



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) 377-5156 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	For in-network providers <b>\$0</b> individual / <b>\$0</b> family Doesn't apply to in-network preventive care.	See the Common Medical Events chart below for your costs for services this <a href="#">plan</a> covers.
Are there services covered before you meet your <a href="#">deductible</a> ?	No.	You will have to meet the <a href="#">deductible</a> before the <a href="#">plan</a> pays for any services.
Are there other <a href="#">deductibles</a> for specific services?	Yes. <b>\$50</b> for In- <a href="#">Network Prescription Drugs</a> Tier 2 and 3. There are no other specific <a href="#">deductibles</a> .	You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	<b>\$7,150</b> /person or <b>\$14,300</b> /family for In- <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 Access. See <a href="http://www.empireblue.com">www.empireblue.com</a> or call (800) 377-5156 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> .



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)	Non-Network Provider (You will pay the most)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$25/visit	Not Covered	-----none-----
	<a href="#">Specialist</a> visit	\$40/visit	Not Covered	-----none-----
	<a href="#">Preventive care/screening/immunization</a>	No charge	Not Covered	Certain preventive care services are subject to age and frequency limitations.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	No charge	Not Covered	-----none-----
	Imaging (CT/PET scans, MRIs)	10% Coinsurance	Not Covered	Precertification is required.
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.empireblue.com/">www.empireblue.com/</a> Essential Formulary	Tier 1 - Typically Generic	\$10/prescription, (retail) and \$20/prescription, (home delivery)	Not Covered	*\$50 Deductible for In-Network Prescription Drugs Tier 2 and 3 only. Tier 1-Generic are not subject to deductible
	Tier 2 - Typically Preferred / Brand	\$35/prescription, (retail) and \$70/prescription, (home delivery)	Not Covered	Mail Order is a 90 day supply
	Tier 3 - Typically Non-Preferred / <a href="#">Specialty Drugs</a>	20% coinsurance \$80 min/\$300 max <a href="#">Prescription Drug</a> (retail and home delivery)	Not Covered	Preferred Generic Program/Home Delivery Complete/Diabetic Drugs and Supplies \$0 Copay
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	10% Coinsurance	Covered as In- <a href="#">Network</a>	Precertification is required.
	Physician/surgeon fees	No charge	Covered as In- <a href="#">Network</a>	Precertification is required.

\* 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)	Non-Network Provider (You will pay the most)	
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$250/visit	Covered as In- <a href="#">Network</a>	<a href="#">Copay</a> waived if admitted.
	<a href="#">Emergency medical transportation</a>	No Charge	Covered as In- <a href="#">Network</a>	Covered in-network, subject to meeting "emergency" criteria. When services are delivered by an out-of-network land ambulance provider that is not licensed under the NY Public Health Law, you may be required to pay up to the difference between the reasonable and customary allowed amount and the provider's total charges.
	<a href="#">Urgent care</a>	\$40/visit	\$40/visit	-----none-----
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	10% Coinsurance	Not Covered	Precertification is required.
	Physician/surgeon fees	No charge	Not Covered	Precertification is required.
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$25/visit	Not Covered	Unlimited number of medically necessary days and necessary visits from mental healthcare professionals.
	Inpatient services	10% Coinsurance	Not Covered	Precertification is required. Unlimited number of medically necessary days and necessary visits from mental healthcare professionals.
<b>If you are pregnant</b>	Office visits	No charge	Not Covered	Precertification is required.
	Childbirth/delivery professional services	No charge	Not Covered	

\* 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)	Non-Network Provider (You will pay the most)	
	Childbirth/delivery facility services	\$100/\$250 copayment per admission/maximum per calendar year per contract	Not Covered	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	No charge	Not Covered	<b>100 visits</b> /benefit period for In-Network Providers.
	<a href="#">Rehabilitation services</a>	\$25/visit	Not Covered	Occupational and speech therapy up to <b>30 visits</b> per person combined in home, office or outpatient facility per calendar year.
	<a href="#">Habilitation services</a>	\$40/visit	Not Covered	Physical therapy up to <b>90 visits</b> combined in home, office or outpatient facility per calendar year.  Physical therapy up to <b>60 inpatient days</b> per calendar year.  Precertification is required  Copay will apply to visit services (examinations and evaluations) in an office; other services performed will be subject to in-network deductible and coinsurance
	<a href="#">Skilled nursing care</a>	10% Coinsurance	Not Covered	Limited up to 60 visits per calendar year (a visit equals 4 hours of care).
	<a href="#">Durable medical equipment</a>	10% Coinsurance	Not Covered	Precertification is required
	<a href="#">Hospice services</a>	No charge	Not Covered	-----none-----
	<b>If your child needs dental or eye care</b>	Children's eye exam	Not Covered	Not Covered
	Children's glasses	Not Covered	Not Covered	-----none-----
	Children's dental check-up	Not Covered	Not Covered	-----none-----

\* 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**.)

