# ConnectiCare : Choice Mass HMO Copay $2000/$4000

**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, www.connecticare.com or 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?** | $0 | See the Common Medical Events chart below for your costs for services this **plan** covers. |
| **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?** | Yes. $2,000 Individual / $4,000 Family Inpatient/Outpatient Facility. | 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?** | Yes. For participating providers $7,000 individual / $14,000 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 participating 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). |
| **Do I 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 | $30 copayment/visit; deductible does not apply | Not covered | None |
| | Specialist visit | $60 copayment/visit; deductible does not apply | Not covered | |
| | Preventive care / screening / immunization | No charge | 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: $50 copayment/visit; deductible does not apply<br>Lab: $10 copayment/visit; deductible does not apply | Not covered | None |
| | Imaging (CT / PET scans, MRIs) | $200 copayment/visit; deductible does not apply | Not covered | Preauthorization is required.<br>up to five copayments per year<br>deductible does not apply |

| 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 drugs to treat your illness or condition**<br>**More information about prescription drug coverage is available at www.ConnectiCare.com** | Preferred Generic drugs | $30 copayment/prescription deductible does not apply; (retail); $60 copayment/ prescription deductible does not apply (mail order) | Not covered (retail); Not covered (mail order) | Certain drugs will require preauthorization<br><br>Covers up to 30-day supply per prescription (retail); 90-day supply per prescription (mail order)<br><br>**Specialty Drugs** are available from specialty retail pharmacies only and cover up to a 30-day supply limit. |
| | Preferred brand drugs | $60 copayment/prescription; deductible does not apply; (retail); $120 copayment/ prescription; deductible does not apply (mail order) | Not covered (retail); Not covered (mail order) | |
| | Non-preferred generic drugs and Non-preferred brand drugs | 50% coinsurance up to a maximum of $300 per prescription; deductible does not apply (retail); 50% coinsurance up to a maximum of $600 per prescription; deductible; does not apply (mail order) | Not covered (retail); Not covered (mail order) | |
| | Preferred Specialty drugs<br><br>Non-preferred Specialty drugs | 50% coinsurance up to a maximum of $350 per prescription; deductible does not apply (specialty retail only)<br>50% coinsurance up to a maximum of $750 per prescription; deductible does not apply (specialty retail only) | Not covered (retail); Not covered (mail order) | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | $500 copayment/visit after benefit deductible | Not covered | Preauthorization is required. |
| | Physician/surgeon fees | 0% coinsurance after benefit deductible | Not covered | 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 immediate medical attention** | Emergency room care | $400 copayment/visit deductible does not apply | Same as In-network benefit | None |
| | Emergency medical transportation | No charge | Same as In-network benefit | |
| | Urgent care | $100 copayment/visit; deductible does not apply | Same as In-network benefit | |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | $500 copayment per admission after benefit deductible | Not covered | Preauthorization is required. |
| | Physician/surgeon fee | 0% coinsurance after benefit deductible | Not covered | None |
| **If you have mental health, behavioral health, or substance abuse needs** | Outpatient services | $30 copayment/visit; deductible does not apply | Not covered | None |
| | Inpatient services | $500 copayment per admission after benefit deductible | Not covered | Preauthorization is required. |
| **If you become pregnant** | Office visits | No charge for prenatal and postnatal care | Not covered | None |
| | Childbirth/delivery professional | 0% coinsurance after benefit deductible | Not covered | |
| | Childbirth/delivery facility services | $500 copayment per admission after benefit deductible | 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) | |
| **If you need help recovering or have other special health needs** | Home health care | No charge | Not covered | Preauthorization is required. |
| | Rehabilitation services | $50 copayment/visit; deductible does not apply | Not covered | Preauthorization is required. up to 60 visits per year (includes services combined for physical and occupational therapy) |
| | Habilitation services | $50 copayment/visit; deductible does not apply | Not covered | up to 60 visits per year (includes services combined for physical, speech and occupational therapy) |
| | Skilled nursing care | $500 copayment per admission after benefit deductible | Not covered | Preauthorization is required. up to 100 days per year |
| | Durable medical equipment | 20% coinsurance; deductible does not apply | Not covered | Preauthorization is required. |
| | Hospice service | Applicable inpatient hospital facility or home health care cost share | Not covered | |
| **If your child needs dental or eye care** | Children's eye exam | $50 copayment/visit; deductible does not apply | Not covered | up to one visit every year |
| | Children's glasses | Lenses: $50<br>Collection frames: $50<br>Non-collection frames: $50 up to the collection frame allowance; any amount over is payable by the member minus a 20% discount; deductible does not apply | Not covered | one pair of frames and lenses per year |
| | Children's dental check-up | No charge | 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
- 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

**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.)**

- Bariatric surgery
- Chiropractic care
- Hearing aids (may be covered with limitations)
- Infertility treatment
- Routine eye care
- Weight loss programs (discounted rate)

## 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 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 Coverage Provide Minimum Essential Coverage? Yes.

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

## Does this Coverage Meet the Minimum Value Standard? Yes.

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

## 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 page.*----------

## 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** | **$60** |
| **Hospital (facility) deductible** | **$2,000** |
| **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** | **$12,800** |

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $2,000 |
| Copayments | $770 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | $2,830 |

### 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** | **$60** |
| **Hospital (facility) deductible** | **$2,000** |
| **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** | **$7,400** |

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles* | $0 |
| Copayments | $1,720 |
| Coinsurance | $300 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Joe would pay is** | $2,080 |

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

| | |
|---|---|
| **The plan's overall deductible** | **$0** |
| **Specialist copayment** | **$60** |
| **Hospital (facility) deductible** | **$2,000** |
| **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** | **$1,900** |

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles* | $0 |
| Copayments | $800 |
| Coinsurance | $10 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | $810 |

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.

## 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 06032, 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. 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

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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 मुफत 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 គឺអាចមានសំរាប់បីរអ្នក។ ចូរ ទូរស័ព្ទ 1-800-224-2273 (TTY: 1-800-842-9710)

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