**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 by calling 718-416-4020.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | **$0** person / **$0** family | See the chart starting on page 2 for your costs for services this plan covers. |
| **Are there other deductibles for specific services?** | No. | You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers. |
| **Is there an out–of–pocket limit on my expenses?** | No. | There's no limit on how much you could pay during a coverage period for your share of the cost of covered services. |
| **What is not included in the out–of–pocket limit?** | The plan has no **out-of-pocket limit.** | Not applicable because there is no **out-of-pocket limit** on your expenses. |
| **Is there an overall annual limit on what the plan pays?** | No. There is no annual limit on what the play pays for "essential health benefits". However, you should note that once the plan pays out $100,000 annually, all claims thereafter will be paid at the rate of 60% of the plan's schedule of benefits until the end of the year. | Once the plan pays out $100,000 annually, you are responsible for 40% of the schedule's rate for the services you and your eligible dependents receive. If you see an out-of-network provider you may be responsible for any charges above the plan's schedule of benefits. |
| **Does this plan use a network of providers?** | Yes. For a list of **preferred providers** (**PPO providers**) call **1-866-497-5711**. | If you use a **PPO** doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your **PPO provider** or hospital may use a non-PPO **provider** for some services. Plans use the term in-network, preferred, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of providers. |
| **Do I need a referral to see a specialist?** | No. You don't need a referral to see a specialist. | You can see the specialist you choose without permission from this plan. |
| **Are there services this plan doesn't cover?** | Yes. | Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about |

- **Copayments** 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 **PPO providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

| Common Medical Event | Services You May Need | Your Cost If You Use a PPO Provider | Your Cost If You Use a Non- PPO provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | $15 copay/visit | $15 copay/visit plus any amount greater than 50% of the Reasonable and Customary Rate | Primary care practice is family practice, general practice, internal medicine, pediatric, physician assistant and nurse practitioners.<br><br>Chiropractor and Podiatrist coverage limited to 30 visits per calendar year.<br><br>One preventative visit per year is covered for each covered person. |
| | Preventive care/screening/ immunization | | | |
| | Specialist visit | $40 copay/visit | $40 copay/visit plus any amount greater than 50% of the Reasonable and Customary Rate | |
| | Other practitioner office visit (Chiropractors and Podiatrist) | | | |
| **If you have a test** | Diagnostic test (x-ray, blood work) | $10 copay/test | $10 copay/test plus any amount greater than 50% of the Reasonable and Customary Rate | Subject to plan limitations. |
| | Imaging (CT/PET scans, MRIs) | $15 copay/test | $15 copay/test plus any amount greater than 50% of the Reasonable and Customary Rate | Pre-certification required for all scans except mammography. |

| Common Medical Event | Services You May Need | Your Cost If You Use a PPO Provider | Your Cost If You Use a Non- PPO provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you need drugs to treat your illness or condition**<br>More information about **prescription drug coverage** is available at (877) 647-4026. | Generic drugs | $15 copay | $15 copay plus any amount greater than 50% of the Reasonable and Customary Rate | Maximum of $6,000 in prescription drug coverage per family per year. |
| | Brand drugs | $25 copay | $25 copay plus any amount greater than 50% of the Reasonable and Customary Rate | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | $0 copay | $0 copay plus any amount greater than 50% of the Reasonable and Customary Rate | Pre-certification required. Additional copay for each surgical procedure. If two procedures through same incision plan pays higher cost procedure only. |
| | Physician/surgeon fees/surgical benefits | $375 copay | $375 copay plus any amount greater than 50% of the Reasonable and Customary Rate | |
| **If you need immediate medical attention** | Emergency room services | $260 copay | $260 copay plus any amount greater than 50% of the Reasonable and Customary Rate | Subject to plan limitations. |
| | Emergency medical transportation | $0 copay | $0 copay | You are responsible for any charge over $1,500. |
| | Urgent care | $60 copay | $60 copay plus any amount greater than 50% of the Reasonable and Customary Rate | Subject to plan limitations. |