- Hearing aids
- Private-duty nursing
- Weight loss programs
- Cosmetic surgery
- Routine eye care
- Dental care
- Routine foot care unless you have been diagnosed with diabetes.

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

- Acupuncture
- Chiropractic care
- Most coverage provided outside the United States. See [www.bcbsglobalcore.com](http://www.bcbsglobalcore.com)
- Bariatric surgery
- Infertility treatment

**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: Department of Labor's Employee Benefits Security Administration at (866) 444-EBSA (3272) or [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.anthem.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>	\$0
■ <a href="#">Specialist copayment</a>	\$40
■ Hospital (facility) <a href="#">copayment</a>	\$1000
■ Other	No charge

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>	\$0
<a href="#">Copayments</a>	\$3,000
<a href="#">Coinsurance</a>	\$50
<i>What isn't covered</i>	
Limits or exclusions	\$150
<b>The total Peg would pay is</b>	<b>\$3,200</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>	\$0
■ <a href="#">Specialist copayment</a>	\$40
■ Hospital (facility) <a href="#">copayment</a>	\$1000
■ Other	No charge

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>	\$0
<a href="#">Copayments</a>	\$1400
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$80
<b>The total Joe would pay is</b>	<b>\$1400</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>	\$0
■ <a href="#">Specialist copayment</a>	\$40
■ Hospital (facility) <a href="#">copayment</a>	\$1000
■ Other	No charge

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	\$1,970
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In this example, Mia would pay:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$1400
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1400</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) 377-5156

**Amharic (አማርኛ):-** ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በነጻ የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር (800) 377-5156 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) 377-5156.

**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) 377-5156:

**Bassa (Bàsɔ̀ Wùdù):** M̄ dyi dyi-diè-dɛ̀ bɛ̀ bédé b́á céè-dɛ̀ nìà ke dyí ní, ɔ̀ m̀ò nì dyí-bédɛ̀in-dɛ̀ b́é m̀ ké gbo-kpá-kpá kè b̄́ kp̄́ d́é m̀ bíd́í-wùdùùn b́ó pídyi. B́é m̀ ké wuɖu-zìin-nyò d̀ò gbo wùdù ke, d́á (800) 377-5156.

**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) 377-5156 -তে কল করুন।

**Burmese (မြန်မာ):** ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အချက်အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖုန်း (800) 377-5156 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) 377-5156。

**Dinka (Dinka):** Na nɔŋ thiëc nē ke de yā thorē, ke yin nɔŋ loŋ bē yi kuony ku wɛr alēu bē gɛɛr yic yin ne thoŋ du ke cin wēu tāāuē ke piny. Te kōr yin ba jam wēnē ran ye thok geryic, ke yin cōl (800) 377-5156.

**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) 377-5156.

**Farsi (فارسي):** 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) 377-5156 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) 377-5156.

## 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) 377-5156.

**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) 377-5156.

**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) 377-5156.

**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) 377-5156.

**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) 377-5156 ।

**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) 377-5156.

**Igbo (Igbo):** O bụr ụ na ị nwere ajujụ o bụla gbasara akwukwọ a, ị nwere ikike ịnweta enyemaka na ozi n'asụsụ gị na akwughị ugwo o bụla. Ka gị na okwọwa okwu kwuo okwu, kpọọ (800) 377-5156.

**Ilokano (Ilokano):** Nu addaan ka iti aniaman a saludsod panggep iti daytoy a dokumento, adda karbengam a makaala ti tulong ken impormasyon babaen ti lenguahem nga awan ti bayad na. Tapno makatungtong ti maysa nga tagipatarus, awagan ti (800) 377-5156.

**Indonesian (Bahasa Indonesia):** Jika Anda memiliki pertanyaan mengenai dokumen ini, Anda memiliki hak untuk mendapatkan bantuan dan informasi dalam bahasa Anda tanpa biaya. Untuk berbicara dengan interpreter kami, hubungi (800) 377-5156.

**Italian (Italiano):** In caso di eventuali domande sul presente documento, ha il diritto di ricevere assistenza e informazioni nella sua lingua senza alcun costo aggiuntivo. / parlare con un interprete, chiami il numero (800) 377-5156

**Japanese (日本語):** この文書についてなにかご不明な点があれば、あなたにはあなたの言語で無料で支援を受け情報を得る権利があります。通訳と話すには、(800) 377-5156 にお電話ください。



## Language Access Services:

**Khmer (ខ្មែរ):** បើអ្នកមានសំណួរផ្សេងទៀតអំពីឯកសារនេះ អ្នកមានសិទ្ធិទទួលជំនួយនិងព័ត៌មានជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។  
ដើម្បីជ្រកជាមួយអ្នកបកប្រែ សូមហៅ (800) 377-5156 ។

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