Your summary of benefits

Empire BlueCross BlueShield

Your Plan: Empire EPO with HRA

Your Network: Blue Access Network

This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This summary does not reflect each and every benefit, exclusion and limitation which may apply to the coverage. For more details, important limitations and exclusions, please review the formal Certificate of Insurance or Evidence of Coverage (EOC). If there is a difference between this summary and the Certificate of Insurance or Evidence of Coverage (EOC), the Certificate of Insurance or Evidence of Coverage (EOC), will prevail.

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible *See notes section to understand how your deductible works. Your plan may also have a separate Prescription Drug Deductible. See Prescription Drug Coverage section.*	$3,000 person / $6,000 family	Not Covered
Out-of-Pocket Limit *When you meet your out-of-pocket limit, you will no longer have to pay cost-shares during the remainder of your benefit period. See notes section for additional information regarding your out of pocket maximum.*	$7,150 person / $14,300 family	Not Covered
Preventive care/screening/immunization *In-network preventive care is not subject to deductible, if your plan has a deductible.*	No charge	Not covered
Doctor Home and Office Services **Primary care visit to treat an injury or illness**	10% Coinsurance after deductible is met	Not covered
Specialist care visit	10% Coinsurance after deductible is met	Not covered

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Prenatal and Post-natal Care	10% Coinsurance after deductible is met	Not covered
Other practitioner visits:		Not covered
Retail health clinic	10% Coinsurance after deductible is met	
On-line Visit	10% Coinsurance	Not covered

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Live Health Online is Empire's preferred telehealth solutions (www.livehealthonline.com)	after deductible is met	
Chiropractor services	10% Coinsurance after deductible is met	Not covered
Acupuncture	10% Coinsurance after deductible is met	Not covered
Other services in an office:		Not covered
Allergy testing performed by a Primary Care Physician	10% Coinsurance after deductible is met	
Allergy testing performed by a Specialist	10% Coinsurance after deductible is met	Not covered
Chemo/radiation therapy performed by a Primary Care Physician	10% Coinsurance after deductible is met	Not covered
Chemo/radiation therapy performed by a Specialist	10% Coinsurance after deductible is met	Not covered
Hemodialysis performed by a Primary Care Physician *Coverage for Non-Network Providers is limited to 10 visits per benefit period.*	10% Coinsurance after deductible is met	10% Coinsurance after medical deductible is met

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Hemodialysis performed by a Specialist *Coverage for Non-Network Providers is limited to 10 visits per benefit period.*	10% Coinsurance after deductible is met	10% Coinsurance after medical deductible is met
Prescription drugs administered in an office by a Primary Care Physician *For the drugs itself dispensed in the office through infusion/injection*	10% Coinsurance after deductible is met	Not covered
Prescription drugs administered in an office by a Specialist *For the drugs itself dispensed in the office through infusion/injection*	10% Coinsurance after deductible is met	Not covered
Diagnostic Services		
Lab:		
Office performed by a Primary Care Physician	10% Coinsurance after deductible is met	Not covered
Office performed by a Specialist	10% Coinsurance after deductible is met	Not covered
Freestanding Lab	10% Coinsurance after deductible is met	Not covered
Outpatient Hospital	10% Coinsurance after deductible is met	Not covered
X-ray:		
Office performed by a Primary Care Physician	10% Coinsurance after deductible is met	Not covered
Office performed by a Specialist	10% Coinsurance after deductible is met	Not covered

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Freestanding Radiology Center	10% Coinsurance after deductible is met	Not covered
Outpatient Hospital	10% Coinsurance after deductible is met	Not covered
Advanced diagnostic imaging (for example, MRI/PET/CAT scans):		
Office	10% Coinsurance after deductible is met	Not covered
Freestanding Radiology Center	10% Coinsurance after deductible is met	Not covered
Outpatient Hospital	10% Coinsurance after deductible is met	Not covered
Emergency and Urgent Care		
Emergency room facility services	10% Coinsurance after deductible is met	10% Coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Emergency room doctor and other services	10% Coinsurance after deductible is met	10% Coinsurance after medical deductible is met
Ambulance (air and ground)	10% Coinsurance after deductible is met	10% Coinsurance after medical deductible is met
Urgent Care (office setting)	10% Coinsurance after deductible is met	Not covered

