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, visit http://www.osc.ct.gov/benefits/docs/MedicalPlanDoceff1012016updt9132016.pdf. 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 http://www.cciio.cms.gov or call Quantum Health at 1-833-740-3258 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network: **$350**/individual; **$1,400**/family **Waived for HEP Members and pre-October 2, 2011 Retirees**	Generally, you must pay all of 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. Primary care and specialist office visits, preventive care, prescription drugs, emergency room care, urgent care, mental health and substance abuse outpatient services, and eye exams are 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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Medical: In-network: **$2,000**/individual; **$4,000**/family Prescription drugs: **$4,600**/individual; **$9,200**/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, penalties for failure to obtain prior authorization for services, 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 carecompass.quantum-health.com 1-833-740-3258 for a list of network 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 full cost if you use an out-of-network provider. 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?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

Important Questions	Answers	Why This Matters:

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
		Preferred In-Network Provider (You will pay the least)	Non-Preferred In-Network Provider	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic PCP telemedicine visits are covered the same as office visits.	Primary care visit to treat an injury or illness	No charge. Deductible does not apply.	$15 copay/visit. Retired before 1999: $5 copay/visit Deductible does not apply.	Not covered	Must select a primary care physician to coordinate care if enrolled in POE-G option.
	Specialist visit	No charge. Deductible does not apply.	$15 copay/visit. Retired before 1999: $5 copay/visit Deductible does not apply.	Not covered	Members enrolled in the POE-G option must select a primary care physician and referrals are required for all specialist services.
	Preventive care/screening/ immunization	No charge. Deductible does not apply.	No charge. Deductible does not apply.	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge.	20% coinsurance.	Not covered	None.
	Imaging (CT/PET scans, MRIs)	No charge.	20% coinsurance.	Not covered	Prior authorization required to avoid penalty of lesser of $500 or 20% of cost of services.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred In-Network Provider (You will pay the least)	Non-Preferred In-Network Provider	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 http://www.osc.ct.gov/benefits/pharmacy.htm	Generic drugs	Preferred generic: Non-Maintenance: $5 copay/fill retail; Maintenance: $5 copay/ fill mail order/maintenance drug pharmacy. Non-preferred generic: Non-Maintenance: $10 copay/ fill retail; Maintenance: $10 copay/ fill mail order/ maintenance drug pharmacy. Retired July 2, 2009 – October 1, 2011: Non-Maintenance: $5 copay/ fill retail; Maintenance: $0 copay/initial fill mail order/maintenance drug pharmacy. Pre-July 1, 2009 retirees: Non-Maintenance: $3 copay/ fill retail; Maintenance: $0 copay/initial fill mail order/maintenance drug pharmacy.		20% coinsurance for acute medication refills at non-participating network pharmacy	Deductible does not apply to prescription drugs. See details of your coverage for slightly adjusted copays for persons retired between July 1, 2009 and October 1, 2011, and after October 1, 2011. Check details at http://www.osc.ct.gov/benefits/pharmacy.html Maintenance drugs must be filled by mail order or Maintenance Drug Network pharmacy after first retail fill. Penalty may apply if brand name drug is requested when a generic is available. Some drugs may require prior authorization. No charge for generic preventive care drugs (e.g., FDA-approved generic contraceptives) or brand name preventive care drugs if generic drugs are not medically appropriate). Prescription drugs purchased at retail pharmacy limited to a maximum 30-day supply; prescription drugs purchased through mail order or maintenance drug pharmacy limited to a maximum 90-day supply. Prescription drug coverage is separately administered.
	Preferred brand drugs	Non-Maintenance: $25 copay/ fill retail; Maintenance: $25 copay/initial fill mail order/maintenance drug pharmacy. Retired July 2, 2009 – October 1, 2011: Non-Maintenance: $10 copay/ fill retail; Maintenance: $10 copay/initial fill; $0 copay/ fill mail order/Maintenance drug pharmacy. Retired before July 1, 2009: Non-Maintenance: $6 copay/ fill retail; Maintenance: $0 copay/initial fill mail order/maintenance drug pharmacy.			
	Non-preferred brand drugs	Non-Maintenance: $40 copay/ fill retail; Maintenance: $40 copay/initial fill mail order/maintenance drug pharmacy. Retired July 2, 2009 – October 1, 2011: Non-Maintenance: $25 copay/ fill retail; Maintenance: $0 copay/initial fill mail order/maintenance drug pharmacy. Retired before July 1, 2009: Non-Maintenance: $6 copay/ fill retail; Maintenance: $0 copay/initial fill mail order/ maintenance drug pharmacy.			
	Specialty drugs	No charge for specialty drugs if enrolled in PrudentRx program. Same as non-preferred brand drugs if not enrolled in PrudentRx program.		Not covered	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred In-Network Provider (You will pay the least)	Non-Preferred In-Network Provider	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge		Not covered	Prior authorization required to avoid penalty of lesser of $500 or 20% of cost of services.
	Physician/surgeon fees	No charge		Not covered	
If you need immediate medical attention	Emergency room care	$250 copay/visit. Retired October 2, 2011 – October 1, 2017: $35 copay/visit. Retired before October 2, 2011: No charge. Deductible does not apply.		$250 copay/visit. Retired October 2, 2011 – October 1, 2017: $35 copay/visit. Retired before October 2, 2011: No charge	$250 copayment waived if admitted or if no reasonable medical alternative.
	Emergency medical transportation	No charge		No charge	None.
	Urgent care	$15 copay/visit. Retired before 1999: $5 copay/visit. Deductible does not apply.		Not covered	Out-of-network services not covered except urgent care services outside the United States
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge		Not covered	Prior authorization required to avoid penalty of lesser of $500 or 20% of cost of services. No coverage in excess of cost of a semi-private room unless medically necessary.
	Physician/surgeon fees	No charge		Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15 copay/visit. Retired before 1999: $5 copay/visit. Deductible does not apply. No charge for non-office visit outpatient services.		Not covered	None.
	Inpatient services	No charge		Not covered	Prior authorization required to avoid penalty of lesser of $500 or 20% of cost of services.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred In-Network Provider (You will pay the least)	Non-Preferred In-Network Provider	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	$15 copay/visit. Retired before 1999: $5 copay/visit. Deductible does not apply.		Not covered	Cost sharing does not apply for preventive services. Depending on the type of service, a copay, coinsurance, or deductible may apply. Maternity care may include tests & services described somewhere else in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	No charge		Not covered	Prior authorization required to avoid penalty of lesser of $500 or 20% of cost of services.
	Childbirth/delivery facility services	No charge		Not covered	
If you need help recovering or have other special health needs	Home health care	No charge		Not covered	Limit: 200 visits/calendar year.
	Rehabilitation services	No charge for physical, occupational and speech therapy and chiropractic care		Not covered	Prior authorization required (except pre-1999 retirees) to avoid penalty of lesser of $500 or 20% of cost of services. Speech therapy limit: 30 visits/calendar year. Limit does not apply to treatment resulting from autism, stroke, tumor removal, injury or congenital anomalies of oropharynx.
	Habilitation services	No charge		Not covered	None.
	Skilled nursing care	No charge		Not covered	Prior authorization required to avoid penalty of lesser of $500 or 20% of cost of services.
	Durable medical equipment	No charge		Not covered	Prior authorization required for certain items to avoid penalty of lesser of $500 or 20% of cost of services.
	Hospice services	No charge		Not covered	Prior authorization required to avoid penalty of lesser of $500 or 20% of cost of services.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred In-Network Provider (You will pay the least)	Non-Preferred In-Network Provider	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	$15 copay/visit Deductible does not apply.		Not covered	Limit: 1 exam visit/calendar year. Copay waived for HEP Members alternate years
	Children's glasses	Not covered		Not covered	You must pay 100% of this service, even in-network.
	Children's dental check-up	Not covered		Not covered	You must pay 100% of this service, even in-network.

