



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 or by calling 1-855-706-7545.

| Important Questions | Answers | Why this Matters: |
|---|--|---|
| What is the overall deductible ? | \$4,250 per person / \$8,500 per family Doesn't apply to preventive care. | 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? | Yes. \$100 person / \$300 family for prescription drugs. There are no other specific deductibles . | 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. \$7,150 employee / \$14,300 family | 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, and health care this plan doesn't 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 <i>specific</i> covered services, such as office visits. |
| Does this plan use a network of providers ? | Yes. See www.CareConnect.com or call 1-855-706-7545 for a list of in-network 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 don't need a referral to see a specialist. | 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 1-855-706-7545 or visit us at www.CareConnect.com.

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 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 More information about prescription drug coverage 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 |
|---|---------------------------|---|---|--|
| If you need help recovering or have other special health needs | 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 Outpatient: \$40 copay / visit | Not Covered | Coverage is limited to 210 days per plan year. |
| If your child needs dental or eye care | 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.)

- Acupuncture
- Bariatric Surgery
- Chiropractic Care
- Hearing Aids
- Intfertility Treatment

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-(800) 205-7665. 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 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 1-800-442-2376

—————*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 |
| Total | \$7,540 |

Patient pays:

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

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 |
| Total | \$5,400 |

Patient pays:

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

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.

Questions: Call 1-855-706-7545 or visit us at www.CareConnect.com.

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 or call 1-855-706-7545 to request a copy.