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 **1-888-990-5702.**

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$6,350**/ person $**12,700**/family	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. **$6,350** / person $**12,700** /family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See **http://newyork.healthrepublic.us/network call 1-888-990-5702** for a list of participating providers.	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. 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 5. See your policy or plan document for additional information about **excluded services**.

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

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	50% cost sharing after deductible	Not covered	——————none——————
	Specialist visit	50% cost sharing after deductible	Not covered	——————none——————
	Other practitioner office visit	50% cost sharing after deductible	Not covered	——————none——————
	Preventive care/screening/immunization	No charge	Not covered	
If you have a test	Diagnostic test (x-ray, blood work)	PCP: 50% cost sharing after deductible Specialist: 50% cost sharing after deductible	Not covered	——————none——————
	Imaging (CT/PET scans, MRIs)	50% cost sharing after deductible	Not covered	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at NewYork.HealthRepublic.us	Selected generic drugs	Retail: $10 copay/prescription after deductible Mail order: $25 copay/prescription after deductible	Not covered	Covers up to a 30-day supply (retail prescription); 90 day supply (mail order prescription)
	Preferred brand drugs	Retail: $35 copay/prescription after deductible Mail order: $87.50 copay/prescription after deductible	Not covered	Covers up to a 30-day supply (retail prescription); 90 day supply (mail order prescription)
	Non-preferred brand drugs	Retail: $70 copay/ prescription after deductible Mail order: $175 copay/prescription after deductible	Not covered	Covers up to a 30-day supply (retail prescription); 90 day supply (mail order prescription)
	Specialty drugs	Retail: $70 copay/ prescription after deductible Mail order: $175 copay/prescription after deductible	Not covered	Covers up to a 30-day supply (retail prescription); 90 day supply (mail order prescription)
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	50% cost sharing after deductible	Not covered	——————none——————
	Physician/surgeon fees	50% cost sharing after deductible	Not covered	——————none——————
If you need immediate medical attention	Emergency room services	50% cost sharing after deductible	50% cost sharing after deductible	——————none——————
	Emergency medical transportation	50% cost sharing after deductible	50% cost sharing after deductible	——————none——————
	Urgent care	50% cost sharing after deductible	Not covered	——————none——————
If you have a hospital	Facility fee (e.g., hospital room)	50% cost sharing after deductible	Not covered	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
stay	Physician/surgeon fee	50% cost sharing after deductible	Not covered	——————none——————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	50% cost sharing after deductible	Not covered	——————none——————
	Mental/Behavioral health inpatient services	50% cost sharing after deductible	Not covered	——————none——————
	Substance use disorder outpatient services	50% cost sharing after deductible	Not covered	Up to 20 visits a plan year may be used for family counseling
	Substance use disorder inpatient services	50% cost sharing after deductible	Not covered	——————none——————
If you are pregnant	Prenatal and postnatal care	PCP: 50% cost sharing Specialist: 50% cost sharing	Not covered	——————none——————
	Delivery and all inpatient services	50% cost sharing after deductible	Not covered	——————none——————
If you need help recovering or have other special health needs	Home health care	50% cost sharing after deductible	Not covered	40 visits per year
	Rehabilitation services	50% cost sharing after deductible	Not covered	60 visits per condition per lifetime
	Habilitation services	50% cost sharing after deductible	Not covered	60 visits per condition per lifetime
	Skilled nursing care	50% cost sharing after deductible	Not covered	200 days per year
	Durable medical equipment	50% cost sharing after deductible	Not covered	$1,500 per year
	Hospice service	Inpatient: 50% cost sharing after deductible Outpatient: 50% cost sharing after deductible	Not covered	210 days per year
If your child needs dental or eye care	Eye exam	50% cost sharing after deductible	Not covered	——————none——————
	Glasses	50% cost sharing after deductible	Not covered	Limited to one pair of glasses per year
	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)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care

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
- Chiropractic care
- Hearing aids
- Infertility treatments
- Weight loss program

Your Rights to Continue Coverage:

Group health 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 **1-888-990-5702.** 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.

Language Services:

SPANISH (Español): Para obtener asistencia en Español, llame al 1-888-990-5702.

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: 1-800-342-3736.

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 or policy 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.**

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** $2,320
- **Patient pays** $5,220

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	**$7,540**

Patient pays:

Deductibles	$3,000
Copays	$20
Coinsurance	$2,000
Limits or exclusions	$200
Total	**$5,220**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $2,720
- **Patient pays** $2,680

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	$3,000
Copays	$500
Coinsurance	$100
Limits or exclusions	$80
Total	**$2,680**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: **1-888-990-5702.**

Questions and answers about the Coverage:

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.

