000 Individual $6,000 Family	$4,000 Individual $8,000 Family
Your out-of-pocket maximum Includes a combination of deductible, copayments and coinsurance for medical and pharmacy services	$4,000 Individual $8,000 Family	$6,000 Individual $12,000 Family
Out-of-network reimbursement	Not applicable	Plan will reimburse the coinsurance percentage of the maximum allowable amount
After you have spent the out-of-pocket maximum amount, ConnectiCare will pay 100% of your covered health care expenses for the remainder of the year.		
Screenings	**In-network member pays**	**Out-of-network member pays**
Baseline routine mammography (ages 35-39)	0% coinsurance after plan deductible	30% coinsurance after plan deductible

Screenings	In-network member pays	Out-of-network member pays
Annual routine mammography (age 40 or older)	No charge	30% coinsurance after plan deductible
Annual routine vision exam	No charge	30% coinsurance after plan deductible
Hearing Screenings one exam per year	No charge	30% coinsurance after plan deductible
Allergy testing Unlimited	0% coinsurance after plan deductible	30% coinsurance after plan deductible
Ongoing Care and Sick Visits	**In-network member pays**	**Out-of-network member pays**
Primary care services (includes office and telemedicine services)	0% coinsurance after plan deductible	30% coinsurance after plan deductible
Specialist services (includes office and telemedicine services)	0% coinsurance after plan deductible	30% coinsurance after plan deductible
Gynecologist services	0% coinsurance after plan deductible	30% coinsurance after plan deductible
Maternity and prenatal care visits May not apply to all laboratory and radiology services – refer to your plan documents	No charge	30% coinsurance after plan deductible
Allergy injections Unlimited	0% coinsurance after plan deductible	30% coinsurance after plan deductible
Telemedicine visit (services rendered by a Teladoc® provider)	0% coinsurance after plan deductible	30% coinsurance after plan deductible
Retail clinic	0% coinsurance after plan deductible	30% coinsurance after plan deductible
Nutritional Counseling Unlimited	0% coinsurance after plan deductible	30% coinsurance after plan deductible
Lab and Radiology Performed in a hospital, lab or radiology facility	**In-network member pays**	**Out-of-network member pays**
Laboratory services	0% coinsurance after plan deductible	30% coinsurance after plan deductible
Non-advanced radiology X-ray, diagnostic	0% coinsurance after plan deductible	30% coinsurance after plan deductible
Advanced radiology Hospital facility MRI, PET and CAT scan and nuclear cardiology	0% coinsurance after plan deductible	30% coinsurance after plan deductible

Lab and Radiology Performed in a hospital, lab or radiology facility	**In-network member pays**	**Out-of-network member pays**
Advanced radiology Stand-alone facility MRI, PET and CAT scan and nuclear cardiology	0% coinsurance after plan deductible	30% coinsurance after plan deductible
Sudden and Unexpected Care	**In-network member pays**	**Out-of-network member pays**
Urgent care or other walk-in clinic	0% coinsurance after plan deductible	Same as In-network benefit
Emergency room	0% coinsurance after plan deductible	Same as In-network benefit
Ambulance	0% coinsurance after plan deductible	Same as In-network benefit
Inpatient Hospital Services	**In-network member pays**	**Out-of-network member pays**
Inpatient hospital services, including room and board	0% coinsurance after plan deductible	30% coinsurance after plan deductible
Skilled nursing and rehabilitation facilities up to 120 days per year	0% coinsurance after plan deductible	30% coinsurance after plan deductible
Inpatient Rehabilitation up to 100 days per year	0% coinsurance after plan deductible	30% coinsurance after plan deductible
Private duty nursing up to $15,000 per year	0% coinsurance after plan deductible	30% coinsurance after plan deductible
Outpatient Hospital Services and Home Care	**In-network member pays**	**Out-of-network member pays**
Hospital outpatient facilities	0% coinsurance after plan deductible	30% coinsurance after plan deductible
Ambulatory surgical center	0% coinsurance after plan deductible	30% coinsurance after plan deductible
Home health services (Nursing and therapeutic services limited to 200 visits) Home Health aide services limited to 80 visits that are applicable to the 200 visit limit	0% coinsurance after plan deductible	25% coinsurance after plan deductible
Outpatient Rehabilitative Services	**In-network member pays**	**Out-of-network member pays**
Rehabilitative Services up to 50 visits per year (includes services combined for physical, speech and occupational therapy and chiropractic services)	0% coinsurance after plan deductible	30% coinsurance after plan deductible

Mental Health and Substance Abuse	In-network member pays	Out-of-network member pays
Inpatient mental health services	0% coinsurance after plan deductible	30% coinsurance after plan deductible
Inpatient alcohol and substance abuse treatment	0% coinsurance after plan deductible	30% coinsurance after plan deductible
Outpatient mental health, alcohol and substance abuse treatment office visits and home services	0% coinsurance after plan deductible	30% coinsurance after plan deductible
Outpatient mental health, alcohol and substance abuse treatment intensive outpatient treatment and partial hospitalization	0% coinsurance after plan deductible	30% coinsurance after plan deductible
Supplies	**In-network member pays**	**Out-of-network member pays**
Durable medical equipment including prosthetics and disposable medical supplies	0% coinsurance after plan deductible	30% coinsurance after plan deductible
Artificial Limbs includes associated supplies and equipment	0% coinsurance after plan deductible	30% coinsurance after plan deductible
Diabetic equipment and supplies	0% coinsurance after plan deductible	30% coinsurance after plan deductible
Modified food products and specialized formula pharmacy tier	0% coinsurance after plan deductible	30% coinsurance after plan deductible

