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, (914) 737-7220. 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.dol.gov/ebsa/healthreform or call (914) 737-7220 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network Provider: $250 Individual/$625 Family Out-of-Network Provider: $2,500 Individual/$6,250 Family	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. In-network: primary care, specialist office visits, preventive care and outpatient rehabilitation services. In-network and out-of-network: emergency/urgent care, home health care, prescription drugs and vision 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 Provider: Medical: $3,000 Individual/$7,500 Family Prescription Drugs: $3,520 Individual/$8,800 Family Out-of-Network Provider: Medical: $9,000 Individual/$25,000 Family Prescription Drugs: No limit	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?	Penalties for failure to obtain preauthorization for services, balance-billed charges, health care this plan doesn't cover, or vision benefits.	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 in-network providers, see www.empireblue.com or call 1-800-553-9603.	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	$20 copay/visit, deductible does not apply.	30% coinsurance	Medications administered in office: In-network: 10% coinsurance after deductible. Out-of-network: 30% coinsurance after deductible.
	Specialist visit	$40 copay/visit, deductible does not apply. Acupuncture: 10% coinsurance Chiropractic Care: Office Visit: $40 copay/visit, deductible does not apply. Outpatient Hospital Services: 10% coinsurance	30% coinsurance	Medications administered in office: In-network: 10% coinsurance after deductible. Out-of-network: 30% coinsurance after deductible.
	Preventive care/screening/ immunization	No charge, deductible does not apply	30% coinsurance	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.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	30% coinsurance	Preauthorization required. Failure to obtain preauthorization may result in a 50% benefit reduction up to $5,000.
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	

