ConnectiCare: Choice SOLO HMO Copay/Coins. $7,700 ded.

Coverage for: Individual + Family | Plan Type: HMO

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:** $7,700 individual / $15,400 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?	There are no other specific deductibles.	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 $9,000 individual / $18,000 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 www.ConnectiCare.com 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; deductible does not apply	Not covered	None.
	Specialist visit	$60 copayment/visit; deductible does not apply	Not covered	None.
	Preventive care / screening / immunization	No cost	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**: $60 copayment/service; deductible does not apply at an Independent Facility 50% coinsurance after plan deductible at a Hospital Facility **Lab**: $25 copayment/service; deductible does not apply	Not covered	Preauthorization is required for certain services (ie: genetic testing)
	Imaging (CT/PET scans, MRIs)	50% coinsurance; deductible does not apply at an Independent Facility 50% coinsurance after plan deductible at a Hospital Facility	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 you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.ConnectiCare.com	Preferred Generic (Tier 1)	$15 copayment/prescription; deductible does not apply (retail); $30 copayment/ prescription; deductible does not apply (mail order)	Not covered	Certain drugs will require preauthorization Covers up to a 30 days supply per prescription (retail); 90 days supply per prescription (mail order) **Specialty Drugs** are available from specialty retail pharmacies only and cover up to a 30-day supply limit.
	Non-Preferred Generic drugs (Tier 2)	50% coinsurance up to a maximum of $250 per prescription after plan deductible (retail); 50% coinsurance up to a maximum of $500 per prescription after plan deductible (mail order)	Not covered	
	Preferred brand drugs (Tier 3)	$50 copayment/prescription; deductible does not apply (retail); $100 copayment/ prescription; deductible does not apply (mail order)	Not covered	
	Non-preferred brand drugs (Tier 4)	50% coinsurance up to a maximum of $500 per prescription after plan deductible (retail); 50% coinsurance up to a maximum of $1,000 per prescription after plan deductible (mail order)	Not covered	
	Preferred Specialty drugs (Tier 5)	50% coinsurance up to a maximum of $500 per prescription after plan deductible (specialty retail only)	Not covered	
	Non-Preferred Specialty drugs (Tier 6)	50% coinsurance up to a maximum of $750 per prescription after plan deductible (specialty retail only)	Not covered	

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)	$500 copayment/visit; deductible does not apply at an Ambulatory Facility 50% coinsurance after plan deductible at an Outpatient Hospital Facility	Not covered	Preauthorization is required.
	Physician/surgeon fees	No charge at an Ambulatory Facility 50% coinsurance after plan deductible at an Outpatient Hospital Facility	Not covered	None.
If you need immediate medical attention	Emergency room care	50% coinsurance after plan deductible	Same as In-Network Benefit	None.
	Emergency medical transportation	50% coinsurance after plan deductible	Same as In-Network Benefit	None.
	Urgent care	$100 copayment/visit; deductible does not apply	Same as In-Network Benefit	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	50% coinsurance after plan deductible	Not covered	Preauthorization is required.
	Physician/surgeon fees	50% coinsurance after plan deductible	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)	
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): 50% coinsurance after plan deductible	Not covered	None.
	Inpatient services	50% coinsurance after plan deductible	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	50% coinsurance after plan deductible	Not covered	
	Childbirth/delivery facility services	50% coinsurance after plan deductible	Not covered	
If you need help recovering or have other special health needs	Home health care	25% coinsurance; deductible does not apply	Not covered	Preauthorization is required. (up to 100 visits per calendar year)
	Rehabilitation services	$30 copayment/visit after plan deductible	Not covered	Preauthorization is required. up to 40 visits per year
	Habilitation services	$30 copayment/visit after plan deductible	Not covered	up to 40 visits per year

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	Skilled nursing care	50% coinsurance after plan deductible	Not covered	Preauthorization is required. up to 90 days per year
	Durable medical equipment	50% coinsurance after plan deductible	Not covered	Preauthorization is required.
	Hospice services	Applicable inpatient hospital facility or home health care cost share	Not covered	Preauthorization is required.
If your child needs dental or eye care	Children's eye exam	$25 copayment/visit; deductible does not apply	Not covered	one exam per calendar year
	Children's glasses	Lenses: 50% after plan deductible Collection frames: 50% after plan deductible Non-collection frames: 50% after plan deductible 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 per calendar year
	Children's dental check-up	No charge	Not covered	None.

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 (discounted rate)

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

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.
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? No.
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 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	$7,700
Specialist copayment	$60
Hospital (facility) coinsurance	50%
Other coinsurance	50%

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	$7,700
Copayments	$400
Coinsurance	$600
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$8,760**

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

The plan's overall deductible	$7,700
Specialist copayment	$60
Hospital (facility) coinsurance	50%
Other coinsurance	50%

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	$1,300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,120**

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

The plan's overall deductible	$7,700
Specialist copayment	$60
Hospital (facility) coinsurance	50%
Other coinsurance	50%

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	$2,100
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,400**

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

ConnectiCare

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 fòma 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.

(Arabic) العربية
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. Ndihma 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 serbisyong 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** 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**.

This notice is available on ConnectiCare's website at: connecticare.com/legal/nondiscrimination**.**