



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, [CCI Individual HMO High Deductible Health Plan \(HDHP\) for Use With a Health Savings Account \(HSA\) Agreement](#), 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 <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 ?	Participating Providers: \$7,500 individual /\$15,000 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 : \$8,300 individual / \$16,600 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 Connecticare.com/CTFindCare 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	\$40 copayment /visit	Not covered	None
	Specialist visit	\$50 copayment /visit	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: \$35 copayment /service at an Independent Facility, 30% coinsurance at a Hospital Facility Lab: \$10 copayment /service at an Independent Facility, 30% coinsurance at a Hospital Facility	Not covered	Preauthorization is required for certain services (ie: genetic testing)
	Imaging (CT/PET scans, MRIs)	\$75 copayment /service up to five copayments per year, then copayment waived at an Independent Facility, 30% coinsurance at a Hospital Facility	Not covered	Preauthorization is required.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at	Generic drugs (Tier 1)	\$10 copayment /prescription; (retail); \$30 copayment /prescription (mail order)	Not covered (retail & mail order)	Certain drugs will require preauthorization
	Preferred brand drugs (Tier 2)	\$60 copayment /prescription (retail); \$180 copayment /prescription (mail order)	Not covered (retail & mail order)	Covers up to a 30 day supply per prescription (retail); 90 day supply per

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)	
Connecticare.com/CTForulary2026	Non-preferred brand drugs (Tier 3)	50% coinsurance up to a maximum of \$500 per prescription (retail) 50% coinsurance up to a maximum of \$1,500 per prescription (mail order)	Not covered (retail & mail order)	prescription (mail order) Specialty Drugs are available from specialty retail pharmacies only and cover up to a 30-day supply limit.
	Specialty drugs (Tier 4)	50% coinsurance up to a maximum of \$750 per prescription (specialty retail only)	Not covered (specialty retail only)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$500 copayment /visit at an Ambulatory Facility 30% coinsurance at an Outpatient Hospital Facility	Not covered	Preauthorization is required.
	Physician/surgeon fees	0% coinsurance at an Ambulatory Facility 30% coinsurance at an Outpatient Hospital Facility	Not covered	None
If you need immediate medical attention	Emergency room care	30% coinsurance	Same as In-Network Benefit	None
	Emergency medical transportation	30% coinsurance	Same as In-Network Benefit	None
	Urgent care	\$100 copayment /visit	Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	Not covered	Preauthorization is required.
	Physician/surgeon fees	30% coinsurance	Not covered	None
If you need mental health, behavioral	Outpatient services	\$40 copayment /visit Outpatient mental health,	Not covered	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)	
health, or substance abuse services		alcohol and substance abuse treatment (intensive outpatient treatment and partial hospitalization): 30% coinsurance		
	Inpatient services	30% coinsurance	Not covered	Preauthorization is required.
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	30% coinsurance	Not covered	None
	Childbirth/delivery facility services	30% coinsurance	Not covered	None
If you need help recovering or have other special health needs	Home health care	25% coinsurance	Not covered	Preauthorization is required. up to 100 visits per calendar year
	Rehabilitation services	\$30 copayment /visit	Not covered	Preauthorization is required. up to 40 visits per year
	Habilitation services	\$30 copayment /visit	Not covered	up to 40 visits per year
	Skilled nursing care	30% coinsurance	Not covered	Preauthorization is required. 90-day calendar year maximum
	Durable medical equipment	30% coinsurance	Not covered	Preauthorization is required.
	Hospice services	Applicable inpatient hospital facility or home health care cost share	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 your child needs dental or eye care	Children's eye exam	\$50 copayment /visit; deductible does not apply	Not covered	one exam per calendar year
	Children's glasses	Lenses: 50% Collection frame: 50% Non-collection frame: 50% 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 or contact lens per calendar year
	Children's dental check-up	No charge	Not covered	Coverage limited to 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 .)		
- Bariatric Surgery - Cosmetic Surgery - Dental Care (Adult) - Emergency care when traveling outside the U.S.	- Long-term care - Non-emergency care when traveling outside the U.S. - Private-duty nursing	- Routine foot care - Routine hearing tests - Weight loss programs

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	- Hearing Aid (may be covered with limitations) - Infertility treatment	- Routine eye care - Termination of Pregnancy

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 on how 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

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 plan meet the Minimum Value Standards? Not Applicable

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	\$7,500
■ Specialist copayment	\$50
■ Hospital (facility) coinsurance	30%
■ Other coinsurance	30%

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:

Cost Sharing	
Deductibles	\$7,500
Copayments	\$10
Coinsurance	\$700
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$8,270

Managing Joe's Type 2 Diabetes

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

■ The plan's overall deductible	\$7,500
■ Specialist copayment	\$50
■ Hospital (facility) coinsurance	30%
■ Other coinsurance	30%

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:

Cost Sharing	
Deductibles	\$2,300
Copayments	\$300
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$2,620

