The Summary of Benefits and Coverage (SBC) document will help you choose a health <u>plan</u>. The SBC shows you how you and the <u>plan</u> would share the cost for covered health care services. NOTE: Information about the cost of this <u>plan</u> (called the <u>premium</u>) 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, www.ny44.e1b.org. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other

www.ny44.e1b.org. For general definitions of common terms, such as <u>allowed amount</u>, <u>balance billing</u>, <u>coinsurance</u>, <u>copayment</u>, <u>deductible</u>, <u>provider</u>, or other <u>underlined</u> terms, see the Glossary. You can view the Glossary at <u>www.dol.gov/ebsa/healthreform</u> or <u>www.ny44.e1b.org/wp-content/uploads/2019/10/Glossary-of-Healthcare-Terms.pdf</u> or call 1-716-821-7161 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: None Out-of-Network: \$2,000 single/ \$5,000 family per calendar year	See the Common Medical Events chart below for your costs for services this <u>plan</u> covers. Generally, you must pay all of the costs from <u>out-of-network providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay for covered services.
Are there services covered before you meet your deductible?	before you meet your deductible; copayments may apply.	This <u>plan</u> covers some items and services even if you haven't met your <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	No	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	In-Network: \$5,000 single/ \$10,000 family Out-of-Network: \$9,500 single/ \$19,000 family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limits</u> has been met.
What is not included in the out-of-pocket limit?	Penalties for failure to obtain precertification of services and prescription drug cost differentials, premiums, balance billing charges and health care this plan does not 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 <u>network provider</u> ?	Yes, call NOVA customer service for a list of network providers 716-631-2661 or 1-800-257-2753	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's</u> network. You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.

Important Questions	Answers	Why This Matters:
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No	You can see the specialist you choose without a referral.

All <u>copayment</u> and <u>coinsurance</u> costs shown in this chart are after your <u>deductible</u> has been met, if a <u>deductible</u> applies.

		What You Will Pay		Limitations, Exceptions, & Other	
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Important Information	
	Primary care visit to treat an injury or illness	\$10 copayment	30% <u>coinsurance</u>	None	
If you visit a health care provider's office or	Specialist visit	\$10 copayment	30% coinsurance	Medically necessary chiropractic care limited to 20 visits per calendar year	
clinic	Preventive care/screening/ immunization	No charge	30% <u>coinsurance</u>	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.	
	Diagnostic test (blood work)	No charge	30% coinsurance	None	
If you have a test	<u>Diagnostic test</u> (x-ray, sonogram, ultrasounds)	\$15 copayment	30% coinsurance	None	
	Imaging (CT/PET scans, MRIs)	\$15 copayment	30% coinsurance	Preauthorization required*	
If you need drugs to treat your illness or condition	Generic drugs (Tier 1)	Retail: \$5 <u>copayment</u> Mail Order: \$12.50 <u>copayment</u>	Not covered	After 2 nd refill at Retail, all maintenance refills will be filled by Mail Order for 90-day supply	
More information about prescription drug coverage is available at	Preferred brand drugs (Tier 2)	Retail: \$25 <u>copayment</u> Mail Order: \$62.50 <u>copayment</u>	Not covered	After 2 nd refill at Retail, all maintenance refills will be filled by Mail Order for 90-day supply	
1-833-772-2779 or https://caprx.adaptiverx.c om/webSearch/index?ke y=8F02B26A288102C27 BAC82D14C006C6FC54 D480F80409B68F7175D	Non-preferred brand drugs (Tier 3)	Retail: \$60 <u>copayment</u> Mail Order: \$150 <u>copayment</u>	Not covered	Member responsible for cost difference between non-preferred brand (Tier 3) medication and generic equivalent (Tier 1), plus copayment; After 2 nd refill at Retail, all maintenance refills will be filled by Mail Order for 90-day supply	

