This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.empireblue.com/nyc or by calling 1-800-767-8672

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For in-network providers **$250 / $625** maximum per admission per Contract per calendar year For out-of-network providers **$1,000** person / **$2,500** family Doesn't apply to in-network services, out-of-network home health care	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. For in-network providers **$0** person / **$0** family For out-of-network providers **$7,500** person / **$18,750** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed 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**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See **www.empireblue.com/nyc or call 1-800-767-8672** for a list of in-network providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this

		plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 copay	30% coinsurance	——————none——————
	Specialist visit	$15 copay	30% coinsurance	——————none——————
	Other practitioner office visit	$15 copay for chiropractor	30% coinsurance	——————none——————
	Preventive care/screening/immunization	No Charge	30% coinsurance	——————none——————
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	30% coinsurance	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
	Imaging (CT/PET scans, MRIs)	No Charge	30% coinsurance	For MRI/MRA services rendered from an Empire PPO provider, the provider must pre-certify in-network services. Outside Empire's network area, you must obtain pre-certification from Empire's Medical Management Program for services from in-network BlueCard PPO providers. For CT/PET scans, Empire's network provider must obtain authorization for clinical /medical necessity for in-network services. Authorizaton is not required for out-of-network services rendered from in-network BlueCard PPO providers outside of Empire's network area.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.empireblue.com/nyc	Generic drugs	Not Covered	Not Covered	——————none——————
	Preferred brand drugs	Not Covered	Not Covered	——————none——————
	Non-preferred brand drugs	Not Covered	Not Covered	——————none——————
	Specialty drugs	Not Covered	Not Covered	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	30% coinsurance	You are responsible for obtaining precertification from Empire's Medical Management Program for these services provided in-network and out-of-network. For ambulatory surgery, precertification is required for reconstructive surgery, outpatient transplants and opthalmological or eye-related procedures. Precertification is also required for cosmetic surgery, an excluded benefit except when medically necessary.
	Physician/surgeon fees	No Charge	30% coinsurance	——————none——————
If you need immediate medical attention	Emergency room services	$35 copay	$35 copay	Copay waived if admitted.
	Emergency medical transportation	No Charge	No Charge	——————none——————
	Urgent care	$15 copay	30% coinsurance	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 / $625 per admission/ maximum per calendar year per contract	30% coinsurance	You are responsible for obtaining precertification from Empire's Medical Management Program for these services provided in-network and out-of-network. You will be responsible for penalties applied if precertification is not obtained.
	Physician/surgeon fee	No Charge	30% coinsurance	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$15 copay	30% coinsurance	You are responsible for obtaining precertification from the Behavioral Healthcare Manager for these services. You will be responsible for penalties applied if precertification is not obtained.
	Mental/Behavioral health inpatient services	$250 / $625 per admission/ maximum per calendar year per contract	30% coinsurance	You are responsible for obtaining precertification from the Behavioral Healthcare Manager for these services. You will be responsible for penalties applied if precertification is not obtained.
	Substance use disorder outpatient services	$15 copay	30% coinsurance	You are responsible for obtaining precertification from the Behavioral Healthcare Manager for these services. You will be responsible for penalties applied if precertification is not obtained.
	Substance use disorder inpatient services	$250 / $625 per admission/ maximum per calendar year per contract	30% coinsurance	You are responsible for obtaining precertification from the Behavioral Healthcare Manager for these services. You will be responsible for penalties applied if precertification is not obtained.
If you are pregnant	Prenatal and postnatal care	No Charge	30% coinsurance	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
	Delivery and all inpatient services	$250 / $625 per admission/ maximum per calendar year per contract	30% coinsurance	You are responsible for obtaining precertification from Empire's Medical Management Program for these services provided in-network and out-of-network. You will be responsible for penalties applied if precertification is not obtained.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
you need help recovering or have other special health needs	Home health care	No Charge	30% coinsurance	Coverage is limited to 200 visits annual max.
	Rehabilitation services	$15 copay	Not Covered	Coverage is limited to 30 visits annual max. physical therapy, and 30 visits annual max. occupational, vision and speech therapy combined. You are responsible for obtaining precertification from Empire's Medical Management Program for these services . Covered in-network only.
	Habilitation services	$15 copay	Not Covered	All rehabilitation and habilitation visits count toward your rehabilitation visit limit.
	Skilled nursing care	No Charge	Not Covered	Coverage is limited to 60 days annual max. You are responsible for obtaining precertification from Empire's Medical Management Program for these services. Covered in-network only.
	Durable medical equipment	No Charge	Not Covered	Covered in-network only. For services rendered by an Empire PPO provider, the provider must pre-certify in-network services.
	Hospice service	No Charge	Not Covered	Coverage is limited to 210 days lifetime max. Covered in-network only.
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	——————none——————
	Glasses	Not Covered	Not Covered	——————none——————
	Dental check-up	Not Covered	Not Covered	——————none——————

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic surgery
- Dental care
- Hearing aids
- Long-term care
- Most coverage provided outside the United States. See www.BCBS.com/bluecardworldwide
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture
- Infertility Treatment
- Bariatric surgery
- Chiropractic care

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-767-8672. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

Empire BlueCross BlueShield
P.O.Box1407
Church Street Station
New York, NY 10008
Phone: 1-800-767-8672

Additionally, a consumer assistance program can help you file your appeal. Contact:
Appeal Coordinator
Empire BlueCross BlueShield
P.O.Box1407
Church Street Station
New York, NY 10008
Phone: 1-800-767-8672

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does not provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does not meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-767-8672

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-767-8672

Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-800-767-8672

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-767-8672

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

Amount owed to providers: $7,540
- **Plan pays** $ 7,090
- **Patient pays** $ 450

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$250
Copays	$0
Coinsurance	$0
Limits or exclusions	$200
Total	**$450**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

Amount owed to providers: $5,400
- **Plan pays** $ 2,455
- **Patient pays** $ 2,945

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$45
Coinsurance	$0
Limits or exclusions	$2,900
Total	**$2,945**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.