
 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 (833) 924-1055 to request a copy.

| Important Questions   | Answers   | Why This Matters:   |
|---|---|---|
| What is the overall <a href="#">deductible</a> ?                                | \$0.  | 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?              | 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> ? | \$3,000/individual or \$7,500/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 (833) 924-1055 for a list of <a href="#">network providers</a> . |   |
| Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?    | Yes.  | This <a href="#">plan</a> will pay some or all of the costs to see a <a href="#">specialist</a> for covered services but only if you have a <a href="#">referral</a> before you see the <a href="#">specialist</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<br>(You will pay the least) | Out-of-Network Provider<br>(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                                    | \$15/visit                                      | Not covered  | -----none-----  |
|  | <a href="#">Specialist</a> visit  | \$15/visit                                      | Not covered  | -----none-----  |
|  | <a href="#">Preventive care/screening/immunization</a>                              | No charge                                       | Not covered  | 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)                                 | No charge                                       | Not covered  | -----none-----  |
|  | Imaging (CT/PET scans, MRIs)  | No charge                                       | Not covered  | -----none-----  |
| If you need drugs to treat your illness or condition<br>More information about <a href="#">prescription drug coverage</a> is available at <a href="#">www.[insert]</a> . | Tier 1 - Typically Generic  | Not covered                                     | Not covered  | Carved out to another vendor.   |
|  | Tier 2 - Typically <a href="#">Preferred</a> / Brand                                | Not covered                                     | Not covered  |   |
|  | Tier 3 - Typically Non- <a href="#">Preferred</a> / <a href="#">Specialty Drugs</a> | Not covered                                     | Not covered  |   |
|  | Tier 4 - Typically <a href="#">Specialty</a> (brand and generic)                    | Not covered                                     | Not covered  |   |
| If you have outpatient surgery   | Facility fee (e.g., ambulatory surgery center)                                      | No charge                                       | Not covered  | -----none-----  |
|  | Physician/surgeon fees  | No charge                                       | Not covered  | -----none-----  |
| If you need immediate medical attention  | <a href="#">Emergency room care</a>   | \$35/occurrence first 1 visit                   | Covered as In- <a href="#">Network</a>             | Copay waived if admitted within 24 hours.   |
|  | <a href="#">Emergency medical transportation</a>                                    | No charge                                       | Covered as In- <a href="#">Network</a>             | -----none-----  |
|  | <a href="#">Urgent care</a>   | \$15/visit                                      | Covered as In- <a href="#">Network</a>             | -----none-----  |
| If you have a hospital stay  | Facility fee (e.g., hospital room)  | \$300/admission                                 | Not covered  | -----none-----  |
|  | Physician/surgeon fees  | No charge                                       | Not covered  | -----none-----  |
| If you need mental health, behavioral health, or substance abuse services  | Outpatient services   | Office Visit<br>\$15/visit                      | Office Visit<br>Not covered                        | Office Visit<br>-----none-----  |
|  |   | Other Outpatient<br>No charge                   | Other Outpatient<br>Not covered                    | Other Outpatient<br>-----none-----  |
|  | Inpatient services  | \$300/admission                                 | Not covered  | -----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<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |  |
| If you are pregnant  | Office visits                             | No charge                                       | Not covered  | <a href="#">Cost sharing</a> does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
|  | Childbirth/delivery professional services | No charge                                       | Not covered  |  |
|  | Childbirth/delivery facility services     | \$300/admission                                 | Not covered  |  |
| If you need help recovering or have other special health needs | <a href="#">Home health care</a>          | No charge                                       | Not covered  | 200 visits/benefit period for <a href="#">In-Network Providers</a> .   |
|  | <a href="#">Rehabilitation services</a>   | \$15/visit                                      | Not covered  | Cost may vary by site of service<br>*See Therapy Services section  |
|  | <a href="#">Habilitation services</a>     | \$15/visit                                      | Not covered  |  |
|  | <a href="#">Skilled nursing care</a>      | \$100/admission                                 | Not covered  | 60 days limit/benefit period for <a href="#">In-Network Providers</a> .  |
|  | <a href="#">Durable medical equipment</a> | 50% <a href="#">coinsurance</a>                 | Not covered  | *See <a href="#">Durable Medical Equipment</a> Section   |
|  | <a href="#">Hospice services</a>          | No charge                                       | Not covered  | -----none-----   |
| If your child needs dental or eye care                         | 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   |

### 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](#).)

- |  |  |  |
|--|--|--|
| <ul style="list-style-type: none"> <li>• Cosmetic surgery</li> <li>• Eye exams for a child</li> <li>• Non-emergency care when traveling outside the U.S.</li> <li>• Routine foot care unless you have been diagnosed with diabetes.</li> <li>• Tier 3 - Typically Non-<a href="#">Preferred</a> / <a href="#">Specialty Drugs</a></li> </ul> | <ul style="list-style-type: none"> <li>• Dental care (adult)</li> <li>• Glasses for a child</li> <li>• Private-duty nursing</li> <li>• Tier 1 - Typically Generic</li> <li>• Tier 4 - Typically <a href="#">Specialty</a> (brand and generic)</li> </ul> | <ul style="list-style-type: none"> <li>• Dental Check-up</li> <li>• Long- term care</li> <li>• Routine eye care (adult)</li> <li>• Tier 2 - Typically <a href="#">Preferred</a> / Brand</li> <li>• Weight loss programs</li> </ul> |
|--|--|--|

