ConnectiCare

FlexPOS-CNT-HSA-2250I/4500F-21-Combined-A Open Access Contract Year Benefit Summary (A)

The individual deductible and out-of-pocket maximum applies if you have coverage only for yourself and not for any dependents. The family deductible and out-of-pocket maximum applies if you have coverage for yourself and one or more eligible dependents. In addition, if you have family coverage, any applicable copayments or coinsurance will not apply to services until the total deductible is met for the family, without regard to how much any one family member has met.

Your ConnectiCare health plan helps you get the care you need. Here are the most frequently used services. Refer to your certificare of coverage on connecticare.com for a complete list of benefits.

Personalized for: Cooperative Educational Services

In-Network Preventive Services
These services are no cost to you when you use an **in-network** doctor or facility. Frequency is based on age and gender. For a complete list of preventive services and to find a doctor, refer to connecticare.com.

Getting care within ConnectiCare's network typically costs you less. You may also get care outside of our network; however, your share of the costs will be higher. Out-of-network doctors and facilities do not appear in the "Find a doctor" directory on connecticare.com.

- **Physical**
- **Well woman visit and pap test**
- **More than 25 screenings, including mammograms and colonoscopies**
- **Flu shot**
- **Vaccinations**
- **Certain birth control and other prevention medications**

	In-network member pays	**Out-of-network member pays**
Your deductible Deductible is combined for medical services and prescription drugs Deductible is combined for in and out-of-network	$2,250 Individual $4,500 Family	$2,250 Individual $4,500 Family
Your out-of-pocket maximum Includes a combination of deductible, copayments and coinsurance for medical and pharmacy services Out-of-pocket is combined for in and out-of-network	$3,000 Individual $6,000 Family	$3,000 Individual $6,000 Family
Out-of-network reimbursement	Not applicable	Plan will reimburse the coinsurance percentage of the maximum allowable amount
After you have spent the out-of-pocket maximum amount, ConnectiCare will pay 100% of your covered health care expenses for the remainder of the year.		

Screenings	In-network member pays	Out-of-network member pays
Baseline routine mammography (ages 35-39)	No charge	20% coinsurance after plan deductible
Annual routine mammography (age 40 or older)	No charge	20% coinsurance after plan deductible
Annual routine vision exam one exam per year	No charge	20% coinsurance after plan deductible
Hearing Screenings one exam every year	No charge	20% coinsurance after plan deductible
Allergy testing Unlimited	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Ongoing Care and Sick Visits	**In-network member pays**	**Out-of-network member pays**
Primary care services (includes office and telemedicine services)	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Specialist services (includes office and telemedicine services)	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Gynecologist services	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Maternity and prenatal care visits May not apply to all laboratory and radiology services – refer to your plan documents	No charge	20% coinsurance after plan deductible
Allergy injections Unlimited	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Telemedicine visit (services rendered by a Teladoc® provider) Primary Care – members must be 18 or older	**Primary Care, Mental Health and General Medical Services:** 0% coinsurance after plan deductible **Dermatologists:** 0% coinsurance after plan deductible	20% coinsurance after plan deductible
Retail clinic	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Nutritional Counseling Limit 3 visits per year	0% coinsurance after plan deductible	20% coinsurance after plan deductible

Ongoing Care and Sick Visits	In-network member pays	Out-of-network member pays
Infertility Infertility benefits outlined in the Certificate of Coverage are unlimited, with no age or cycle restrictions	0% coinsurance (Office visit) after plan deductible 0% coinsurance (Ambulatory Services Outpatient) after plan deductible 0% coinsurance (Inpatient Hospital) after plan deductible	20% coinsurance after plan deductible
Lab and Radiology **Performed in a hospital, lab or radiology facility**	**In-network member pays**	**Out-of-network member pays**
Laboratory services	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Non-advanced radiology X-ray, diagnostic	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Advanced radiology **Hospital facility** MRI, PET and CAT scan and nuclear cardiology	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Advanced radiology **Stand-alone facility** MRI, PET and CAT scan and nuclear cardiology	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Sudden and Unexpected Care	**In-network member pays**	**Out-of-network member pays**
Urgent care or other walk-in clinic	0% coinsurance after plan deductible	Same as In-network benefit
Emergency room	0% coinsurance after plan deductible	Same as In-network benefit
Ambulance	0% coinsurance after plan deductible	Same as In-network benefit
Inpatient Hospital Services	**In-network member pays**	**Out-of-network member pays**
Inpatient hospital services, including room and board	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Skilled nursing facilities up to 120 days per year	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Inpatient Rehabilitation up to 100 days per year	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Private duty nursing up to $15,000 per year	0% coinsurance after plan deductible	20% coinsurance after plan deductible

