




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 <u>deductible</u> ?	In-Network Provider: \$250 Individual/\$625 Family Out-of-Network Provider: \$1,500 Individual/\$3,750 Family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>In-network</u> : primary care, <u>specialist</u> office visits, <u>preventive care</u> . <u>In-network</u> and <u>out-of-network</u> : <u>emergency/urgent care</u> , <u>home health care</u> , <u>prescription drugs</u> and vision are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other <u>deductibles</u> for specific services?	No	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	In-Network Provider: \$1,250 Individual/\$3,125 Family Out of Network Provider: \$4,500 Individual/\$11,250 Family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	Penalties for failure to obtain <u>preauthorization</u> for services, <u>balance-billed</u> charges, health care this <u>plan</u> doesn't cover, <u>prescription drugs</u> , vision or dental benefits.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. For a list of <u>in-network providers</u> , see www.empireblue.com or call 1-800-553-9603.	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 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 <u>provider's office</u> or clinic	Primary care visit to treat an injury or illness	\$20 <u>copay/visit</u> , <u>deductible</u> does not apply.	30% <u>coinsurance</u>	Medications administered in office: <u>In-network</u> : 10% <u>coinsurance</u> after <u>deductible</u> . <u>Out-of-network</u> : 30% <u>coinsurance</u> after <u>deductible</u> .
	<u>Specialist</u> visit	\$20 <u>copay/visit</u> , <u>deductible</u> does not apply. Acupuncture: 10% <u>coinsurance</u> Chiropractic Care: PCP/ <u>Specialist</u> Office: \$20 <u>copay/visit</u> , <u>deductible</u> does not apply. Outpatient Hospital Services: 10% <u>coinsurance</u>	30% <u>coinsurance</u>	Medications administered in office: <u>In-network</u> : 10% <u>coinsurance</u> after <u>deductible</u> . <u>Out-of-network</u> : 30% <u>coinsurance</u> after <u>deductible</u> .
	<u>Preventive care/screening/immunization</u>	No charge	30% <u>coinsurance</u>	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> required. Failure to obtain <u>preauthorization</u> may result in a 50% benefit reduction up to \$5,000.
	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	

