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?	In-Network: $0; Out-of-Network: $500 member / $1,500 family	See the chart starting on page 2 for your other costs for services this plan covers.
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.
Is there an out-of-pocket limit on my expenses?	Yes. For participating providers $3,000 member / $9,000 family. For non-participating providers $3,000 member / $9,000 family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, balance-billed 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**.
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	$25 Copayment per visit	20% after Plan Deductible	-----none-----
	Specialist visit	$40 Copayment per visit	20% after Plan Deductible	-----none-----
	Other practitioner office visit	$40 Copayment per visit for chiropractor	20% after Plan Deductible for chiropractor	up to 20 visits per year
	Preventive care / screening / immunization	No Member cost	20% after Plan Deductible	Frequency limits apply
If you have a test	Diagnostic test (x-ray, blood work)	Xray: No Member cost, Lab: No Member cost	20% after Plan Deductible	-----none-----
	Imaging (CT / PET scans, MRIs)	No Member cost	20% after Plan Deductible	-----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	$15 Copayment (retail); $30 Copayment (mail order)	50% (retail); 100% (mail order)	Covers up to a 30 day supply (retail prescription); 90 day supply (mail order prescription)
	Preferred brand drugs	$25 Copayment (retail); $50 Copayment (mail order)	50% (retail); 100% (mail order)	Covers up to a 30 day supply (retail prescription); 90 day supply (mail order prescription)
	Non-preferred brand drugs	$40 Copayment (retail); $80 Copayment (mail order)	50% (retail); 100% (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	50% (retail); 100% (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)	$100 Copayment per visit	20% after Plan Deductible	-----none-----
	Physician/surgeon fees	No Member cost	20% after Plan Deductible	-----none-----
If you need immediate medical attention	Emergency room services	$100 Copayment per visit	$100 Copayment per visit	-----none-----
	Emergency medical transportation	No Member cost	No Member cost	-----none-----
	Urgent care	$25 Copayment per visit	$25 Copayment per visit	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	$100 Copayment per day up to $500 per year	20% after Plan Deductible	-----none-----
	Physician/surgeon fee	No Member cost	20% after Plan Deductible	-----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	$25 Copayment per visit	20% after Plan Deductible	-----none-----
	Mental/Behavioral health inpatient services	$100 Copayment per day up to $500 per year	20% after Plan Deductible	-----none-----
	Substance use disorder outpatient services	$25 Copayment per visit	20% after Plan Deductible	-----none-----
	Substance use disorder inpatient services	$100 Copayment per day up to $500 per year	20% after Plan Deductible	-----none-----
If you become pregnant	Prenatal and postnatal care	No Member cost	20% after Plan Deductible	-----none-----
	Delivery and all inpatient services	$100 Copayment per day up to $500 per year	20% after Plan Deductible	-----none-----
If you need help recovering or have other special health needs	Home health care	No Member cost	20% after $50 Benefit Deductible	up to 100 visits per year
	Rehabilitation services	$40 Copayment per visit	20% after Plan Deductible	up to 40 visits per year
	Habilitation services	Not covered	Not covered	Not covered
	Skilled nursing care	No Member cost	20% after Plan Deductible	up to 90 days per year
	Durable medical equipment	20%	20% after Plan Deductible	-----none-----
	Hospice service	No Member cost	20% after Plan Deductible	Pre-authorization is required
If your child needs dental or eye care	Eye exam	$10 Copayment per visit	20% after Plan Deductible	up to one visit every year
	Glasses	25% Discount	Not covered	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
- Habilitation Services
- Routine foot care

- Bariatric surgery
- Cosmetic Surgery
- Dental Care (Adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- 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.)

- 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/

Does this Coverage Provide Minimum Essential Coverage?

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.**

----------*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:** $7,170
- **Patient pays:** $370

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	$220
Co-insurance	$0
Limits or exclusions	$150
Total	**$370**

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:** $4,070
- **Patient pays:** $1,330

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	$1,000
Co-insurance	$250
Limits or exclusions	$80
Total	**$1,330**

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.