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?	In-Network: $300 per person per calendar year; applies to medical and pharmacy Out-of-Network: $3,000 single/ $6,000 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 providers up to the deductible amount before this plan begins to pay for covered services. 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 all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes, for In-Network services only; preventive services are covered before you meet your deductible; copayments may apply. No, Out-of-Network services are covered before deductible	This plan covers some items and services even if you haven't met your deductible amount. But 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	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-Network: $5,000 single/ $10,000 family Out-of-Network: $19,000 single/ $38,000 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?	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 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. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
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	$15 copayment	Not covered	None
	Specialist visit	$15 copayment	Not covered.	Medically necessary chiropractic care limited to 20 visits per calendar year
	Preventive care/screening/ immunization	No charge	Not covered	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-rays, blood work)	No charge	30% coinsurance	None
	Imaging (CT/PET scans, MRIs)	$15 copayment	30% coinsurance	Preauthorization required*
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at Rightway 1-833-419-8361	Generic drugs (Tier 1)	Retail: $5 copayment Mail Order: $12.50 copayment	Not covered	After 2nd refill at Retail, all maintenance refills will be filled by Mail Order or your preferred pharmacy for 90-day supply
	Preferred brand drugs (Tier 2)	Retail: $40 copayment Mail Order: $100 copayment	Not covered	After 2nd refill at Retail, all maintenance refills will be filled by Mail Order or your preferred pharmacy for 90-day supply
	Non-preferred brand drugs (Tier 3)	Retail: $75 copayment Mail Order: $187.50 copayment	Not covered	Member responsible for cost difference between non-preferred brand (Tier 3) medication and generic equivalent (Tier 1),

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)	
				plus copayment; After 2nd refill at Retail, all maintenance refills will be filled by Mail Order or your preferred pharmacy for a 90 day supply
	Specialty drugs	7% coinsurance to a maximum of $120 for a 30-day	Not covered	Walgreens Specialty
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$75 copayment applied to facility charge	Not covered	Preauthorization required*
	Physician/surgeon fees	$75 copayment applies to both facility charge and procedures in an office setting	Not covered	Preauthorization required*
If you need immediate medical attention	Emergency room care	$200 copayment	$200 copayment	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
	Urgent care	No charge	No charge	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 copayment	Not covered	Maximum two copayments per calendar year In-Network; not covered Out-of-Network, except in emergency; Preauthorization required*
	Physician/surgeon fees	$500 copayment	Not covered	Maximum two copayments per calendar year In-Network; not covered Out-of-Network, except in emergency; Preauthorization required*
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15 copayment	30% coinsurance	None
	Inpatient services	$500 copayment	Not covered	Maximum two copayments per calendar year In-Network; not covered Out-of-

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)	
				Network, except in emergency; Preauthorization required*
If you are pregnant	Office visits	$15 copayment	Not covered	Applies to initial visit only for In-Network
	Childbirth/delivery professional services	No charge	Not covered	None
	Childbirth/delivery facility services	$500 copayment	Not covered	Maximum two copayments per calendar year In-Network
If you need help recovering or have other special health needs	Home health care	$15 copayment	Not covered	Limit 40 visits per calendar year; Preauthorization required*
	Rehabilitation services	$15 copayment	Not covered	Number of visits per therapy may be limited per calendar year; Preauthorization required*
	Habilitation services	$15 copayment	Not covered	Number of visits per therapy may be limited per calendar year; Preauthorization required*
	Skilled nursing care	Inpatient $500 copayment; Outpatient services $15 copayment	Not covered	Maximum two copayments per calendar year In-Network; limit 45 days per calendar year; Preauthorization required*
	Durable medical equipment	50% coinsurance	50% coinsurance	Preauthorization required*
	Hospice services	Inpatient $500 copayment; Outpatient services $15 copayment	Not covered	Maximum two copayments per calendar year In-Network; not covered Out-of-Network, except in emergency for Inpatient services
If your child needs dental or eye care	Children's eye exam	$15 copayment	Not covered	Limit of one exam per calendar year
	Children's glasses	Not covered	Not covered	Not covered
	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
- Cosmetic surgery
- Custodial care
- Dental care
- Hearing aids
- Long term care
- Non-emergency care when traveling outside the U.S.
- Eyeglasses
- 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 preauthorization
- Chiropractic services (maintenance therapy excluded; limited to 20 visits)
- 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 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 1-800-257-2755. 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, kwiijigo holne' 1-800-257-2753.

About these Coverage Examples:

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

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	**$300**
Specialist (copayment)	**$15**
Hospital (facility)	**$500**
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	
Deductibles	$300
Copayments	$560
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$860**

Managing Joe's Type 2 Diabetes

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

The plan's overall deductible	**$300**
Specialist (copayment)	**$15**
Hospital (facility)	**$0**
Other (Tier 3 insulin copayment)	**$75**

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**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$300
Copayments (mail order)	$765
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1065**

Mia's Simple Fracture

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

The plan's overall deductible	**$300**
Specialist (copayment)	**$15**
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**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$300
Copayments	$215
Coinsurance	$35
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$550**

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