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, call 844-552-7805. 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 www.healthcare.gov/sbc-glossary/ or call 844-552-7805 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network providers under Basic Plan: $2,000/individual or $4,000/family Out-of-network providers under Basic Plan: $5,000/individual Does not apply to the Critical Illness Benefit.	Generally, you must pay all of the costs from providers up to the deductible amount before this Plan begins to pay. If you have other family members on the Plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care, Critical Illness, Convalescent/Custodial Care, Nursing Home, Assisted Living Facilities and Home Health Care benefits are covered before you meet your deductible.	This Plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this Plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-network providers under Basic Plan: $2,000/individual, $4,000/family; Out-of-network providers under Basic Plan: No limit	The out-of-pocket limit is the most you could pay in a year for covered services involving essential health benefits. If you have other family members in this Plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover, non-essential health benefits including private duty nursing, custodial care in a skilled nursing facility, and care in a convalescent home, custodial care facility, nursing home, or assisted living facility, expenses for services from out-of-network providers under your Basic Plan, and care for which you fail to obtain pre-authorization required under your Basic Plan.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Will you pay less if you use a network provider?	Yes. See the website for your Basic Plan or call your Basic Plan for a list of its in-network providers.	You will pay less if you use a provider who is in-network under your Basic Plan. You will pay the most if you use an out-of-network provider under your Basic Plan, and you might receive a bill from a provider for the difference between the provider's charge and what your Basic Plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes	If a referral is required by your Basic Plan, this Plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

⚠ 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
		Network Provider under Basic Plan (You will pay the least)	Out-of-Network Provider under Basic Plan (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Amounts over Covered Charges	30% coinsurance plus amounts over Covered Charges	Acupuncture and chiropractic services limited to 30 visits each per calendar year. This Plan will pay Covered Charges, less whatever payments were made by the Basic Plan(s), up to any applicable maximums and subject to any coinsurance requirements. No benefits are payable if you are not enrolled in a Basic Plan at the time the claim is incurred. This Plan considers in-network providers under your Basic Plan to be in-network under this Plan. *See the Benefits, Exclusions and Limitations and Coordination of Benefits sections of the plan document for a definition of Covered Charges and more information on how benefits are calculated under this Plan.
	Specialist visit	Amounts over Covered Charges	30% coinsurance plus amounts over Covered Charges	
	Preventive care/screening/ immunization	No charge. Deductible does not apply.	No charge. Deductible does not apply.	Age and frequency limitations apply. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. This Plan will pay Covered Charges, less whatever payments were made by the Basic Plan(s), up to any applicable maximums and subject to any

