ConnectiCare : Choice Gold Alternative POS

**Coverage for: Individual + Family | Plan Type: POS**

**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, CBI POS Individual Exchange Aggreement, 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?** | **Participating** Providers: $2,000 individual /$4,000 family. **Non-Participating** Providers: $7,000 individual / $14,000 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, Primary Care Physician and Specialist visits are 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?** | Yes. $75 Individual / $150 Family for drug coverage. Out-of-Network $500 Individual / $1,000 Family for drug coverage and $50 per Individual for Home Health care | You must pay all the costs for these services up to the specific deductible amount before this plan begins to pay for these services. |
| **What is the out-of-pocket limit for this plan?** | For participating providers $7,900 individual / $15,800 family. For non-participating providers $12,000 individual / $24,000 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 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. |

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **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 per visit; deductible does not apply | 50% coinsurance per visit | None |
| | Specialist visit | $50 copayment per visit; deductible does not apply | 50% coinsurance per visit | None |
| | Preventive care/screening/immunization | No charge | 50% coinsurance per visit; deductible does not apply | 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. Frequency limits apply. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | **Xray:** 30% coinsurance per service at a Hospital Facility<br>$50 copayment per service; deductible does not apply at an Independent Facility<br><br>**Lab**: $10 copayment per service; deductible does not apply | 50% coinsurance per service | Preauthorization is required. If you don't get preauthorization, you may be responsible for the total cost of the service or benefits may be reduced by the lesser of $500 or 50%. |
| | Imaging (CT/PET scans, MRIs) | 30% coinsurance per service at a Hospital Facility<br><br>$75 copayment per service up to a combined annual maximum of $375 for MRI and CAT scans; $400 for PET | 50% coinsurance per service | Preauthorization is required. If you don't get preauthorization, you may be responsible for the total cost of the service or benefits may be reduced by the lesser of $500 or 50%. |

| 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) | |
| | | scans at an Independent Facility; deductible does not apply | | |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at ConnectiCare.com/CTFormulary2026 | Generic drugs (Tier 1) | $10 copayment per prescription; deductible does not apply (retail); $30 copayment per prescription; deductible does not apply (mail order) | 50% coinsurance per prescription (retail & mail order) | Certain drugs will require preauthorization<br><br>Covers up to a 30-day supply per prescription (retail); 90-day supply per prescription (mail order)<br><br>Specialty Drugs are available from specialty retail pharmacies only and cover up to a 30-day supply limit. |
| | Preferred brand drugs (Tier 2) | $40 copayment per prescription; deductible does not apply (retail); $120 copayment per prescription; deductible does not apply (mail order) | 50% coinsurance per prescription (retail & mail order) | |
| | Non-preferred brand drugs (Tier 3) | 20% coinsurance per prescription (retail & mail order) | 50% coinsurance per prescription (retail & mail order) | |
| | Specialty drugs (Tier 4) | 20% coinsurance up to a maximum of $750 per prescription (specialty retail only) | 50% coinsurance per prescription (specialty retail only) | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 30% coinsurance per visit at an Outpatient Hospital Facility<br><br>$250 copayment per visit; deductible does not apply at an Ambulatory Surgery Center | 50% coinsurance per visit | Preauthorization is required. If you don't get preauthorization, 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 | 30% coinsurance per visit at an Outpatient Hospital Facility | 50% coinsurance per visit | 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) | |
| | | No charge at an Ambulatory Surgery Center | | |
| **If you need immediate medical attention** | Emergency room care | 30% coinsurance per visit | Covered the same as Participating Provider | None |
| | Emergency medical transportation | 30% coinsurance per service | Covered the same as Participating Provider | None |
| | Urgent care | 30% coinsurance per visit; deductible does not apply | 50% coinsurance per visit | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 30% coinsurance per admission | 50% coinsurance per admission | Preauthorization is required. If you don't get preauthorization, 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 | 30% coinsurance per admission | 50% coinsurance per admission | None |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $40 copayment per visit; deductible does not apply **Outpatient mental health, alcohol and substance use disorder treatment (intensive outpatient treatment and partial hospitalization):** hospitalization): 0% coinsurance per visit | 50% coinsurance per visit | None |
| | Inpatient services | 30% coinsurance per admission | 50% coinsurance per admission | Preauthorization is required. If you don't get preauthorization, you may be responsible for the total cost of the service or benefits may be reduced by the lesser of $500 or 50%. |

