Summary of
Benefits & Coverage

WellCare of New York: Essential Plan 2 Plus Vision & Dental
Coverage for: **Individual**
Plan Type: **HMO**

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Summary of Benefits and Coverage:
What this Plan Covers & What You Pay for Covered Services

Coverage Period: 01/01/2020-12/31/2020

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 healthcare 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 **1-855-582-6172** or visit us at **www.wellcare.com/New-York**. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, co-payment, deductible, provider or other underlined terms, see the Glossary. You can view the Glossary at **https://www.healthcare.gov/sbc-glossary/** or call **1-855-582-6172** to request a copy.

Important Questions	Answers	Why this Matters
What Is the Overall Deductible?	$0 per person.	See the chart starting on Page 2 to find out how much you pay for covered services.
Are there Services Covered Before You Meet Your Deductible?	No.	See the chart starting on Page 2 to find out how much you pay for covered services.
Are there Other Deductibles for Specific Services?	No.	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.
What Is the Out-of-Pocket Limit for this Plan?	$200 per person.	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 healthcare expenses.
What Is Not Included in the Out-of-Pocket Limit?	**Premiums**, **balance-billed** charges, Healthcare received but not covered by this **plan** and penalties.	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.** For a list of participating **providers**, see **www.wellcare.com/New-York/Find-a-Provider** or call **1-855-582-6172**.	If you use an in-network doctor or other healthcare **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 o**ut-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 You Need a Referral to See a Specialist?	**Yes**. A written **referral** is required.	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**.

All co-payment 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 and Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If You Visit a Healthcare Provider's Office or Clinic	Primary care visit to treat an injury or illness	$0 co-pay	Not Covered	None
	Specialist visit	$0 co-pay	Not Covered	None
	Preventive care/ screening/ immunization	Covered in full.	Not Covered	Limited to the U.S. Preventive Services Task Force recommendations (A and B only), Advisory Committee on Immunization Practices (ACIP) recommendations, and Health Resources and Service Administration guidelines for women and children.
If You Have a Test	Diagnostic test (X-ray, blood work)	$0 co-pay	Not Covered	Co-pay may vary based on services provided and the setting where covered services are received.
	Imaging (CT/ PET scans, MRIs)	$0 co-pay	Not Covered	Prior authorization may be required. Co-pay may vary based on services provided and the setting where covered services are received.
If You Need Drugs to Treat Your Illness or Condition More information about prescription drug coverage is available at **www.wellcare.com/New-York/Members/Health-Care-Exchange/New-York-Essential-Plan-2020/Pharmacy-Services**	Generic drugs	$1 co-pay (retail) $2.50 co-pay (mail order)	Not Covered	Covers up to a 30-day supply (retail) and a 90-day supply (mail order).
	Preferred brand drugs	$3 co-pay (retail) $7.50 co-pay (mail order)	Not Covered	Covers up to a 30-day supply (retail) and a 90-day supply (mail order).
	Non-preferred brand drugs	$3 co-pay (retail) $7.50 co-pay (mail order)	Not Covered	Covers up to a 30-day supply (retail) and a 90-day supply (mail order).
	Specialty drugs	$3 co-pay (mail order)	Not Covered	Covers up to a 30-day supply (mail order).

* For more information about limitations and exceptions, see the plan or policy document at **www.wellcare.com/New-York/Members/Health-Care-Exchange/New-York-Essential-Plan-2020**.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions and Other Important Information
		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)	$0 co-pay	Not Covered	Prior authorization may be required.
	Physician/surgeon fees	$0 co-pay	Not Covered	Prior authorization may be required.
If You Need Immediate Medical Attention	Emergency Room Care	$0 co-pay	$0 co-pay	Waived if admitted.
	Emergency Medical Transportation	$0 co-pay	Not Covered	None
	Urgent Care	$0 co-pay	$0 co-pay	None
If You Have a Hospital Stay	Facility fee (e.g., hospital room)	$0 co-pay	Not Covered	Prior authorization may be required.
	Physician/surgeon fees	$0 co-pay	Not Covered	Prior authorization may be required. Inpatient Rehabilitation limited to 60 days per **plan** year combined therapies.
If You Need Mental Health, Behavioral Health or Substance Abuse Services	Outpatient services	$0 co-pay	Not Covered	Prior authorization may be required. For substance abuse, up to 20 visits per plan year may be used for family counseling.
	Inpatient services	$0 co-pay	Not Covered	Prior authorization may be required.
If You Are Pregnant	Office visits	$0 co-pay	Not Covered	Prior authorization may be required.
	Childbirth/delivery professional services	$0 co-pay	Not Covered	Prior authorization may be required.
	Childbirth/delivery facility services	$0 co-pay	Not Covered	Prior authorization may be required.