Outpatient Hospital Services and Home Care	In-network member pays	Out-of-network member pays
Hospital outpatient facilities	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Ambulatory surgical center	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Home health services Nursing and therapeutic services limited to 200 visits Home Health aide services limited to 80 visits that are applicable to the 200 visit limit	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Outpatient Rehabilitative Services	**In-network member pays**	**Out-of-network member pays**
Rehabilitative Services up to 60 visits per year includes services combined for physical, speech and occupational therapy and chiropractic services	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Mental Health and Substance Abuse	**In-network member pays**	**Out-of-network member pays**
Inpatient mental health services	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Inpatient alcohol and substance abuse treatment	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Outpatient mental health, alcohol and substance abuse treatment office visits and home services	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Outpatient mental health, alcohol and substance abuse treatment intensive outpatient treatment and partial hospitalization	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Supplies	**In-network member pays**	**Out-of-network member pays**
Durable medical equipment including prosthetics and disposable medical supplies Includes wigs prescribed by an oncologist for a member suffering hair loss as a result of chemotherapy or radiation therapy up to one wig per year	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Artificial Limbs includes associated supplies and equipment	0% coinsurance after plan deductible	20% coinsurance after plan deductible

Supplies	In-network member pays	Out-of-network member pays
Diabetic equipment and supplies	0% coinsurance after plan deductible	20% coinsurance after plan deductible
Modified food products and specialized formula pharmacy tier	0% coinsurance after plan deductible	20% coinsurance after plan deductible

Important information

- This is a brief summary of benefits. Refer to your ConnectiCare Insurance Company, Inc. Certificate of Coverage for complete details on benefits, conditions, limitations and exclusions, or consult with your benefits manager. All benefits described are per member per Contract year.
- Ovarian cancer screening and monitoring services coverage and cost share details are available in your Certificate of Coverage.
- Mammogram screenings, breast ultrasounds, and breast MRIs - Please refer to the Certificate of Coverage for details.
- To learn more about your Teladoc® provider benefits contact Teladoc® at teladoc.com/connecticare or call 1-800-835-2362 (TTY: 711).
- Insulin and noninsulin drugs are covered up to a cost share maximum of $25 for each 30-day supply.
- Diabetes Devices and Diabetic Ketoacidosis Devices are covered up to a cost share maximum of $100 per 30-day supply.
- Please refer to the certificate of coverage for additional cost share maximums regarding diabetic services. Some diabetic services fall under preventive care and cost share may be waived.
- Certain services require Prior Authorization, please refer to your Certificate of Coverage for a detailed list of services or call member service at 1-800-251-7722.
- If you have questions regarding your plan, visit our website at **www.connecticare.com** or call us at (860) 674-5757 or 1-800-251-7722.
- Out-of-Network reimbursement is based on the maximum allowable amount. Members are responsible to pay any charges in excess of this amount. Please refer to your ConnectiCare Insurance Company, Inc. Certificate of Coverage for more information.
- If you are a Massachusetts resident, please refer to your *amendatory rider for Massachusetts mandated benefits* for additional details of your benefits.
- If you are a Massachusetts resident, this plan along with pharmacy services meets Massachusetts Minimum Creditable Coverage standards for 2023.