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.)

- Children's dental check-up
- Children's glasses
- Cosmetic surgery
- Dental care (Adult)
- Non-emergency care when traveling outside the United States (urgent care covered)
- Long-term care
- Routine foot care
- Weight loss programs (except as required by the health reform law)

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture (covered only if medically necessary limited to 20 visits per year
- Bariatric surgery (prior authorization required)
- Chiropractic care
- Hearing aid (limit: 1 set/36 month period; prior authorization may be required for bone-anchored devices)
- Infertility treatment (prior authorization required)
- Private duty nursing (prior authorization required)
- Routine eye care (Adult) (limit: 1 exam/year)

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: the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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.

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 on how 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:

Quantum Health
5240 Blazer Parkway
Dublin, OH 43017
1-833-740-3258

CVS/Caremark
Prescription Claim Appeals MC109
P.O. Box 52084
Phoenix, AZ 85072-2084
Fax: 1-866-443-1172

Additionally, a consumer assistance program can help you file your appeal. Contact the Connecticut Office of the Healthcare Advocate at 833-466-4446.

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 plan meet the Minimum Value Standards? 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.

Language Access Services:
Para obtener asistencia en Español, llame al 1-800-385-9055.
Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-385-9055.
如果需要中文的帮助，请拨打这个号码 1-800-385-9055.
Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-385-9055.

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	**$350**
Specialist copayment	**$15**
Hospital (facility)	**$0**
Other	**$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	$350
Copays	$25
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$435**

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

The plan's overall deductible	**$350**
Specialist copayment	**$15**
Hospital (facility)	**$0**
Other	**$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	$120
Copays	$190
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$310**

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

The plan's overall deductible	**$350**
Specialist copayment	**$15**
Hospital (facility)	**$0**
Other cost sharing	**$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	$350
Copays	$320
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$670**

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 cost. For more information about the wellness program, please visit http://osc.ct.gov/benefits.htm.

The **plan** would be responsible for the other costs of these EXAMPLE covered services.