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 **1-888-990-5702.**

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$2,000** / person **$4,000**/family	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. **$5,500** / person $**11,000** /family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See **http://newyork.healthrepublic.us/network call 1-888-990-5702** for a list of participating providers.	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. 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 5. See your policy or plan document for additional information about **excluded services**.

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

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay/visit after deductible	Not covered	——————none——————
	Specialist visit	$50 copay/visit after deductible	Not covered	——————none——————
	Other practitioner office visit	$50 copay/visit after deductible	Not covered	——————none——————
	Preventive care/screening/immunization	No charge	Not covered	
If you have a test	Diagnostic test (x-ray, blood work)	PCP: $30 copay/visit after deductible Specialist: $50 copay/visit after deductible	Not covered	——————none——————
	Imaging (CT/PET scans, MRIs)	$50 copay/visit after deductible	Not covered	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at NewYork.HealthRepublic.us	Selected generic drugs	Retail: $10 copay/ Prescription Mail order: $25 copay/prescription	Not covered	Covers up to a 30-day supply (retail prescription); 90 day supply (mail order prescription)
	Preferred brand drugs	Retail: $35 copay/ Prescription Mail order: $87.50 copay/prescription	Not covered	Covers up to a 30-day supply (retail prescription); 90 day supply (mail order prescription)
	Non-preferred brand drugs	Retail: $70 copay/ prescription Mail order: $175 copay/prescription	Not covered	Covers up to a 30-day supply (retail prescription); 90 day supply (mail order prescription)
	Specialty drugs	Retail: $70 copay/ prescription Mail order: $175 copay/prescription	Not covered	Covers up to a 30-day supply (retail prescription); 90 day supply (mail order prescription)
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$100 copay/ admission after deductible	Not covered	——————none——————
	Physician/surgeon fees	$100 copay/case after deductible	Not covered	——————none——————
If you need immediate medical attention	Emergency room services	$150 copay/visit after deductible	$150 copay/visit after deductible	——————none——————
	Emergency medical transportation	$150 copay/visit after deductible	$150 copay/visit after deductible	——————none——————
	Urgent care	$70 copay/visit after deductible	Not covered	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	$1,500 copay/ admission after deductible	Not covered	——————none——————
	Physician/surgeon fee	$100 copay/case after deductible	Not covered	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$30 copay/visit after deductible	Not covered	——————none——————
	Mental/Behavioral health inpatient services	$1,500 copay/ admission after deductible	Not covered	——————none——————
	Substance use disorder outpatient services	$30 copay/visit after deductible	Not covered	Up to 20 visits a plan year may be used for family counseling
	Substance use disorder inpatient services	$1,500 copay/ admission after deductible	Not covered	——————none——————
If you are pregnant	Prenatal and postnatal care	PCP: $30 copay/visit Specialist: $50 copay/visit	Not covered	——————none——————
	Delivery and all inpatient services	$1,500 copay/ admission after deductible	Not covered	——————none——————
If you need help recovering or have other special health needs	Home health care	$30 copay/visit after deductible	Not covered	40 visits per year
	Rehabilitation services	$30 copay/visit after deductible	Not covered	60 visits per condition per lifetime
	Habilitation services	$30 copay/visit after deductible	Not covered	60 visits per condition per lifetime
	Skilled nursing care	$1,500 copay/ admission after deductible	Not covered	200 days per year
	Durable medical equipment	30% cost sharing after deductible	Not covered	$1,500 per year
	Hospice service	Inpatient: $1,500 copay / admission after deductible Outpatient: $30 copay/visit after deductible	Not covered	210 days per year
If your child needs dental or eye care	Eye exam	$30 copay/visit after deductible	Not covered	——————none——————
	Glasses	30% cost sharing after deductible	Not covered	Limited to one pair of glasses per year
	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)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care

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
- Chiropractic care
- Hearing aids
- Infertility treatments
- Weight loss programs

Your Rights to Continue Coverage:

Group health coverage

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For more information on your rights to continue coverage, contact the plan at **1-888-990-5702.** 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.

Language Services:

SPANISH (Español): Para obtener asistencia en Español, llame al 1-888-990-5702.