ConnectiCare

FlexPOS Combined Deductible Prescription Drug Plan for Use with Health Savings Account (HSA) Benefit Summary

This is a brief summary of your prescription drug benefits. Refer to your prescription drug rider for complete details on benefits, conditions, limitations and exclusions, or consult with your benefits manager. All benefits described below are per member per Contract year.

Personalized for: Cooperative Educational Services

Covered prescription drugs through retail participating pharmacies or our mail order service. **Generics are dispensed unless the provider writes "Dispense as Written" on the prescription.** Your Plan includes the following: Mandatory drug substitution, Generic substitution program, Pay the difference waiver, Tiered cost-share program, and Voluntary mail order program.

	In-network member pays	**Out-of-network member pays**
Your deductible Deductible is combined for medical services and prescription drugs Deductible is combined for In and out-of-network	$2,250 Individual $4,500 Family	$2,250 Individual $4,500 Family
Your out-of-pocket maximum Includes a combination of deductible, copayments and coinsurance for medical and pharmacy services Out-of-pocket maximum is combined for In and out-of-network	$3,000 Individual $6,000 Family	$3,000 Individual $6,000 Family
Retail Pharmacy (up to a 34 day supply per prescription)	**In-network member pays**	**Out-of-network member pays**
Generic drugs (Tier 1)	$5 copayment/prescription after plan deductible	20% coinsurance after plan deductible
Preferred brand drugs (Tier 2)	$20 copayment/prescription after plan deductible	20% coinsurance after plan deductible
Non-preferred brand drugs (Tier 3)	$35 copayment/prescription after plan deductible	20% coinsurance after plan deductible

Mail Order Pharmacy (up to a 100 day supply per prescription)	In-network member pays	Out-of-network member pays
Generic drugs (Tier 1)	$10 copayment/prescription after plan deductible	20% coinsurance after plan deductible
Preferred brand drugs (Tier 2)	$40 copayment/prescription after plan deductible	20% coinsurance after plan deductible
Non-preferred brand drugs (Tier 3)	$70 copayment/prescription after plan deductible	20% coinsurance after plan deductible

Additional Information

- Under this program covered prescription drugs and supplies are put into categories (i.e., tiers) to designate how they are to be covered and the member's cost-share. The placement of a drug or supply into one of the tiers is determined by the ConnectiCare Pharmacy Services Department and approved by the ConnectiCare Pharmacy & Therapeutics Committee based on the drug's or supply's clinical effectiveness and cost, not on whether it is a generic drug or supply or brand name drug or supply.
- Most specialty drugs are dispensed through specialty pharmacies by mail, up to a 30 day supply. Specialty pharmacies have the same member cost share as all other participating pharmacies and are not part of ConnectiCare's voluntary mail order program. The member cost share for specialty pharmacy is different from the cost share for ConnectiCare's mail order program.
- Insulin and noninsulin drugs are covered up to a cost share maximum of $25 for each 30-day supply.
- Diabetes Devices and Diabetic Ketoacidosis Devices are covered up to a cost share maximum of $100 per 30-day supply.
- Please refer to the prescription drug rider for additional cost share maximums regarding diabetic services. Some diabetic services fall under preventive care and cost share may be waived.
- If you are a Massachusetts resident, please refer to your *amendatory rider for Massachusetts mandated benefits* for additional details of your benefits.

