**This is only a summary**. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.ConnectiCare.com or by calling 1-800-251-7722.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | $0 | See the chart starting on page 2 for your other costs for services this plan covers. |
| **Are there other deductibles for specific services?** | Yes. $100 for Durable Medical Equipment coverage. | You must pay all the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services. |
| **Is there an out-of-pocket limit on my expenses?** | No. | There's no limit on how much you could pay during a policy period for your share of the cost of covered services. |
| **What is not included in the out-of-pocket limit?** | This plan has no out-of-pocket limit. | Not applicable because there's no **out-of-pocket limit** on your expense. |
| **Is there an overall annual limit on what the insurer pays?** | No. | The chart starting on page 2 describes any limits on what the insurer will pay for *specific* covered services, such as office visits. |
| **Does this plan use a network of providers?** | Yes. See www.ConnectiCare.com or call 1-800-251-7722 for a list of participating providers and hospitals. | If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**. |
| **Do I need a referral to see a specialist?** | No. You don't need a referral to see a specialist. | You can see the **specialist** you choose without permission from this plan. |
| **Are there services this plan doesn't cover?** | Yes. | Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about **excluded services**. |

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**)
- The plan may encourage you to use **In-network providers** by charging you lower **deductibles**, **copayments**, and **coinsurance** amounts.

| Common Medical Event | Services You May Need | Your cost if you use an | | Limitations & Exceptions |
|---|---|---|---|---|
| | | In-network Provider | Out-of-network Provider | |
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | $15 Copayment per visit | Not covered | -----none----- |
| | Specialist visit | $15 Copayment per visit | Not covered | -----none----- |
| | Other practitioner office visit | $15 Copayment per visit for chiropractor | Not covered for chiropractor | up to 20 visits per year |
| | Preventive care / screening / immunization | $15 Copayment per visit | Not covered | Frequency limits apply |
| **If you have a test** | Diagnostic test (x-ray, blood work) | Xray: No Member cost, Lab: No Member cost | Not covered | -----none----- |
| | Imaging (CT / PET scans, MRIs) | No Member cost | Not covered | -----none----- |

| Common Medical Event | Services You May Need | Your cost if you use an In-network Provider | Your cost if you use an Out-of-network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.ConnectiCare.com** | Generic drugs | $5 Copayment (retail); $10 Copayment (mail order) | Not covered (retail); Not covered (mail order) | Covers up to a 30 day supply (retail prescription); 90 day supply (mail order prescription) |
| | Preferred brand drugs | $20 Copayment (retail); $40 Copayment (mail order) | Not covered (retail); Not covered (mail order) | Covers up to a 30 day supply (retail prescription); 90 day supply (mail order prescription) |
| | Non-preferred brand drugs | $35 Copayment (retail); $70 Copayment (mail order) | Not covered (retail); Not Covered (mail order) | Covers up to a 30 day supply (retail prescription); 90 day supply (mail order prescription) |
| | Specialty drugs | Varies based on above drug categories | Not covered (retail); Not covered (mail order) | Covers up to a 30 day supply (retail prescription); 90 day supply (mail order prescription); |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | $50 Copayment per visit | Not covered | -----none----- |
| | Physician/surgeon fees | No Member cost | Not covered | -----none----- |
| **If you need immediate medical attention** | Emergency room services | $50 Copayment per visit | $50 Copayment per visit | -----none----- |
| | Emergency medical transportation | No Member cost | No Member cost | -----none----- |
| | Urgent care | $30 Copayment per visit | $30 Copayment per visit | -----none----- |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | $75 Copayment per admission | Not covered | -----none----- |
| | Physician/surgeon fee | No Member cost | Not covered | -----none----- |

