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 1-800251-7722 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Preferred Network: $1,700 individual / $3,400 family. Participating Network: $3,400 individual / $6,800 family. Out-of-Network: N/A individual / N/A 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 is covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	There are no other specific deductibles.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For participating providers $9,100 individual / $18,200 family. For non-participating providers N/A individual /N/A 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.

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
		Preferred Provider (You will pay the least)	Participating Provider (You will pay more)	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	$20 copayment per visit; deductible does not apply	40% coinsurance per visit after INET plan deductible is met	Not covered	None
	Specialist visit	$45 copayment per visit; deductible does not apply	Same as Preferred Provider cost share	Not covered	None
	Preventive care/screening/ immunization	No charge	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Xray: 20% coinsurance per service after INET plan deductible is met at a Preferred Hospital Facility $10 copayment per service at a Freestanding Facility; deductible does not apply Lab: $10 copayment per service; deductible	Xray: 40% coinsurance per service after INET plan deductible is met at a Hospital Facility Same as Preferred Provider cost share when done at a Freestanding Facility Lab: Same as Preferred Provider	Not covered	Preauthorization is required for certain services (ie: genetic testing)

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Participating Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
		does not apply	cost share		
	Imaging (CT/PET scans, MRIs)	20% coinsurance per service after INET plan deductible is met at a Preferred Hospital Facility $40 copayment per service up to a combined annual maximum of $375 for MRI and CAT scans; $400 for PET scans at a Freestanding Facility	40% coinsurance per service after INET plan deductible is met at a Hospital Facility Same as Preferred Provider cost share when done at a Freestanding Facility	Not covered	Preauthorization is required.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.ConnectiCare.com	Generic drugs (Tier 1)	$5 copayment per prescription (retail); $10 copayment per prescription (mail order) deductible does not apply	Same as Preferred Provider cost share (retail & mail order)	Not covered	Certain drugs will require preauthorization Covers up to a 30-day supply per prescription (retail); 90-day supply per prescription (mail order)
	Preferred brand drugs (Tier 2)	$40 copayment per prescription (retail); $80 copayment per prescription (mail order) deductible does not apply	Same as Preferred Provider cost share (retail & mail order)	Not covered	
	Non-preferred brand drugs (Tier 3)	50% coinsurance per prescription after INET plan deductible is met (retail & mail order)	Same as Preferred Provider cost share (retail & mail order)	Not covered	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Participating Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
	Specialty drugs (Tier 4)	50% coinsurance up to a maximum of $500 per prescription after INET plan deductible is met (specialty retail only)	Same as Preferred Provider cost share	Not covered	Specialty Drugs are available from specialty retail pharmacies only and cover up to a 30-day supply limit.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance per visit after INET plan deductible is met at a Preferred Outpatient Hospital Facility $300 copayment per visit; deductible does not apply at an Ambulatory Surgery Center	40% coinsurance per visit after INET plan deductible is met at an Outpatient Hospital Facility Same as Preferred Provider cost share for Outpatient behavioral health, Mental health and substance abuse services	Not covered	Preauthorization is required. If you don't get preauthorization, you may be responsible for the total cost of the service.
	Physician/surgeon fees	20% coinsurance per visit after INET plan deductible is met at a Preferred Outpatient Hospital Facility No charge at an Ambulatory Surgery Center	40% coinsurance per visit after INET plan deductible is met at an Outpatient Hospital Facility Same as Preferred Provider cost share for Outpatient behavioral health, Mental health and substance abuse services	Not covered	Preauthorization is required.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Participating Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	20% coinsurance per visit after INET plan deductible is met	Same as Preferred Provider cost share	20% coinsurance per visit after INET plan deductible is met	None
	Emergency medical transportation	20% coinsurance per service after INET plan deductible is met	Same as Preferred Provider cost share	20% coinsurance per service after INET plan deductible is met	
	Urgent care	$75 copayment per visit; deductible does not apply	Same as Preferred Provider cost share	Not covered	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance per admission after INET plan deductible is met at a Preferred Hospital Facility	40% coinsurance per admission after INET plan deductible is met The cost share for Inpatient behavioral health, mental health and substance abuse services is the same as Preferred Provider	Not covered	Preauthorization is required. If you don't get preauthorization, you may be responsible for the total cost of the service.
	Physician/surgeon fees	20% coinsurance per admission after INET plan deductible is met at a Preferred Hospital Facility	40% coinsurance per admission after INET plan deductible is met	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$45 copayment per visit; deductible does not apply **Outpatient mental**	Same as Preferred Provider cost share	Not covered	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Participating Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
		health, alcohol and substance abuse treatment (intensive outpatient treatment and partial hospitalization): 20% coinsurance per visit after INET plan deductible is met			Preauthorization is required.
	Inpatient services	20% coinsurance per admission after INET plan deductible is met at a Preferred Hospital Facility	40% coinsurance per admission after INET plan deductible is met The cost share for Inpatient behavioral health, mental health and substance abuse services is the same as Preferred Provide	Not covered	
If you are pregnant	Office visits	No charge for prenatal and postnatal care	Same as Preferred Provider cost share	Not covered	Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	20% coinsurance per admission after INET plan deductible is met	40% coinsurance per admission after INET plan deductible is met	Not covered	
	Childbirth/delivery facility services	20% coinsurance per admission after INET plan deductible is met	40% coinsurance per admission after INET plan deductible is met	Not covered	
If you need help recovering or have	Home health care	$25 copayment per visit; deductible does	Same as Preferred Provider cost share	Not covered	**up to 100 visits per year** Preauthorization is required.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Participating Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
other special health needs		not apply			
	Rehabilitation services	$30 copayment per visit after INET plan deductible is met	Same as Preferred Provider cost share	Not covered	**Rehab Services**: up to 40 visits/year Preauthorization is required. **Habilitation services:** up to 40 visits/year
	Habilitation services	$30 copayment per visit after INET plan deductible is met	Same as Preferred Provider cost share	Not covered	
	Skilled nursing care	20% coinsurance per admission after INET plan deductible is met	40% coinsurance per admission after INET plan deductible is met	Not covered	Preauthorization is required. **up to 90 visits per year**
	Durable medical equipment	20% coinsurance per equipment/ supply; deductible does not apply	Same as Preferred Provider cost share	Not covered	Preauthorization is required.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Participating Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
	Hospice services	Applicable inpatient hospital facility or home health care cost share	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	$45 copayment per visit; deductible does not apply	Same as Preferred Provider cost share	Not covered	Coverage limited to one exam/year.
	Children's glasses	Lenses: 50% Collection frame: 50% 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	Same as Preferred Provider cost share	Not covered	One pair of frames and lenses or contact lens per calendar year
	Children's dental check-up	No charge	Same as Preferred Provider cost share	Not covered	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 aid (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.**
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	$3,400
Specialist copayment	$45
Hospital (facility) coinsurance	40%
Other coinsurance	20%

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	$3,400
Copayments	$10
Coinsurance	$2,600
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$6,070**

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

The plan's overall deductible	$3,400
Specialist copayment	$45
Hospital (facility) coinsurance	40%
Other coinsurance	20%

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	$100
Copayments	$700
Coinsurance	$80
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$900**

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

The plan's overall deductible	$3,400
Specialist copayment	$45
Hospital (facility) coinsurance	40%
Other coinsurance	20%

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	$1,800
Copayments	$200
Coinsurance	$20
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,020**

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 contact1-800-390-3522.
*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).