



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) 342-9816 to request a copy.

Important Questions	Answers	Why This Matters
What is the overall deductible?	<p>\$1,500/individual or \$3,000/family deductible for In-Network Providers and \$1,500/individual or \$3,000/family for Out-of-Network Providers. This HRA account reimburses you for certain deductibles and coinsurance amounts up to \$1,000/single coverage or \$2,000/family coverage.</p>	<p>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 policy, the overall family deductible must be met before the plan begins to pay. Out of Network deductible accumulates to In-Network deductible. In-Network deductible does not accumulate to Out Of-Network deductible</p>
Are there services covered before you meet your deductible?	<p>Yes. Preventive care for In-Network Providers.</p>	<p>This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.</p>
Are there other deductibles for specific services?	<p>No.</p>	<p>You don't have to meet deductibles for specific services.</p>
What is the out-of-pocket limit for this plan?	<p>\$3,425/ individual or \$6,850/family for In-Network Providers. \$7,500/ individual or \$15,000/family for Out-of-Network Providers.</p>	<p>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, the overall family out-of-pocket limit must be met.</p>
What is not included in the out-of-pocket limit?	<p>Premiums, Balance-Billing charges, and Health Care this plan doesn't cover.</p>	<p>Even though you pay these expenses, they don't count toward the out-of-pocket limit.</p>

<p>Will you pay less if you use a network provider?</p>	<p>Yes, Blue Card PPO. See www.empireblue.com or call (800) 342-9816 for a list of <u>network providers</u>.</p>	<p>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.</p>
<p>Do you need a referral to see a specialist?</p>	<p>No.</p>	<p>You can see the specialist you choose without a referral.</p>

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 provider's office or clinic	Primary care visit to treat an injury or illness Specialist visit	10% coinsurance	30% coinsurance	-----none-----
If you have a test	Preventive care/screening/immunization Diagnostic test (x-ray, blood work) Imaging (CT/PET scans, MRIs)	10% coinsurance No charge	30% coinsurance	-----none----- 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 need drugs to treat your illness or condition More information about prescription drug coverage is available at www.empireblue.com	Tier 1 - Typically Generic Tier 2 - Typically Preferred / Brand Tier 3 - Typically Non-Preferred / Specialty Drugs Tier 4 - Typically Specialty (brand and generic)	10% coinsurance \$10/prescription (retail) and \$20/prescription (home delivery) \$20/prescription, (retail) and \$40/prescription, (home delivery) \$40/prescription, (retail) and \$80/prescription, (home delivery) Not Applicable	30% coinsurance Not covered Not covered Not covered Not Applicable	-----none----- *See Prescription Drug section
If you have outpatient surgery	Facility fee (e.g. ambulatory surgery center)	10% coinsurance	30% coinsurance	-----none-----

* 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)	
If you need immediate medical attention	Physician/surgeon fees	10% coinsurance	30% coinsurance	-----none-----
	Emergency room care	10% coinsurance	Covered as In-Network	-----none-----
If you have a hospital stay	Emergency medical transportation	10% coinsurance	Covered as In-Network	-----none-----
	Urgent care	10% coinsurance	Covered as In-Network	-----none-----
If you need mental health, behavioral health, or substance abuse services	Facility fee (e.g. hospital room)	10% coinsurance	30% coinsurance	-----none-----
	Physician/surgeon fees	10% coinsurance	30% coinsurance	-----none-----
If you are pregnant	Outpatient services	Office Visit 10% coinsurance Other Outpatient 10% coinsurance	Office Visit 30% coinsurance Other Outpatient 30% coinsurance	Office Visit -----none----- Other Outpatient -----none-----
	Inpatient services	10% coinsurance	30% coinsurance	-----none-----
If you need help recovering or have other special health needs	Office visits	10% coinsurance	30% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	10% coinsurance	30% coinsurance	200 visits/benefit period.
If your child needs dental or eye care	Childbirth/delivery facility services	10% coinsurance	30% coinsurance	*See Therapy Services section
	Home health care	10% coinsurance	30% coinsurance	120 days limit/benefit period.
If you need help recovering or have other special health needs	Rehabilitation services	10% coinsurance	30% coinsurance	-----none-----
	Habilitation services	10% coinsurance	30% coinsurance	210 days limit/lifetime.
If your child needs dental or eye care	Skilled nursing care	10% coinsurance	30% coinsurance	*See Vision Services section
	Durable medical equipment	10% coinsurance	30% coinsurance	*See Dental Services section
If your child needs dental or eye care	Hospice services	10% coinsurance	30% coinsurance	
	Children's eye exam	\$5/exam	\$30 allowance	
If your child needs dental or eye care	Children's glasses	\$115 allowance	\$64 allowance	
	Children's dental check-up	Not covered	Not covered	

* 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.)