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?	$2,250 individual / $4,500 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 policy, the overall family deductible must be met before the plan begins to pay.
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?	$3,000 individual / $6,000 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 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	0% coinsurance after plan deductible	20% coinsurance after plan deductible	None.
	Specialist visit	0% coinsurance after plan deductible	20% coinsurance after plan deductible	None.
	Preventive care / screening / immunization	No charge	20% coinsurance after plan deductible	None.
If you have a test	Diagnostic test (x-ray, blood work)	Xray: 0% coinsurance after plan deductible, Lab: 0% coinsurance after plan deductible	20% coinsurance after plan deductible	Preauthorization is required for certain services (ie: genetic testing)
	Imaging (CT/PET scans, MRIs)	**Hospital facility:** 0% coinsurance after plan deductible **Stand-alone facility:** 0% coinsurance after plan deductible	20% 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
		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	Generic drugs (Tier 1)	$5 copayment/prescription after plan deductible (retail); $10 copayment/prescription after plan deductible (mail order)	20% coinsurance after plan deductible (retail); 20% coinsurance after plan deductible (mail order)	Certain drugs will require preauthorization Covers up to a 34 day supply per prescription (retail); 100 day supply per prescription (mail order) **Specialty Drugs** are available from specialty retail pharmacies only and cover up to a 30-day supply limit.
	Preferred brand drugs (Tier 2)	$20 copayment/prescription after plan deductible (retail); $40 copayment/prescription after plan deductible (mail order)	20% coinsurance after plan deductible (retail); 20% coinsurance after plan deductible (mail order)	
	Non-preferred brand drugs (Tier 3)	$35 copayment/prescription after plan deductible (retail); $70 copayment/prescription after plan deductible (mail order)	20% coinsurance after plan deductible (retail); 20% coinsurance after plan deductible (mail order)	
	Specialty drugs (Tier 4)	Varies based on above drug categories	20% coinsurance after plan deductible (specialty retail only)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	**Hospital facility:** 0% coinsurance after plan deductible **Ambulatory Center:** 0% coinsurance after plan deductible	20% 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	0% coinsurance after plan deductible	20% coinsurance after plan deductible	None.
If you need immediate medical attention	Emergency room care	0% coinsurance after plan deductible	Same as In-network benefit	None.
	Emergency medical transportation	0% coinsurance after plan deductible	Same as In-network benefit	None.
	Urgent care	0% coinsurance after plan deductible	Same as In-network benefit	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 have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance after plan deductible	20% 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	0% coinsurance after plan deductible	20% coinsurance after plan deductible	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% coinsurance after plan deductible	20% coinsurance after plan deductible	None.
	Inpatient services	0% coinsurance after plan deductible	20% 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%.
If you are pregnant	Office visits	No charge for prenatal and postnatal care	20% 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 services	0% coinsurance after plan deductible	20% coinsurance after plan deductible	None
	Childbirth/delivery facility services	0% coinsurance after plan deductible	20% coinsurance after plan deductible	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 help recovering or have other special health needs	Home health care	0% coinsurance after plan deductible	20% coinsurance after plan deductible	None. 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%. Nursing and therapeutic services limited to 200 visits Home Health aide services limited to 80 visits that are applicable to the 200 visit limit
	Rehabilitation services	0% coinsurance after plan deductible	20% coinsurance after plan deductible	None. 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 60 visits per year includes services combined for physical, speech and occupational therapy and chiropractic services
	Habilitation services	Not covered	Not covered	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 need help recovering or have other special health needs	Skilled nursing care	0% coinsurance after plan deductible	20% 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 120 days per year
	Durable medical equipment	0% coinsurance after plan deductible	20% 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%. Includes wigs prescribed by an oncologist for a member suffering hair loss as a result of chemotherapy or radiation therapy up to one wig per year
	Hospice services	Applicable inpatient hospital facility or home health care cost share	Applicable inpatient hospital facilty or home health care cost share	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%.
If your child needs dental or eye care	Children's eye exam	No charge	20% coinsurance after plan deductible	one exam per 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 Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Cosmetic Surgery	• Long-term care	• Routine foot care
• Dental Care (Adult)	• Non-emergency care when traveling outside the U.S.	• Weight loss programs (discounted rate)
• Habilitation Services		

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture	• Hearing aid (may be covered with limitations)	• Routine eye care
• Bariatric Surgery	• Infertility treatment	• Routine hearing tests
• Chiropractic care	• Private-duty nursing	

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? Yes.
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	$2,250
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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	$2,250
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,320**

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

The plan's overall deductible	$2,250
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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	$2,250
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,570**

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

The plan's overall deductible	$2,250
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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	$2,250
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,250**

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 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).