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, https://eoc.empireblue.com/eocdps/fi. 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.healthcare.gov/sbc-glossary/ or call (800) 563-0317 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$0**/individual or **$0**/family for In-Network Providers. **$1,000**/individual or **$2,500**/family for Out-of-Network Providers.	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?	No.	You will have to meet the deductible before the plan pays for any services.
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?	**$4,224**/individual or **$10,560**/family for In-Network Providers. **$4,000**/individual or **$10,000**/family for Out-of-Network Providers.	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?	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, Blue Card PPO. See www.empireblue.com or call (800) 563-0317 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: In-Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20/visit	20% coinsurance	--------none--------
	Specialist visit	$20/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 needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	$20/visit	20% coinsurance	--------none--------
	Imaging (CT/PET scans, MRIs)	$20/visit	20% coinsurance	--------none--------
If you need drugs to treat your illness or condition The following benefits are provided and administered by Express Scripts, a separate company that does not provide Blue Cross products or services, and which is not in any way affiliated with Empire Blue Cross. Express Scripts is solely responsible for its products and services. The summary provided below is for member convenience only. All questions regarding this section should be directed to Express Scripts at 1-800-251-7690.	Tier 1 - Typically Generic	$10/prescription for retail & home delivery	Amount over Plan Allowance	Supply limits: 30-day for retail 90-day for home delivery Special rules apply to Specialty Medications; see the section on Specialty Medications The Affordable Care Act limits the amount of money you have to pay out of pocket for co-insurance and co-payments in a calendar year. For 2018, these limits are $6,650 per individual and $13,300 per family per prescription drug expenses. A separate maximum applies to your in-network co-insurance and co-payments for other medical expenses under this plan.
	Tier 2 - Typically Preferred / Brand	$25/prescription for retail, $50 for home delivery	Amount over Plan Allowance	
	Tier 3 - Typically Non-Preferred / Specialty Drugs	$45/prescription for retail, $90 for home delivery	Amount over Plan Allowance	
	Tier 4 - Typically Specialty (brand and generic)	Call Express Scripts: 1-800-251-7690	Amount over Plan Allowance	
If you have	Facility fee (e.g., ambulatory surgery center)	No charge	20% coinsurance	--------none--------

* For more information about limitations and exceptions, see **plan** or policy document at https://eoc.empireblue.com/eocdps/fi.

outpatient surgery	Physician/surgeon fees	No charge	20% coinsurance	--------none--------
If you need immediate medical attention	Emergency room care	$50/admission	Covered as In-Network	Copay waived if admitted within 24 hours.
	Emergency medical transportation	No charge	Covered as In-Network	--------none--------
	Urgent care	$20/visit	20% coinsurance	--------none--------
If you have a hospital stay	Facility fee (e.g., hospital room)	$100/admission up to $250/admission	20% coinsurance	--------none--------
	Physician/surgeon fees	No charge	20% coinsurance	--------none--------

Common Medical Event	Services You May Need	What You Will Pay: In-Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit $20/visit Other Outpatient	Office Visit 20% coinsurance Other Outpatient 20% coinsurance	Office Visit --------none-------- Other Outpatient --------none--------
	Inpatient services	$100/admission up to $250/admission	20% coinsurance	--------none--------
If you are pregnant	Office visits	$20/visit	20% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No charge	20% coinsurance	
	Childbirth/delivery facility services	$100/admission up to $250/admission	20% coinsurance	
If you need help recovering or have other special health needs	Home health care	No charge	20% coinsurance	200 visits/benefit period.
	Rehabilitation services	$20/visit	20% coinsurance	*See Therapy Services section
	Habilitation services	$20/visit	20% coinsurance	
	Skilled nursing care	No charge	Not covered	120 days limit/benefit period for In-Network Providers.
	Durable medical equipment	No charge	Not covered	*See Durable Medical Equipment Section.
	Hospice services	No charge	Not covered	210 days limit/lifetime for In-Network Providers.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	*See Vision Services section
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	*See Dental Services section

* For more information about limitations and exceptions, see **plan** or policy document at https://eoc.empireblue.com/eocdps/fi.

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.)

- Dental care (adult)
- Dental Check-up
- Eye exams for a child
- Glasses for a child

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 (Limits apply)
- Cosmetic surgery
- Hearing aids (Limits apply)
- Infertility treatment
- Long- term care
- Most coverage provided outside the United States. See www.bcbsglobalcore.com
- Private-duty nursing
- Routine eye care (adult)
- Routine foot care unless you have been diagnosed with diabetes.
- Weight loss programs

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 State Department of Financial Services, One State Street, New York, NY 10004-1511, (800) 342-3736, (212) 480-6400, (518) 474-6600. Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), 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:

ATTN: Grievances and Appeals, P.O. Box 1407, Church Street Station, New York, NY 10008-1407

Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), www.dol.gov/ebsa/healthreform

New York State Department of Financial Services, One State Street, New York, NY 10004-1511, (800) 342-3736, (212) 480-6400, (518) 474-6600

* For more information about limitations and exceptions, see **plan** or policy document at https://eoc.empireblue.com/eocdps/fi.

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.

* For more information about limitations and exceptions, see **plan** or policy document at https://eoc.empireblue.com/eocdps/fi.

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	$20
Hospital (facility) copayment	$100
Other copayment	$20

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	**$12,840**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$96
The total Peg would pay is	**$596**

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	$20
Hospital (facility) copayment	$100
Other copayment	$20

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	**$7,460**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$740
Coinsurance	$0
What isn't covered	
Limits or exclusions	$80
The total Joe would pay is	**$820**

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

The plan's overall deductible	$0
Specialist copayment	$20
Hospital (facility) copayment	$100
Other copayment	$20

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	**$2,010**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$310
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$310**

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