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?	$600 per person / $1,200 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?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. $4,000 employee / $8,000 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 *specific* 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.

- **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	$25 copay / visit after deductible	Not Covered	----------None----------
	Specialist visit	$40 copay / visit after deductible	Not Covered	----------None----------
	Other practitioner office visit	$40 copay / visit for chiropractor after deductible	Not Covered	----------None----------
	Preventive care / screening / immunization	Covered in full	Not Covered	----------None----------
If you have a test	Diagnostic test (x-ray, blood work)	$25 copay / test after deductible	Not Covered	----------None----------
	Imaging (CT/PET scans, MRIs)	$40 copay / test after deductible	Not Covered	----------None----------
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at .	Generic drugs	$10 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 ahalf times the regular copay at mail order.
	Preferred brand drugs	$35 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 ahalf times the regular copay at mail order.
	Non-preferred brand drugs	$70 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 ahalf times the regular copay at mail order.
	Specialty drugs	$70 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 ahalf 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)	$100 copay / procedure after deductible	Not Covered	----------None----------
	Physician/surgeon fees	$100 copay / procedure after deductible	Not Covered	----------None----------
If you need immediate medical attention	Emergency room services	$150 copay after deductible / visit	$150 copay after deductible / visit	----------None----------
	Emergency medical transportation	$150 copay / transport after deductible	$150 copay / transport after deductible	----------None----------
	Urgent care	$60 copay after deductible / visit	Not covered	----------None----------
If you have a hospital stay	Facility fee (e.g., hospital room)	$1,000 copay after deductible / admission	Not covered	----------None----------
	Physician/surgeon fee	$100 copay after deductible / procedure for surgeons	Not covered	----------None----------
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$25 copay / visit after deductible	Not covered	----------None----------
	Mental/Behavioral health inpatient services	$1,000 copay after deductible / admission	Not covered	----------None----------
	Substance use disorder outpatient services	$25 copay / visit after deductible	Not covered	----------None----------
	Substance use disorder inpatient services	$1,000 copay after deductible / admission	Not covered	----------None----------
If you are pregnant	Prenatal and postnatal care	Covered in full	Not covered	----------None----------
	Delivery and all inpatient services	$1,000 copay after deductible / admission and $100 copay after deductible 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	$25 copay / visit after deductible	Not Covered	Coverage is limited to 40 visits per plan year.
	Rehabilitation services	$30 copay / visit after deductible	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	$30 copay / visit after deductible	Not Covered	Coverage is limited to 60 visits per condition, per plan year combined therapies.
	Skilled nursing care	$1,000 copay 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: $1,000 copay / admission after deductible Outpatient: $25 copay / visit after deductible	Not Covered	Coverage is limited to 210 days per plan year.
If your child needs dental or eye care	Eye exam	$25 copay / visit after deductible	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	$25 copay / visit after deductible	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.)

- Acupuncture
- 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
- Bariatric Surgery
- Chiropractic Care
- Hearing Aids
- Intfertility 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 1-800-501-3439. 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 1-800-442-2376

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 $5,460.00**
- **Patient pays $2,080.00**

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	$600.00
Co-pays	$1,330.00
Co-insurance	$0.00
Limits or exclusions	$150.00
Total	$2,080.00

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

- **Amount owed to providers: $5,400**
- **Plan pays $3,880.00**
- **Patient pays $1,520.00**

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	$600.00
Co-pays	$590.00
Co-insurance	$250.00
Limits or exclusions	$80.00
Total	$1,520.00

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.