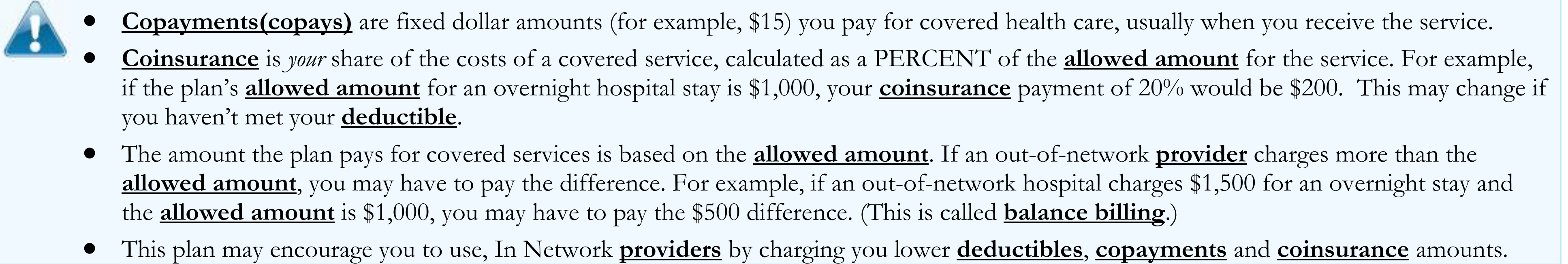
This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.ny44.e1b.org or by calling 1-716-821-7161.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**None** for In-Network services **$1,000** single/ **$2,000** family for out of network services	For out of network services, you must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. The deductible is a calendar year deductible (it starts January 1st). See the chart starting on page 2 for your costs for covered out of network services after you meet the deductible.
Are there other deductibles for specific services?	No	You do not have to meet deductibles for specific services but see the chart starting on page 2 for other cost for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes **$9,500** single/ **$19,000** family	The out-of-pocket limit is the most you could pay during a calendar year for your share of the cost of covered medical and pharmacy services.
What is not included in The out–of–pocket limit?	Premiums, balance billed charges and health care services this plan does not cover	Even though you pay these expenses, they do not count towards the out of pocket limit.
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2, describes copayments and deductibles for specific services, but there is no plan payment maximum
Does this plan use a network of providers?	Yes, for a list of network providers see www.ny44.e1b.org or call 800-257-2753	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, but their services will be treated as in-network. The plan uses the term in-network or participating for providers in the network.
Do I need a referral to see a specialist?	No	You can see the specialist you choose without permission from the plan.
Are there services this plan doesn't cover?	Yes	Some of the services this plan does not cover are listed on page 6. See your Summary Plan Description (SPD) at www.ny44.e1b.org for additional information about excluded services.



- **Copayments(copays)** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** 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 **coinsurance** 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**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$0 copay/visit	30% coinsurance	None
	Specialist visit	$0 copay/visit	30% coinsurance	None
	Other practitioner office visit	$0 copay/visit	30% coinsurance	None
	Preventive care/screening/immunization	$0 copay/visit	30% coinsurance	Immunizations provided to those over 19 years of age are not covered out of network
If you have a test	Diagnostic test (x-ray, blood work)	$0 copay/visit	30% coinsurance	None
	Imaging (CT/PET scans, MRIs)	$0/visit	30% coinsurance	Precertification is required, failure to obtain Precertification will mean you are responsible for 50%of the covered charges in addition to any applicable deductible and coinsurance or copayment.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.ny44.e1b.org	Generic drugs	$0 copay/ 30 day supply	Not Covered	Not covered out of network
	Preferred brand drugs	$15 copay/ 30 day supply	Not Covered	Not covered out of network
	Non-preferred brand drugs	$30 copay/ 30 day supply	Not Covered	Not covered out of network
	Specialty drugs	$30 copay/ 30 day supply	Not Covered	Not covered out of network
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$0 copay/visit	30% coinsurance	None
	Physician/surgeon fees	$0 copay/visit	30% coinsurance	None
If you need immediate medical attention	Emergency room services	$50 copay per visit	$50 copay per visit	None
	Emergency medical transportation	$25 copay per trip	$25 copay per trip	None
	Urgent care	$0 copay/visit	$0 copay/visit	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$0 copay/visit	30% coinsurance	Precertification is required, failure to obtain Precertification will mean you are responsible for 50% of the covered charges, in addition to any applicable deductible and coinsurance or copayment.
	Physician/surgeon fee	$0 copay/visit	30% coinsurance	None

