Bronze 25, C

Coverage Period: _____

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** _____ | **Plan Type: HMO**

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.easychoiceny.com or by calling Member Services at 1-866-747-8422 Monday – Friday, 9 AM to 5 PM.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$0**	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	**$0**	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?	This plan has no **out–of–pocket limit**.	Not applicable because there's no **out–of–pocket limit** on your expenses.
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.** For a list of **participating providers**, see www.easychoiceny.com or call 1-866-747-8422.	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. The health plan uses the term in-network or participating for **providers** in our **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?	**Yes.**	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist**.
Are there services this plan doesn't cover?	**Yes.**	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about **excluded services**.

Questions: Call 1-866-747-8422 or visit us at www.easychoiceny.com.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.easychoiceny.com or call 1-866-747-8422 to request a copy.

- **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 $150. 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 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	$25 co-pay/visit	Not Covered	none
	Specialist visit	$40 co-pay/visit	Not Covered	Prior Authorization is required for all specialty care visits, including obstetrics and chiropractic care after the initial visit
	Other practitioner office visit	$25 co-pay/visit	Not Covered	Prior Authorization is required for visits related to radiation treatment, chemotherapy and dialysis.
	Preventive care/screening/immunization	No Charge.	Not Covered	none
If you have a test	Diagnostic test (x-ray, blood work)	$25 co-pay/visit	Not Covered	Prior Authorization is required for diagnostic procedures such as EEG, EMG, nerve conduction studies, nuclear stress tests, uroflowmetery studies, genetic testing, some laboratory testing
	Imaging (CT/PET scans, MRIs)	$25 co-pay/visit	Not Covered	Prior Authorization is required for imaging studies, including CT, MRI, MRA, Nuclear Medicine, PET Scans, and more than 2 OB ultrasounds during pregnancy

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.easychoiceny.com.	Generic drugs	$20 co-pay.	Not Covered	$0 co-pay for each mail order generic prescription. Retail is limited to a 34-day supply. Mail order is limited to a 90-day supply. Other quantity limits and prior authorization rules may apply.
	Preferred brand drugs	$30 co-pay.	Not Covered	Co-pay is one and half times (1.5x) the regular co-pay for 90 day brand maintenance mail order drugs. Retail is limited to a 34-day supply. Mail order is limited to a 90-day supply. Other quantity limits and prior authorization rules may apply.
	Non-preferred brand drugs	$40 co-pay	Not Covered	Non-preferred brand drugs are referred to as non-formulary brand drugs in your prescription rider. Retail is limited to a 34-day supply. Mail order is limited to a 90-day supply. Other quantity limits and prior authorization rules may apply.
	Specialty drugs	$20/$30/$40 co-pay.	Not Covered	Co-pays for specialty drugs have the same co-pay level as non-specialty drugs.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$75 co-pay.	Not Covered	Prior Authorization is required for ambulatory/outpatient procedures and any assistant surgeons.
	Physician/surgeon fees	Lesser of 20% coinsurance or $200 co-pay.	Not Covered	——————none——————
If you need immediate medical attention	Emergency room services	$50 co-pay/visit	$50 co-pay/visit	Co-pay is waived if admitted to the hospital.
	Emergency medical transportation	$50 co- pay.	$50 co-pay.	——————none——————
	Urgent care	$25 co-pay/visit	Not Covered	——————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 a hospital stay	Facility fee (e.g., hospital room)	$500 co-pay.	Not Covered	Prior Authorization is required. Co-pay is per continuous confinement. Out of network hospital stays may be covered if the hospital stay is after an emergency room visit.
	Physician/surgeon fee	No Charge.	Not Covered	——————none——————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$40 co-pay/visit	Not Covered	Prior Authorization is required. Limited to 20 visits per calendar year.
	Mental/Behavioral health inpatient services	$500 co-pay.	Not Covered	Prior Authorization is required. Co-pay is per continuous confinement. Limited to 30 days per calendar year. Out of network inpatient services may be covered if the inpatient care is after an emergency room visit.
	Substance use disorder outpatient services	$40 co-pay/visit	Not Covered	Prior Authorization is required. Limited to 60 visits per calendar year, where up to 20 visits may be used for family therapy.
	Substance use disorder inpatient services	$500 co-pay.	Not Covered	Prior Authorization is required. Inpatient rehabilitation is not covered. Inpatient Detoxification is limited to 7 days per calendar year. Co-pay is per continuous confinement. Out of network inpatient services may be covered if the inpatient care is after an emergency room visit.
If you are pregnant	Prenatal and postnatal care	$25 co-pay/visit	Not Covered	It is atypical that our network providers will collect co-pays for OB visits because they typically bill a global code at the time of delivery for all maternity services, including prenatal and postnatal care and delivery.

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
	Delivery and all inpatient services	Physician Co-pay: Lesser of 20% coinsurance or $200. Hospital Co-Pay: $500.	Not Covered	Prior Authorization is required. Out of network inpatient services may be covered if emergent.
If you need help recovering or have other special health needs	Home health care	$25 co-pay.	Not Covered	Prior Authorization is required for all types of home health visits. Limited to 40 visits per calendar year.
	Rehabilitation services	$500 co-pay inpatient; $40 co-pay outpatient.	Not Covered	Prior Authorization is required. Inpatient stays are limited to 30 days per diagnosis per calendar year. Co-pay is per continuous confinement. Outpatient Visits are limited to 20 visits per diagnosis per calendar year following an inpatient hospital stay only.
	Habilitation services	Not Covered	Not Covered	Excluded Service
	Skilled nursing care	$500 co-pay.	Not Covered	Prior Authorization is required. 30-day benefit limit. Co-pay is per continuous confinement.
	Durable medical equipment	20% coinsurance	Not Covered	Prior Authorization is required for DME costing more than $500. Diabetic equipment & supplies require $25 co-pay per item or 34-day supply.
	Hospice service	No Charge.	Not Covered	Prior Authorization is required. Inpatient stays are limited to 210 days combined with outpatient. Bereavement Counseling Visits are limited to 5 visits per calendar year.
If your child needs dental or eye care	Eye exam	$40 co-pay/visit	Not Covered	Optometry not covered.
	Glasses	Not Covered	Not Covered	Excluded Service
	Dental check-up	Not Covered	Not Covered	Excluded Service

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
- Dental Care (Adult & Child)
- Habilitation
- Hearing Aids
- Infertility Treatment
- Long-term Care
- Non-emergency care when traveling outside the U.S.
- Private-duty Nursing
- Routine Eye Care (Adult & Child)
- 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
- Weight Loss Programs

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 1-866-747-8422. 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: Easy Choice Health Plan of New York, Member Grievances and Appeals Department, 45 Broadway, Suite 300, New York, NY 10006 at 1-866-747-8422 or you can contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or you can contact the Department of Financial Services at Consumer Assistance Unit, NYS Department of Financial Services, 25 Beaver Street, New York, NY 10004-2319 at 1-800-342-3736 or http://www.dfs.ny.gov/consumer/fileacomplaint.htm or you can contact the consumer assistance program in New York State, Community Service Society of New York, Community Health Advocates, 105 East 22nd Street, 8th floor, New York, NY 10010 at 1-888-614-5400 or http://www.communityhealthadvocates.org/.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-747-8422.

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** $6,300
- **Patient pays** $1,240

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$250
Radiology	$250
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$1,090
Coinsurance	$0
Limits or exclusions	$150
Total	**$1,240**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,690
- **Patient pays** $1,710

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	$1,630
Coinsurance	$0
Limits or exclusions	$80
Total	**$1,710**

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.