ConnectiCare : Choice Silver Standard POS (CSR 94%)

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: $0 individual /$0 family. **Non-Participating** Providers: $10,000 individual / $20,000 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 , Specialist and Emergency room care 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. For drug coverage. **Non-Participating** Providers: $500 Individual / $1,000 Family and Home Health care **Non-Participating** Providers: $50 per Individual	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 $1,350 individual / $2,700 family. For non-participating providers $18,200 individual / $36,400 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	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

Important Questions	Answers	Why This Matters:
	or call 1-800-251-7722 for a list of participating providers.	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 more)	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	$15 copayment per visit; deductible does not apply	40% coinsurance per visit	None
	Specialist visit	$30 copayment per visit; deductible does not apply	40% coinsurance per visit	None
	Preventive care/screening/immunization	No charge	40% 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: $25 copayment per service; deductible does not apply Lab: $10 copayment per service; deductible does not apply	40% 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)	$50 copayment per service up to a combined annual maximum of $350 for MRI and CAT scans; $400 for PET scans; deductible	40% 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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay more)	Non-Participating Provider (You will pay the most)	
		does not apply		the lesser of $500 or 50%.
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)	$5 copayment per prescription; deductible does not apply (retail) $15 copayment per prescription; deductible does not apply (mail order)	40% coinsurance per prescription (retail & 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.
	Preferred brand drugs (Tier 2)	$10 copayment per prescription; deductible does not apply (retail); $30 copayment per prescription; deductible does not apply (mail order)	40% coinsurance per prescription (retail & mail order)	
	Non-preferred brand drugs (Tier 3)	$30 copayment per prescription; deductible does not apply (retail); $90 copayment per prescription; deductible does not apply (mail order)	40% coinsurance per prescription (retail & mail order)	
	Specialty drugs (Tier 4)	20% coinsurance up to a maximum of $60 per prescription; deductible does not apply (specialty retail only)	40% coinsurance per prescription (specialty retail only)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$75 copayment per visit; deductible does not apply at an Outpatient Hospital Facility $45 copayment per visit; deductible does not apply at an Ambulatory Surgery Center	40% 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	No charge	40% coinsurance per visit	None
If you need immediate medical attention	Emergency room care	$50 copayment per visit; deductible does not apply	Covered the same as Participating Provider	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay more)	Non-Participating Provider (You will pay the most)	
	Emergency medical transportation	No charge	Covered the same as Participating Provider	None
	Urgent care	$25 copayment per visit; deductible does not apply	40% coinsurance per visit	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$75 copayment per day up to a maximum of $300 per admission; deductible does not apply	40% 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	No charge	40% coinsurance per admission	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15 copayment per visit; deductible does not apply **Outpatient mental health, alcohol and substance use disorder treatment (intensive outpatient treatment and partial hospitalization):** hospitalization): $75 copayment per visit; deductible does not apply	40% coinsurance per visit	None
	Inpatient services	$75 copayment per day up to a maximum of $300 per admission; deductible does not apply	40% 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%.
If you are pregnant	Office visits	No charge for prenatal and postnatal care	40% coinsurance per visit	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay more)	Non-Participating Provider (You will pay the most)	
				include tests and services described elsewhere in the SBC (i.e. ultrasound)
	Childbirth/delivery professional services	No charge	40% coinsurance per admission	None
	Childbirth/delivery facility services	$75 copayment per day up to a maximum of $300 per admission; deductible does not apply	40% coinsurance per admission	None
If you need help recovering or have other special health needs	Home health care	No charge	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	$20 copayment per visit; deductible does not apply	40% 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	$20 copayment per visit; deductible does not apply	40% coinsurance per visit	up to 40 visits per year
	Skilled nursing care	$75 copayment per day up to a maximum of $300 per admission; deductible does not apply	40% 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 more)	Non-Participating Provider (You will pay the most)	
				90-day calendar year maximum
	Durable medical equipment	40% coinsurance per equipment/supply; deductible does not apply	40% 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	$30 copayment per visit; deductible does not apply	40% coinsurance per visit	one exam per calendar year
	Children's glasses	**Lenses**: No charge **Collection frame**: No charge **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	**$0**
Specialist copayment	**$30**
Hospital (facility) copayment	**$75**
Other coinsurance	**40%**

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	$0
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$460**

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

The plan's overall deductible	**$0**
Specialist copayment	**$30**
Hospital (facility) copayment	**$75**
Other coinsurance	**40%**

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	$0
Copayments	$500
Coinsurance	$300
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$820**

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

The plan's overall deductible	**$0**
Specialist copayment	**$30**
Hospital (facility) copayment	**$75**
Other coinsurance	**40%**

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	$0
Copayments	$300
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$400**

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 Español	Para obtener servicios gratuitos de asistencia lingüística, así como ayudas y servicios auxiliares, llame al 1-800-251-7722 (TTY: 711).
Portuguese 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 Polski	Aby uzyskać bezpłatną pomoc językową oraz dodatkowe wsparcie i usługi, należy zadzwonić pod numer 1-800-251-7722 (TTY: 711).
Chinese (Traditional) 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 Italiano	Per i servizi di assistenza gratuiti in italiano nonché per supporti e servizi ausiliari, chiamare 1-800-251-7722 (TTY: 711).
French 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 Kreyòl Ayisyen	Pou asistans lang gratis, epi èd ak sèvis oksilyè, rele 1-800-251-7722 (TTY: 711).
Russian Русский	Для получения бесплатных услуг языковой помощи, а также вспомогательных средств и услуг, позвоните: 1-800-251-7722 (телетайп: 711).
Vietnamese 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 العربية	اتصل على الرقم 1-800-251-7722 (الهاتف النصي (TTY): 711) لتلقي خدمات المساعدة اللغوية المجانية والخدمات والمساعدات الإضافية.
Korean 한국인	무료 언어 지원 서비스와 보조 지원 및 서비스를 원하시면1-800-251-7722 (TTY: 711)로 연락 주시기 바랍니다.
Albanian shqip	Për shërbime falas të asistencës gjuhësore në shqip, mbështetje dhe shërbime shtesë, telefononi numrin 1-800-251-7722 (TTY: 711).
Hindi 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 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