- Weight loss programs
- Dental care (adult)
- Hearing aids
- Private-duty nursing
- Weight loss programs
- Dental Check-up
- Routine foot care unless you have been diagnosed with diabetes
- Dental Check-up
- Cosmetic surgery
- Glasses for a child
- Long-term care
- Cosmetic surgery

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

- Chiropractic care
- Acupuncture
- Infertility treatment
- Routine eye care (adult)
- Bariatric surgery

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. 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

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.

-----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 \$1,500
- Specialist coinsurance 10%
- Hospital (facility) coinsurance 10%
- Other coinsurance 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

In this example, Peg would pay:

Cost Sharing	
Deductibles	\$1,500
Copayments	\$0
Coinsurance	\$1,262
Limits or exclusions	\$60
The total Peg would pay is	\$2,822

What isn't covered

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

- The plan's overall deductible \$1,500
- Specialist coinsurance 10%
- Hospital (facility) coinsurance 10%
- Other coinsurance 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

In this example, Joe would pay:

Cost Sharing	
Deductibles	\$1,078
Copayments	\$0
Coinsurance	\$120
Limits or exclusions	\$21
The total Joe would pay is	\$1,219

What isn't covered

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

- The plan's overall deductible \$1,500
- Specialist coinsurance 10%
- Hospital (facility) coinsurance 10%
- Other coinsurance 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

In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1,500
Copayments	\$0
Coinsurance	\$193
Limits or exclusions	\$0
The total Mia would pay is	\$1,693

What isn't covered

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

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) 342-9816.

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 διεγμηνέα, τηλεφωνήστε στο (800) 342-9816.

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) 342-9816.

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) 342-9816.

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) 342-9816 ।

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) 342-9816.

Igbo (Igbo): O bụrụ na ị nwere ajuju o bụla gbasara akwụkwọ a, ị nwere ikike inweta enyemaka na ozi n'asụsụ gị na akwụghị ugwo o bụla. Ka gị na okwowa okwu kwuo okwu, kpọọ (800) 342-9816.

Ilokano (Ilokano): Nu addaan ka iti aniaman a saludsod panggep iti daytoy a dokumento, adda karbengam a makaala ti tulong ken impormasyon babaen ti lengguahem nga awan ti bayad na. Tapno makatungtong ti maysa nga tagipatarus, awagan ti (800) 342-9816.

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) 342-9816.

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 (800) 342-9816.

Japanese (日本語): この文書についてなにかご不明な点があれば、あなたにはあなただけ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) 342-9816 にお電話ください。

Language Access Services:

Khmer (ខ្មែរ): បើអ្នកមានសំណួរផ្សេងទៀតអំពីឯកសារនេះ អ្នកមានសិទ្ធិទទួលបានជំនួយនិងព័ត៌មានជាភាសាបស់អ្នកដោយឥតគិតថ្លៃ។
ស្នើឱ្យជជែកជាមួយអ្នកបកប្រែ សូមហៅ (800) 342-9816 ។

Kirundi (Kirundi): Ugize ikibazo icyo arico cose kuri iyi nyandiko, ufise uburenganzira bwo kuronka ubufasha mu rurimi rwawe ata giciro. Kugira uvugishye umusemuzi, akura (800) 342-9816.

Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면 (800) 342-9816 로 문의하십시오.

Lao (ພາສາລາວ): ຖ້າທ່ານມີຄໍາຖາມໃດໆກ່ຽວກັບເອກະສານນີ້, ທ່ານມີສິດໄດ້ຮັບຄວາມຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນບັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ.
ເບື້ອງໂຮ້ງນັບກັບລ່າມແປພາສາ, ໃຫ້ໃບທາ (800) 342-9816.

Navajo (Diné): Dii naaltsoos bika'ígíí labgo bina'ídiikidgo ná bəhónéedzǎ́ dóó bee ahóót'í' f'áá ni nizaad k'ehj'í bee níl hodooníí f'áadoo báh'ílinígóó. Ata' hainé'ígíí' ía' bich'í' hadeesdzih nínízingo koj'í' hodiilnih (800) 342-9816.

