



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-251-7722. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary> or call 1-800-251-7722 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall deductible ? | In-Network: \$3,000 individual / \$6,000 family. | Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible . |
| Are there services covered before you meet your deductible ? | Yes. Preventive care is covered before you meet your deductible . | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/#preventive-care-benefits/ . |
| Are there other deductibles for specific services? | There are no other specific deductibles . | You don't have to meet deductibles for specific services. |
| What is the out-of-pocket limit for this plan ? | For participating providers \$6,500 individual / \$13,000 family | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| What is not included in the out-of-pocket limit ? | Premiums , balance-billing charges, and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the out-of-pocket limit . |
| Will you pay less if you use a network provider ? | Yes. See www.ConnectiCare.com or call 1-800-251-7722 for a list of participating providers . | This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use a non-participating provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| Do you need a referral to see a specialist ? | No | You can see the specialist you choose without a referral . |

 All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|------------------------------------------------------------------------|----------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|
| | | Participating Provider (You will pay the least) | Non-Participating Provider (You will pay the most) | |
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness | \$25 copayment /visit after plan deductible | Not covered | None |
| | Specialist visit | \$50 copayment /visit after plan deductible | Not covered | None |
| | Preventive care / screening / immunization | No charge | Not covered | You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. |
| If you have a test | Diagnostic test (x-ray, blood work) | Xray: \$50 copayment /visit after plan deductible , Lab: \$15 copayment /visit after plan deductible | Not covered | Preauthorization is required for certain services (ie: genetic testing) |
| | Imaging (CT/PET scans, MRIs) | \$75 copayment /visit after plan deductible | Not covered | Preauthorization is required. |

