



**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.CareConnect.com](http://www.CareConnect.com) or by calling 1-855-706-7545.

| Important Questions                                       | Answers  | Why this Matters:   |
|---|--|---|
| What is the overall <b>deductible</b> ?                   | \$4,250 per person / \$8,500 per family<br>Doesn't apply to preventive care.   | You must pay all the costs up to the <b>deductible</b> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <b>deductible</b> 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 <b>deductible</b> .   |
| Are there other <b>deductibles</b> for specific services? | Yes. \$100 person / \$300 family for prescription drugs. There are no other specific <b>deductibles</b> .                        | You must pay all of the costs for these services up to the specific <b>deductible</b> amount before this plan begins to pay for these services.   |
| Is there an <b>out-of-pocket limit</b> on my expenses?    | Yes. \$7,150 employee / \$14,300 family  | The <b>out-of-pocket limit</b> 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 <b>out-of-pocket limit</b> ?  | Premiums, balance-billed charges, and health care this plan doesn't cover.   | Even though you pay these expenses, they don't count toward the <b>out-of-pocket limit</b> .  |
| 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 <i>specific</i> covered services, such as office visits.  |
| Does this plan use a <b>network</b> of <b>providers</b> ? | Yes. See <a href="http://www.CareConnect.com">www.CareConnect.com</a> or call 1-855-706-7545 for a list of in-network providers. | If you use an in-network doctor or other health care <b>provider</b> , 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 <b>provider</b> for some services. Plans use the term in-network, <b>preferred</b> , or participating for <b>providers</b> in their <b>network</b> . See the chart starting on page 2 for how this plan pays different kinds of <b>providers</b> . |
| Do I need a referral to see a <b>specialist</b> ?         | No. You don't need a referral to see a specialist.   | You can see the <b>specialist</b> 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 <b>excluded services</b> .   |

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If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at [www.cciio.cms.gov](http://www.cciio.cms.gov) or call 1-855-706-7545 to request a copy.



- **Co-payments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** 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 **co-insurance** 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 in-network **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

| Common Medical Event   | Services You May Need                            | Your cost if you use a Participating Provider        | Your cost if you use a Non-Participating Provider | Limitations & Exceptions   |
|--|--|--|---|--|
| If you visit a health care provider's office or clinic   | Primary care visit to treat an injury or illness | \$40 copay / visit                                   | Not Covered                                       | -----None-----   |
|  | Specialist visit                                 | \$60 copay / visit                                   | Not Covered                                       | -----None-----   |
|  | Other practitioner office visit                  | \$60 copay / visit for chiropractor                  | Not Covered                                       | -----None-----   |
|  | Preventive care / screening / immunization       | Covered in full                                      | Not Covered                                       | -----None-----   |
| If you have a test   | Diagnostic test (x-ray, blood work)              | \$40 copay / test                                    | Not Covered                                       | -----None-----   |
|  | Imaging (CT/PET scans, MRIs)                     | \$60 copay / test                                    | Not Covered                                       | -----None-----   |
| If you need drugs to treat your illness or condition<br><br>More information about <b>prescription drug coverage</b> is available at . | Generic drugs                                    | \$15 copay / retail prescription                     | Not Covered                                       | Covers Up to a 30-day supply. Copay for up to a 90 day supply is three times the regular copay at retail and two and a half times the regular copay at mail order. |
|  | Preferred brand drugs                            | \$35 copay / retail prescription after Rx deductible | Not Covered                                       | Covers Up to a 30-day supply. Copay for up to a 90 day supply is three times the regular copay at retail and two and a half times the regular copay at mail order. |
|  | Non-preferred brand drugs                        | \$75 copay / retail prescription after Rx deductible | Not Covered                                       | Covers Up to a 30-day supply. Copay for up to a 90 day supply is three times the regular copay at retail and two and a half times the regular copay at mail order. |
|  | Specialty drugs                                  | \$75 copay / retail prescription after Rx deductible | Not Covered                                       | Covers Up to a 30-day supply. Copay for up to a 90 day supply is three times the regular copay at retail and two and a half times the regular copay at mail order. |

| Common Medical Event   | Services You May Need                          | Your cost if you use a Participating Provider                                       | Your cost if you use a Non-Participating Provider | Limitations & Exceptions |
|--|--|---|---|--------------------------|
| If you have outpatient surgery   | Facility fee (e.g., ambulatory surgery center) | \$350 copay / procedure   | Not Covered                                       | -----None-----           |
|  | Physician/surgeon fees                         | \$100 copay / procedure   | Not Covered                                       | -----None-----           |
| If you need immediate medical attention                                | Emergency room services                        | \$350 copay / visit   | \$350 copay / visit                               | -----None-----           |
|  | Emergency medical transportation               | \$150 copay / transport   | \$150 copay / transport                           | -----None-----           |
|  | Urgent care                                    | \$60 copay / visit  | Not covered                                       | -----None-----           |
| If you have a hospital stay  | Facility fee (e.g., hospital room)             | 20% coinsurance after deductible  | Not covered                                       | -----None-----           |
|  | Physician/surgeon fee                          | \$100 copay / procedure for surgeons  | Not covered                                       | -----None-----           |
| If you have mental health, behavioral health, or substance abuse needs | Mental/Behavioral health outpatient services   | \$40 copay / visit  | Not covered                                       | -----None-----           |
|  | Mental/Behavioral health inpatient services    | 20% coinsurance after deductible  | Not covered                                       | -----None-----           |
|  | Substance use disorder outpatient services     | \$40 copay / visit  | Not covered                                       | -----None-----           |
|  | Substance use disorder inpatient services      | 20% coinsurance after deductible  | Not covered                                       | -----None-----           |
| If you are pregnant  | Prenatal and postnatal care                    | Covered in full   | Not covered                                       | -----None-----           |
|  | Delivery and all inpatient services            | 20% coinsurance after deductible / admission and \$100 copay for physician services | Not covered                                       | -----None-----           |