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Outpatient Mental/Behavioral Health and Substance Abuse		
Doctor office visit	10% Coinsurance after deductible is met	Not covered
Facility visit:		Not covered
Facility fees	10% Coinsurance after deductible is met	
Doctor Services	10% Coinsurance after deductible is met	Not covered
Outpatient Surgery		
Facility fees:		
Hospital	10% Coinsurance after deductible is met	Not covered
Freestanding Surgical Center	10% Coinsurance after deductible is met	Not covered
Doctor and other services		
Surgery performed by a Primary Care Physician	10% Coinsurance after deductible is met	Not covered
Surgery performed by a Specialist	10% Coinsurance after deductible is met	Not covered

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider

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Hospital Stay (all inpatient stays including maternity, mental / behavioral health, and substance abuse) Facility fees (for example, room & board) *Coverage for Inpatient physical medicine and rehabilitation including day rehabilitation programs In-Network Providers is limited to 30 days per benefit period.*	10% Coinsurance after deductible is met	Not covered
Doctor and other services	10% Coinsurance after deductible is met	Not covered
Recovery & Rehabilitation **Home health care** *Coverage for In-Network Providers is limited to 200 visits per benefit period.*	10% Coinsurance after deductible is met	Not covered
Rehabilitation services (for example, physical/speech/occupational therapy): Office *Coverage for physical therapy and occupational therapy combined is limited to **90 visits** per benefit period and Speech Therapy is limited to **30 visits** per benefit period. Apply to In-Network Providers.*	10% Coinsurance after deductible is met	Not covered
Outpatient hospital *Coverage for physical therapy and occupational therapy combined is limited to **90 visits** per benefit period and Speech Therapy is limited to **30 visits** per benefit period. Apply to In-Network Providers.*	10% Coinsurance after deductible is met	Not covered
Habilitation services (for example, physical/speech/occupational therapy): Office *Habilitation and Rehabilitation visits count towards your Rehabilitation limit.*	10% Coinsurance after deductible is met	Not covered
Outpatient hospital *Habilitation and Rehabilitation visits count towards your Rehabilitation limit.*	10% Coinsurance after deductible is met	Not covered
Cardiac rehabilitation Office	10% Coinsurance after deductible is met	Not covered

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Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Outpatient hospital	10% Coinsurance after deductible is met	Not covered
Skilled nursing care (in a facility) *Coverage for In-Network Providers is limited to **60 days** per benefit period.*	10% Coinsurance after deductible is met	Not covered
Hospice	10% Coinsurance after deductible is met	Not covered
Durable Medical Equipment	10% Coinsurance after deductible is met	Not covered
Prosthetic Devices	10% Coinsurance after deductible is met	Not covered

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Covered Prescription Drug Benefits Essential Formulary	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Pharmacy Deductible	Combined with medical deductible	Not Covered
Pharmacy Out of Pocket	Combined with medical out of pocket	Not Covered
Prescription Drug Coverage		
Tier 1 - Typically Generic	$10 copay after deductible is met ($20 copay retail and home delivery)	Not covered
Tier 2 - Typically Preferred / Brand *If you select a brand name drug when a generic drug is available, additional cost sharing amounts may apply.*	$35 copay after deductible is met ($70 copay retail and home delivery)	Not covered
Tier 3 - Typically Non-Preferred / Specialty Drugs *If you select a brand name drug when a generic drug is available, additional cost sharing amounts may apply.*	20% Coinsurance after deductible is met, $80 min/$300 max (retail and home delivery)	Not covered
Home Delivery Complete- mandatory mail order for maintenance medications.		

Notes:

If You seek coverage for services that require Preauthorization or notification, You or Your Provider must call Us or Our vendor at the number indicated on Your ID card.

The prescription drug plan listed on this Summary meets the Centers for Medicare and Medicaid Services (CMS) standard for Creditable Coverage under the Medicare Modernization Act of 2003.

