




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 <a href="#">deductible</a> ?	<b>In-Network:</b> \$5,000 individual / \$10,000 family. <b>Out-of-Network:</b> \$10,000 individual / \$20,000 family	Generally, you must pay all the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> , <a href="#">Primary Care Physician</a> , <a href="#">Specialist</a> , and <a href="#">Emergency room</a> visits are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/#preventive-care-benefits/">https://www.healthcare.gov/coverage/#preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	There are no other specific <a href="#">deductibles</a> .	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	For participating <a href="#">providers</a> \$7,300 individual / \$14,600 family. For non-participating <a href="#">providers</a> \$15,000 individual / \$30,000 family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.ConnectiCare.com">www.ConnectiCare.com</a> or call 1-800-251-7722 for a list of participating <a href="#">providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use a non-participating <a href="#">provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$40 <a href="#">copayment</a> /visit; <a href="#">deductible</a> does not apply	50% <a href="#">coinsurance</a> after plan <a href="#">deductible</a>	None.
	<a href="#">Specialist</a> visit	\$80 <a href="#">copayment</a> /visit; <a href="#">deductible</a> does not apply	50% <a href="#">coinsurance</a> after plan <a href="#">deductible</a>	None.
	<a href="#">Preventive care</a> / <a href="#">screening</a> / immunization	No charge	50% <a href="#">coinsurance</a> after plan <a href="#">deductible</a>	Frequency limits apply
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	<b>Xray:</b> \$50 <a href="#">copayment</a> /service; <a href="#">deductible</a> does not apply at an <b>Independent Facility</b>  20% <a href="#">coinsurance</a> after plan <a href="#">deductible</a> at a <b>Hospital Facility, Lab:</b> 20% <a href="#">coinsurance</a> after plan <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after plan <a href="#">deductible</a>	<a href="#">Preauthorization</a> is required for certain services (ie: genetic testing)
	Imaging (CT/PET scans, MRIs)	<b>Independent facility:</b> \$100 <a href="#">copayment</a> /service; <a href="#">deductible</a> does not apply  <b>Hospital facility:</b> 20% <a href="#">coinsurance</a> after plan <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after plan <a href="#">deductible</a>	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , you may be responsible for the total cost of the service or benefits may be reduced by the lesser of \$500 or 50%. up to five copayments per year, then <a href="#">copayment</a> waived

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)	
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.ConnectiCare.com">www.ConnectiCare.com</a>	Preferred Generic (Tier 1)	\$10 <a href="#">copayment</a> /prescription (retail); \$20 <a href="#">copayment</a> /prescription (mail order)	50% <a href="#">coinsurance</a> (retail); Not covered (mail order)	Certain drugs will require <a href="#">preauthorization</a> Covers up to a 30 day supply per prescription (retail); 90 day supply per prescription (mail order) <b>Specialty Drugs</b> are available from specialty retail pharmacies only and cover up to a 30-day supply limit.
	Non-Preferred Generic drugs (Tier 2)	50% <a href="#">coinsurance</a> up to \$250 maximum per prescription (retail); 50% <a href="#">coinsurance</a> up to \$500 maximum per prescription (mail order)	50% <a href="#">coinsurance</a> (retail); Not covered (mail order)	
	Preferred brand drugs (Tier 3)	\$50 <a href="#">copayment</a> /prescription (retail); \$100 <a href="#">copayment</a> /prescription (mail order)	50% <a href="#">coinsurance</a> (retail); Not covered (mail order)	
	Non-preferred brand drugs (Tier 4)	50% <a href="#">coinsurance</a> up to \$500 maximum per prescription (retail); 50% <a href="#">coinsurance</a> up to \$1,000 maximum per prescription (mail order)	50% <a href="#">coinsurance</a> (retail); Not covered (mail order)	
	<a href="#">Preferred Specialty drugs</a> (Tier 5)	50% <a href="#">coinsurance</a> up to \$500 maximum per prescription (specialty retail only)	Not covered (specialty retail only)	
	<a href="#">Non-Preferred Specialty drugs</a> (Tier 6)	50% <a href="#">coinsurance</a> up to \$750 maximum per prescription (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)	<b>Ambulatory Center:</b> \$500 <a href="#">copayment</a> /visit; <a href="#">deductible</a> does not apply <b>Hospital facility:</b> 20% <a href="#">coinsurance</a> after plan <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after plan <a href="#">deductible</a>	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , you may be responsible for the total cost of the service or benefits may be reduced by the lesser of \$500 or 50%.
	Physician/surgeon fees	<b>Ambulatory Center:</b> No charge <b>Hospital facility:</b> 20% <a href="#">coinsurance</a> after plan <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after plan <a href="#">deductible</a>	None.
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$400 <a href="#">copayment</a> /visit; <a href="#">deductible</a> does not apply	Same as In-network benefit	<a href="#">copayment</a> waived if admitted
	<a href="#">Emergency medical transportation</a>	\$400 <a href="#">copayment</a> per trip; <a href="#">deductible</a> does not apply	Same as In-network benefit	None.
	<a href="#">Urgent care</a>	\$75 <a href="#">copayment</a> /visit; <a href="#">deductible</a> does not apply	Same as In-network benefit	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a> after plan <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after plan <a href="#">deductible</a>	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , you may be responsible for the total cost of the service or benefits may be reduced by the lesser of \$500 or 50%.
	Physician/surgeon fees	20% <a href="#">coinsurance</a> after plan <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after plan <a href="#">deductible</a>	None.

