




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.dol.gov/ebsa/healthreform or www.ny44.e1b.org/wp-content/uploads/2019/10/Glossary-of-Healthcare-Terms.pdf or call 1-716-821-7161 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	<u>In-Network</u> : None <u>Out-of-Network</u> : \$1,000 single/ \$2,000 family per calendar year	See the Common Medical Events chart below for your costs for services this plan 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 plan begins to pay for covered services.
Are there services covered before you meet your deductible?	Yes, for <u>In-Network</u> services only; <u>preventive services</u> are covered before you meet your <u>deductible</u> ; <u>copayments</u> may apply. No, <u>Out-of-Network</u> services are covered before <u>deductible</u>	This plan 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 plan 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 out-of-pocket limit for this plan?	<u>In-Network</u> : \$5,000 single/ \$10,000 family <u>Out-of-Network</u> : \$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 plan , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	Penalties for failure to obtain <u>precertification</u> of services and <u>prescription drug</u> cost differentials, <u>premiums</u> , <u>balance billing</u> charges and health care this plan does not cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a network provider?	Yes, call NOVA customer service for a list of <u>network providers</u> at 716-631-2661 or 1-800-257-2753	This plan uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the plan's 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 plan 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 referral to see a specialist ?	No	You can see the specialist you choose without a referral .

 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	No charge	30% coinsurance	None
	Specialist visit	No charge	30% coinsurance	Medically necessary chiropractic care limited to 36 visits per calendar year
	Preventive care/screening/ immunization	No charge	30% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	30% coinsurance	None
	Imaging (CT/PET scans, MRIs)	No charge	30% coinsurance	Preauthorization required*
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at Rightway-(833)419-8361or	Generic drugs (Tier 1)	No charge	Not covered	After 2 nd refill at Retail, all maintenance refills will be filled by Mail Order or preferred pharmacy for 90-day supply.
	Preferred brand drugs (Tier 2)	Retail: \$15 copayment Mail Order: \$37.50 copayment	Not covered	After 2 nd refill at Retail, all maintenance refills will be filled by Mail Order or preferred pharmacy for 90-day supply.
	Non-preferred brand drugs (Tier 3)	Retail: \$30 copayment Mail Order: \$75 copayment	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 or your preferred pharmacy for 90-day supply.

	Specialty drugs	Paid according to applicable Tier	Not covered	Walgreens Specialty
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	30% <u>coinsurance</u>	<u>Preauthorization</u> may be required*
	Physician/surgeon fees	No charge	30% <u>coinsurance</u>	<u>Preauthorization</u> may be required*
If you need immediate medical attention	Emergency room care	\$200 <u>copayment</u>	\$200 <u>copayment</u>	<u>Copayments</u> are waived if admitted or for certain long-term observation holds; capped at two times <u>copayment</u> in the event a common accident or injury occurs for a family unit at the same time.
	Emergency medical transportation	\$25 <u>copayment</u>	\$25 <u>coinsurance</u>	Subject to <u>Medical Necessity</u>
	Urgent care	No charge	No charge	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	30% <u>coinsurance</u>	<u>Preauthorization</u> required*
	Physician/surgeon fees	No charge	30% <u>coinsurance</u>	<u>Preauthorization</u> required*
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	30% <u>coinsurance</u>	None
	Inpatient services	No charge	30% <u>coinsurance</u>	<u>Preauthorization</u> required*
If you are pregnant	Office visits	No charge	30% <u>coinsurance</u>	None
	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% <u>coinsurance</u>	Limit 40 visits per calendar year; <u>Preauthorization</u> required*
	Rehabilitation services	No charge	30% <u>coinsurance</u>	Number of visits per therapy may be limited per calendar year; <u>Preauthorization</u> may be required*
	Habilitation services	No charge	30% <u>coinsurance</u>	Number of visits per therapy may be limited per calendar year; <u>Preauthorization</u> may be required*
	Skilled nursing care	No charge	30% <u>coinsurance</u>	Limit 45 days per calendar year;

				<u>Preauthorization</u> required*
	Durable medical equipment	50% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> required*
	Hospice services	No charge	30% <u>coinsurance</u>	None
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	Limit of one exam every 12 months
	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

* Preauthorization required: Failure to obtain preauthorization 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	• Hearing aids	• Private-duty nursing	
• Cosmetic surgery	• Long term care	• Routine foot care	
• Custodial care	• Non-emergency care when traveling outside the U.S.	• Weight loss programs	
• Dental care			
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)			
• Bariatric surgery with preauthorization	• Eyeglasses	• Routine eye care	
• Chiropractic services (maintenance therapy excluded; limited to 36 visits)	• Infertility treatment (subject to limitations)		

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 [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 on how 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 Rightway Customer Service 1-833-419-8361. 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

[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, kwijigo 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 [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	\$0
■ Hospital (facility)	\$0
■ Other	\$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	\$12,700
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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	\$0
■ Hospital (facility)	\$0
■ Other (Tier 3 insulin copayment)	\$30

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	\$5,600
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayments (mail order)	\$300
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Joe would pay is	\$300

Mia's Simple Fracture

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

■ The plan's overall deductible	\$0
■ Specialist	\$0
■ Hospital (facility) (ER copayment)	\$200
■ Other (DME coinsurance)	\$35

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	\$2,800
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$200
Coinsurance	\$35
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$235

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.