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$0 copay/visit	30% coinsurance	Precertification is required. Failure to obtain Precertification will mean you are responsible for 50% of the covered charges, in addition to any applicable deductible and coinsurance or copayment.
	Mental/Behavioral health inpatient services	$0 copay/visit	30% coinsurance	Precertification is required, failure to obtain Precertification will mean you will be responsible for the first $1,200 of otherwise covered charges in addition to any applicable deductible and coinsurance or copayments
	Substance use disorder outpatient services	$0 copay/visit	30% coinsurance	Precertification is required, failure to obtain Precertification will mean you are responsible for 50% of the covered charges, in addition to any applicable deductible and coinsurance or copayment.
	Substance use disorder inpatient services	$0 copay/visit	30% coinsurance	Precertification is required, failure to obtain Precertification will mean you will be responsible for the first $1,200 of otherwise covered charges in addition to any applicable deductible and coinsurance or copayments.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you are pregnant	Prenatal and postnatal care	$0 copay/visit	30% coinsurance	None
	Delivery and all inpatient services	$0 copay/visit	30% coinsurance	None

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
services and long term therapy are not covered **If you need help recovering or have other special health needs**	Home health care	$0 copay/visit	30% coinsurance	Precertification is required, failure to obtain Precertification will mean you are responsible for 50% of the covered charges, in addition to any applicable deductible and coinsurance or copayment. custodial services and long term therapy are not covered. Benefit limit is 40 days per calendar year.
	Rehabilitation services	$0 copay/visit	30% coinsurance	Limit to 30 visits per therapy per calendar year. Precertification is required, failure to obtain Precertification will mean you are responsible for 50% of the covered charges, in addition to any applicable deductible and coinsurance or copayment. Custodial services and long term therapy are not covered.
	Habilitation services	$0 copay/visit	30% coinsurance	Limit to 30 visits per therapy per calendar year. Precertification is required, failure to obtain Precertification will mean you are responsible for 50% of the covered charges, in addition to any applicable deductible and coinsurance or copayment. Custodial services and long term therapy are not covered.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
	Skilled nursing care	$0/per day	30% coinsurance	Precertification is required, failure to obtain Precertification will mean you will be responsible for the first $1,200 of otherwise covered charges in addition to any applicable deductible and coinsurance or copayments; custodial services and long term therapy are not covered. Benefits limited to 45 days per calendar year.
	Durable medical equipment	50% coinsurance	50% coinsurance	Precertification is required, failure to obtain Precertification will mean you are responsible for 50% of the covered charges, in addition to any applicable deductible and coinsurance or copayment.
	Hospice service	$0 copay	30% coinsurance	None
If your child needs dental or eye care	Eye exam	$0 copay/visit	Not covered	Not covered out of network
	Glasses - Frames	60% coinsurance	Not covered	Not covered out of network
	Glasses – Single Vision Lenses	$50 copay	Not covered	Not covered out of network; different copayments apply to other lenses and lens options
	Dental check-up	Not covered	Not covered	Not Covered

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
- Custodial care
- Dental care (Adults)
- Eye exams and glasses out of network
- Hearing aids
- Immunizations for those over 19 years of age when provided out of network
- Long term care
- Non-emergency care when traveling outside the U.S.
- Prescription drugs out of network
- Private-duty nursing
- 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.)

- Bariatric surgery with Precertification
- Chiropractic care (maintenance care is not covered)
- Infertility treatment with Precertification
- Routine eye care

Your Rights to Continue Coverage:

If you lose coverage under this plan, then, depending upon the circumstances, Federal and State laws may provide protection that allows you to keep this health coverage. Any such rights may be limited in duration and will require you to pay a premium which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage contact, the plan at 716-821-7161 or Nova Customer service at 716-631-2661 or 1-800-257-2753. You may also contact the New York State Department of Insurance at 1-800-358-9260, the U.S. Department of Labor, Employee Benefits Security

Administration at 1-866-444-3272 or www.dol.gov/ebsa or the US Department of Health and Human Services at 1-877-267-2323, extension 61565 or www.cciio.cms.gov.

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 visit www.ny44.e1b.org or 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 Services at 1-800-665-3089. Additionally, a consumer assistance program can help you file your appeal. Contact Community Service Society of New York 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 care coverage that qualifies as "minimum essential coverage." This plan **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:

[Spanish (Español): Para obtener asistencia en Español, llame al 716-631-2661 or 1-800-257-2753

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 716-631-2661 or 1-800-257-2753

[Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 716-631-2661 or 1-800-257-2753

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 716-631-2661 or 1-800-257-2753

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** $7,540
- **Patient pays** $ 0

Sample care costs:

Item	Cost
Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions (generic drugs)	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Item	Cost
Deductibles	$0
Copays	$0
Coinsurance	$0
Limits or exclusions	$0
Total	**$0**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $5,400
- **Patient pays** $0

Sample care costs:

Item	Cost
Prescriptions (generic drugs)	$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:

Item	Cost
Deductibles	$0
Copays	$0
Coinsurance	$0
Limits or exclusions	$0
Total	**$0**

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**, **copayments**, and **coinsurance** 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 **copayments**, **deductibles**, and **coinsurance**. 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.