		What You Will Pay		Limitations Evacutions 9 Other	
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information	
<u>0DC1577226</u>	Specialty drugs	7% <u>coinsurance</u> to a maximum of \$120 for a 30-day supply; please see note on Payer Matrix	Not covered	Payer Matrix – participants are required to contact Payer Matrix (877-305-6202). If the Payer Matrix program is not utilized, the full cost of the specialty drug will be the participant's responsibility.	
	Facility fee (e.g., ambulatory surgery center)	\$75 copayment applied to facility charge	30% coinsurance	Preauthorization required*	
If you have outpatient surgery	Physician/surgeon fees	\$75 copayment applies to both facility charge and procedures in an office setting	30% <u>coinsurance</u>	Preauthorization required*	
If you need immediate medical attention	Emergency room care	\$400 <u>copayment</u>	\$400 <u>copayment</u>	Copayments are waived if admitted or for certain long-term observation holds; capped at two times copayment in the event a common accident or injury occurs for a family unit at the same time.	
	Emergency medical transportation	\$50 copayment	\$50 copayment	Subject to Medical Necessity	
	<u>Urgent care</u>	No charge	No charge	None	
If you have a hospital	Facility fee (e.g., hospital room)	No charge	30% coinsurance	Preauthorization required*	
stay	Physician/surgeon fees	No charge	30% coinsurance	Preauthorization required*	
If you need mental health, behavioral	Outpatient services	\$10 copayment	30% coinsurance	None	
health, or substance abuse services	Inpatient services	No charge	30% coinsurance	Preauthorization required*	
If you are pregnant	Office visits	\$10 copayment	30% coinsurance	Applies to initial visit only for In-Network	
	Childbirth/delivery professional services	No charge	30% <u>coinsurance</u>	None	
	Childbirth/delivery facility services	No charge	30% <u>coinsurance</u>	None	

If you need help recovering or have other special health needs	Home health care	No charge	30% coinsurance	Limit 40 visits per calendar year; <u>Preauthorization</u> required*
	Rehabilitation services	Copayment determined by type of service	30% coinsurance	Number of visits per therapy may be limited per calendar year; <u>Preauthorization</u> may be required*
	Habilitation services	Copayment determined by type of service	30% coinsurance	Number of visits per therapy may be limited per calendar year; <u>Preauthorization</u> may be required*
	Skilled nursing care	No charge	30% coinsurance	Limit 45 days per calendar year; Preauthorization required*
	Durable medical equipment	50% coinsurance	50% coinsurance	Preauthorization required*
	Hospice services	No charge	30% coinsurance	None
If your child needs	Children's eye exam	\$10 copayment	Not covered	Limit of one exam every 12 months
dental or eye care	Children's glasses	Covered at 40% of retail price	Not covered	Limit one every 12 months
	Children's dental check-up	Not covered	Not covered	Not covered

^{* &}lt;u>Preauthorization</u> required: Failure to obtain <u>preauthorization</u> may result in Nova denying payment of your claim and you may be responsible for some or all the charges.

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.)

- Acupuncture
- Cosmetic surgery
- Custodial care
- Dental care

- Hearing aids
- Long term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- 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.)

- Bariatric surgery with <u>preauthorization</u>
- Chiropractic services are limited to 20 visits per calendar year if <u>medically necessary</u>
- Eyeglasses
- Infertility treatment (subject to limitations)
- Routine eye care

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: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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 <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information on how to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. For more information about your rights, this notice, or assistance, contact: NOVA Customer Service at 716-631-2661 or 1-800-257-2753. If you receive a denial of coverage for a prescription drug, you can contact Capital Rx Customer Service 1-833-772-2779. Additionally, a consumer assistance program can help you fill your appeal. Contact Community Service Society of New York at 1-888-614-5400 or <u>cha@cssny.org</u>

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-257-2753.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-257-2753.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-257-2753.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-257-2753.

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 <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost-sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. 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 <u>plan's</u> overall <u>deductible</u>	\$0
■ Specialist (copayment)	\$10
■ Hospital (facility)	\$0
Other (Diagnostic copayment)	\$15

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	\$12,700	
In this example, Peg would pay:		
Cost Sharing		
<u>Deductibles</u>	\$0	
<u>Copayments</u>	\$40	
Coinsurance	\$0	
What isn't covered		
Limits or exclusions	\$0	
The total Peg would pay is	\$40	

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$0
Specialist (copayment)	\$10
■ Hospital (facility)	\$0
Other (Tier 3 insulin copayment)	\$60

This EXAMPLE event includes services like:

<u>Primary care physician</u> office visits (including disease education)

Diagnostic tests (blood work)

Prescription drugs

Durable medical equipment (glucose meter)

Total Example Cost	\$5,600	
In this example, Joe would pay:		
Cost Sharing		
<u>Deductibles</u>	\$0	
Copayments (mail order)	\$610	
Coinsurance	\$0	
What isn't covered		
Limits or exclusions	\$0	
The total Joe would pay is	\$610	

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$0
■ Specialist (copayment)	\$10
■ Hospital (facility) (ER copayment)	\$400
Other (DME coinsurance)	\$35

This EXAMPLE event includes services like:

Emergency room care (including medical supplies)

Diagnostic test (x-ray)

<u>Durable medical equipment</u> (crutches)

Rehabilitation services (physical therapy)

Total Example Cost	\$2,800
In this example, Mia would pay:	
Cost Sharing	
<u>Deductibles</u>	\$0
Copayments	\$410
Coinsurance	\$35
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$445