* For more information about limitations and exceptions, see the plan document at www.healthsmart.com/nysut.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider under Basic Plan (You will pay the least)	Out-of-Network Provider under Basic Plan (You will pay the most)	
				coinsurance requirements. No benefits are payable if you are not enrolled in a Basic Plan at the time the claim is incurred. This Plan considers in-network providers under your Basic Plan to be in-network under this Plan. *See the Benefits, Exclusions and Limitations and Coordination of Benefits sections of the plan document for a definition of Covered Charges and more information on how benefits are calculated under this Plan.
If you have a test	Diagnostic test (x-ray, blood work)	Amounts over Covered Charges	30% coinsurance plus amounts over Covered Charges	This Plan will pay Covered Charges, less whatever payments were made by the Basic Plan(s), up to any applicable maximums and subject to any coinsurance requirements. No benefits are payable if you are not enrolled in a Basic Plan at the time the claim is incurred. This Plan considers in-network providers under your Basic Plan to be in-network under this Plan. *See the Benefits, Exclusions and Limitations and Coordination of Benefits sections of the plan document for a definition of Covered Charges and more information on how benefits are calculated under this Plan.
	Imaging (CT/PET scans, MRIs)	Amounts over Covered Charges	30% coinsurance plus amounts over Covered Charges	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available from the administrator, HealthSmart Benefit Solutions, at 844-552-	Generic drugs	Amounts over Covered Charges	30% coinsurance plus amounts over Covered Charges	This Plan will pay Covered Charges, less whatever payments were made by the Basic Plan(s), up to any applicable maximums and subject to any coinsurance requirements. No benefits are payable if you are not enrolled in a Basic Plan at the time the claim is incurred. This Plan considers in-network providers under your Basic Plan to be in-network under this Plan. *See the Benefits, Exclusions and Limitations and Coordination of
	Preferred brand drugs	Amounts over Covered Charges	30% coinsurance plus amounts over Covered Charges	
	Non-preferred brand drugs	Amounts over Covered Charges	30% coinsurance plus amounts over Covered Charges	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider under Basic Plan (You will pay the least)	Out-of-Network Provider under Basic Plan (You will pay the most)	
7805	Specialty drugs	Amounts over Covered Charges	30% coinsurance plus amounts over Covered Charges	Benefits sections of the plan document for a definition of Covered Charges and more information on how benefits are calculated under this Plan.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Amounts over Covered Charges	30% coinsurance plus amounts over Covered Charges	This Plan will pay Covered Charges, less whatever payments were made by the Basic Plan(s), up to any applicable maximums and subject to any coinsurance requirements. No benefits are payable if you are not enrolled in a Basic Plan at the time the claim is incurred. This Plan considers in-network providers under your Basic Plan to be in-network under this Plan. *See the Benefits, Exclusions and Limitations and Coordination of Benefits sections of the plan document for a definition of Covered Charges and more information on how benefits are calculated under this Plan.
	Physician/surgeon fees	Amounts over Covered Charges	30% coinsurance plus amounts over Covered Charges	
If you need immediate medical attention	Emergency room care	Amounts over Covered Charges	30% coinsurance plus amounts over Covered Charges	This Plan will pay Covered Charges, less whatever payments were made by the Basic Plan(s), up to any applicable maximums and subject to any coinsurance requirements. No benefits are payable if you are not enrolled in a Basic Plan at the time the claim is incurred. This Plan considers in-network providers under your Basic Plan to be in-network under this Plan. *See the Benefits, Exclusions and Limitations and Coordination of Benefits sections of the plan document for a definition of Covered Charges and more information on how benefits are calculated under this Plan.
	Emergency medical transportation	Amounts over Covered Charges	30% coinsurance plus amounts over Covered Charges	
	Urgent care	Amounts over Covered Charges	30% coinsurance plus amounts over Covered Charges	
If you have a hospital stay	Facility fee (e.g., hospital room)	Amounts over Covered Charges	30% coinsurance plus amounts over Covered	Only the cost of a semi-private room is covered unless a private room is determined (by the Administrator or its designee) to be Medically

