CareConnect Value Gold 45/45 Access

CareConnect Insurance Company, Inc.

Coverage for: Individual + Spouse, Family | Plan Type: EPO

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 1-855-706-7545 or visit www.CareConnect.com. 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 www.cciio.cms.gov or call 1-855-706-7545 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$1,000** per person / **$2,000** per family.	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 plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care and primary care services 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 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?	For participating providers **$6,000** individual / **$12,000** 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, 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 (unless balance-billing is prohibited), 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.CareConnect.com or call **1-855-706-7545** 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 most if you use an out-of-network 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.

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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	$45 copay / visit; deductible does not apply	Not Covered	----------None----------
	Specialist visit	$45 copay / visit; deductible does not apply	Not Covered	----------None----------
	Preventive care/screening/ immunization	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)	$90 copay / test; deductible does not apply	Not Covered	Preauthorization is required. If you don't get preauthorization, services will not be covered.*
	Imaging (CT/PET scans, MRIs)	$100 copay / test; deductible does not apply	Not Covered	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.careconnect.com/find-resources/prescription-drug-information	Tier 1 (Generic Drugs)	$0 copay / retail prescription; deductible does not apply	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. Preauthorization is required for certain drugs. If you don't get preauthorization, these drugs will not be covered.*
	Tier 2 (Preferred brand drugs)	$50 copay / retail prescription; deductible does not apply	Not Covered	
	Tier 3 (Non-preferred brand drugs and Specialty drugs)	50% coinsurance after deductible up to max $500	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$250 copay after deductible / procedure	Not Covered	Preauthorization is required. If you don't get preauthorization, services will not be covered.*
	Physician/surgeon fees	No charge; deductible does not apply	Not Covered	

* For more information about limitations and exceptions, see the plan or policy document at www.CareConnect.com.

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 immediate medical attention	Emergency room care	$250 copay / visit; deductible does not apply	$250 copay / visit; deductible does not apply	----------None----------
	Emergency medical transportation	$100 copay / transport; deductible does not apply	$100 copay / transport; deductible does not apply	
	Urgent care	$75 copay / visit; deductible does not apply	Not covered	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance after deductible / admission	Not covered	Preauthorization is required. If you don't get preauthorization, services will not be covered.*
	Physician/surgeon fees	No charge; deductible does not apply	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge; deductible does not apply	Not covered	Non-routine outpatient services may require preauthorization. If you don't get required preauthorization, services will not be covered.*
	Inpatient services	10% coinsurance after deductible / admission	Not covered	Preauthorization is required except for emergency admissions or for Participating OASAS-certified facilities. If you don't get preauthorization, services will not be covered.*
If you are pregnant	Office visits	$45 copay / visit; deductible does not apply; no charge for prenatal and postnatal care	Not covered	Preauthorization is required. If you don't get preauthorization, services will not be covered. All breast pumps require a preauthorization. * Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) One (1) Home Care Visit is Covered at no cost sharing if mother is discharged from the hospital early.
	Childbirth/delivery professional services	No charge; deductible does not apply	Not covered	
	Childbirth/delivery facility services	10% coinsurance after deductible	Not covered	

* For more information about limitations and exceptions, see the plan or policy document at www.CareConnect.com.

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	$45 copay / visit; deductible does not apply	Not Covered	Coverage is limited to 40 visits per plan year. Preauthorization is required. If you don't get required preauthorization, services will not be covered.*
	Rehabilitation services	$45 copay / visit; deductible does not apply	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. Preauthorization is required. If you don't get required preauthorization, services will not be covered.*
	Habilitation services	$45 copay / visit; deductible does not apply	Not Covered	Coverage is limited to 60 visits per condition, per plan year combined therapies. Preauthorization is required. If you don't get required preauthorization, services will not be covered.*
	Skilled nursing care	10% coinsurance after deductible / admission	Not Covered	Coverage is limited to 200 days per plan year. Preauthorization is required. If you don't get required preauthorization, services will not be covered.*
	Durable medical equipment	10% coinsurance after deductible	Not Covered	Preauthorization may be required. If you don't get required preauthorization, services will not be covered. Coverage is for standard equipment only. Over the counter durable medical equipment is not covered.*
	Hospice services	Inpatient: 10% coinsurance after deductible / admission Outpatient: $45 copay / visit	Not Covered	Coverage is limited to 210 days per plan year and 5 visits of family bereavement counseling. Preauthorization is required. If you don't get preauthorization, services will not be covered.*

* For more information about limitations and exceptions, see the plan or policy document at www.CareConnect.com.