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 mental health, behavioral health, or substance abuse services	Outpatient services	\$40 <a href="#">copayment</a> /visit; <a href="#">deductible</a> does not apply	50% <a href="#">coinsurance</a> after plan <a href="#">deductible</a>	None.
	Inpatient services	20% <a href="#">coinsurance</a> after plan <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after plan <a href="#">deductible</a>	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , you may be responsible for the total cost of the service or benefits may be reduced by the lesser of \$500 or 50%.
If you are pregnant	Office visits	No charge for prenatal and postnatal care	50% <a href="#">coinsurance</a> after plan <a href="#">deductible</a>	Cost sharing does not apply to certain preventive services. Depending on the type of services, <a href="#">coinsurance</a> or <a href="#">copayments</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% <a href="#">coinsurance</a> after plan <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after plan <a href="#">deductible</a>	None.
	Childbirth/delivery facility services	20% <a href="#">coinsurance</a> after plan <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after plan <a href="#">deductible</a>	None.

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	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a> after plan <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after plan <a href="#">deductible</a>	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , you may be responsible for the total cost of the service or benefits may be reduced by the lesser of \$500 or 50%. up to 100 visits per year
	<a href="#">Rehabilitation services</a>	\$80 <a href="#">copayment</a> /visit; <a href="#">deductible</a> does not apply	50% <a href="#">coinsurance</a> after plan <a href="#">deductible</a>	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , you may be responsible for the total cost of the service or benefits may be reduced by the lesser of \$500 or 50%. up to 40 visits per contract year includes services combined for physical, speech and occupational therapy
	<a href="#">Habilitation services</a>	\$80 <a href="#">copayment</a> /visit; <a href="#">deductible</a> does not apply	50% <a href="#">coinsurance</a> after plan <a href="#">deductible</a>	40 visit per contract year limit combined for Habilitative speech, physical and occupational therapies

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	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a> after plan <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after plan <a href="#">deductible</a>	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , you may be responsible for the total cost of the service or benefits may be reduced by the lesser of \$500 or 50%. up to 90 days per year
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a> after plan <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after plan <a href="#">deductible</a>	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , you may be responsible for the total cost of the service or benefits may be reduced by the lesser of \$500 or 50%.
	<a href="#">Hospice services</a>	Applicable inpatient hospital facility or home health care cost share	Applicable inpatient hospital facility or home health care cost share	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , you may be responsible for the total cost of the service or benefits may be reduced by the lesser of \$500 or 50%.
If your child needs dental or eye care	Children's eye exam	\$80 <a href="#">copayment</a> /visit <a href="#">deductible</a> does not apply	50% <a href="#">coinsurance</a> after plan <a href="#">deductible</a>	up to one visit every year
	Children's glasses	25% Discount	Not covered	25% Discount
	Children's dental check-up	Not covered	Not covered	Not covered

## 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](#).)

- |                     |  |                         |
|---------------------|--|-------------------------|
| • Bariatric Surgery | • Infertility treatment                              | • Routine foot care     |
| • Cosmetic Surgery  | • Long-term care                                     | • Routine hearing tests |
| • Dental Care       | • Non-emergency care when traveling outside the U.S. | • Weight loss programs  |
| • Hearing aid       | • Private-duty nursing                               |                         |

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

- |  |                     |                    |
|--|---------------------|--------------------|
| • Acupuncture coverage is limited to pain management | • Chiropractic care | • Routine eye care |
|--|---------------------|--------------------|

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

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

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## 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](#) \$5000
- [Specialist copayment](#) \$80
- Hospital (facility) [coinsurance](#) 20%
- 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
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In this example, Peg would pay:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$5,000
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$1,000
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$6,070</b>

### Managing Joe's type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$5000
- [Specialist copayment](#) \$80
- Hospital (facility) [coinsurance](#) 20%
- 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
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In this example, Joe would pay:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$1,200
<a href="#">Copayments</a>	\$600
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,820</b>

### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$5000
- [Specialist copayment](#) \$80
- Hospital (facility) [coinsurance](#) 20%
- 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
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In this example, Mia would pay:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$700
<a href="#">Copayments</a>	\$1,200
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,900</b>

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



## Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

**English ATTENTION:** If you speak another language, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call **800-251-7722** (TTY: **711**) or speak to your provider.