* For more information about limitations and exceptions, see the plan document at www.healthsmart.com/nysut.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider under Basic Plan (You will pay the least)	Out-of-Network Provider under Basic Plan (You will pay the most)	
			Charges	Necessary. This Plan will pay Covered Charges, less whatever payments were made by the Basic Plan(s), up to any applicable maximums and subject to any coinsurance requirements. No benefits are payable if you are not enrolled in a Basic Plan at the time the claim is incurred. This Plan considers in-network providers under your Basic Plan to be in-network under this Plan.*See the Benefits, Exclusions and Limitations and Coordination of Benefits sections of the plan document for a definition of Covered Charges and more information on how benefits are calculated under this Plan.
	Physician/surgeon fees	Amounts over Covered Charges	30% coinsurance plus amounts over Covered Charges	This Plan will pay Covered Charges, less whatever payments were made by the Basic Plan(s), up to any applicable maximums and subject to any coinsurance requirements. No benefits are payable if you are not enrolled in a Basic Plan at the time the claim is incurred. This Plan considers in-network providers under your Basic Plan to be in-network under this Plan. *See the Benefits, Exclusions and Limitations and Coordination of Benefits sections of the plan document for a definition of Covered Charges and more information on how benefits are calculated under this Plan.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Amounts over Covered Charges	30% coinsurance plus amounts over Covered Charges	This Plan will pay Covered Charges, less whatever payments were made by the Basic Plan(s), up to any applicable maximums and subject to any coinsurance requirements. No benefits are payable if you are not enrolled in a Basic Plan at the time the claim is incurred. This Plan considers in-network providers under your Basic Plan to be in-
	Inpatient services	Amounts over Covered Charges	30% coinsurance plus amounts over Covered Charges	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider under Basic Plan (You will pay the least)	Out-of-Network Provider under Basic Plan (You will pay the most)	
				network under this Plan. *See the Benefits, Exclusions and Limitations and Coordination of Benefits sections of the plan document for a definition of Covered Charges and more information on how benefits are calculated under this Plan.
If you are pregnant	Office visits	Amounts over Covered Charges	30% coinsurance plus amounts over Covered Charges	This Plan will pay Covered Charges, less whatever payments were made by the Basic Plan(s), up to any applicable maximums and subject to any coinsurance requirements. No benefits are payable if you are not enrolled in a Basic Plan at the time the claim is incurred. This Plan considers in-network providers under your Basic Plan to be in-network under this Plan. *See the Benefits, Exclusions and Limitations and Coordination of Benefits sections of the plan document for a definition of Covered Charges and more information on how benefits are calculated under this Plan.
	Childbirth/delivery professional services	Amounts over Covered Charges	30% coinsurance plus amounts over Covered Charges	
	Childbirth/delivery facility services	Amounts over Covered Charges	30% coinsurance plus amounts over Covered Charges	
If you need help recovering or have other special health needs	Home health care	Amounts over Covered Charges	70% coinsurance plus amounts over Covered Charges	Benefits begin following 60 hours of paid home health care per calendar year; maximum 25 hours per week; limited to 6,000 hours per lifetime while covered under this Plan. This Plan will pay Covered Charges, less whatever payments were made by the Basic Plan(s), up to any applicable maximums and subject to any coinsurance requirements. No benefits are payable if you are not enrolled in a Basic Plan at the time the claim is incurred. Refer to the Plan Document for the definition of Home Health Care Agencies that are considered In-Network under the Plan. *See the Benefits, Exclusions and Limitations and Coordination of Benefits sections of the Plan Document for a

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider under Basic Plan (You will pay the least)	Out-of-Network Provider under Basic Plan (You will pay the most)	
				definition of Covered Charges and more information on how benefits are calculated under this Plan.
	Rehabilitation services	Amounts over Covered Charges	30% coinsurance plus amounts over Covered Charges	Physical therapy, speech therapy, and occupational therapy in the outpatient department of a facility or in a provider's office up to combined 30 visits per calendar year. This Plan will pay Covered Charges, less whatever payments were made by the Basic Plan(s), up to any applicable maximums and subject to any coinsurance requirements. No benefits are payable if you are not enrolled in a Basic Plan at the time the claim is incurred. This Plan considers in-network providers under your Basic Plan to be in-network under this Plan. *See the Benefits, Exclusions and Limitations and Coordination of Benefits sections of the plan document for a definition of Covered Charges and more information on how benefits are calculated under this Plan.
	Habilitation services	Amounts over Covered Charges	30% coinsurance plus amounts over Covered Charges	
	Skilled nursing care	Amounts over Covered Charges	For active and progressive treatment, 30% coinsurance plus amounts over Covered Charges.	Coverage for active and progressive treatment in a skilled nursing facility or subacute care facility up to 100 days while covered under this Plan. Private Duty Nursing (up to $15 per hour ($360/day) and maximum of $35,000 while covered under this Plan). This Plan will pay Covered Charges, less whatever payments were made by the Basic Plan(s), up to any applicable maximums and subject to any coinsurance requirements. No benefits are payable if you are not enrolled in a Basic Plan at the time the claim is incurred. This Plan considers in-network providers under your Basic Plan to be in-network under this Plan. *See the Benefits, Exclusions and Limitations and

