



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, www.HealthReformPlanSBC.com or by calling 1-888-982-3862. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary/> or call 1-888-982-3862 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	\$0.	See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.
Are there services covered before you meet your <u>deductible</u> ?	Not Applicable .	You will have to meet the <u>deductible</u> before the <u>plan</u> pays for any services
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	In- <u>Network</u> : Individual \$3,175 / Family \$6,350.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premiums</u> , <u>balance-billing</u> charges & health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See www.aetna.com/docfind or call 1-888-982-3862 for a list of in- <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u>. You will pay less if you use a <u>provider</u> in the <u>plan's network</u>. You will not have coverage when using an <u>out-of-network provider</u> with the following exceptions: • Emergencies: See "If you need immediate medical attention" section of this document for specifics. Please note that Out of Network Urgent Care services are not covered in emergency situations • Network Insufficiency When using an <u>out-of-network provider</u> you might receive a bill from the <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$25 <u>copay</u> /visit; except no charge for office surgery	Not covered	None
	<u>Specialist</u> visit	\$30 <u>copay</u> /visit for NYP-Affiliated Specialist; except no charge for office surgery \$40 <u>copay</u> /visit for non-NYP specialist; except no charge for office surgery	Not covered	If the place of service the member visits is identified as Facility Setting rather than Office Setting the \$40 copay will apply.
	<u>Preventive care</u> / <u>screening</u> /immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
Other specialist visit	Acupuncture	\$0 <u>copay</u> for the first 25 visits of a calendar year and \$25 thereafter	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a test	<u>Diagnostic test:</u> Blood work	No charge for laboratory	Not covered	None
	<u>Diagnostic test:</u> X-ray	\$30 <u>copay</u> /visit for X-Ray with NYP-Affiliated Specialist \$40 <u>copay</u> /visit for X-Ray with non-NYP Specialist	Not covered	\$40 copay applies if the service is provided outside of an office visit with an NYP-affiliated specialist. Additionally if the place of service the member visits is identified as Facility Setting rather than Office Setting the \$40 copay will apply.
	Imaging (CT/PET scans, MRIs)	\$30 <u>copay</u> /visit for NYP-Affiliated Specialist; \$40 <u>copay</u> /visit for non-NYP specialist;	Not covered	\$40 copay applies if the service is provided outside of an office visit with an NYP-affiliated specialist. Additionally if the place of service the member visits is identified as Facility Setting rather than Office Setting the \$40 copay will apply.
<u>If you need prescription drugs</u>	Refer to www.caremark.com			
Telemedicine	Aetna Teladoc	General Medicine and Mental health; \$25 <u>copay</u> /visit	Not applicable	Telemedicine
		Non-NYP Specialist (i.e., dermatologist): \$40 <u>copay</u> /visit		
	NYP Virtual Urgent Care – Adult and Pediatric	\$0 <u>copay</u> /visit	Not applicable	Telemedicine

