HealthyCT: Platinum Ultra Standard SG PPO

Coverage Period: Beginning on or after 1/1/2016

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Group | **Plan Type:** PPO

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.healthyct.org or by calling 1-855-458-4928.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-Network: Individual **$100**/ Family **$200**; Out-of-Network: Individual **$2,000**/ Family **$4,000**	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes. In-Network : Individual **$2,000**/ Family **$4,000** ; Out-of-Network: Individual **$4,000**/ Family **$8,000**	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, penalties for failure to obtain prior authorization, and health care services this plan does not 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 plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See www.healthyct.org or call 1-855-458-4928 for a list of participating providers.	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 for **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 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 5. See your policy or plan document for additional information about **excluded services**.

Questions: Call 1-855-458-4928 or visit us at www.healthyct.org.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-855-458-4928 to request a copy.

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146

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- **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**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

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 visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 copay/visit	20% coinsurance/visit after deductible	——————none——————
	Specialist visit	$35 copay/visit	20% coinsurance/visit after deductible	——————none——————
	Other practitioner office visit	$35 copay/visit for chiropractor	20% coinsurance/visit for chiropractic care after deductible	Maximum of 20 visits per calendar year for chiropractic care
	Preventive care/screening/immunization	No charge	20% coinsurance	Age and frequency schedules may apply.
If you have a test	Diagnostic test (x-ray, blood work)	$20 copay/lab test $45 copay/x-ray $20 copay/mammography ultrasound	20% coinsurance/ service after deductible	——————none——————
	Imaging (CT/PET scans, MRIs)	$75 copay/service to a combined annual maximum of $375 for MRI and CT scans; $400 for PET scans	20% coinsurance/ service after deductible	Prior Authorization required.

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.healthyct.org	Generic drugs	$5 copay/prescription (30 day supply retail) ; $10 copay/prescription (90 day supply retail and mail order)	20% coinsurance (30 day supply retail) after prescription drug deductible	If you use an out-of-network pharmacy, you pay for the prescription(s) and seek reimbursement. Specialty drugs, when prior authorized, will be dispensed for a maximum of 30 days. No coverage for out-of-network mail order or retail pharmacy (90 day supply).
	Preferred brand drugs	$25 copay/prescription (30 day supply retail); $50 copay/prescription (90 day supply retail and mail order)	20% coinsurance (30 day supply retail) after prescription drug deductible	
	Non-preferred brand drugs	$40 copay/prescription (30 day supply retail); $80 copay/prescription (90 day supply retail and mail order)	20% coinsurance (30 day supply retail) after prescription drug deductible	
	Specialty drugs	20% coinsurance/prescription (30 day supply) up to a maximum of $100/prescription	20% coinsurance (30 day supply retail) after prescription drug deductible	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$300 copay/visit after deductible	20% coinsurance/ visit after deductible	————————none————————
	Physician/surgeon fees			
If you need immediate medical attention	Emergency room services	$100 copay/ visit	$100 copay/visit	Waived if admitted directly to the hospital from the emergency room.
	Emergency medical transportation	No charge	No charge	————————none————————
	Urgent care	$50 copay/visit	20% coinsurance/visit after deductible	————————none————————
If you have a hospital stay	Facility fee (e.g., hospital room)	$300 copay/day up to $600 maximum/admission after deductible	20% coinsurance/ admission after deductible	Prior Authorization required.
	Physician/surgeon fee			

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	$15 copay/visit	20% coinsurance/visit after deductible	————————none————————
	Mental/Behavioral health inpatient services	$300 copay/day up to $600 maximum/admission after deductible	20% coinsurance/ admission after deductible	Prior Authorization required.
	Substance use disorder outpatient services	$15 copay/visit	20% coinsurance/visit after deductible	————————none————————
	Substance use disorder inpatient services	$300 copay/day up to $600 maximum/admission after deductible	20% coinsurance/ admission after deductible	Prior Authorization required.
If you are pregnant	Prenatal and postnatal care	No charge	20% coinsurance/visit	Cost-share applicable to well visits
	Delivery and all inpatient services	$300 copay/day up to $600 maximum/admission after deductible	20% coinsurance/ admission after deductible	Prior Authorization required.
If you need help recovering or have other special health needs	Home health care	No charge	20% coinsurance/visit after $50 deductible	Maximum of 100 visits per calendar year; Prior Authorization required.
	Rehabilitation services	$15 copay/visit	20% coinsurance/visit after deductible	Maximum of 40 visits per calendar year for all rehabilitative and habilitative services combined. Prior Authorization required after first 10 visits.
	Habilitation services	$15 copay/ visit	20% coinsurance/visit after deductible	
	Skilled nursing care	$300 copay/day up to $600 maximum/admission after deductible	20% coinsurance/ admission after deductible	Maximum of 90 days per calendar year. Prior Authorization required.
	Durable medical equipment	20% coinsurance/ DME item	20% coinsurance/ DME item after deductible	Includes prosthetic devices
	Hospice service	$300 copay/day up to $600 maximum/admission after deductible	20% coinsurance/service after deductible	Prior Authorization required (inpatient).
If your child needs dental or eye care	Eye exam	$35 copay/visit	20% coinsurance/ visit after deductible	Limited to one routine exam per calendar year

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
	Glasses	No charge for lenses and collection frames	Not covered	Limited to one pair of frames and lenses per calendar year
	Dental check-up	No charge	50% coinsurance/ visit after deductible	One check-up every six months

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
- Bariatric Surgery
- Cosmetic Surgery
- Dental Care (Adult)
- Long-term Care
- Non-emergency care when traveling outside the U.S.
- Private-duty Nursing
- Routine foot care, except for members with diabetes
- Weight loss programs

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: up to one hearing aid every 24 months
- Infertility treatment (limitations apply)
- Routine Adult Vision Exam, limited to one routine exam per calendar year

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 1-855-458-4928. 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 and 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: HealthyCT at **1-855-458-4928.** Additionally, a consumer assistance program can help you file your appeal. Contact the State of Connecticut Insurance Department at (860)297-3900 or the State of Connecticut Office of the Healthcare Advocate at 1-866-466-4446. You may also contact the Department of Labor's Employee Benefit Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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.**

Does this Coverage Meet the Minimum Value Standard?

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:

Spanish (Español): Para obtener asistencia en Español, llame al 1-855-208-1641

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-208-1641

Chinese (中文): 如果需要中文的帮助，**请拨打这个号码**1-855-208-1641

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-208-1641

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 this plan. The actual care you receive will be different from these examples, and the cost of that care will also 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** $5,900
- **Patient pays** $1,640

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	$100
Copays	$1,390
Coinsurance	$0
Limits or exclusions	$150
Total	**$1,640**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,500
- **Patient pays** $900

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	$100
Copays	$490
Coinsurance	$230
Limits or exclusions	$80
Total	**$900**

Questions and answers about the 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 by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The 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**, **copayments**, and **coinsurance** 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 Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in 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 **copayments**, **deductibles**, and **coinsurance**. You should also 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.