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, contact the Plan at 212-695-5206. 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://eoc.empireblue.com/eocdps/aso or www.dol.gov/ebsa/healthreform or call Empire at 1-800-553-9603 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: $0 Out-of-Network: $500 Individual/$1,250 Family	In-Network: See the Common Medical Events chart below for your costs for services this plan covers. Out-of-Network: 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 policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Out-of-Network Home Health care and medical supplies.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
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: $500 Individual/$1,250 Family Out-of-Network: $3,000 Individual/ $7,500 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, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Copayments on certain services, premiums, balance-billing charges, penalties for failure to obtain preauthorization 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.empireblue.com or call 1-800-553-9603 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	$30 copay/ per visit plus 10% coinsurance	30% coinsurance plus balance billing	You may have to pay extra for services billed separately from an office visit.
	Specialist visit	$30 copay/per visit plus 10% coinsurance	30% coinsurance plus balance billing	You may have to pay extra for services billed separately from an office visit.
	Preventive care/screening/ immunization	Well-child care: No charge; Bone density, pap smears, mammogram and well-woman care: Office visits: $30 copay/per visit plus 10% coinsurance	30% coinsurance plus balance billing	Age and frequency limits apply. You may have to pay extra for services billed separately from a preventive care visit.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	30% coinsurance plus balance billing	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance plus balance billing	Out-of-network imaging tests require preauthorization to avoid a benefit reduction by 50% up to $2,500 penalty.

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 drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.empireblue.com or call **1-833-271-2374**; TDD for hearing impaired 800-682-8786	Generic drugs/ Preferred formulary drugs	$10 copay/script (retail and mail order)	Not covered	Retail covers up to 34-day supply; mail order covers a 3-month supply (one copay for 3-month supply). Your doctor is encouraged to prescribe generic-equivalent drugs as appropriate when possible and to prescribe drugs from the preferred drug formulary when prescribing brand-name drugs.
	Brand name drugs/Preferred formulary drugs	$20 copay/script (covers retail and mail order)	Not covered	
	Non-preferred formulary drugs	$20 copay/script (covers retail and mail order)	Not covered	If a prescription drug is not on the formulary, you may request a formulary exception for a clinically appropriate prescription. Request should include a statement from physician that all formulary drugs will be or have been ineffective, would not be as effective as the non-formulary drug, or would have adverse effects. Contact Empire to find out more about this process.
	Specialty drugs	Subject to applicable cost share	Not covered	Contact Empire for a list of the network Specialty Pharmacies and covered specialty drugs. Physician required to order specialty drugs directly from a network Specialty Pharmacy. Certain drugs that must be administered by a physician/practitioner are required to be ordered from the network Specialty Pharmacy in order to be covered as a medical benefit. If you require one of those drugs, your physician or other treating practitioner will order the drug from the required pharmacy. You will not be required to fill a prescription for this category of drug.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance plus balance billing	Requires preauthorization to avoid a benefit reduction by 50% up to $2,500 penalty.
	Physician/surgeon fees	No charge	30% coinsurance plus balance billing	

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 immediate medical attention	Emergency room care	$75 copay/visit	$75 copay/visit	Copayment waived if admitted within 24 hours. Professional/physician charges may be billed separately.
	Emergency medical transportation	Emergency Air/Land Ambulance: 10% coinsurance	Emergency Air/Land Ambulance: 10% coinsurance	Must meet "emergency" criteria. Air ambulance: Transport to nearest acute care facility for emergency admissions; Land ambulance: Transport to nearest hospital
	Urgent care	$30 copay/visit plus 10% coinsurance	30% coinsurance plus balance billing	You may have to pay extra for services billed separately from an office visit.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance plus balance billing	Requires preauthorization to avoid a benefit reduction by 50% up to $2,500 penalty.
	Physician/surgeon fees	No charge	30% coinsurance plus balance billing	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visits: $5 copay/visit; Other outpatient facility services: No charge	Office visits: 20% coinsurance plus balance billing; Other outpatient services: 20% coinsurance plus balance billing	Requires preauthorization to avoid a benefit reduction by 50% up to $2,500 penalty for other outpatient services (facility charges). No preauthorization required for office visits.
	Inpatient services	Inpatient facility and physician: No charge	Inpatient facility and physician: 20% coinsurance plus balance billing	Requires preauthorization to avoid a benefit reduction by 50% up to $2,500 penalty.
If you are pregnant	Office visits	No charge	30% coinsurance plus balance billing	Maternity care may include tests and services described somewhere else in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	No charge	30% coinsurance plus balance billing	
	Childbirth/delivery facility services	No charge	30% coinsurance plus balance billing	