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

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

- Acupuncture
- Hearing aids once every 1, 2 and 3 years.
- Bariatric surgery
- Infertility treatment
- Chiropractic care

**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 Health and Human Services, Center for Consumer Information and Insurance Oversight, 1-877-267-2323 x61565, [www.cciio.cms.gov](http://www.cciio.cms.gov). 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 Health and Human Services, Center for Consumer Information and Insurance Oversight, 1-877-267-2323 x61565, [www.cciio.cms.gov](http://www.cciio.cms.gov)

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**

[Minimum Essential Coverage](#) generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the premium tax credit.

**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.*

## 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>                          | \$15  |
| ■ Hospital (facility) <a href="#">copayment</a>                 | \$300 |
| ■ Other <a href="#">coinsurance</a>                             | 0%    |

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 | \$12,700 |
|--------------------|----------|

In this example, Peg would pay:

| <a href="#">Cost Sharing</a>      |              |
|-----------------------------------|--------------|
| <a href="#">Deductibles</a>       | \$0          |
| <a href="#">Copayments</a>        | \$300        |
| <a href="#">Coinsurance</a>       | \$0          |
| <i>What isn't covered</i>         |              |
| Limits or exclusions              | \$70         |
| <b>The total Peg would pay is</b> | <b>\$370</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>                          | \$15  |
| ■ Hospital (facility) <a href="#">copayment</a>                 | \$300 |
| ■ Other <a href="#">coinsurance</a>                             | 0%    |

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 | \$5,600 |
|--------------------|---------|

In this example, Joe would pay:

| <a href="#">Cost Sharing</a>      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$0            |
| <a href="#">Copayments</a>        | \$200          |
| <a href="#">Coinsurance</a>       | \$0            |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$4,300        |
| <b>The total Joe would pay is</b> | <b>\$4,500</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>                          | \$15  |
| ■ Hospital (facility) <a href="#">copayment</a>                 | \$300 |
| ■ Other <a href="#">coinsurance</a>                             | 0%    |

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 | \$2,800 |
|--------------------|---------|

In this example, Mia would pay:

| <a href="#">Cost Sharing</a>      |              |
|-----------------------------------|--------------|
| <a href="#">Deductibles</a>       | \$0          |
| <a href="#">Copayments</a>        | \$100        |
| <a href="#">Coinsurance</a>       | \$100        |
| <i>What isn't covered</i>         |              |
| Limits or exclusions              | \$10         |
| <b>The total Mia would pay is</b> | <b>\$210</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 (833) 924-1055

**Amharic (አማርኛ):-** ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በነጻ የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር (833) 924-1055 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 (833) 924-1055.

**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՝ (833) 924-1055:

**Bassa (Bàsɔ̀ Wùdù):** M̄ dyi dyi-diè-dɛ̀ bɛ̀ bédé b́á céè-dɛ̀ nìà kɛ dyí ní, ɔ̀ m̀ò nì dyí-bédèin-dɛ̀ bɛ̀ m̄ kɛ̀ gbo-kpá-kpá kè b̄́ kp̄́ dɛ̀ m̄ bídí-wùdùùn b́ó pídyi. B́é m̄ kɛ̀ wuɖu-zìin-nyò d̀ò gbo wùdù kɛ̀, d́á (833) 924-1055.

**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 (833) 924-1055 -তে কল করুন।

**Burmese (မြန်မာ):** ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အချက်အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖုန်း (833) 924-1055 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 (833) 924-1055。

**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 kɔr yin ba jam wēnē ran ye thok geryic, ke yin cəl (833) 924-1055.

**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 (833) 924-1055.

**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 (833) 924-1055 تماس بگیرید.



## Language Access Services:

**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 (833) 924-1055.

**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 (833) 924-1055.

**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 (833) 924-1055.

**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 (833) 924-1055.

**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 (833) 924-1055.

**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 (833) 924-1055 ।

**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 (833) 924-1055.

**Igbo (Igbo):** O bụrụ na ị nwere ajujụ ọ bụla gbasara akwụkwọ a, ị nwere ikike ịnweta enyemaka na ozi n'asụsụ gị na akwụghị ụgwọ ọ bụla. Ka gị na ọkọwa okwu kwuo okwu, kpọọ (833) 924-1055.

**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 (833) 924-1055.

**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 (833) 924-1055.

**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 (833) 924-1055

**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、(833) 924-1055 にお電話ください。

## Language Access Services:

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