| Common Medical Event  | Services You May Need     | Your cost if you use a Participating Provider   | Your cost if you use a Non-Participating Provider | Limitations & Exceptions   |
|---|---------------------------|---|---|--|
| <b>If you need help recovering or have other special health needs</b> | Home health care          | \$40 copay / visit  | Not Covered                                       | Coverage is limited to 40 visits per plan year.  |
|   | Rehabilitation services   | \$60 copay / visit  | Not Covered                                       | Coverage is limited to 60 visits per condition, per plan year combined therapies. Speech and Physical Therapy are only covered following a hospital stay or surgery. |
|   | Habilitation services     | \$60 copay / visit  | Not Covered                                       | Coverage is limited to 60 visits per condition, per plan year combined therapies.  |
|   | Skilled nursing care      | 20% coinsurance after deductible / admission  | Not Covered                                       | Coverage is limited to 200 days per plan year.   |
|   | Durable medical equipment | 20% coinsurance after deductible  | Not Covered                                       | Preauthorization is required for items above \$500.  |
|   | Hospice service           | Inpatient: 20% coinsurance after deductible / admission<br>Outpatient: \$40 copay / visit | Not Covered                                       | Coverage is limited to 210 days per plan year.   |
| <b>If your child needs dental or eye care</b>                         | Eye exam                  | \$40 copay / visit  | Not covered                                       | Coverage is limited to one exam per plan year.   |
|   | Glasses                   | 20% coinsurance after deductible  | Not covered                                       | Coverage is limited to one prescribed lenses and frames per plan year.   |
|   | Dental check up           | \$40 copay / visit  | Not covered                                       | Coverage is limited to one exam per plan year.   |

## 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.)

- Cosmetic Surgery
- Dental Care (Adult)
- Long-Term Care
- Non-Emergency Care When Traveling Outside the U.S.
- Private-Duty Nursing
- Routine Eye Care(Adult)
- Routine Foot Care
- 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.)

- Abortion Services
- Acupuncture
- Bariatric Surgery
- Chiropractic Care
- Hearing Aids
- Infertility Treatment

## Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 1-855-706-7545. You may also contact your state insurance department at 1-800-342-3736.

## 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 the New York State Department of Financial Services at 1-800-400-8882 or by e-mail at: Externalappealquestions@dfs.ny.gov. Additionally, a consumer assistance program can help you file your appeal. Contact Community Service Society, Community Health Advocates at 1-888-614-5400 or cha@cssny.org.

## Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health 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

Para obtener asistencia en Español, llame al 1-855-706-7545

—————*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 **\$2,590.00**
- Patient pays **\$4,950.00**

#### 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           |
| <b>Total</b>               | <b>\$7,540</b> |

#### Patient pays:

|                      |                   |
|----------------------|-------------------|
| Deductibles          | \$4,250.00        |
| Co-pays              | \$510.00          |
| Co-insurance         | \$40.00           |
| Limits or exclusions | \$150.00          |
| <b>Total</b>         | <b>\$4,950.00</b> |

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

- Amount owed to providers: **\$5,400**
- Plan pays **\$2,910.00**
- Patient pays **\$2,490.00**

#### 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          |
| <b>Total</b>                   | <b>\$5,400</b> |

#### Patient pays:

|                      |                   |
|----------------------|-------------------|
| Deductibles          | \$1,270.00        |
| Co-pays              | \$1,140.00        |
| Co-insurance         | \$0.00            |
| Limits or exclusions | \$80.00           |
| <b>Total</b>         | <b>\$2,490.00</b> |

## 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**, **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 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 **co-payments**, **deductibles**, and **co-insurance**. 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.

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CareConnect:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact CareConnect's Senior Director, Quality Improvement.

If you believe that CareConnect 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:

CareConnect  
Senior Director, Quality Improvement  
2200 Northern Blvd., Suite 104, East Hills, NY 11548  
Phone: 855-706-7545  
TTY: 855-226-7318  
Fax: 844-447-2525  
Email: [CareConnectAppeals@nsljcc.com](mailto:CareConnectAppeals@nsljcc.com)

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Senior Director, Quality Improvement 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 for 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, D.C. 20201  
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-855-226-7318 (TTY: 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-226-7318 (TTY: 711).

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 1-855-226-7318 (TTY: 711)。

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-226-7318 (TTY: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-855-226-7318 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-226-7318 (TTY: 711)번으로 전화해 주십시오.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-226-7318 (TTY: 711).

אויפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופט 1-855-226-7318 (TTY: 711).

লক্ষ্য করুন: যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন 1-855-226-7318 (TTY: 711)।

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-855-226-7318 (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-855-226-7318 (رقم هاتف الصم والبكم: 711).

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-226-7318 (TTY: 711).

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں - کال کریں 1-855-226-7318 (TTY: 711)

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-226-7318 (TTY: 711).

ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-855-226-7318 (TTY: 711).

KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-855-226-7318 (TTY: 711).