




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

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	<b>\$0</b>	See the chart on page 2 for your costs for services this plan covers..
Are there other <u>deductibles</u> for specific services?	Yes. <b>\$100</b> person/ <b>\$300</b> family for prescription drugs.	You have to pay the amount up to the <b>deductible</b> for prescription drugs. The chart starting on page 3 explains the costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. <b>\$6,350</b> person / <b>\$12,700</b> 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 <u>out-of-pocket limit</u> ?	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 <u>network of providers</u> ?	Yes. See <a href="http://www.NSLIJCareConnect.com">www.NSLIJCareConnect.com</a> or call 1-855-706-7545 for a list of participating 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 <u>specialist</u> ?	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 6 See your policy or plan document for additional information about <b>excluded services</b> .

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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 a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care <b>provider's</b> office or clinic	Primary care visit to treat an injury or illness	\$30 copay	Not covered	—————none—————
	Specialist visit	\$50 copay	Not covered	—————none—————
	Other practitioner office visit	\$50 copay for chiropractor	Not covered	—————none—————
	Preventive care/screening/immunization	No charge	Not covered	
If you have a test	Diagnostic test (x-ray, blood work)	\$50 copay	Not covered	—————none—————
	Imaging (CT/PET scans, MRIs)	\$100 copay	Not covered	—————none—————

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## Tradition Gold Copay 30/50 Plan Coverage Period: 01/01/2015–12/31/2015

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs **Coverage for:** Individual + Spouse, Family | **Plan Type:** EPO

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 drugs to treat your illness or condition</b>  More information about <b>prescription drug coverage</b> is available at <a href="http://www.nsljcareconnect.com">www.nsljcareconnect.com</a> .	Generic drugs	\$15/ copay after Rx deductible /prescription (retail and mail order)	Not covered	Copay amount applies after prescription drug deductible is met. 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 after Rx deductible /prescription (retail and mail order)	Not covered	—————none—————
	Non-preferred brand drugs	\$75 copay after Rx deductible /prescription (retail and mail order)	Not covered	—————none—————
	Specialty drugs	\$75 copay after Rx deductible /prescription (retail and mail order)	Not covered	—————none—————
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$300 copay	Not covered	—————none—————
	Physician/surgeon fees	\$500 copay	Not covered	—————none—————
<b>If you need immediate medical attention</b>	Emergency room services	\$350 copay	\$350 copay	—————none—————
	Emergency medical transportation	\$150 copay	\$150 copay	—————none—————
	Urgent care	\$50 copay	Not covered	—————none—————

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**Tradition Gold Copay 30/50 Plan Coverage Period: 01/01/2015–12/31/2015**

**Summary of Benefits and Coverage: What this Plan Covers & What it Costs Coverage for: Individual + Spouse, Family | Plan Type: EPO**

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 have a hospital stay</b>	Facility fee (e.g., hospital room)	\$500 copay per day up to \$1,500 max per admit	Not covered.	\$500 copay per day up to \$1,500 max per admit.
	Physician/surgeon fee	\$500	Not covered	
<b>If you have mental health, behavioral health, or substance abuse needs</b>	Mental/Behavioral health outpatient services	\$30 copay	Not covered	—————none—————
	Mental/Behavioral health inpatient services	\$500 copay per day up to \$1,500 max per admit	Not covered	
	Substance use disorder outpatient services	\$30 copay	Not covered	Unlimited services. Up to 20 visits per plan year may be used for family counseling.
	Substance use disorder inpatient services	\$500 copay per day up to \$1,500 max per admit.	Not covered	\$500 copay per day up to \$1,500 max per admit.
<b>If you are pregnant</b>	Prenatal and postnatal care	\$0	Not covered	—————none—————
	Delivery and all inpatient services	\$500 copay per day up to \$1,500 max per admit.	Not covered	\$500 copay per day up to \$1,500 max per admit.

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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	\$30 copay	Not covered	Coverage is limited to 40 visits per year.
	Rehabilitation services	\$30 copay	Not covered	Coverage is limited to 60 visits per condition per lifetime for combined therapies.
	Habilitation services	\$30 copay	Not covered	Coverage is limited to 60 visits per condition per lifetime for combined therapies.
	Skilled nursing care	\$500 copay per day up to \$1,500 max per admit.	Not covered	Coverage is limited to 200 days per year. \$500 copay per day up to \$1,500 max per admit.
	Durable medical equipment	\$0	Not covered	Preauthorization required for items above \$500.
	Hospice service	Inpatient: \$500 copay per day up to \$1,500 max per admit.  Outpatient: \$30 copay	Not covered	Inpatient: Coverage is limited to 210 days per year.. \$500 copay per day up to \$1,500 max per admit. Outpatient: Coverage provides 5 visits for family bereavement counseling.
<b>If your child needs dental or eye care</b>	Eye exam	\$30 copay	Not Covered	Coverage is limited to one exam per year.
	Glasses	20% coinsurance	Not Covered	Coverage is limited to one pair of glasses per year.
	Dental check-up	\$30 copay	Not Covered	Coverage is limited to one exam every six months.

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## 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
- Most coverage provided outside the United States. See [www.NSLIJCareConnect.com](http://www.NSLIJCareConnect.com)
- 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.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids
- Infertility treatment –limitations may apply

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## Tradition Gold Copay 30/50 Plan Coverage Period: 01/01/2015–12/31/2015

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs **Coverage for:** Individual + Spouse, Family | **Plan Type:** EPO

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### 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 1-855-706-7545. 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](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cco.cms.gov](http://www.cco.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: the plan at 1-855-706-7545; the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) (if your coverage is subject to ERISA); or the New York State Department of Financial Services (if your coverage is insured). In addition, if you are covered by a non-federal governmental group health plan or group church plan you can contact member assistance at 1-855-706-7545. 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](mailto:cha@cssny.org).

### 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:** Para obtener asistencia en Español, llama al 855-706-7545.

—————*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*—————

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## 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: **\$6,300**
- Patient pays: **\$1,240**

#### 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	\$0
Copays	\$1,070
Coinsurance	\$0
Limits or exclusions	\$150
<b>Total</b>	<b>\$1,240</b>

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

- Amount owed to providers: **\$5,400**
- Plan pays: **\$4,180**
- Patient pays: **\$1,220**

#### 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	\$100
Copays	\$1,040
Coinsurance	\$0
Limits or exclusions	\$80
<b>Total</b>	<b>\$1,220</b>

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## 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.

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