| Common Medical Event | Services You May Need | Your Cost If You Use a PPO Provider | Your Cost If You Use a Non- PPO provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | $740 copay | $740 copay plus any amount greater than 50% of the Reasonable and Customary Rate | Pre-certification required. |
| | Physician/surgeon fee/ surgical benefits | $375 copay | $375 copay plus any amount greater than 50% of the Reasonable and Customary Rate | Pre-certification required. Additional copay for each surgical procedure. If two procedures through same incision plan pays higher cost procedure only. |
| **If you have mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | Not covered. | Not covered. | ——————none—————— |
| | Mental/Behavioral health inpatient services | Not covered. | Not covered. | ——————none—————— |
| | Substance use disorder outpatient services | Not covered. | Not covered. | ——————none—————— |
| | Substance use disorder inpatient services | Not covered. | Not covered. | ——————none—————— |
| **If you are pregnant** | Prenatal and postnatal care | $40 copay/visit | $40 copay/visit plus any amount greater than 50% of the Reasonable and Customary Rate | Subject to plan limitations. |
| | Delivery and all inpatient services | $40 copay/birth | $40 plus any amount greater than 50% of the Reasonable and Customary Rate | Pre-certification required. |

| Common Medical Event | Services You May Need | Your Cost If You Use a PPO Provider | Your Cost If You Use a Non- PPO provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you need help recovering or have other special health needs** | Home health care | $45 per day copay | $45 per day copay plus any amount greater than 50% of the Reasonable and Customary Rate | Pre-certification is required. 200 day maximum. |
| | Rehabilitation services | $40 copay | $40 copay plus any amount greater than 50% of the Reasonable and Customary Rate | Physical Therapy – 30 visit annual maximum for any combination of physical therapy, physical medicine or rehabilitation services, per person. Occupational Therapy – 14 visit annual maximum for any combination of occupational or speech therapy, per person. |
| | Habilitation services | Not Covered | Not Covered. | ——————none—————— |
| | Skilled nursing care | Not Covered | Not Covered. | ——————none—————— |
| | Durable medical equipment | $10 copay | $10 copay plus any amount greater than 50% of the Reasonable and Customary Rate | Pre-certification is required. $1500 annual maximum per person. |
| | Hospice service | $40 per day copay. | $40 per day copay plus any amount greater than 50% of the Reasonable and Customary Rate | 210 day lifetime limit. |
| **If your child needs dental or eye care** | Eye exam | Not Covered | Not Covered | ——————none—————— |
| | Glasses | Not Covered | Not Covered | ——————none—————— |
| | Dental check-up | Not Covered | Not Covered | ——————none—————— |

## 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.)**

- Cosmetic surgery
- Dental Care (Adult)
- Habilitation Services
- Infertility treatment
- Long-term care
- Mental/behavioral health and substance abuse
- Private-duty nursing
- Routine foot care
- Skilled Nursing 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.)**

- Acupuncture
- Bariatric surgery (when medically necessary)
- Chiropractic care
- Organ Transplant
- Hospice Service
- Hearing aids (one device every four years)
- Non-emergency care when traveling outside the U.S.
- Abortion (for Participant & Spouse only)
- Routine eye care (Adult)
- Physical Therapy
- Occupational and/or Speech Therapy
- Allergist

### Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep 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 718-416-4020. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 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 contact the plan at: 718-416-4020 or the Department of Labor's Employee Benefits Security Administration at 866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or New York State Department of Insurance at www.dfs.ny.gov. Additionally, a consumer assistance program can help you file your appeal. Contact http://www.communityhealthadvocates.org

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

# 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** $7,340
- **Patient pays** $200

**Sample care costs:**

| | |
|---|---|
| Hospital charges (mother) | $2,700 |
| Routine obstetric care | $2,100 |
| Hospital charges (baby) | $900 |
| Anesthesia | $900 |
| Laboratory tests | $500 |
| Prescriptions | $200 |
| Radiology | $200 |
| Vaccines, other preventive | $40 |
| **Total** | **$7,400** |

**Patient pays:**

| | |
|---|---|
| Deductibles | $0 |
| Copays | $680 |
| Coinsurance | $0 |
| Limits or exclusions | $0 |
| **Total** | **$680** |

Note: This number assumes all providers used were in-network PPO-providers and the patient has given notice of her pregnancy to the plan. If you are pregnant and you use non-PPO providers and/or you have not given notice of your pregnancy, your costs may be higher. For more information: 718-416-4020.

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,800
- **Patient pays** $600

**Sample care costs:**

| | |
|---|---|
| Prescriptions | $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:**

| | |
|---|---|
| Deductibles | $0 |
| Copays | $430 |
| Coinsurance | $0 |
| Limits or exclusions | $300 |
| **Total** | **$600** |

Note: This number assumes all providers used were in-network PPO-providers. If you have diabetes and you do not use PPO-providers your costs may be higher. For more information please contact the plan at: 718-416-4020.

# 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.