* For more information about limitations and exceptions, see the plan or policy document at www.wellcare.com/New-York/Members/Health-Care-Exchange/New-York-Essential-Plan-2020.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions and Other Important Information
		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	Home healthcare	$0 co-pay	Not Covered	Prior authorization may be required. Limited to 40 visits per **plan** year.
	Rehabilitation services	$0 co-pay	Not Covered	Prior authorization may be required. Limited to 60 visits per condition, per **plan** year combined therapies. Speech and physical therapy are only covered following a hospital stay or surgery.
	Habilitation services	$0 co-pay	Not Covered	Prior authorization may be required. Limited to 60 visits per condition, per **plan** year combined therapies.
	Skilled nursing care	$0 co-pay	Not Covered	Prior authorization may be required. Limited to 200 days per **plan** year.
	Durable medical equipment	$0 co-pay	Not Covered	Prior authorization may be required.
	Hospice services	$0 co-pay	Not Covered	Prior authorization may be required. Limited to 210 days per **plan** year. Five (5) visits for family bereavement counseling.
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

* For more information about limitations and exceptions, see the plan or policy document at www.wellcare.com/New-York/Members/Health-Care-Exchange/New-York-Essential-Plan-2020.

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 for morbid obesity
- Cosmetic surgery, unless to correct a functional impairment
- Dental care (Children)
- Long-term care
- Non-emergency care when traveling outside of the U.S.
- Private duty nursing
- Eye care (Children)
- 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.)

- Hearing aid
- Infertility treatment
- Chiropractic care
- Dental care (Adult)
- Eye care (Adult)

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: New York Department of Financial Services **1-800-342-3736**. 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: WellCare of New York at **1-855-582-6172**.

Does this Plan Provide Minimum Essential Coverage? Yes, this plan does provide minimum essential coverage.
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, this health coverage does meet the minimum value standard for the benefits it provides.
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:
Español: Para obtener ayuda en español llame al 1-877-374-4056.
Tagalog: Upang makatanggap ng tulong sa wikang Tagalog, tumawag sa 1-877-374-4056.
中文: 如需中文服務，請撥打 1-877-374-4056。
Diné: Dinéjí ata' hane' nínízingo, kojį' hodíílnih 1-877-374-4056.

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

* For more information about limitations and exceptions, see the plan or policy document at **wwww.wellcare.com/New-York/Members/Health-Care-Exchange/New-York-Essential-Plan-2020**.

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, co-payments 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 prenatal care and a hospital delivery)

• The plan's overall deductible	$0
• Specialist Co-payment	$0
• Hospital (facility) Co-payment	$0
• Other Coinsurance	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	**$12,667**

In this example, **Peg would pay:**

Cost Sharing	
Deductibles	$0
Co-payments	$4
Coinsurance	$0
What Isn't Covered	
Limits or exclusions	$60
The total Peg would pay is	**$64**

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 Co-payment	$0
• Hospital (facility) Co-payment	$0
• Other Coinsurance	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	**$7,264**

In this example, **Joe would pay:**

Cost Sharing	
Deductibles	$0
Co-payments	$70
Coinsurance	$0
What Isn't Covered	
Limits or exclusions	$55
The total Joe would pay is	**$125**

Mia's Simple Fracture

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

• The plan's overall deductible	$0
• Specialist Co-payment	$0
• Hospital (facility) Co-payment	$0
• Other Coinsurance	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	**$1,925**

In this example, **Mia would pay:**

Cost Sharing	
Deductibles	$0
Co-payments	$0
Coinsurance	$0
What Isn't Covered	
Limits or exclusions	$0
The total Mia would pay is	**$0**

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