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider under Basic Plan (You will pay the least)	Out-of-Network Provider under Basic Plan (You will pay the most)	
				Coordination of Benefits sections of the plan document for a definition of Covered Charges and more information on how benefits are calculated under this Plan.
	Durable medical equipment	Amounts over Covered Charges	30% coinsurance plus amounts over Covered Charges	Covers artificial limbs, crutches, wheelchairs and other medical equipment, appliances and supplies as medically necessary. This Plan will pay Covered Charges, less whatever payments were made by the Basic Plan(s), up to any applicable maximums and subject to any coinsurance requirements. No benefits are payable if you are not enrolled in a Basic Plan at the time the claim is incurred. This Plan considers in-network providers under your Basic Plan to be in-network under this Plan. *See the Benefits, Exclusions and Limitations and Coordination of Benefits sections of the plan document for a definition of Covered Charges and more information on how benefits are calculated under this Plan.
	Hospice services	Amounts over Covered Charges	30% coinsurance plus amounts over Covered Charges	Limited to 210 consecutive days of confinement per lifetime while covered under this Plan and 5 visits per lifetime while covered under this Plan for bereavement counseling to the family of the terminally ill participant. This Plan will pay Covered Charges, less whatever payments were made by the Basic Plan(s), up to any applicable maximums and subject to any coinsurance requirements. No benefits are payable if you are not enrolled in a Basic Plan at the time the claim is incurred. This Plan considers in-network providers under your Basic Plan to be in-network under this Plan. *See the Benefits, Exclusions and Limitations and Coordination of Benefits sections of the plan

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider under Basic Plan (You will pay the least)	Out-of-Network Provider under Basic Plan (You will pay the most)	
				document for a definition of Covered Charges and more information on how benefits are calculated under this Plan.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	You pay 100% of these expenses, even in-network.
	Children's glasses	Not covered	Not covered	You pay 100% of these expenses, even in-network.
	Children's dental check-up	Not covered	Not covered	You pay 100% of these expenses, even in-network.

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.)

- Cosmetic surgery (covered if result of non-occupational related injury or sickness or congenital disease or anomaly of a child resulting in functional defect)
- Dental Care (Adult and Child)
- Hearing Aids
- Non-emergency care when traveling outside the U.S.
- Routine Eye care (Adult & Child) (eye care, treatment or surgery covered if medically necessary and result of non-job related injury)
- Routine foot care
- Weight loss programs (except as required by the federal Affordable Care Act)

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

- Acupuncture (if medically necessary; limited to 30 visits per calendar year)
- Bariatric surgery (if medically necessary)
- Chiropractic care (if medically necessary; limited to 30 visits per calendar year)
- Infertility Services (for diagnosis and treatment of medical conditions that result in infertility; expenses related to services that induce pregnancy are not covered)
- Long-Term care (covered charges for care in convalescent home/custodial care facility up to $72/day to maximum $80,000 while covered under this Plan; benefits begin on 20th day of confinement)
- Private duty nursing (Up to $15/hour ($360 per day); maximum of $35,000 while covered under this Plan).

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 the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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

* For more information about limitations and exceptions, see the plan document at www.healthsmart.com/nysut.

assistance, contact: the Administrator at 844-552-7805. You may also contact Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact the Department of Financial Services, One State Street, New York, NY 10004-1511; (800) 342-3736; http://www.dfs.ny.gov/consumers.

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 the Minimum Value Standards? **No**

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.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 844-552-7805.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 844-552-7805.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 844-552-7805.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 844-552-7805.

*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 plan's overall deductible** **$2,000**
- **Specialist cost sharing** **$0**
- **Hospital (facility) cost sharing** **$0**
- **Other cost sharing** **$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	**$12,800 ($240 remaining after Basic Plan pays)**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$240
Copayments	$
Coinsurance	$
What isn't covered	
Limits or exclusions	$
The total Peg would pay is	**$240**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$2,000**
- **Specialist cost sharing** **$0**
- **Hospital (facility) cost sharing** **$0**
- **Other cost sharing** **$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	**$7,400 ($2,190 remaining after Basic Plan pays)**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$
Coinsurance	$
What isn't covered	
Limits or exclusions	$
The total Joe would pay is	**$2,000**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$2,000**
- **Specialist cost sharing** **$0**
- **Hospital (facility) cost sharing** **$0**
- **Other cost sharing** **$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	**$1,970 ($1,250 remaining after Basic Plan pays)**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,250
Copayments	$
Coinsurance	$
What isn't covered	
Limits or exclusions	$
The total Mia would pay is	**$1,250**

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