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	None
	Physician/surgeon fees	No charge	Not covered	None
If you need immediate medical attention	<u>Emergency room care</u>	\$150 <u>copay</u> /visit	\$150 <u>copay</u> /visit	No coverage for non-emergency use.
	<u>Emergency medical transportation</u>	No charge	No charge	Non-emergency transport: not covered, except if pre-authorized.
	<u>Urgent care</u>	\$35 <u>copay</u> /visit	Not covered	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$150 <u>copay</u> /day first 3 days per stay	Not covered	Max <u>copay</u> /per admission: \$450. Pre-authorization required for care.
	Physician/surgeon fees	No charge	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$25 <u>copay</u> /Office visit Other outpatient services: No charge Facility: No charge	Not covered	None
	Inpatient services	\$150 <u>copay</u> /day first 3 days per stay	Not covered	Max <u>copay</u> /per admission \$450. Pre-authorization required for care.
If you are pregnant	Office visits	No charge	Not covered	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Max <u>copay</u> /per admission: \$450.
	Childbirth/delivery professional services	No charge	Not covered	
	Childbirth/delivery facility services	\$150 <u>copay</u> /day first 3 days per stay	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you are seeking gender affirming care	<u>Specialist</u> office visit	\$30 <u>copay</u> /visit for NYP-Affiliated Specialist; except no charge for office surgery \$40 <u>copay</u> /visit for non-NYP specialist; except no charge for office surgery	Not covered	Coverage for gender affirming care follows the clinical guidelines outlined in CPB #0615 (Gender Affirming Surgery). Your NYP plan also includes enhanced coverage for gender affirming care. This enhanced coverage is inclusive of the following services: Facial Feminization surgery Thyroid chondroplasty Rhytidectomy Electrolysis Voice Surgery Jaw surgery
	Outpatient Services: - Facility fee (e.g., ambulatory surgery center) - Physician/surgeon fees	No charge	Not covered	
	Inpatient services: Facility fee (e.g. hospital room)	\$150 <u>copay</u> /day first 3 days per stay	Not covered	
	Inpatient services: Physician/surgeon fees	No charge	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	<u>Home health care</u>	No charge	Not covered	200 visits/calendar year.
	<u>Rehabilitation services</u>	\$30 <u>copay</u> /visit for NYP Affiliated Specialist; except no charge for office surgery \$40 <u>copay</u> /visit for non-NYP specialist; except no charge for office surgery	Not covered	60 visits/calendar year for Physical Therapy 30 visits/calendar year for Speech & Occupational Therapy combined, including outpatient hospital services.
	<u>Habilitation services</u>	\$25 <u>copay</u> /visit	Not covered	None
	<u>Skilled nursing care</u>	No charge	Not covered	60 days/calendar year. Pre-authorization required for care.
	<u>Durable medical equipment</u>	No charge	Not covered	Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse. Includes Electric Breast Pumps limited to 1 per 12 months.
	<u>Hospice services</u>	No charge	Not covered	Pre-authorization required for care.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

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|--------------------|--|---|
| • Cosmetic surgery | • Long-term care | • Private-duty nursing |
| • Dental care | • Non-emergency care when traveling outside the U.S. | • Routine foot care |
| • Glasses | • <u>Prescription drugs</u> | • Weight loss programs - Except for required <u>preventive services</u> . |

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

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| • Acupuncture | • Chiropractic care | • Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition, artificial insemination & ovulation induction. Advanced reproductive technology (subject to <u>coinsurance</u>): \$30,000 maximum/lifetime <u>for iatrogenic infertility only</u> at specific NYP facilities and Aetna® Institutes of Excellence™. Includes: IVF, cryopreservation, storage, thawing (for eggs, sperm and embryo). For Infertility related questions and additional details on infertility benefits please reach out to NIU at 1-800-575-5999 once enrolled. |
| • Bariatric surgery | • Hearing aids - \$6,000 maximum/3 years. | |
| • NYP Virtual Urgent Care | • Routine Eye Care 1 routine medical eye exam/calendar year. Refer to https://nyp.aetna.com/ under Plan Offerings and select Vision plan for a detailed list of additional vision benefits. | |
| • Gender Affirming Care | | |

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is:

- For more information on your rights to continue coverage, contact the plan at 1-888-982-3862.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <http://www.dol.gov/ebsa/healthreform>
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- If your coverage is a church plan, church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law.

Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

- If your group health coverage is subject to ERISA, you may contact Aetna directly by calling the toll-free number on your Medical ID Card, or by calling our general number at 1-888-982-3862. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <http://www.dol.gov/ebsa/healthreform>
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- Additionally, a consumer assistance program can help you file your appeal. Contact information is at: <http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html>.

Does this plan provide Minimum Essential Coverage? Yes.

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? Yes.