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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.**

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** $3,840
- **Patient pays** $3,700

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	**$7,540**

Patient pays:

Deductibles	$2,000
Copays	$1,500
Coinsurance	$0
Limits or exclusions	$200
Total	**$3,700**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $2,720
- **Patient pays** $2,680

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	$2,000
Copays	$500
Coinsurance	$100
Limits or exclusions	$80
Total	**$2,680**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: **1-888-990-5702.**

Questions and answers about the Coverage:

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?

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Can I use Coverage Examples to compare plans?

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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.

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 **1-888-990-5702**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$600**/ person $**1,200**/family	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. **$4,000**/ person $**8,000**/family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See **http://newyork.healthrepublic.us/network call 1-888-990-5702** for a list of participating providers.	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. 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 5. See your policy or plan document for additional information about **excluded services**.

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

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay/visit after deductible	Not covered	——————none——————
	Specialist visit	$40 copay/visit after deductible	Not covered	——————none——————
	Other practitioner office visit	$40 copay/visit after deductible	Not covered	——————none——————
	Preventive care/screening/immunization	No charge	Not covered	
If you have a test	Diagnostic test (x-ray, blood work)	PCP: $25 copay/visit after deductible Specialist: $40 copay/visit after deductible	Not covered	——————none——————
	Imaging (CT/PET scans, MRIs)	$40 copay/visit after deductible	Not covered	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at NewYork.HealthRepublic.us	Selected generic drugs	Retail: $10 copay/prescription Mail order: $25 copay/prescription	Not covered	Covers up to a 30-day supply (retail prescription); 90 day supply (mail order prescription)
	Preferred brand drugs	Retail: $30 copay/prescription Mail order: $75 copay/prescription	Not covered	Covers up to a 30-day supply (retail prescription); 90 day supply (mail order prescription)
	Non-preferred brand drugs	Retail: $70 copay/prescription Mail order: $135 copay/prescription	Not covered	Covers up to a 30-day supply (retail prescription); 90 day supply (mail order prescription)
	Specialty drugs	Retail: $70 copay/prescription Mail order: $135 copay/prescription	Not covered	Covers up to a 30-day supply (retail prescription); 90 day supply (mail order prescription)
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$100 copay/ admission after deductible	Not covered	——————none——————
	Physician/surgeon fees	$100 copay/case after deductible	Not covered	——————none——————
If you need immediate medical attention	Emergency room services	$150 copay/visit after deductible	$150 copay/visit after deductible	——————none——————
	Emergency medical transportation	$150 copay/visit after deductible	$150 copay/visit after deductible	——————none——————
	Urgent care	$60 copay/visit after deductible	Not covered	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	$1,000 copay/ admission after deductible	Not covered	——————none——————
	Physician/surgeon fee	$100 copay/case after deductible	Not covered	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$25 copay/visit after deductible	Not covered	——————none——————
	Mental/Behavioral health inpatient services	$1,000 copay/ admission after deductible	Not covered	——————none——————
	Substance use disorder outpatient services	$25 copay/visit after deductible	Not covered	Up to 20 visits a plan year may be used for family counseling
	Substance use disorder inpatient services	$1,000 copay/ admission after deductible	Not covered	——————none——————
If you are pregnant	Prenatal and postnatal care	PCP: $25 copay/visit Specialist: $40 copay /visit	Not covered	——————none——————
	Delivery and all inpatient services	$1,000 copay/ admission after deductible	Not covered	——————none——————
If you need help recovering or have other special health needs	Home health care	$25 copay/visit after deductible	Not covered	40 visits per year
	Rehabilitation services	$30 copay/visit after deductible	Not covered	60 visits per condition per lifetime
	Habilitation services	$30 copay/visit after deductible	Not covered	60 visits per condition per lifetime
	Skilled nursing care	$1,000 copay/ admission after deductible	Not covered	200 days per year
	Durable medical equipment	20% coinsurance after deductible	Not covered	$1,500 per year
	Hospice service	Inpatient: $1,000 copay/admission after deductible Outpatient: $25 copay/visit after deductible	Not covered	210 days per year
If your child needs dental or eye care	Eye exam	$25 copay/visit after deductible	Not covered	——————none——————
	Glasses	20% coinsurance after deductible	Not covered	Limited to one pair of glasses per year
	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)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care

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
- Chiropractic care
- Hearing aids
- Infertility treatments
- Weight loss programs

Your Rights to Continue Coverage:

Group health 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 **1-888-990-5702.** 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.

Language Services:

SPANISH (Español): Para obtener asistencia en Español, llame al 1-888-990-5702.