| 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 | 50% coinsurance per visit | 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). Cost sharing waived at non- IHCP with IHCP referral. |
| | Childbirth/delivery professional services | 30% coinsurance per admission | 50% coinsurance per admission | None |
| | Childbirth/delivery facility services | 30% coinsurance per admission | 50% coinsurance per admission | None |
| **If you need help recovering or have other special health needs** | Home health care | 25% coinsurance per visit after separate $50 deductible is met | 25% coinsurance per visit after separate $50 deductible is met | Preauthorization is required. If you don't get preauthorization, 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 calendar year |
| | Rehabilitation services | 30% coinsurance per visit | 50% coinsurance per visit | Preauthorization is required. If you don't get preauthorization, 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 year |
| | Habilitation services | 30% coinsurance per visit | 50% coinsurance per visit | up to 40 visits per year |
| | Skilled nursing care | 30% coinsurance per admission | 50% coinsurance per admission | Preauthorization is required. If you don't get preauthorization, you may be responsible for the total cost of the service or benefits may be reduced by the lesser of $500 or 50%. 90-day calendar year 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) | |
| | Durable medical equipment | 30% coinsurance per equipment/supply | 50% coinsurance per equipment/supply | Preauthorization is required. If you don't get preauthorization, you may be responsible for the total cost of the service or benefits may be reduced by the lesser of $500 or 50%. |
| | Hospice services | Applicable inpatient hospital facility or home health care cost share | Applicable inpatient hospital facility or home health care cost share | Preauthorization is required. If you don't get preauthorization, 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 | $50 copayment per visit; deductible does not apply | 50% coinsurance per visit | one exam per calendar year |
| | Children's glasses | **Lenses**: 50% coinsurance<br>**Collection frame**: 50% coinsurance<br>**Non-collection frame:** Members choosing to upgrade from a collection frame to a non-collection frame will be given a credit substantially equal to the cost of the collection frame and will be entitled to any discount negotiated by the carrier with the retailer | 50% coinsurance per visit | one pair of frames and lenses or contact lens per calendar year |
| | Children's dental check-up | No charge | 50% coinsurance per visit | Coverage limited to two exams per calendar 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** | **$2,000** |
| **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** |
|---|---|
| **In this example, Peg would pay:** | |
| *Cost Sharing* | |
| Deductibles | $2,000 |
| Copayments | $200 |
| Coinsurance | $2,000 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$4,260** |

### Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

| | |
|---|---|
| **The plan's overall deductible** | **$2,000** |
| **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** |
|---|---|
| **In this example, Joe would pay:** | |
| *Cost Sharing* | |
| Deductibles | $800 |
| Copayments | $900 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$1,720** |

### Mia's Simple Fracture
(in-network emergency room visit and follow up care)

| | |
|---|---|
| **The plan's overall deductible** | **$2,000** |
| **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** |
|---|---|
| **In this example, Mia would pay:** | |
| *Cost Sharing* | |
| Deductibles | $2,000 |
| Copayments | $200 |
| Coinsurance | $100 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$2,300** |

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<br>Español | Para obtener servicios gratuitos de asistencia lingüística, así como ayudas y servicios auxiliares, llame al 1-800-251-7722 (TTY: 711). |
| Portuguese<br>Português | Para obter serviços de assistência linguística e materiais e serviços auxiliares gratuitos ligue para 1-800-251-7722 (telefone de texto [TTY]: 711). |
| Polish<br>Polski | Aby uzyskać bezpłatną pomoc językową oraz dodatkowe wsparcie i usługi, należy zadzwonić pod numer 1-800-251-7722 (TTY: 711). |
| Chinese (Traditional)<br>中文（台灣繁體） | 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）。 |
| Italian<br>Italiano | Per i servizi di assistenza gratuiti in italiano nonché per supporti e servizi ausiliari, chiamare 1-800-251-7722 (TTY: 711). |
| French<br>Français | Pour bénéficier de services d'assistance linguistique gratuits, ainsi que de services et aides complémentaires, appelez le 1-800-251-7722 (ATS : 711). |
| French Creole<br>Kreyòl Ayisyen | Pou asistans lang gratis, epi èd ak sèvis oksilyè, rele 1-800-251-7722 (TTY: 711). |
| Russian<br>Русский | Для получения бесплатных услуг языковой помощи, а также вспомогательных средств и услуг, позвоните: 1-800-251-7722 (телетайп: 711). |
| Vietnamese<br>Tiếng Việt | 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). |
| Arabic<br>العربية | اتصل على الرقم 1-800-251-7722 (الهاتف النصي (TTY): 711) لتلقي خدمات المساعدة اللغوية المجانية والخدمات والمساعدات الإضافية. |
| Korean<br>한국인 | 무료 언어 지원 서비스와 보조 지원 및 서비스를 원하시면1-800-251-7722 (TTY: 711)로 연락 주시기 바랍니다. |
| Albanian<br>shqip | Për shërbime falas të asistencës gjuhësore në shqip, mbështetje dhe shërbime shtesë, telefononi numrin 1-800-251-7722 (TTY: 711). |
| Hindi<br>हिंदी | नि:शुल्क भाषा सहायता सेवाओं और सहायक ऐड एवं सेवाओं के लिए 1-800-251-7722 (TTY: 711) पर कॉल करें। |
| Tagalog | Para sa libreng serbisyo sa tulong sa wika, at mga auxiliary aid at serbisyo, tumawag sa 1-800-251-7722 (TTY: 711). |
| Greek<br>Ελληνικά | Για δωρεάν υπηρεσίες γλωσσικής υποστήριξης, καθώς και βοηθητικά μέσα και υπηρεσίες, καλέστε στο 1-800-251-7722 (TTY: 711). |

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. 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

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