Important information

- This is a brief summary of benefits. Refer to your ConnectiCare Insurance Company, Inc. Certificate of Coverage for complete details on benefits, conditions, limitations and exclusions, or consult with your benefits manager. All benefits described are per member per Contract year.
- Mammogram screenings, breast ultrasounds, and breast MRIs - Please refer to the Certificate of Coverage for details.
- To learn more about your Teladoc® provider benefits contact Teladoc® at teladoc.com/connecticare or call 1-800-835-2362 (TTY: 711).
- Insulin and noninsulin drugs are covered up to a cost share maximum of $25 for each 30-day supply.
- Diabetes Devices and Diabetic Ketoacidosis Devices are covered up to a cost share maximum of $100 per 30-day supply.
- Please refer to the certificate of coverage for additional cost share maximums regarding diabetic services. Some diabetic services fall under preventive care and cost share may be waived.
- If you have questions regarding your plan, visit our website at **www.connecticare.com** or call us at (860) 674-5757 or 1-800-251-7722.
- Out-of-Network reimbursement is based on the maximum allowable amount. Members are responsible to pay any charges in excess of this amount. Please refer to your ConnectiCare Insurance Company, Inc. Certificate of Coverage for more information.
- If you are a Massachusetts resident, please refer to your *amendatory rider for Massachusetts mandated benefits* for additional details of your benefits.
- If you are a Massachusetts resident, this plan along with pharmacy services meets Massachusetts Minimum Creditable Coverage standards for 2022.

ConnectiCare

FlexPOS Copayment Prescription Drug Plan for Use with Health Savings Account (HSA) Benefit Summary

This is a brief summary of your prescription drug benefits. Refer to your prescription drug rider for complete details on benefits, conditions, limitations and exclusions, or consult with your benefits manager. All benefits described below are per member per Contract year.

Personalized for: Town of Ellington

Covered prescription drugs through retail participating pharmacies or our mail order service. **Generics are dispensed unless the provider writes "Dispense as Written" on the prescription.**

Your Plan includes the following: Mandatory drug substitution, Generic substitution program, Pay the difference waiver, Tiered cost-share program, and Voluntary mail order program.

	In-network member pays	**Out-of-network member pays**
Your deductible Deductible is combined for medical services and prescription drugs	$3,000 Individual $6,000 Family	$4,000 Individual $8,000 Family
Your out-of-pocket maximum Includes a combination of deductible, copayments and coinsurance for medical and pharmacy services	$4,000 Individual $8,000 Family	$6,000 Individual $12,000 Family
Retail Pharmacy (up to a 30 day supply per prescription)	**In-network member pays**	**Out-of-network member pays**
Generic drugs (Tier 1)	$5 copayment/prescription after plan deductible	30% coinsurance after plan deductible
Preferred brand drugs (Tier 2)	$25 copayment/prescription after plan deductible	30% coinsurance after plan deductible
Non-preferred brand drugs (Tier 3)	$40 copayment/prescription after plan deductible	30% coinsurance after plan deductible
Mail Order Pharmacy (up to a 90 day supply per prescription)	**In-network member pays**	**Out-of-network member pays**
Generic drugs (Tier 1)	$5 copayment/prescription after plan deductible	30% coinsurance after plan deductible

Mail Order Pharmacy (up to a 90 day supply per prescription)	In-network member pays	Out-of-network member pays
Preferred brand drugs (Tier 2)	$50 copayment/prescription after plan deductible	30% coinsurance after plan deductible
Non-preferred brand drugs (Tier 3)	$80 copayment/prescription after plan deductible	30% coinsurance after plan deductible

Additional Information

- 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 member's 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 drug's or supply's clinical effectiveness and cost, not on whether it is a generic drug or supply or brand name drug or supply.
- Amounts paid by members because they must pay a price difference for a brand name drug do not count towards meeting any deductibles, coinsurance and copayment.
- Most specialty drugs are dispensed through specialty pharmacies by mail, up to a 30 day supply. Specialty pharmacies have the same member cost share as all other participating pharmacies and are not part of ConnectiCare's voluntary mail order program. The member cost share for specialty pharmacy is different from the cost share for ConnectiCare's mail order program.
- Insulin and noninsulin drugs are covered up to a cost share maximum of $25 for each 30-day supply.
- Diabetes Devices and Diabetic Ketoacidosis Devices are covered up to a cost share maximum of $100 per 30-day supply.
- Please refer to the prescription drug rider for additional cost share maximums regarding diabetic services. Some diabetic services fall under preventive care and cost share may be waived.
- If you are a Massachusetts resident, please refer to your *amendatory rider for Massachusetts mandated benefits* for additional details of your benefits.