Nepali (नेपाली): यदि यो कागजातबारे तपाईंसँग केही प्रश्नहरू छन् भने, आफ्नै भाषामा निःशुल्क सहयोग तथा जानकारी प्राप्त गर्न पाउने हक तपाईंसँग छ।
दोभाषेसँग कुरा गर्नका लागि, यहाँ कल गर्नुहोस् (800) 342-9816

Oromo (Oromifaa): Sanaadi kanaa wajjin walqabaate gaffi kamiyyuu yoo qabduu tanaan, Gargaarsa argachuu fi odeeffanoo afaan ketiin kaffaltii alla argachuuf mirгаа qabdaa. Turjumaana dubaachuuf, (800) 342-9816 bilbilaa.

Pennsylvania Dutch (Deutsch): Wann du Frooge iwwer selle Document hoscht, du hoscht die Recht um Helfe un Information zu griege in dei Schprooch mitaus Koscht. Um mit en Iwwersetze zu schwetze, tuff (800) 342-9816 aa.

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 (800) 342-9816.

Portuguese (Português): Se tiver quaisquer dúvidas acerca deste documento, tem o direito de solicitar ajuda e informações no seu idioma, sem qualquer custo. Para falar com um intérprete, ligue para (800) 342-9816.

Punjabi (ਪੰਜਾਬੀ): ਜੇ ਤੁਹਾਡੇ ਇਸ ਦਸਤਾਵੇਜ਼ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹੁੰਦੇ ਹਨ ਤਾਂ ਤੁਹਾਡੇ ਕੋਲ ਮੁਫਤ ਵਿੱਚ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੁੰਦਾ ਹੈ। ਇੱਕ ਦੁਬਾਰੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, (800) 342-9816 ਤੇ ਕਾਲ ਕਰੋ।

Language Access Services:

Romanian (Română): Dacă aveți întrebări referitoare la acest document, aveți dreptul să primiți ajutor și informații în limba dumneavoastră în mod gratuit. Pentru a vă adresa unui interpret, contactați telefonic (800) 342-9816.

Russian (Русский): Если у вас есть какие-либо вопросы в отношении данного документа, вы можете право на бесплатное получение помощи и информации на вашем языке. Чтобы связаться с устным переводчиком, позвоните по тел. (800) 342-9816.

Samoaan (Samoa): Afai e iai ni ou fesili e uiga i lenei tusi, e iai lou 'aia e maua se fesoasoani ma faamatalaga i lou lava gagana e aunoa ma se totogi. Ina ia talanoa i se tagata faaliliu, vili (800) 342-9816.

Serbian (Srpski): Ukoliko imate bilo kakvih pitanja u vezi sa ovim dokumentom, imate pravo da dobijete pomoć i informacije na vašem jeziku bez ikakvih troškova. Za razgovor sa prevodiocem, pozovite (800) 342-9816.

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 (800) 342-9816.

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 (800) 342-9816.

Thai (ไทย): หากท่านมีคำถามใดๆ เกี่ยวกับเอกสารฉบับนี้ ท่านมีสิทธิ์ที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของท่านโดยไม่มีค่าใช้จ่าย โดยโทร (800) 342-9816 เพื่อพูดคุยกับสำน

Ukrainian (Українська): якщо у вас виникли запитання з приводу цього документа, ви маєте право безкоштовно отримати допомогу й інформацію вашою рідною мовою. Щоб отримати послуги перекладача, зателефонуйте за номером (800) 342-9816.

کے مترجم سے بات کرنے کے
کسی حاصل ہے۔ کسی حاصل کرنے کا حق حاصل کرنے میں آپ کا کوئی سوال ہے، تو آپ کو مدد اور اپنی زبان میں مفت معلومات حاصل کرنے کے
پر کال کریں۔ (800) 342-9816

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 (800) 342-9816.

אין איבערזעצער, טופט 342-9816 (800).
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אין איבערזעצער, טופט 342-9816 (800).

Yoruba (Yorùbá): Ti o bá ní èyíkẹyí ibèrè nipa àkọsílẹ̀ yì, o ní èrò látí gba ànàwó àti iwífún ní èdè rẹ l'òṣẹ́. Bá wa ògbuńfọ̀ kan sòrò, pe (800) 342-9816.

Language Access Services:

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://ocportal.hhs.gov/ocr/portal/lobby.jsf>. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.