Mia's Simple Fracture

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

■ The plan's overall deductible	\$7,500
■ Specialist copayment	\$50
■ Hospital (facility) coinsurance	30%
■ Other coinsurance	30%

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:

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

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

English	For free language assistance services, and auxiliary aids and services, call 1-800-251-7722 (TTY: 711).
Spanish	Para obtener servicios gratuitos de asistencia lingüística, así como ayudas y servicios auxiliares, llame al 1-800-251-7722 (TTY: 711).
Español	
Portuguese	Para obter serviços de assistência linguística e materiais e serviços auxiliares gratuitos ligue para 1-800-251-7722 (telefone de texto [TTY]: 711).
Português	
Polish	Aby uzyskać bezpłatną pomoc językową oraz dodatkowe wsparcie i usługi, należy zadzwonić pod numer 1-800-251-7722 (TTY: 711).
Polski	
Chinese (Traditional)	如需免費的語言協助服務以及輔助裝置和服務，請致電1-800-251-7722（聽障專線：711）。
中文（台灣繁體）	
Italian	Per i servizi di assistenza gratuiti in italiano nonché per supporti e servizi ausiliari, chiamare 1-800-251-7722 (TTY: 711).
Italiano	
French	Pour bénéficier de services d'assistance linguistique gratuits, ainsi que de services et aides complémentaires, appelez le 1-800-251-7722 (ATS : 711).
Français	
French Creole	Pou asistans lang gratis, epi èd ak sèvis oksilyè, rele 1-800-251-7722 (TTY: 711).
Kreyòl Ayisyen	
Russian	Для получения бесплатных услуг языковой помощи, а также вспомогательных средств и услуг, позвоните: 1-800-251-7722 (телетайп: 711).
Русский	
Vietnamese	Để sử dụng dịch vụ hỗ trợ ngôn ngữ miễn phí cũng như các dịch vụ và tính năng hỗ trợ thêm, hãy gọi 1-800-251-7722 (TTY: 711).
Tiếng Việt	
Arabic	اتصل على الرقم 1-800-251-7722 (الهاتف النصي 711) لتلقي خدمات المساعدة اللغوية المجانية والخدمات والمساعدات الإضافية.
العربية	
Korean	무료 언어 지원 서비스와 보조 지원 및 서비스를 원하시면 1-800-251-7722 (TTY: 711)로 연락 주시기 바랍니다.
한국인	
Albanian	Për shërbime falas të asistencës gjuhësore në shqip, mbështetje dhe shërbime shtesë, telefononi numrin 1-800-251-7722 (TTY: 711).
shqip	
Hindi	निःशुल्क भाषा सहायता सेवाओं और सहायक ऐड एवं सेवाओं के लिए 1-800-251-7722 (TTY: 711) पर कॉल करें।
हिंदी	
Tagalog	Para sa libreng serbisyo sa tulong sa wika, at mga auxiliary aid at serbisyo, tumawag sa 1-800-251-7722 (TTY: 711).
Greek	Για δωρεάν υπηρεσίες γλωσσικής υποστήριξης, καθώς και βοηθητικά μέσα και υπηρεσίες, καλέστε στο 1-800-251-7722 (TTY: 711).
Ελληνικά	
1557 Notice of Availability Member Notice	

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

To help you effectively communicate with us, ConnectiCare provides services free of charge and in a timely manner:

- ConnectiCare provides reasonable modifications and appropriate aids and services to people with disabilities.
This includes: (1) Qualified interpreters. (2) Written Information in other formats, such as large print, audio, accessible electronic formats, and Braille.
- ConnectiCare provides language services to people who speak another language or have limited English skills.
This includes: (1) Qualified oral interpreters. (2) Information translated in your language.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact ConnectiCare Member Services at 1-800-251-7722 or TTY/TDD: 711, Monday to Friday, 8 a.m. to 6 p.m., local time.

If you believe we have discriminated on the basis of age, color, disability, national origin, race, or sex, you can file a grievance. You can file a grievance by phone, fax, mail, or through your secure member portal. If you need help writing your grievance, we will help you. You may obtain our grievance procedure by visiting our website at [Connecticare.com/legal/nondiscrimination](https://connecticare.com/legal/nondiscrimination). Call our Civil Rights Coordinator at 1-800-251-7722, TTY/TDD: 711 or submit your grievance to:

ConnectiCare Grievance and Appeals Department
P.O. Box 4061
Farmington, CT 06034-4061
Fax: 1-800-319-0089
Website: [MyConnectiCarePortal.com](https://myconnecticareportal.com)

You can also file a civil rights complaint (grievance) with the U.S. Department of Health and Human Services, Office for Civil Rights, online through the Office for Civil Rights Complaint Portal 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, D.C. 20201
Phone: 1-800-368-1019
TTY: 1-800-537-7697

Complaint forms are available here: <https://www.hhs.gov/sites/default/files/ocr-cr-complaint-form-package.pdf>