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

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

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The <u>plan's</u> overall <u>deductible</u>	\$0
■ <u>Specialist</u> <u>copayment</u>	\$40
■ Hospital (facility) <u>copayment</u>	\$0
■ Other <u>copayment</u>	\$0

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$40
<u>Coinsurance</u>	\$0
The total Peg would pay is	\$40

Managing Joe's Type 2 Diabetes

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

■ The <u>plan's</u> overall <u>deductible</u>	\$0
■ Primary care <u>copayment</u>	\$50
■ Hospital (facility) <u>copayment</u>	\$150
■ Other <u>copayment</u>	\$0

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$200
<u>Coinsurance</u>	\$0
The total Joe would pay is	\$200

Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$0
■ <u>Specialist</u> <u>copayment</u>	\$120
■ Hospital (facility) <u>copayment</u>	\$150
■ Other <u>copayment</u>	\$0

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	\$2,800
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In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$270
<u>Coinsurance</u>	\$0
The total Mia would pay is	\$270

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

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Cynthia is Undergoing a Breast Augmentation in an Outpatient Setting

(A year of in-network clinically assisted gender affirming in accordance with the plan generals)

■ The <u>plan's</u> overall <u>deductible</u>	\$0
■ <u>Specialist copayment</u>	\$40
■ Hospital (facility) <u>copayment</u>	\$150
■ Other <u>copayment</u>	\$0

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment

Total Example Cost	\$17,500
In this example, Cynthia would pay:	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$190
<u>Coinsurance</u>	\$0
The total Cynthia would pay is	\$190

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

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 866-393-0002.

Smartphone or Tablet

To view documents from your smartphone or tablet, the free WinZip app is required. It may be available from your App Store.

Non-Discrimination

Aetna complies with applicable Federal civil rights laws and does not unlawfully discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, disability, gender identity or sexual orientation.

We provide free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator,

P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: P.O. Box 24030, Fresno, CA 93779),

1-800-648-7817, TTY: 711,

Fax: 859-425-3379 (CA HMO customers: 860-262-7705), CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates.

TTY: 711

Language Assistance:

For language assistance in your language call 1-888-982-3862 at no cost.

Albanian -	Për asistencë në gjuhën shqipe telefononi falas në 1-888-982-3862.
Amharic -	ለቋንቋ እገዛ በ አማርኛ በ 1-888-982-3862 በነጻ ይደውሉ
Arabic -	1-888-982-3862 للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني
Armenian -	Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-888-982-3862 առանց գնով:
Bahasa Indonesia -	Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-888-982-3862 tanpa dikenakan biaya.
Bantu-Kirundi -	Niba urondera uwugufasha mu Kirundi, twakure kuri iyi numero 1-888-982-3862 ku busa
Bengali-Bangala -	বাংলায় ভাষা সহায়তার জন্য বিনামূল্যে 1-888-982-3862-তে কল করুন।
Bisayan-Visayan -	Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-888-982-3862 nga walay bayad.
Burmese -	ငွေကုန်ကျခံရမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-888-982-3862 ကို ခေါ်ဆိုပါ။
Catalan -	Per rebre assistència en (català), truqui al número gratuït 1-888-982-3862.
Chamorro -	Para ayuda gi fino' (Chamoru), ågang 1-888-982-3862 sin gåstu.
Cherokee -	ᎠᎩᏍᏔ ᏌᏍᏗᎦᎩᏍᏔ ᏊᎦᎩᏍᏔᎦᎩᏍᏔ ᎠᎩᏍᏔ (CWY) ᎠᎩᏍᏔᎦᎩᏍᏔ 1-888-982-3862 ᎠᎩᏍᏔ ᎠᎩᏍᏔ ᎠᎩᏍᏔ ᎠᎩᏍᏔ.
Chinese -	欲取得繁體中文語言協助，請撥打1-888-982-3862，無需付費。
Choctaw -	(Chahta) anumpa ya apela a chi l paya hinla 1-888-982-3862.
Cushite -	Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-888-982-3862 irratti bilisaan bilbilaa.
Dutch -	Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-888-982-3862.
French -	Pour une assistance linguistique en français appeler le 1-888-982-3862 sans frais.
French Creole -	Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-888-982-3862 gratis.
German -	Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-888-982-3862 an.
Greek -	Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-888-982-3862 χωρίς χρέωση.
Gujarati -	ગુજરાતીમાં ભાષામાં સહાય માટે કોઈ પણ ખર્ચ વગર 1-888-982-3862 પર કોલ કરો.
Hawaiian -	No ke kōkua ma ka ‘ōlelo Hawai‘i, e kahea aku i ka helu kelepona 1-888-982-3862. Kāki ‘ole ‘ia kēia kōkua nei.

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