**Español (Spanish) ATENCIÓN:** Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al **800-251-7722** (TTY: **711**) o hable con su proveedor.

**Português do Brasil (Portuguese) ATENÇÃO:** Se você fala português, serviços gratuitos de assistência linguística estão disponíveis para você. Auxílios e serviços auxiliares apropriados para fornecer informações em formatos acessíveis também estão disponíveis gratuitamente. Ligue para **800-251-7722** (TTY: **711**) ou fale com seu provedor.

**POLSKI (Polish) UWAGA:** Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer **800-251-7722** (TTY: **711**) lub porozmawiaj ze swoim dostawcą.

**中文 (Simplified Chinese) 注意:** 如果您说[中文], 我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务, 以无障碍格式提供信息。致电 **800-251-7722** (文本电话: **711**) 或咨询您的服务提供商。

**Italiano (Italian) ATTENZIONE:** se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama l' **800-251-7722** (tty: **711**) o parla con il tuo fornitore.

**Français (French)** ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le **800-251-7722** (TTY: **711**) ou parlez à votre fournisseur.

**Kreyòl Ayisyen (Haitian Creole)** ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd aladispozisyon w gratis pou lang ou pale a. Èd ak sèvis siplemantè apwopriye pou bay enfòmasyon nan fòm aksesib yo disponib gratis tou. Rele nan **800-251-7722** (TTY: **711**) oswa pale avèk founisè w la.

**РУССКИЙ (Russian)** ВНИМАНИЕ: Если вы говорите на русском, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются

бесплатно. Позвоните по телефону **800-251-7722** (TTY: **711**) или обратитесь к своему поставщику услуг.

**Việt (Vietnamese)** LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số **800-251-7722** (Người khuyết tật: **711**) hoặc trao đổi với người cung cấp dịch vụ của bạn.

**العربية (Arabic)** تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم **800-251-7722 (711)** أو تحدث إلى مقدم الخدمة.

**한국어 (Korean)** 주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. **800-251-7722 (TTY: 711)** 번으로 전화하거나 서비스 제공업체에 문의하십시오.

**SHQIP (Albanian)** VINI RE: Nëse flisni shqip, shërbime falas të ndihmës së gjuhës janë në dispozicion për ju. Ndiurma të përshtatshme dhe shërbime shtesë për të siguruar informacion në formate të përdorshme janë gjithashtu në dispozicion falas. Telefononi **800-251-7722** (TTY: **711**) ose bisedoni me ofruesin tuaj të shërbimit.

**हिंदी (Hindi)** ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। **800-251-7722** (TTY: **711**) पर कॉल करें या अपने प्रदाता से बात करें।

**Tagalog (Tagalog)** PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyonang tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa **800-251-7722** (TTY: **711**) o makipag-usap sa iyong provider.

**Ελληνικά (Greek)** ΠΡΟΣΟΧΗ: Εάν μιλάτε ελληνικά, υπάρχουν διαθέσιμες δωρεάν υπηρεσίες υποστήριξης στη συγκεκριμένη γλώσσα. Διατίθενται δωρεάν κατάλληλα βοηθήματα και υπηρεσίες για παροχή πληροφοριών σε προσβάσιμες μορφές. Καλέστε το **800-251-7722** (TTY: **711**) ή απευθυνθείτε στον πάροχό σας.

## NOTICE OF NONDISCRIMINATION POLICY

### Discrimination is Against the Law

ConnectiCare complies with Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity, and sex stereotypes. ConnectiCare does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

#### ConnectiCare:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
  - Qualified sign language interpreters.
  - Written information in other formats (large print, audio, accessible electronic formats, and other formats).
- Provides free language assistance services to people whose primary language is not English, which may include:
  - Qualified interpreters.
  - Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services contact the Civil Rights Coordinator by calling Member Services at **800- 251-7722** (TTY: **711**).

If you believe that ConnectiCare has failed to provide these services or discriminated in another way based on race, color, national origin, age, disability, or sex, you can file a grievance with the Civil Rights Coordinator by writing to ConnectiCare Grievance and Appeals Department, P.O. Box 4061, Farmington, CT 06034-4061; faxing them at **800-319-0089**; or calling Member Services at **800-251-7722**. (Dial **711** for TTY services.) You can file a grievance in person, by mail, by fax, or through your secure member portal. If you need help filing a grievance, ConnectiCare's Grievance and Appeals Department 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 **[ocrportal.hhs.gov/ocr/portal/lobby.jsf](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; 800-368-1019 (TTY: 800-537-7697)**. Complaint forms are available at **[hhs.gov/ocr/office/file/index.html](https://hhs.gov/ocr/office/file/index.html)**.

This notice is available on ConnectiCare's website at: [connecticare.com/legal/nondiscrimination](https://connecticare.com/legal/nondiscrimination).