ConnectiCare : FlexPOS HSA $5,000 50%

Coverage for: Individual + Family | **Plan Type:** POS

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?	In-Network: $5,000 individual / $10,000 family. Doesn't apply to preventive care. Out-of-Network: $10,000 individual / $20,000 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 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, but see the chart starting on page 2 for other costs for services this plan covers.
What is the out-of-pocket limit for this plan?	Yes. For participating providers $6,750 individual / $13,500 family. For non-participating providers $13,500 individual / $27,000 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, the overall family out-of-pocket limit must be 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 after plan deductible	50% coinsurance after plan deductible	**Primary Care Visits at a Sanitas Medical Center:** 0% coinsurance after plan deductible
	Specialist visit	$50 copayment/visit after plan deductible	50% coinsurance after plan deductible	
	Preventivecare/screening/ immunization	No charge	50% coinsurance after plan deductible	Frequency limits apply
If you have a test	Diagnostic test (x-ray,bloodwork)	Xray: $40 copayment/service after plan deductible Lab: $10 copayment/visit after plan deductible	50% coinsurance after plan deductible	Preauthorization is required for certain services (ie: genetic testing)
	Imaging(CT/PETscans,MRIs)	**Hospital Facility:** 50% coinsurance after plan deductible **Stand-alone Facility:** $100 copayment/service after plan deductible up to five copayments per year then copayment waived	50% coinsurance after plan deductible	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%

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 **More information about prescription drug coverage is available at www.ConnectiCare.com**	Preferred Generic drugs	$10 copayment/prescription after plan deductible (retail); $20 copayment/prescription after plan deductible (mail order)	50% coinsurance after plan deductible (retail); Not covered order)	Certain drugs will require preauthorization Covers up to 30 day supply per prescription (retail); 90 day supply per prescription (mail order) **SpecialtyDrugs** are available from specialty retail pharmacies only and cover up to a 30-day supply limit. **Non-preferred brand drugs** 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)
	Preferred Brand drugs	$50 copayment/prescription after plan deductible (retail); $100 copayment/prescription after plan deductible (mail order)	50% coinsurance after plan deductible (retail); Not covered (mail order)	
	Non-Preferred Generic drugs	50% coinsurance up to $250 maximum per prescription after plan deductible (retail); 50% coinsurance up to $500 maximum per prescription after plan deductible (mail order)	50% coinsurance after plan deductible (retail); Not covered order)	
	Preferred Specialty drugs	50% coinsurance up to a maximum of $500 per prescription after plan deductible (specialty retail only)	50% coinsurance after plan deductible (specialty retail only)	
	Non-Preferred Specialty drugs	50% coinsurance up to a maximum of $750 per prescription after plan deductible (specialty retail only)		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	50% coinsurance after plan deductible	50% coinsurance after plan deductible	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	50% coinsurance after plan deductible	50% coinsurance after plan deductible	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	50% coinsurance after plan deductible	Same as In-network benefit	None
	Emergency medical transportation	50% coinsurance after plan deductible	Same as In-network benefit	
	Urgent care	$75 copayment/visit after plan deductible	Same as In-network benefit	
If you have a hospital stay	Facilityfee(e.g.,hospital room)	50% coinsurance after plan deductible	50% coinsurance after plan deductible	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 fee	50% coinsurance after plan deductible	50% coinsurance after plan deductible	None
If you have mental health, behavioral health, or substance abuse needs	Outpatient services	$50 copayment/visit after plan deductible	50% coinsurance after plan deductible	None
	Inpatient services	50% coinsurance after plan deductible	50% coinsurance after plan deductible	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%

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 become pregnant	Office visits	No charge for prenatal and postnatal care	50% coinsurance after plan deductible	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance or copayments may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional	50% coinsurance after plan deductible	50% coinsurance after plan deductible	None
	Childbirth/delivery facility services	50% coinsurance after plan deductible	50% coinsurance after plan deductible	

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 healthcare	50% coinsurance after plan deductible	50% coinsurance after plan deductible	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% up to 100 visits per year
	Rehabilitation services	$50 copayment/visit after plan deductible	50% coinsurance after plan deductible	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% up to 40 visits per year includes services combined for physical, speech and occupational therapy
	Habilitation services	$50 copayment/visit after plan deductible	50% coinsurance after plan deductible	up to 40 visits per year
	Skilled nursing care	50% coinsurance after plan deductible	50% coinsurance after plan deductible	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% up to 90 days per year
	Durable medical equipment	50% coinsurance after plan deductible	50% coinsurance after plan deductible	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% up to 100 visits per year
	Hospice service	Applicable inpatient hospital facility or home health care cost share	Applicable inpatient hospital facility or home health care cost share	

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 your child needs dental or eye care	Children's eye exam	$50 copayment; deductible does not apply	50% coinsurance after plan deductible	up to one visit every year
	Children's glasses	25% Discount	Not covered	25% Discount
	Children's 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.)

- Bariatric surgery
- Cosmetic surgery
- Dental care
- Hearing Aids
- Infertility treatment
- 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 (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture coverage is limited to pain management
- Chiropractic Care
- 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 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	**$5,000**
Specialist copayment	**$50**
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	**$12,800**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$5,000
Copayments	$30
Coinsurance	$1,750
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$6,840

Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)	
The plan's overall deductible	**$5,000**
Specialist copayment	**$50**
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	**$7,400**
In this example, Joe would pay:	
Cost Sharing	
Deductibles*	$5,000
Copayments	$400
Coinsurance	$240
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	$5,700

Mia's Simple Fracture (in-network emergency room visit and follow up care)	
The plan's overall deductible	**$5,000**
Specialist copayment	**$50**
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	**$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: 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 المساعدة اللغوية المتوافرة لك تتوافر بالمجان. اتصل برقم 1-800-251-7722 (رقم الهاتف 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 નઃશુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-224-2273 (TTY: 1-800-842-9710).