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|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| | | Participating Provider (You will pay the least) | Non-Participating Provider (You will pay the most) | |
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.ConnectiCare.com | Preferred Generic (Tier 1) | \$25 copayment /prescription after plan deductible (retail); \$50 copayment /prescription after plan deductible (mail order) | Not covered (retail); Not covered (mail order) | Certain drugs will require preauthorization Covers up to a 30-day supply per prescription (retail); 90-day supply per prescription (mail order) Specialty Drugs are available from specialty retail pharmacies only and cover up to a 30-day supply limit. |
| | Non-Preferred Generic drugs (Tier 2) | 50% coinsurance up to a maximum of \$300 per prescription after plan deductible (retail); 50% coinsurance up to a maximum of \$600 per prescription after plan deductible (mail order) | Not covered (retail); Not covered (mail order) | |
| | Preferred brand drugs (Tier 3) | \$40 copayment /prescription after plan deductible (retail); \$80 copayment /prescription after plan deductible (mail order) | Not covered (retail); Not covered (mail order) | |
| | Non-preferred brand drugs (Tier 4) | 50% coinsurance up to a maximum of \$300 per prescription after plan deductible (retail); 50% coinsurance up to a maximum of \$600 per prescription after plan deductible (mail order) | Not covered (retail); Not covered (mail order) | |
| | Preferred Specialty drugs (Tier 5) | 50% coinsurance up to a maximum of \$250 per prescription after plan deductible (specialty retail only) | Not covered (specialty retail only) | |
| | Non-Preferred Specialty drugs (Tier 6) | 50% coinsurance up to a maximum of \$750 per prescription after plan deductible (specialty retail only) | Not covered (specialty retail only) | |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---------------------------------------------------------------------------|--------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|--------------------------------------------------------|
| | | Participating Provider (You will pay the least) | Non-Participating Provider (You will pay the most) | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | \$100 copayment /visit after plan deductible | Not covered | Preauthorization is required. |
| | Physician/surgeon fees | 0% coinsurance after plan deductible | Not covered | None |
| If you need immediate medical attention | Emergency room care | \$250 copayment /visit after plan deductible | Same as In-network benefit | copayment waived if admitted |
| | Emergency medical transportation | \$250 copayment /service after plan deductible | Same as In-network benefit | None |
| | Urgent care | \$75 copayment /visit after plan deductible | Same as In-network benefit | None |
| If you have a hospital stay | Facility fee (e.g., hospital room) | \$100 copayment /day up to \$400 per admission after plan deductible | Not covered | Preauthorization is required. |
| | Physician/surgeon fees | 0% coinsurance after plan deductible | Not covered | None |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | \$25 copayment /visit after plan deductible Outpatient mental health, alcohol and substance abuse treatment (intensive outpatient treatment and partial hospitalization): \$100 copayment/visit after plan deductible | Not covered | None |
| | Inpatient services | \$100 copayment /day up to \$400 per admission after plan deductible | Not covered | Preauthorization is required. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|----------------------------------------------------------------|-------------------------------------------|------------------------------------------------------------------------------------------------------|-------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| | | Participating Provider (You will pay the least) | Non-Participating Provider (You will pay the most) | |
| If you are pregnant | Office visits | No charge for prenatal and postnatal care | Not covered | Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
| | Childbirth/delivery professional services | 0% coinsurance after plan deductible | Not covered | None |
| | Childbirth/delivery facility services | \$100 copayment /day up to \$400 per admission after plan deductible | Not covered | None |
| If you need help recovering or have other special health needs | Home health care | 0% coinsurance after plan deductible | Not covered | Preauthorization is required. |
| | Rehabilitation services | \$50 copayment /visit after plan deductible | Not covered | Preauthorization is required. up to 60 visits per year (includes services combined for physical and occupational therapy) Speech and hearing therapy, prescribed by applicable law, apply to, but are not limited by the visit maximum |
| | Habilitation services | \$50 copayment /visit after plan deductible | Not covered | up to 60 visits per year (includes services combined for physical and occupational therapy) Speech and hearing therapy, prescribed by applicable law, apply to, but are not limited by the visit maximum |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|----------------------------------------------------------------|-------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|-----------------------------------------------------------------------|
| | | Participating Provider (You will pay the least) | Non-Participating Provider (You will pay the most) | |
| If you need help recovering or have other special health needs | Skilled nursing care | \$100 copayment /day up to \$400 per admission after plan deductible | Not covered | Preauthorization is required. up to 100 days per year |
| | Durable medical equipment | 20% coinsurance after plan deductible | Not covered | Preauthorization is required. |
| | Hospice services | Applicable inpatient hospital facility or home health care cost share | Not covered | Preauthorization is required. |
| If your child needs dental or eye care | Children's eye exam | \$25 copayment /visit; deductible does not apply | Not covered | up to one visit per year |
| | Children's glasses | Lenses: \$50 after plan deductible Collection frames: \$50 after plan deductible Non-collection frames: \$50 after plan deductible up to the collection frame allowance; any amount over is payable by the member minus a 20% discount | Not covered | one pair of frames and lenses per year |
| | Children's dental check-up | No charge | Not covered | two exams per year |

Excluded Services & Other Covered Services

Services Your [Plan](#) Generally Does NOT Cover (Check your policy or [plan](#) document for more information and a list of any other [excluded services](#).)

- | | | |
|-----------------------|------------------------------------------------------|-------------------------|
| • Acupuncture | • Long-term care | • Routine foot care |
| • Cosmetic Surgery | • Non-emergency care when traveling outside the U.S. | • Routine hearing tests |
| • Dental Care (Adult) | • Private-duty nursing | |

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- | | | |
|---------------------|-------------------------------------------------|------------------------|
| • Bariatric Surgery | • Hearing aid (may be covered with limitations) | • Routine eye care |
| • Chiropractic care | • Infertility treatment | • Weight loss programs |

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323 X61565 or www.cciio.cms.gov or the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa. Other coverage options may be available to you too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318-2596. For more information on your rights to continue coverage, you may also contact the [plan](#) at 1-800-251-7722.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: ConnectiCare Member Appeals: PO Box 4061, Farmington, CT 06034-4061 or 1-800-251-7722

Connecticut Residents: CT State Department of Insurance at 1-800-203-3447 or www.ct.gov/cid/site/default.asp

Massachusetts Residents: MA Division of Insurance at 1-877-563-4467 or www.mass.gov/ocabr/government/oca-agencies/doi-lp/

Employee Benefits Security Administration: 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform

Does this plan provide Minimum Essential Coverage? Yes.