| Common Medical Event | Services You May Need | Your cost if you use an In-network Provider | Your cost if you use an Out-of-network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you have mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | $15 Copayment per visit | Not covered | -----none----- |
| | Mental/Behavioral health inpatient services | $75 Copayment per admission | Not covered | -----none----- |
| | Substance use disorder outpatient services | $15 Copayment per visit | Not covered | -----none----- |
| | Substance use disorder inpatient services | $75 Copayment per admission | Not covered | -----none----- |
| **If you become pregnant** | Prenatal and postnatal care | No Member Cost | Not covered | -----none----- |
| | Delivery and all inpatient services | $75 Copayment per admission | Not covered | -----none----- |
| **If you need help recovering or have other special health needs** | Home health care | No Member cost | Not covered | up to 100 visits per year |
| | Rehabilitation services | $15 Copayment per visit | Not covered | up to 40 visits per year |
| | Habilitation services | Not covered | Not covered | Not covered |
| | Skilled nursing care | No Member cost | Not covered | up to 90 days per year |
| | Durable medical equipment | 20% after Benefit Deductible | Not covered | up to $1,500 per year |
| | Hospice service | No Member cost | Not covered | Pre-authorization is required |
| **If your child needs dental or eye care** | Eye exam | $10 Copayment per visit | Not covered | up to one visit every year |
| | Glasses | 25% Discount | | 25% Discount |
| | Dental check-up | Not Applicable | Not covered | -----none----- |

## Excluded Services & Other Covered Services:

**Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Acupuncture
- Bariatric surgery
- Habilitation Services
- Long-term care
- Routine foot care
- Routine hearing tests

- Cosmetic Surgery
- Dental Care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Weight loss programs (discounted rate)

**Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Chiropractic care
- Hearing aids (may be covered with limitations)
- Infertility treatment
- Routine eye care

## Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.
For more information on your rights to continue coverage, contact the plan at 1-800-251-7722. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

## Your Grievance Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

ConnectiCare Member Appeals, PO Box 4061, Farmington, CT 06034-4061 or 1-800-251-7722 or Facsimile 1-800-319-0089
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/

## Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-251-7722.
Polish (Polski): Pomoc w języku polskim jest dostępna pod numerem telefonu 1-800-251-7722.

----------*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*----------

# About These Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under the plan. The actual care you receive will be different from these examples, and the cost of that care also will be different.

See the next page for important information about these examples.

## Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $7,270
- **Patient pays:** $270

**Sample care costs:**

| | |
|---|---|
| Hospital charges (mother) | $2,700 |
| Routine obstetric care | $2,100 |
| Hospital charges (baby) | $900 |
| Anesthesia | $900 |
| Laboratory tests | $500 |
| Prescriptions | $200 |
| Radiology | $200 |
| Vaccines, other preventive | $40 |
| **Total** | **$7,540** |

**Patient pays:**

| | |
|---|---|
| Deductibles | $0 |
| Co-pays | $120 |
| Co-insurance | $0 |
| Limits or exclusions | $150 |
| **Total** | **$270** |

Note: These numbers assume the patient has given notice of her pregnancy to the plan. If you are pregnant and have not given notice of your pregnancy, your costs may be higher. For more information about the diabetes wellness program, please contact: 1-800-390-3522.

## Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $4,680
- **Patient pays:** $720

**Sample care costs:**

| | |
|---|---|
| Prescriptions | $2,900 |
| Medical Equipment and Supplies | $1,300 |
| Office Visits and Procedures | $700 |
| Education | $300 |
| Laboratory tests | $100 |
| Vaccines, other preventive | $100 |
| **Total** | **$5,400** |

**Patient pays:**

| | |
|---|---|
| Deductibles | $0 |
| Co-pays | $410 |
| Co-insurance | $230 |
| Limits or exclusions | $80 |
| **Total** | **$720** |

# Questions and answers about Coverage Examples:

## What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied to the U.S. Department of Health and Human Services, and are not specific to a particular geographic area or health plan.
- Patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

## What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

## Does the Coverage Example predict my own care needs?

✘ No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is and many other factors.

## Does the Coverage Example predict my future expenses?

✘ No. Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

## Can I use Coverage Examples to compare plans?

✓ Yes. When you look at the Summaries of Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box for each example. The smaller that number, the more coverage the plan provides.

## Are there other costs I should consider when comparing plans?

✓ Yes. An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles** and **co-insurance**. You also should consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.