
 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/](http://www.healthcare.gov/sbc-glossary/) or call (800) 563-0317 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$500/individual or \$1,250/family for In- <a href="#">Network Providers</a> . \$1,500/individual or \$3,750/family for Out-of- <a href="#">Network Providers</a> .	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> for In- <a href="#">Network Providers</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain preventive services without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$1,500/individual or \$3,750/family for In- <a href="#">Network Providers</a> . \$5,500/individual or \$13,750/family for Out-of- <a href="#">Network Providers</a> .	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes, Blue Card PPO. See <a href="http://www.empireblue.com">www.empireblue.com</a> or call (800) 563-0317 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an out-of- <a href="#">network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware your <a href="#">network provider</a> might use an out-of- <a href="#">network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.

Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .
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 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
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$30/visit	40% <a href="#">coinsurance</a>	-----none-----
	<a href="#">Specialist</a> visit	\$30/visit	40% <a href="#">coinsurance</a>	-----none-----
	<a href="#">Preventive care</a> / <a href="#">screening</a> / <a href="#">immunization</a>	No charge	40% <a href="#">coinsurance</a>	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	-----none-----
	Imaging (CT/PET scans, MRIs)	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	-----none-----
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="#">www.[insert]</a> .	Tier 1 - Typically Generic	\$10/prescription for retail & home delivery	Amount over Plan	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 coinsurance 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
	Tier 2 - Typically <a href="#">Preferred</a> / Brand	\$25/prescription for retail, \$50 for home delivery	Amount over Plan	
	Tier 3 - Typically Non- <a href="#">Preferred</a> / <a href="#">Specialty Drugs</a>	\$45/prescription for retail, \$90 for home delivery	Amount over Plan	
	Tier 4 - Typically <a href="#">Specialty</a> (brand and generic)	Call Express Scripts: 1-800-251-7690	Amount over Plan	

\* For more information about limitations and exceptions, see [plan](#) or policy document at <https://eoc.empireblue.com/eocdps/fi>.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				other medical expenses under this plan.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	-----none-----
	Physician/surgeon fees	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	-----none-----
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$50/admission	Covered as In- <a href="#">Network</a>	Copay waived if admitted within 24 hours.
	<a href="#">Emergency medical transportation</a>	10% <a href="#">coinsurance</a>	Covered as In- <a href="#">Network</a>	-----none-----
	<a href="#">Urgent care</a>	\$30/visit	40% <a href="#">coinsurance</a>	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <a href="#">coinsurance</a> up to \$250/admission	40% <a href="#">coinsurance</a>	-----none-----
	Physician/surgeon fees	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	-----none-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit \$30/visit Other Outpatient 10% <a href="#">coinsurance</a>	Office Visit 40% <a href="#">coinsurance</a> Other Outpatient 40% <a href="#">coinsurance</a>	Office Visit -----none----- Other Outpatient -----none-----
	Inpatient services	10% <a href="#">coinsurance</a> up to \$250/admission	40% <a href="#">coinsurance</a>	-----none-----
If you are pregnant	Office visits	\$30/visit	40% <a href="#">coinsurance</a>	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	10% <a href="#">coinsurance</a> up to \$250/admission	40% <a href="#">coinsurance</a>	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	10% <a href="#">coinsurance</a> <a href="#">deductible</a> does not apply	40% <a href="#">coinsurance</a> <a href="#">deductible</a> does not apply	200 visits/benefit period.
	<a href="#">Rehabilitation services</a>	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	*See Therapy Services section
	<a href="#">Habilitation services</a>	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
	<a href="#">Skilled nursing care</a>	No charge	Not covered	120 days limit/benefit period for In- <a href="#">Network Providers</a> .
	<a href="#">Durable medical equipment</a>	No charge	Not covered	*See <a href="#">Durable Medical Equipment Section</a>
	<a href="#">Hospice services</a>	No charge	Not covered	Unlimited days limit/lifetime for In- <a href="#">Network Providers</a> .

\* For more information about limitations and exceptions, see [plan](#) or policy document at <https://eoc.empireblue.com/eocdps/fi>.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If your child needs dental or eye care</b>	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)
- Glasses for a child
- Tier 3 - Typically Non-[Preferred](#) / [Specialty Drugs](#)
- Dental Check-up
- Tier 1 - Typically Generic
- Tier 4 - Typically [Specialty](#) (brand and generic)
- Eye exams for a child
- Tier 2 - Typically [Preferred](#) / Brand

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

- Acupuncture
- Cosmetic surgery
- Long- term care
- Routine eye care (adult)
- Bariatric surgery
- Hearing aids (Limits apply)
- Most coverage provided outside the United States. See [www.bcbsglobalcore.com](http://www.bcbsglobalcore.com)
- Routine foot care unless you have been diagnosed with diabetes.
- Chiropractic care (Limits apply)
- Infertility treatment
- Private-duty nursing
- 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](http://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](http://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](http://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

**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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$500
■ <a href="#">Specialist copayment</a>	\$30
■ Hospital (facility) <a href="#">coinsurance</a>	10%
■ Other <a href="#">coinsurance</a>	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	\$12,840
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In this example, Peg would pay:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$500
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$1,000
<i>What isn't covered</i>	
Limits or exclusions	\$96
<b>The total Peg would pay is</b>	<b>\$1,596</b>