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

Does this Coverage Meet the Minimum Value Standard? Yes.

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.

About these Coverage Examples



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

- The [plan's](#) overall [deductible](#) \$3,000
- [Specialist copayment](#) \$50
- Hospital (facility) [copayment](#) \$100
- Other [coinsurance](#) 20%

This EXAMPLE event includes services like:

[Specialist](#) office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
[Diagnostic tests](#) (*ultrasounds and blood work*)
[Specialist](#) visit (*anesthesia*)

| | |
|--------------------|----------|
| Total Example Cost | \$12,700 |
|--------------------|----------|

In this example, Peg would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| Deductibles | \$3,000 |
| Copayments | \$200 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$3,260 |

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$3,000
- [Specialist copayment](#) \$50
- Hospital (facility) [copayment](#) \$100
- Other [coinsurance](#) 20%

This EXAMPLE event includes services like:

[Primary care physician](#) office visits (*including disease education*)
[Diagnostic tests](#) (*blood work*)
 Prescription drugs
[Durable medical equipment](#) (*glucose meter*)

| | |
|--------------------|---------|
| Total Example Cost | \$5,600 |
|--------------------|---------|

In this example, Joe would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| Deductibles | \$3,000 |
| Copayments | \$400 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$20 |
| The total Joe would pay is | \$3,420 |

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$3,000
- [Specialist copayment](#) \$50
- Hospital (facility) [copayment](#) \$100
- Other [coinsurance](#) 20%

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)
[Diagnostic test](#) (*x-ray*)
[Durable medical equipment](#) (*crutches*)
[Rehabilitation services](#) (*physical therapy*)

| | |
|--------------------|---------|
| Total Example Cost | \$2,800 |
|--------------------|---------|

In this example, Mia would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| Deductibles | \$2,800 |
| Copayments | \$0 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$2,800 |

Note: These numbers assume the patient does not participate in the [plan's](#) wellness program. If you participate in the [plan's](#) wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-800-390-3522.

*Note: This [plan](#) may have other [deductibles](#) for specific services included in this coverage example. See "Are there other [deductibles](#) for specific services?" row above.

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services

Accessibility and Nondiscrimination 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 06034, 1-800-251-7722, and TTY number 1-800-833-8134. You can file a [grievance](#) in person at 175 Scott Swamp Road, Farmington, CT, or by mail, or fax (860) 674-2232 or email memberservices@connecticare.com. 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 of 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>.

Language Access Services:

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-251-7722 (TTY: 1-800-833-8134).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-251-7722 (TTY: 1-800-833-8134).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-251-7722 (TTY: 1-800-833-8134).

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: 1-800-833-8134)。

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-251-7722 (TTY: 1-800-833-8134).

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-251-7722 (ATS: 1-800-833-8134).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-251-7722 (TTY: 1-800-833-8134).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-251-7722 (телетайп: 1-800-833-8134).

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: 1-800-833-8134).

(ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-251-7722 (رقم هاتف الصم والبكم: 1-800-833-8134).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.
1-800-251-7722 (TTY: 1-800-833-8134)번으로 전화해 주십시오.

KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-800-224-2273 (TTY: 1-800-842-9710).

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-224-2273 (TTY: 1-800-842-9710) पर कॉल करें।

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-224-2273 (TTY: 1-800-842-9710).

ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-800-224-2273 (TTY: 1-800-842-9710).

ប្រយ័ត្ន: បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតល្អូល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-224-2273 (TTY: 1-800-842-9710)។

सुचना: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-224-2273 (TTY: 1-800-842-9710).