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 your child needs dental or eye care	Children's eye exam	$45 copay / visit; deductible does not apply	Not covered	Coverage is limited to one exam per plan year for members through the end of the month in which they turn 19 years of age.
	Children's glasses	10% coinsurance after deductible	Not covered	Coverage is limited to one prescribed lenses and frames per plan year for members through the end of the month in which they turn 19 years of age. Non-standard frames incur additional cost.
	Children's dental check-up	$45 copay / visit; deductible does not apply	Not covered	Coverage is limited to one exam and one cleaning per 6 month period for members through the end of the month in which they turn 19 years of age. Please refer to the Pediatric Dental Care section of your plan or policy document for additional coverage information.

* For more information about limitations and exceptions, see the plan or policy document at www.CareConnect.com.

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

- Abortion Services (elective abortions are limited to one procedure per member per plan year)
- Acupuncture
- Bariatric Surgery
- Chiropractic Care
- Hearing Aids (requires a written recommendation by a physician; a single purchase includes repair and/or replacement of hearing aids for one (1) or both ears once every three (3) years; bone anchored hearing aides have additional limitations)*.
- Infertility Treatment (limited to individuals between ages 21 and 44 inclusive; in vitro fertilization, costs for a donor, storage costs, reversal of sterilization, surrogate motherhood, cloning, and experimental procedures are not covered; additional limitations apply*)

All of these listed services require prior authorization. If you don't get required preauthorization, services will not be covered.*

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 Labor, Employee Benefits Security Administration at 1-866-444-EBSA or visit www.dol.gov/ebsa/healthreform; Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323 x61565 or visit www.cciio.cms.gov; New York State Department of Financial Services Consumer Assistance Unit at 1-800-342-3736 or visit www.dfs.ny.gov; or please call CareConnect at 1-855-706-7545 or visit CareConnect.com.

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 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: CareConnect at 1-855-706-7545 or visit CareConnect.com; New York State Department of Financial Services Consumer Assistance Unit at 1-800-342-3736 or visit www.dfs.ny.gov; or U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA or visit www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact Community Health Advocates at 1-888-614-5400, e-mail cha@cssny.org or visit www.communityhealthadvocates.org.

Does this plan provide Minimum Essential Coverage? **Yes.**
If you don't have Minimum essential coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

* For more information about limitations and exceptions, see the plan or policy document at www.CareConnect.com.

Does this plan meet Minimum Value Standards? **Yes.**
If your plan doesn't meet the Minimum value standard, you may be eligible for a premium tax credits to help you pay for a plan through the Marketplace.

Language Access Services:
If you are in need of language assistance, please reference the multi-language taglines and nondiscrimination notification at the end of this document, or call us at 855-706-7545.
----------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	$1,000
Specialist copayment	$45
Hospital (facility) coinsurance	10%
Other copayment	$90

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	$12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$900
Coinsurance	$900
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$2,860

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

The Plan's overall deductible	$1,000
Specialist copayment	$45
Hospital (facility) coinsurance	10%
Other copayment	$90

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	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$1,100
Coinsurance	$200
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	$2,360

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

The Plan's overall deductible	$1,000
Specialist copayment	$45
Hospital (facility) coinsurance	10%
Other copayment	$90

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	$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles	$30
Copayments	$1,000
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,030

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

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Notice of Non-Discrimination

CareConnect Insurance Company, Inc. (“CareConnect”) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. CareConnect does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

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@nslijcc.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.

Multi-Language Interpreter Services

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).

লক্ষ্য্ করনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করন 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).

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