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: 1-800-342-3736.

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 or policy 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.**

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** $5,640
- **Patient pays** $1,900

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	**$7,540**

Patient pays:

Deductibles	$600
Copays	$1,100
Coinsurance	$0
Limits or exclusions	$200
Total	**$1,900**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,820
- **Patient pays** $1,580

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	$600
Copays	$700
Coinsurance	$200
Limits or exclusions	$80
Total	**$1,580**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: **1-888-990-5702.**

Questions and answers about the Coverage:

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.

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 **1-888-990-5702.**

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$0**/ person **$0**/family	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. **$2,000**/ person **$4,000**/family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See **http://newyork.healthrepublic.us/network call 1-888-990-5702** for a list of participating providers.	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. 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 5. See your policy or plan document for additional information about **excluded services**.

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

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating 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	Not covered	——————none——————
	Specialist visit	$35 copay/visit	Not covered	——————none——————
	Other practitioner office visit	$35 copay/visit	Not covered	——————none——————
	Preventive care/screening/immunization	No charge	Not covered	
If you have a test	Diagnostic test (x-ray, blood work)	PCP: $15 copay/visit Specialist: $35 copay/visit	Not covered	——————none——————
	Imaging (CT/PET scans, MRIs)	$35 copay/visit	Not covered	——————none——————
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at NewYork.HealthRepub	Selected generic drugs	Retail: $10 copay/prescription Mail order: $25 copay/prescription	Not covered	Covers up to a 30-day supply (retail prescription); 90 day supply (mail order prescription)
	Preferred brand drugs	Retail: $30 copay/prescription Mail order: $75 copay/prescription	Not covered	Covers up to a 30-day supply (retail prescription); 90 day supply (mail order prescription)
	Non-preferred brand drugs	Retail: $60 copay/ prescription Mail order: $150 copay/prescription	Not covered	Covers up to a 30-day supply (retail prescription); 90 day supply (mail order prescription)

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
lic.us.	Specialty drugs	Retail: $60 copay/ prescription Mail order: $150 copay/prescription	Not covered	Covers up to a 30-day supply (retail prescription); 90 day supply (mail order prescription)
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$100 copay/visit	Not covered	——————none——————
	Physician/surgeon fees	$100 copay/case	Not covered	——————none——————
If you need immediate medical attention	Emergency room services	$100 copay/visit	$100 copay/visit after deductible	——————none——————
	Emergency medical transportation	$100 copay/visit	$100 copay/visit after deductible	——————none——————
	Urgent care	$55 copay/visit	Not covered	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 copay/ admission	Not covered	——————none——————
	Physician/surgeon fee	$100 copay/case	Not covered	——————none——————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$15 copay/visit	Not covered	——————none——————
	Mental/Behavioral health inpatient services	$500 copay/ admission	Not covered	——————none——————
	Substance use disorder outpatient services	$15 copay/visit	Not covered	Up to 20 visits a plan year may be used for family counseling
	Substance use disorder inpatient services	$500 copay/ admission	Not covered	——————none——————
If you are pregnant	Prenatal and postnatal care	PCP: $15 copay/visit Specialist: $35 copay / visit	Not covered	——————none——————
	Delivery and all inpatient services	$500 copay/ admission	Not covered	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	$15 copay/visit	Not covered	40 visits per year
	Rehabilitation services	$25 copay/visit	Not covered	60 visits per condition per lifetime
	Habilitation services	$25 copay/visit	Not covered	60 visits per condition per lifetime
	Skilled nursing care	$500 copay/ admission	Not covered	200 days per year
	Durable medical equipment	10% coinsurance	Not covered	$1,500 per year
	Hospice service	Inpatient: $500 copay/admission Outpatient: $15 copay/visit	Not covered	210 days per year
If your child needs dental or eye care	Eye exam	$15 copay/visit	Not covered	——————none——————
	Glasses	10% coinsurance	Not covered	Limited to one pair of glasses per year
	Dental check-up	Not covered	Not covered	——————none——————

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- Private-duty nursing
- Routine eye care (Adult)
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Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,440
- **Patient pays** $1,100

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	**$7,540**

Patient pays:

Deductibles	$0
Copays	$900
Coinsurance	$0
Limits or exclusions	$200
Total	**$1,100**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,320
- **Patient pays** $1,080

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	$900
Coinsurance	$100
Limits or exclusions	$80
Total	**$1,080**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: **1-888-990-5702.**

Questions and answers about the Coverage:

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- 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.
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