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.MyPOMCO.com or 1-866-317-2098. 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 1-866-317-2098 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Out-of-Network: $100/Individual	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 and primary care services 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?	Yes. $100 for out-of-network providers physical therapy, occupational therapy and chiropractic services.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	Medical: For network providers $5,080 individual / $10,160 family. Prescription Drug: $1,270 individual / $2,540 family.	The out-of-pocket limit is the most you could pay in a year for covered services. 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?	Services paid at 100%, premiums, balance-billing charges, and health care this plan doesn't cover.	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 www.MyPOMCO.com or call 1-866-317-2098 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your 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?	No.	You can see the specialist you choose without a referral.

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 (You will pay the least)	Out-of-Network Provider (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	$10 copay/visit	20% coinsurance	None
	Specialist visit	$10 copay/visit	20% coinsurance	None
	Preventive care/screening/ immunization	No charge	20% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	$10 copay/visit	20% coinsurance	Outpatient hospital : $15 copay/visit
	Imaging (CT/PET scans, MRIs)	$10 copay/visit	20% coinsurance	Outpatient hospital : $15 copay/visit
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.Express-Scripts.com	Generic drugs	$5 copay/prescription (retail & mail order)	Reimbursed up to the network pharmacy amount.	Student health center prescriptions: $28 copay/prescription during the summer period; $7 copay/prescription all others.
	Preferred brand drugs	$25 copay/prescription (retail); $50 copay/prescription (mail order)		
	Non-preferred brand drugs	$45 copay/prescription (retail); $90 copay/prescription (mail order)		
	Specialty drugs	See above copay limits.		Details see www.Express-Scripts.com
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$10 copay/visit	20% coinsurance	None
	Physician/surgeon fees	$10 copay/visit	20% coinsurance	None
If you need immediate medical attention	Emergency room care	$25 copay/visit	$25 copay/visit	None
	Emergency medical transportation	$15 copay/visit	$15 copay/visit	None
	Urgent care	$10 copay/visit	20% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$200 copay/admission	20% coinsurance	Precertify or 50% benefit reduction.
	Physician/surgeon fees	No charge	20% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$10 copay/visit	20% coinsurance	None
	Inpatient services	$200 copay/admission	20% coinsurance	Precertify or 50% benefit reduction.
If you are pregnant	Office visits	$10 copay/visit	20% coinsurance	None
	Childbirth/delivery professional services	No charge	20% coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery facility services	$200 copay/admission	20% coinsurance	Precertify or 50% benefit reduction.
If you need help recovering or have other special health needs	Home health care	No charge	20% coinsurance	Precertify or 50% benefit reduction.
	Rehabilitation services	$10 copay/visit	20% coinsurance	Outpatient hospital : $15 copay/visit
	Habilitation services			
	Skilled nursing care	Not covered	Not covered	None
	Durable medical equipment	No charge	20% coinsurance	Excludes vehicle modifications, home modifications, exercise, and bathroom equipment.
	Hospice services	No charge	No charge	Limited to 210 days per plan year.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

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.)

- Acupuncture
- Bariatric Surgery
- Cosmetic Surgery
- Dental Care
- Hearing Aids
- Infertility Treatment
- Long Term Care
- Routine eye care
- Routine Foot Care
- Weight Loss Programs

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

- Chiropractic Care
- Non-emergency care when traveling outside the U.S. unless travel is for the sole purpose of obtaining medical services
- Private Duty Nursing

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: ERISA 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 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: ERISA Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA(3272).

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the 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 plan's overall deductible	$0
Specialist	$10
Hospital (facility)	$200
Other	100%

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	**$12,759**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$420
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$480**

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

The plan's overall deductible	$0
Specialist	$10
Hospital (facility)	$200
Other	100%

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	**$7,431**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$740
Coinsurance	$0
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$795**

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

The plan's overall deductible	$0
Specialist	$10
Hospital (facility)	$200
Other	100%

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	**$1,925**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$200**

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

The health plan/program complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The health plan/program does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The health plan/program:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Kathleen Caggiano-Siino.

If you believe that the health plan/program has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Kathleen Caggiano-Siino, Vice President of Human Resources, 35 State St., 1.518.434.7132, Kathleen.caggiano-siino@rfsuny.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Kathleen Caggiano-Siino, Vice President of Human Resources is available to help you.

You can also file a civil rights complaint with the US Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

US Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201
1.800.368.1019, 800.537.7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

The health plan/program complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATTENTION: If you speak one of the languages listed below, language assistance services, free of charge, are available to you. Call 1.866.317.2098 (TTY: 1.866.317.2098).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1.866.317.2098 (TTY: 1.866.317.2098).

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1.866.317.2098 (TTY: 1.866.317.2098)。

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1. 866.317.2098 (телетайп: 1. 866.317.2098).

French Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1. 866.317.2098 (TTY: 1. 866.317.2098).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1. 866.317.2098 (TTY: 1. 866.317.2098)번으로 전화해 주십시오.

Italian: ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1.800.234.4393 (TTY: 1. 866.317.2098).

Yiddish: אויפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופט 1. 866.317.2098 (TTY: 1. 866.317.2098).

Bengali: লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১1. 866.317.2098 (TTY: ১1. 866.317.2098)।

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1. 866.317.2098 (TTY: 1. 866.317.2098).

Arabic:

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-3934.432.008 (رقم هاتف الصم والبكم: 1-8902.713.668).

French: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1.866.317.2098 (ATS : 1.866.317.2098).

Urdu: خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں1.866.317.2098 (TTY: 1.866.317.2098).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1.866.317.2098 (TTY: 1.866.317.2098).

Greek: ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1.866.317.2098 (TTY: 1.866.317.2098).

Albanian: KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1.866.317.2098 (TTY: 1.866.317.2098).