Our Preauthorization is required before You receive certain Covered Services. You are responsible for requesting Preauthorization for the following services: All inpatient admissions, including maternity

admissions and admissions for illness or injury to newborns; Inpatient Mental Health Care, Substance Abuse Care and Alcohol Detoxification; Skilled Nursing Facility; Outpatient/Ambulatory Surgical Treatments (certain procedures); Chiropractic Care (after the 5th visit); Physical, Occupational, and Speech Therapy; Diagnostics;
Outpatient Treatments; Air Ambulance; High tech radiology services: MRI, MRA, PET, CAT, Nuclear Technology services; Durable Medical Equipment; Prosthetics and Orthotics; Assistive Communication Devices.

Preventive care benefits not subject to copay, deductible and coinsurance; when provided In-Network include: mammography screenings, cervical cancer screenings, colorectal cancer screenings, prostate cancer screenings, hypercholesterolemia screenings, diabetes screenings for pregnant women, bone density testing, annual physical examinations and annual obstetric and gynecological examinations. May also include other services as required under State and Federal Law. May be subject to age and frequency limits.

To receive a 90-day supply of prescription drugs through Empire's Mail Order Program, the prescription must be written specifically for a 90-day supply.

Questions:(844) 241-7087 or visit us at www.empireblue.com
NY/L/F/Empire EPO with HRA/2MJC/NA/07-17

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Language Access Services:

Get help in your language

Curious to know what all this says? We would be too. Here's the English version:

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If you have any questions about this document, you have the right to get help and information in your language at no cost. To talk to an interpreter, call (844) 241-7087.

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

(TTY/TDD: 711)

Arabic (العربية): إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (844) 241-7087.

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՝ (844) 241-7087:

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 (844) 241-7087。

Farsi (فارسي) : در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه ای به زبان مادری‌تان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره (844) 241-7087 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 (844) 241-7087.

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 (844) 241-7087.

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. Per parlare con un interprete, chiami il numero (844) 2417087.

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、(844) 241-7087 にお電話ください。

Korean (한국어): 본문서에대해어떠한문의사항이라도있을경우, 귀하에게는귀하가사용하는언어로 무료도움및정보를얻을권리가있습니다. 통역사와이야기하려면 (844) 241-7087 로문의하십시오.

Navajo (Diné): Díí naaltsoos biká'ígíí łahgo bína'ídíłkidgo ná bohónéedzą dóó bee ahóót'i' t'áá ni nizaad k'ehjí bee nił hodoonih t'áadoo bą́ą́h ílínígóó. Ata' halne'ígíí ła' bich'į' hadeesdzih nínízingo kojį' hodíílnih (844) 241-7087.

Language Access Services:

Polish (polski): W przypadku jakichkolwiek pytań związanych z niniejszym dokumentem masz prawo do bezpłatnego uzyskania pomocy oraz informacji w swoim języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer: (844) 2417087.

Punjabi (ਪੰਜਾਬੀ): ਜੇ ਤੁਹਾਡੇ ਇਸ ਦਸਤਾਵੇਜ਼ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹੁੰਦੇ ਹਨ ਤਾਂ ਤੁਹਾਡੇ ਕੋਲ ਮੁਫ਼ਤ ਵਿੱਚ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੁੰਦਾ ਹੈ। ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, (844) 241-7087 ਤੇ ਕਾਲ ਕਰੋ।

Russian (Русский): если у вас есть какие-либо вопросы в отношении данного документа, вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы связаться с устным переводчиком, позвоните по тел. (844) 241-7087.

Spanish (Español): Si tiene preguntas acerca de este documento, tiene derecho a recibir ayuda e información en su idioma, sin costos. Para hablar con un intérprete, llame al (844) 241-7087.

Tagalog (Tagalog): Kung mayroon kang anumang katanungan tungkol sa dokumentong ito, may karapatan kang humingi ng tulong at impormasyon sa iyong wika nang walang bayad. Makipag-usap sa isang tagapagpaliwanag, tawagan ang (844) 241-7087.

Vietnamese (Tiếng Việt): Nếu quý vị có bất kỳ thắc mắc nào về tài liệu này, quý vị có quyền nhận sự trợ giúp và thông tin bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Để trao đổi với một thông dịch viên, hãy gọi (844) 241-7087.

It's important we treat you fairly

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building;
Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.