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)	
<p>If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.OptumRx.com or by calling (866) 863-1408</p>	Generic drugs	Retail and mail order: 20% <u>coinsurance</u>	Retail and mail order: 20% <u>coinsurance</u> plus amount over Average Wholesale Price	<p>The <u>deductible</u> does not apply. Your <u>cost sharing</u> for these benefits is not included in the plan's <u>out-of-pocket limit</u>.</p> <p>Retail: 31-day supply. Mail order: 90-day supply.</p> <p>Mail order drugs should be ordered from OptumRx Mail Order. Your <u>provider</u> may fax prescriptions to 1-800-491-7997. For questions, call 1-877-889-6358.</p> <p><u>Preauthorization</u> is required for some drugs.</p> <p>No coverage for non-formulary drugs and prescriptions filled at Walmart.</p> <p>Erectile Dysfunction Drugs are limited to 6 per month.</p> <p><u>Specialty drugs</u> must be ordered through BrioVaRx Pharmacy. Your <u>provider</u> may fax prescriptions to 1-877-342-4596 or they may be sent electronically via ecripts. For questions, call 1-855-427-4682.</p> <p>No coverage for non-formulary drugs.</p>
	Preferred brand drugs	Retail and mail order: 20% <u>coinsurance</u>	Retail and mail order: 20% <u>coinsurance</u> plus amount over Average Wholesale Price	
	Non-preferred brand drugs	Retail and mail order: 20% <u>coinsurance</u>	Retail and mail order: 20% <u>coinsurance</u> plus amount over Average Wholesale Price.	
	<u>Specialty drugs</u>	Retail and mail order: 20% <u>coinsurance</u> , <u>deductible</u> does not apply.	Not covered.	
<p>If you have outpatient surgery</p>	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<p>Failure to obtain <u>preauthorization</u> may result in a 50% benefit reduction up to \$5,000.</p>
	Physician/surgeon fees	10% <u>coinsurance</u>	30% <u>coinsurance</u>	
<p>If you need immediate medical attention</p>	<u>Emergency room care</u>	\$50 <u>copay</u> /visit, <u>deductible</u> does not apply.	\$50 <u>copay</u> /visit, <u>deductible</u> does not apply.	<u>Copay</u> waived if admitted to hospital within 24 hours. Professional/physician charges may be billed separately
	<u>Emergency medical transportation</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	None.
	<u>Urgent care</u>	\$20 <u>copay</u> /visit, <u>deductible</u> does not apply.	30% <u>coinsurance</u>	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% <u>coinsurance</u>	30% <u>coinsurance</u>	Failure to obtain <u>preauthorization</u> may result in a 50% benefit reduction up to \$5,000.
	Physician/surgeon fees	10% <u>coinsurance</u>	30% <u>coinsurance</u>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Hospital services: 10% <u>coinsurance</u> Office visit: \$20 <u>copay</u> /visit, <u>deductible</u> does not apply.	Hospital Services and Office visit: 30% <u>coinsurance</u>	<u>Preauthorization</u> required for intensive outpatient, partial hospitalization and inpatient hospital services. Failure to obtain <u>preauthorization</u> may result in a 50% benefit reduction up to \$5,000. No <u>preauthorization</u> required for outpatient office visits.
	Inpatient services	10% <u>coinsurance</u>	30% <u>coinsurance</u> after <u>deductible</u> .	
If you are pregnant	Office visits	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Depending on the type of services and/or <u>provider</u> , a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply. Maternity care may include tests and services described somewhere else in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None.
	Childbirth/delivery facility services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	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	<u>Home health care</u>	10% <u>coinsurance</u> , <u>deductible</u> does not apply.	30% <u>coinsurance</u> , <u>deductible</u> does not apply.	Limited to 200 visits per Benefit Period.
	<u>Rehabilitation services</u>	Outpatient <u>Rehabilitation Services</u> : \$20 <u>copay</u> , <u>deductible</u> does not apply. Inpatient <u>Rehabilitation Services</u> : 10% <u>coinsurance</u> , after <u>deductible</u> .	Outpatient <u>Rehabilitation Services</u> : Not covered. Inpatient <u>Rehabilitation Services</u> : 30% <u>coinsurance</u> , after <u>deductible</u> .	Outpatient: Limited to 30 visits per Benefit Period Inpatient: Limited to 30 days per Benefit Period. Failure to obtain <u>preauthorization</u> for all inpatient physical therapy, occupational, and speech therapy admissions may result in a 50% benefit reduction up to \$5,000.
	<u>Habilitation services</u>	10% <u>coinsurance</u>	Not covered.	All habilitation visits count toward your rehabilitation visit limit.
	<u>Skilled nursing care</u>	10% <u>coinsurance</u>	Not covered.	Limited to 60 days per Benefit Period. Failure to obtain <u>preauthorization</u> may result in a 50% benefit reduction up to \$5,000.
	<u>Durable medical equipment</u>	10% <u>coinsurance</u>	Not covered.	Failure to obtain <u>preauthorization</u> may result in a 50% benefit reduction up to \$5,000.
	<u>Hospice services</u>	10% <u>coinsurance</u>	Not covered.	Limited to 210 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 <u>Plan</u> allowance (combined with glasses) Vision Resource: \$5 <u>copay</u> .	Amount over \$50 <u>Plan</u> 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: <u>In-network</u> : \$10 <u>copay</u> for new patients. Lenses: <u>In-network</u> : \$5 <u>copay</u> /bifocals or \$110 <u>copay</u> /progressives
	Children's glasses	Vision Network: Amount over \$125 <u>Plan</u> allowance (combined with eye exam) Vision Resource: Amount over \$100 <u>Plan</u> allowance for frames and \$1 <u>copay</u> /single vision lenses.	Amount over \$100 <u>Plan</u> allowance for frames and amount over \$29 <u>Plan</u> allowance for single vision lenses.	Vision benefits administered separately. The <u>deductible</u> does not apply. Your <u>cost sharing</u> for these benefits is not included in the <u>plan's out-of-pocket limit</u> . Out-of-Network reimbursement based on Vision Resource schedule.
	Children's dental check-up	Not covered.	Not covered.	You must pay 100% of these expenses, even <u>In-Network</u> .

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. Most coverage provided outside the United States. 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 \$20
- 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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$250
Copayments	\$0
Coinsurance	\$1,000
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$1,310

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 \$20
- 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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$170
Copayments	\$120
Coinsurance	\$960
<i>What isn't covered</i>	
Limits or exclusions	\$420
The total Joe would pay is	\$1,670

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

- The plan's overall deductible \$250
- Specialist deductible \$20
- 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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$250
Copayments	\$130
Coinsurance	\$60
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$440