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.OptumRx.com or by calling (866) 863-1408	Generic drugs	Retail and mail order: 20% coinsurance	Retail and mail order: 20% coinsurance plus amount over Average Wholesale Price	The deductible does not apply. Your cost sharing for these benefits count toward the plan's out-of-pocket limit for prescription drugs. No charge for generic contraceptives or other generic ACA-required preventive drugs (or for brand if the generic is not medically appropriate). Retail: 31-day supply. Mail order: 90-day supply. Mail order drugs should be ordered from OptumRx Mail Order. Your provider may fax prescriptions to 1-800-491-7997. For questions, call 1-877-889-6358. Preauthorization is required for some drugs in order to be covered. No coverage for non-formulary drugs and prescriptions filled at Walmart. Erectile Dysfunction Drugs are limited to 6 per month.
	Preferred brand drugs	Retail and mail order: 20% coinsurance	Retail and mail order: 20% coinsurance plus amount over Average Wholesale Price	
	Non-preferred brand drugs	Retail and mail order: 20% coinsurance	Retail and mail order: 20% coinsurance plus amount over Average Wholesale Price.	
	Specialty drugs	Retail and mail order: 20% coinsurance, deductible does not apply.	Not covered.	Specialty drugs must be ordered through BriovaRx Pharmacy. Your provider may fax prescriptions to 1-877-342-4596 or they may be sent electronically via escripts. For questions, call 1-855-427-4682. No coverage for non-formulary drugs.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance	Failure to obtain preauthorization may result in a 50% benefit reduction up to $5,000.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	
If you need immediate medical attention	Emergency room care	$200 copay/visit, deductible does not apply.	$200 copay/visit, deductible does not apply.	Copay waived if admitted to hospital within 24 hours. Professional/physician charges may be billed separately
	Emergency medical transportation	10% coinsurance	10% coinsurance	None.
	Urgent care	$35 copay/visit, deductible does not apply.	30% 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 have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	Failure to obtain preauthorization may result in a 50% benefit reduction up to $5,000.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Freestanding facility and Outpatient Hospital services: 10% coinsurance; Office visit: $20 copay/visit, deductible does not apply.	Hospital Services and Office visit: 30% coinsurance	Preauthorization required for intensive outpatient, partial hospitalization and inpatient hospital services. Failure to obtain preauthorization may result in a 50% benefit reduction up to $5,000. No preauthorization required for outpatient office visits.
	Inpatient services	10% coinsurance	30% coinsurance after deductible.	
If you are pregnant	Office visits	10% coinsurance	30% coinsurance	Cost-sharing does not apply for in-network ACA-required preventive screenings/services. Depending on the type of services and/or provider, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described somewhere else in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	10% coinsurance	30% coinsurance	None.
	Childbirth/delivery facility services	10% coinsurance	30% 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 help recovering or have other special health needs	Home health care	10% coinsurance, deductible does not apply.	30% coinsurance, deductible does not apply.	Limited to 200 visits per Benefit Period.
	Rehabilitation services	Outpatient Rehabilitation Services: $40 copay, deductible does not apply. Inpatient Rehabilitation Services: 10% coinsurance, after deductible.	Outpatient Rehabilitation Services: Not covered. Inpatient Rehabilitation Services: 30% coinsurance, after deductible.	Outpatient: Limited to 30 visits per Benefit Period Inpatient: Limited to 30 days per Benefit Period. Failure to obtain preauthorization for all inpatient physical therapy, occupational, and speech therapy admissions may result in a 50% benefit reduction up to $5,000.
	Habilitation services	10% coinsurance	Not covered.	All habilitation visits count toward your rehabilitation visit limit.
	Skilled nursing care	10% coinsurance	Not covered.	Limited to 60 days per Benefit Period. Failure to obtain preauthorization may result in a 50% benefit reduction up to $5,000.
	Durable medical equipment	10% coinsurance	Not covered.	Failure to obtain preauthorization may result in a 50% benefit reduction up to $5,000.
	Hospice services	10% coinsurance	Not covered.	Limited to 365 days per lifetime; 5 visits for family bereavement counseling.
If your child needs dental or eye care	Children's eye exam	Vision Network: Amount over $125 Plan allowance (combined with glasses) Vision Resource: $5 copay.	Amount over $50 Plan allowance.	Eye exam and lenses limited to once per year. Frames limited to once every two years. Active participants may also get one pair of Safety Glasses per year. Vision Resource: Eye Exam: In-network: $10 copay for new patients. Lenses: In-network: $5 copay/bifocals or $110 copay/progressives Vision benefits administered separately by Vision Resources and Vision Network.. The deductible does not apply. Your cost sharing for these benefits is not included in the plan's out-of-pocket limit. Out-of-Network reimbursement based on Vision Resource schedule.
	Children's glasses	Vision Network: Amount over $125 Plan allowance (combined with eye exam) Vision Resource: Amount over $100 Plan allowance for frames and $1 copay/single vision lenses.	Amount over $100 Plan allowance for frames and amount over $29 Plan allowance for single vision lenses.	
	Children's dental check-up	Not covered.	Not covered.	You must 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
- Dental care (Adult & Child)
- Hearing aids
- Private-duty nursing
- Routine foot care
- Weight loss programs (except as required by the health reform law)

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

- Acupuncture
- Bariatric Surgery
- Chiropractic care
- Infertility treatment
- Long-term care (subject to Plan criteria)
- Non-emergency care when traveling outside the U.S. See www.BCBS.com/bluecardworldwide
- Routine eye care (Adult & Child)

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 U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. For more information on your rights to continue coverage, you may also contact the plan at (914) 737-7220. 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 the plan at (914) 737-7220. 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**

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.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-662-5193.

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	$250
Specialist deductible	$40
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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$250
Copayments	$0
Coinsurance	$1,220
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,530**

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

The plan's overall deductible	$250
Specialist deductible	$40
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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$130
Copayments	$160
Coinsurance	$1,180
What isn't covered	
Limits or exclusions	$390
The total Joe would pay is	**$1,860**

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

The plan's overall deductible	$250
Specialist deductible	$40
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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$250
Copayments	$360
Coinsurance	$60
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$670**

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