The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-251-7722. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary or call 1-800-251-7722 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: $6,000/Member or $12,000/Family Out-of-Network: $12,000/Member or $24,000/Family	Generally, you must pay all of 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 and primary care services 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. In-Network: $50/Member Home Health Care Out-of-Network: $50/Member Home Health Care There are no other specific deductibles.	You must pay all of 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 In-network providers $7,900 Member/ $15,800 Family; for out-of-network providers $15,800 Member / $31,600 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?	Copayments for certain services, premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.ConnectiCare.com or call 1-800-251-7722 for a list of network 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 an out-of-network 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
		Network Provider (You will pay the least)	Out-of-Network 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; deductible does not apply	50% coinsurance after OON plan deductible is met	None
	Specialist visit	$50 copayment/visit after INET plan deductible is met	50% coinsurance after OON plan deductible is met	None
	Preventive care/screening/ immunization	No charge	50% coinsurance; 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.
If you have a test	Diagnostic test (x-ray, blood work)	$40 copayment/service after INET plan deductible for X-ray $10 copayment/service after INET plan deductible for Lab	50% coinsurance after OON plan deductible is met	Preauthorization is required for certain services (ie: genetic testing). 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)	$75 copayment/service up to a combined annual maximum of $375 for MRI and CAT scans; $400 for PET scans after INET plan deductible is met	50% coinsurance after OON plan 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%.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.ConnectiCare.com	Generic drugs (Tier 1)	$5 copayment/prescription; deductible does not apply (retail) $10 copayment/prescription; deductible does not apply (mail order)	50% coinsurance after OON plan deductible is met (retail); Not covered (mail order)	Certain drugs will require preauthorization Covers up to 30-day supply per prescription (retail); 90-day supply per prescription (mail order, available for Generic, Preferred Brand and Non-Preferred Brand drugs) Specialty drugs are available from specialty retail pharmacies only and cover up to a 30-day supply limit.
	Preferred brand drugs (Tier 2)	50% coinsurance/prescription after INET plan deductible is met (retail and mail order)	50% coinsurance after OON plan deductible is met (retail); Not covered (mail order)	
	Non-preferred brand drugs (Tier 3)	50% coinsurance/prescription after INET plan deductible is met (retail and mail order)	50% coinsurance after OON plan deductible is met (retail); Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
			(mail order)	
	Specialty drugs (Tier 4)	50% coinsurance/prescription up to a maximum of $500 per prescription after INET plan deductible is met (specialty retail only)	50% coinsurance after OON plan deductible is met (specialty retail only); Not covered (mail order)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$500 copayment/visit after INET plan deductible is met	50% coinsurance after OON plan 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%.
	Physician/surgeon fees	0% coinsurance after INET plan deductible is met	50% coinsurance after OON plan deductible is met	None
If you need immediate medical attention	Emergency room care	$200 copayment/visit after INET plan deductible is met	Same as In-network benefit	None
	Emergency medical transportation	0% coinsurance after INET plan deductible is met	Same as In-network benefit	
	Urgent care	$75 copayment/visit; deductible does not apply	50% coinsurance after OON plan deductible is met	
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 copayment/day up to $1,000/admission after INET plan deductible is met	50% coinsurance after OON plan 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%.
	Physician/surgeon fees	0% coinsurance after INET plan deductible is met	50% coinsurance after OON plan deductible is met	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$40 copayment/visit; deductible does not apply **Outpatient mental health, alcohol and substance abuse treatment** (intensive outpatient treatment and partial hospitalization): $100 copayment/ visit after INET plan deductible is met	50% coinsurance after OON plan deductible is met	None
	Inpatient services	$500 copayment/day up to $1,000/admission after INET plan deductible is met	50% coinsurance after OON plan 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%.
If you are pregnant	Office visits	No charge for prenatal and postnatal care	50% coinsurance after OON plan deductible is met	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	0% coinsurance after INET plan deductible is met	50% coinsurance after OON plan deductible is met	
	Childbirth/delivery facility services	$500 copayment/day up to $1,000/admission after INET plan deductible is met	50% coinsurance after OON plan deductible is met	
If you need help recovering or have other special health needs	Home health care	25% coinsurance after $50 deductible is met	25% coinsurance after $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%. 100 visits/year
	Rehabilitation services	$30 copayment/visit after INET plan deductible is met	50% coinsurance after OON plan 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%. 40 visits/year

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Habilitation services	$30 copayment/visit after INET plan deductible is met	50% coinsurance after OON plan 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%. 40 visits/year
	Skilled nursing care	$500 copayment/day up to $1,000/admission after INET plan deductible is met	50% coinsurance after OON plan 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%. 90 days/calendar year
	Durable medical equipment	40% coinsurance/equipment and supply after INET plan deductible is met	50% coinsurance after OON plan 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%.
	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/visit after INET plan deductible is met	50% coinsurance after OON plan deductible is met	Coverage limited to one exam/year.
	Children's glasses	Lenses: No charge Collection frames: No charge Non-collection frames: 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	Not covered	Coverage limited to one pair of glasses/year.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Children's dental check-up	No charge	50% coinsurance after OON plan deductible is met	Coverage limited to two exams/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
- 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 aids (may be covered with limitations)
- Infertility treatment
- Routine eye care
- Termination of Pregnancy/abortion

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

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

ConnectiCare Member Appeals: PO Box 4061, Farmington, CT 06034-4061 or 1-800-251-7722
Connecticut Residents: CT State Department of Insurance at 1-800-203-3447 or www.ct.gov/cid/site/default.asp
Massachusetts Residents: MA Division of Insurance at 1-877-563-4467 or www.mass.gov/ocabr/government/oca-agencies/doi-lp/
Employee Benefits Security Administration: 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform

Does this plan provide Minimum Essential Coverage? Yes.
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? 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.

Language Access Services:

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

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

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	$6,000
Specialist copayment	$50
Hospital (facility) copayment	$500
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	$12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	$6,000
Copayments	$1,100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$7,160

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

The plan's overall deductible	$6,000
Specialist copayment	$50
Hospital (facility) copayment	$500
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	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$5,700
Copayments	$480
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	$6,240

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

The plan's overall deductible	$6,000
Specialist copayment	$50
Hospital (facility) copayment	$500
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	$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$1,900
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,900

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: [insert].
*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

The plan would be responsible for the other costs of these EXAMPLE covered services.

Accessibility and Nondiscrimination Notice

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

ConnectiCare:

- Provides free aids and services to people with disabilities to communicate effectively with us including qualified interpreters and information in alternate formats.

- Provides free language services to people whose primary language is not English, including translated documents and oral interpretation.

If you need these services, contact The Committee for Civil Rights.

If you believe that ConnectiCare has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: The Committee for Civil Rights, ConnectiCare, 175 Scott Swamp Road, Farmington, CT 06034, 1-800-251-7722, and TTY number 1-800-833-8134. You can file a grievance in person at 175 Scott Swamp Road, Farmington, CT, or by mail, or fax (860) 674-2232 or email memberservices@connecticare.com. If you need help filing a grievance, The Committee for Civil Rights is available to help you. You can also file a civil rights complaint with the U.S, Department of Health and Human Services, Office for Civil Rights, electronically through the Office of Civil Rights Complaint Portal, available at: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at: http://www.hhs.gov/ocr/office/file/index.html.

Language Access Services:

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

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

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

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-251-7722 (TTY: 1-800-833-8134)。

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

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

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

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

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-251-7722 (TTY: 1-800-833-8134).

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

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

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

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

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

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

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

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