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 help recovering or have other special health needs	Home health care	10% coinsurance	30% coinsurance plus balance billing; deductible does not apply	Limited to 200 visits per calendar year (a visit equals 4 hours of care). Requires preauthorization to avoid a benefit reduction by 50% up to $2,500 penalty.
	Rehabilitation services	Inpatient physical therapy: No charge Outpatient physical, occupational, speech and vision therapy: $30 copay/visit plus 10% coinsurance	30% coinsurance plus balance billing	Inpatient physical therapy limited to 30 days per calendar year; occupational, speech and vision therapy not covered on an inpatient basis. Outpatient therapy limited to 30 visits per calendar year, in and out-of-network services combined. All rehabilitation and habilitation services count toward your rehabilitation visit limit. You may have to pay extra for services billed separately from an office visit. Participants with cerebral palsy can have up to an additional 126 visits if they are medically necessary.
	Habilitation services	Inpatient physical therapy: No charge; Outpatient physical, occupational, speech and vision therapy: $30 copay/visit plus 10% coinsurance	30% coinsurance plus balance billing	
	Skilled nursing care	10% coinsurance	Not covered	Limited to 60 days per calendar year. Requires preauthorization to avoid a benefit reduction by 50% up to $2,500 penalty.
	Durable medical equipment	10% coinsurance	30% coinsurance plus balance billing; Other medical supplies (catheters, oxygen and syringes): Difference between maximum Plan allowance and total charge; Deductible and coinsurance do not apply	Requires preauthorization to avoid a benefit reduction by 50% up to $2,500 penalty.
	Hospice services	10% coinsurance	Not covered	Limited to 210 days per lifetime. Requires preauthorization to avoid a benefit reduction by 50% up to $2,500 penalty.

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 your child needs dental or eye care	Children's eye exam	Your cost depends on the separate vision plan you select.	Your cost depends on the separate vision plan you select.	Vision benefits separately administered by GVS or Vision Services. Limited to 1 eye exam and 1 complete pair of glasses or supply of contact lenses every calendar year.
	Children's glasses	Your cost depends on the separate vision plan you select.	Your cost depends on the separate vision plan you select.	
	Children's dental check-up	No charge	Amount over Plan allowance	Dental benefits separately administered by Guardian. Frequency limits apply.

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.)

- Bariatric surgery
- Cosmetic surgery
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- 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.)

- Acupuncture
- Chiropractic care (Limited to $600 per person per calendar year)
- Dental care (Adult) (Annual maxes vary depending on length of eligibility)
- Hearing aids (After 36 consecutive months of eligibility, 1 hearing aid for each ear, once every 36 months, up to a maximum benefit of $500/hearing aid; Contact HearUSA; Children under the age of 19: Limit of $5,500, available once every three years, if medically necessary)
- Infertility treatment
- Routine eye care (Adult) (Limited to 1 eye exam and/or 1 complete pair of glasses or supply of contact lenses up to a dollar maximum once every calendar year)

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 assistance, contact: Empire Blue Cross & Blue Shield, P.O. Box 140, Church Street Station, New York, NY 10008-1407 (Appeal & Grievance Department) or call 1-800-553-9603. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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? **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.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-553-9603

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 copayment	$30
Hospital (facility) coinsurance	10%
Other Coinsurance	10%

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**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$60
Coinsurance	$150
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$270**

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 copayment	$30
Hospital (facility) coinsurance	10%
Other Coinsurance	10%

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**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,210
Coinsurance	$90
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,320**

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

The plan's overall deductible	$0
Specialist copayment	$30
Hospital (facility) coinsurance	10%
Other Coinsurance	10%

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**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$320
Coinsurance	$160
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$480**

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