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$500
■ <a href="#">Specialist copayment</a>	\$30
■ Hospital (facility) <a href="#">coinsurance</a>	10%
■ Other <a href="#">coinsurance</a>	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	\$7,460
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In this example, Joe would pay:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$500
<a href="#">Copayments</a>	\$300
<a href="#">Coinsurance</a>	\$13
<i>What isn't covered</i>	
Limits or exclusions	\$6,041
<b>The total Joe would pay is</b>	<b>\$6,854</b>

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$500
■ <a href="#">Specialist copayment</a>	\$30
■ Hospital (facility) <a href="#">coinsurance</a>	10%
■ Other <a href="#">coinsurance</a>	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	\$2,010
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In this example, Mia would pay:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$500
<a href="#">Copayments</a>	\$240
<a href="#">Coinsurance</a>	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$840</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.



## Language Access Services:

(TTY/TDD: 711)

**Albanian (Shqip):** Nëse keni pyetje në lidhje me këtë dokument, keni të drejtë të merrni falas ndihmë dhe informacion në gjuhën tuaj. Për të kontaktuar me një përkthyes, telefononi (800) 563-0317

**Amharic (አማርኛ):-** ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በነጻ የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር (800) 563-0317 ይደውሉ።

**Arabic (العربية):** إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (800) 563-0317.

**Armenian (հայերեն).** Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (800) 563-0317:

**Bassa (Bàsɔ́ Wùdù):** M̄ dyi dyi-diè-dɛ̀ bɛ̀ bédé b́á céè-dɛ̀ nià ke dyí ní, ɔ̀ m̀ò̀ nì dyí-bédɛ̀in-dɛ̀ bɛ̀ é̀ m̀ kɛ̀ gbo-kpá-kpá kè b̄́ kp̄́ dɛ̀ m̀ bídǐ-wùdù̀ùn b́ó pídyi. B́é̀ m̀ kɛ̀ wuɖu-zìin-nyò̀ d̀ò̀ gbo wùdù̀ kɛ̀, d́á (800) 563-0317.

**Bengali (বাংলা):** যদি এই নথিপত্রের বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য পাওয়ার ও তথ্য পাওয়ার অধিকার আপনার আছে। একজন দোভাষীর সাথে কথা বলার জন্য (800) 563-0317 -তে কল করুন।

**Burmese (မြန်မာ):** ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အချက်အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖုန်း (800) 563-0317 သို့ ခေါ်ဆိုပါ။

**Chinese (中文) :** 如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電 (800) 563-0317。

**Dinka (Dinka):** Na nɔŋ thiëc në ke de yä thorë, ke yin nɔŋ loŋ bë yi kuony ku wër alëu bë gɛɛr yic yin ne thoŋ du ke cin wëu tääuë ke piny. Te kør yin ba jam wënë ran ye thok geryic, ke yin cəl (800) 563-0317.

**Dutch (Nederlands):** Bij vragen over dit document hebt u recht op hulp en informatie in uw taal zonder bijkomende kosten. Als u een tolk wilt spreken, belt u (800) 563-0317.

**Farsi (فارسی):** در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه‌ای به زبان مادری‌تان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره (800) 563-0317 تماس بگیرید.

**French (Français) :** Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (800) 563-0317.

## Language Access Services:

**German (Deutsch):** Wenn Sie Fragen zu diesem Dokument haben, haben Sie Anspruch auf kostenfreie Hilfe und Information in Ihrer Sprache. Um mit einem Dolmetscher zu sprechen, bitte wählen Sie (800) 563-0317.

**Greek (Ελληνικά)** Αν έχετε τυχόν απορίες σχετικά με το παρόν έγγραφο, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας δωρεάν. Για να μιλήσετε με κάποιον διερμηνέα, τηλεφωνήστε στο (800) 563-0317.

**Gujarati (ગુજરાતી):** જો આ દસ્તાવેજ અંગે આપને કોઈપણ પ્રશ્નો હોય તો, કોઈપણ ખર્ચ વગર આપની ભાષામાં મદદ અને માહિતી મેળવવાનો તમને અધિકાર છે. દુભાષિયા સાથે વાત કરવા માટે, કોલ કરો (800) 563-0317.

**Haitian Creole (Kreyòl Ayisyen):** Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (800) 563-0317.

**Hindi (हिंदी):** अगर आपके पास इस दस्तावेज़ के बारे में कोई प्रश्न हैं, तो आपको निःशुल्क अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। दुभाषिये से बात करने के लिए, कॉल करें (800) 563-0317 ।

**Hmong (White Hmong):** Yog tias koj muaj lus nug dab tsi ntsig txog daim ntawv no, koj muaj cai tau txais kev pab thiab lus qhia hais ua koj hom lus yam tsim xam tus nqi. Txhawm rau tham nrog tus neeg txhais lus, hu xov tooj rau (800) 563-0317.

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ເພື່ອໂອ້ນລັບກ່ຽວກັບລາຍລະອຽດ, ໃຫ້ໂທຫາ (800) 563-0317.

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दोभाषेसँग कुरा गर्नका लागि, यहाँ कल गर्नुहोस् (800) 563-0317

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