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, www.ny44.e1b.org. 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.ny44.e1b.org.com or call 1-716-821-7161 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	None In network Out of network $2,000 single/ $5,000 family per calendar year	Generally, you must pay all of the cost 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 the family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes In-Network. Preventive care services are covered before you meet your deductible No out of network services are covered before deductible	You do not have to meet deductibles for specific services but see the chart, starting on page 2, 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 https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No	There is only one deductible under this plan, which is listed above.
What is the out-of-pocket limit for this plan?	In network $5,000 single/ $10,000 family Out of network $9,500 single/ $19,000 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 and health care this plan does not cover.	Even though you pay these expenses, they do not count toward the out of pocket limit.
Will you pay less if you use a network provider?	Yes Call NOVA customer service for a list of network providers 716-631-2661 or 1-800-257-2753	This plan uses a provider network. You will pay less if you use a provider in the plan's network
Do you need a referral to see a specialist?	No	This plan will pay all of the cost to see a specialist, for covered services in network There are deductible and co-insurance out of network

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
		Network Provider (You will pay the least)	Out-of-Network 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	$0 co-pay	Deductible and coinsurance	Deductible, co-payments and coinsurance out of network
	Specialist visit	$0 co-pay	Deductible and coinsurance	Deductible, co-payments and coinsurance out of network
	Preventive care/screening/ immunization	$0 co-pay	Deductible and coinsurance	Deductible, co-payments and coinsurance out of network
If you have a test	Diagnostic test (x-ray, blood work)	$0 co-pay	Deductible and coinsurance	Deductible, co-payments and coinsurance out of network
	Imaging (CT/PET scans, MRIs)	$0 co-pay	Deductible and coinsurance	Deductible, co-payments and coinsurance out of network
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at 1-800-665-3089	Generic drugs	$0 co-pay	Not covered	
	Preferred brand drugs	$15 co-pay	Not covered	
	Non-preferred brand drugs	$30 co-pay	Not covered	
	Specialty drugs	$30 co-pay for a 30 day supply	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$0 co-pay	Deductible and coinsurance	Deductible, co-payments and coinsurance out of network
	Physician/surgeon fees	$0 co-pay	Deductible and coinsurance	Deductible, co-payments and coinsurance out of network
If you need immediate medical attention	Emergency room care	$50 co-pay	$50 co-pay	Co-payments are waived if admitted
	Emergency medical transportation	$25 co-pay	Deductible, co-payments and coinsurance	None In-network; Deductible, co-payments and coinsurance out of network
	Urgent care	$0 co-pay	$0 co-pay	$0 co-pay
If you have a hospital stay	Facility fee (e.g., hospital room)	$0 co-pay	Deductible, and coinsurance	Deductible, co-payments and coinsurance out of network
	Physician/surgeon fees	$0 co-pay	Deductible, and coinsurance	Deductible, co-payments and coinsurance out of network

* For more information about limitations and exceptions, see the plan or policy document at www.ny44.e1b.org

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$0 co-pay	Deductible, co-payments and coinsurance	Deductible and coinsurance out of network
	Inpatient services	$0 co-pay	Deductible, co-payments and coinsurance	None In network; Deductible and coinsurance out of network Deductible, co-payments and coinsurance out of network
If you are pregnant	Office visits	$0 co-pay	Deductible and coinsurance	None In network; Deductible and coinsurance out of network
	Childbirth/delivery professional services	$0 co-pay	Deductible and coinsurance	None In network; Deductible and coinsurance out of network
	Childbirth/delivery facility services	$0 co-pay	Deductible and coinsurance	None In network; Deductible, and coinsurance out of network
If you need help recovering or have other special health needs	Home health care	$0 co-pay	Deductible and coinsurance	Covered in full in network; deductible and coinsurance out of network. Limit 40 visits per calendar year
	Rehabilitation services	$0 co-pay	Deductible and coinsurance	Deductible and co-payments in network; deductible and coinsurance out of network. Limit 30 visits per therapy per calendar year
	Habilitation services	$0 co-pay	Deductible and coinsurance	Deductible and co-payments in network; deductible and coinsurance out of network. Limit 30 visits per therapy per calendar year
	Skilled nursing care	$0 co-pay	Deductible and coinsurance	Covered in full in network; Deductible and coinsurance out of network. Limit 45 days per calendar year.
	Durable medical equipment	50% coinsurance	Deductible, then 50% coinsurance	Deductible and co-insurance out of network
	Hospice services	$0 co-pay	Deductible and coinsurance	None In network; Deductible and coinsurance out of network
If your child needs dental or eye care	Children's eye exam	$0 co-pay	Not covered	None In network; Not covered out of network
	Children's glasses	Covered at 40% of retail price	Not covered	Covered at 40% of retail price in network, not covered out of network
	Children's dental check-up	Not covered	Not covered	Not covered

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 Hearing aids, Routine foot care, Non-emergency care when traveling outside the U.S.
- Acupuncture, Dental care, Weight loss programs, Eye glasses
- Long term care, Custodial care, Private-duty nursing

Other Covered Services (Limitations may apply to these services. This is not a complete list. Please see your plan document.)

- Routine eye care
- Chiropractic services after 30 visits will be denied if visit are maintenance
- Infertility treatment with preauthorization
- Bariatric surgery with preauthorization

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. 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: 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 PBD Customer Service 1-800-665-3089. Additionally, a consumer assistance program can help you fill your appeal. Contact Community Service Society of New York at 1-888-614-5400 or cha@cssny.org

Does this plan provide Minimum Essential Coverage? Yes

If you do not 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.

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.

* For more information about limitations and exceptions, see the plan or policy document at www.ny44.e1b.org

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** [insert telephone number 1-800-257-2753

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' [insert telephone number 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 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	$0
Specialist ***[cost sharing]***	$0
Hospital (facility) ***[cost sharing]***	$0
Other ***[cost sharing]***	$0

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	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	$0

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 ***[cost sharing]***	$0
Hospital (facility) ***[cost sharing]***	$0
Other ***[cost sharing]***	$15

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	$0
Copayments	$30
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	$30

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

The plan's overall deductible	$0
Specialist ***[cost sharing]***	$0
Hospital (facility) ***[cost sharing]***	$50
Other ***[cost sharing]***	$15

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	$0
Copayments	$65
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$65

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