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, call 1-212-869-5994. 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 http://www.cciio.cms.gov or call 1-800-553-9603 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$0** In-Network **$300** Individual / **$750** Family Out-of-Network.	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 plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	No.	You will have to meet the deductible before the plan pays for any services.
Are there other deductibles for specific services?	Yes. **$50** per individual for prescription drug coverage.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	Not Applicable.	This plan does not have an out-of-pocket limit on your expenses.
What is not included in the out-of-pocket limit?	Not Applicable.	This plan does not have an out-of-pocket limit on your expenses.
Will you pay less if you use a network provider?	Yes. See http://www.empireblue.com or call 1-800-553-9603 for a list of network providers.	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.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

 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
		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	$25 copay / visit	20% coinsurance plus balance billing	None.
	Specialist visit	$35 copay / visit	20% coinsurance plus balance billing	None.
	Preventive care/screening/ immunization	No charge	20% coinsurance plus balance billing	Limited to one Adult Physical per year. 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 have a test	Diagnostic test (x-ray, blood work)	No charge	20% coinsurance plus balance billing	None.
	Imaging (CT/PET scans, MRIs)	No charge	20% coinsurance plus balance billing	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.optumrx.com	Generic drugs	Greater of $5.00 copay or 10% coinsurance / prescription (retail) Greater of $12.50 copay or 8% coinsurance / Prescription (mail order)	Not covered	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription) For maintenance drugs (i.e. medications typically prescribed to a person who is required to take the drug for an extended period of time), you are required to fill a 90-day prescription through the mail order program. The difference in cost between the brand drug and its generic equivalent will be charged in addition to the copay if a brand name drug is used when appropriate generic equivalent is available.
	Brand drugs	Greater of $10.00 copay or 20% coinsurance / prescription (retail) Greater of $25.00 copay or 17% coinsurance / Prescription (mail order)	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge.	Not covered	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service.
	Physician/surgeon fees	No charge.	Not covered	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service.
If you need immediate medical attention	Emergency room care	$35 copay	Not covered	Copay waived if admitted to a hospital within 24 hours.
	Emergency medical transportation	No charge.	20% coinsurance plus balance billing	Air ambulance is covered in-network only and requires preauthorization.
	Urgent care	$35 copay	Not covered	None.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge.	Not covered	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service.
	Physician/surgeon fees	No charge.	Not covered	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay No charge for Substance Abuse Disorder	Not covered	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service.
	Inpatient services	No charge	Not covered	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service.
If you are pregnant	Office visits	No charge	Not covered	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service.
	Childbirth/delivery professional services	No charge	Not covered	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service.
	Childbirth/delivery facility services	No charge	Not covered	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service. Limited to 200 visits per calendar year.
	Rehabilitation services	$35 copay for outpatient services No charge for inpatient services	Not covered	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service. Outpatient services limited to 30 visits per year. Inpatient services limited to 30 days per year.
	Habilitation services	Not covered	Not covered	None.
	Skilled nursing care	No charge	Not covered	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service. Limited to 60 days per year.
	Durable medical equipment	No charge	20% coinsurance plus balance billing	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service.
	Hospice services	No charge	Not covered	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service. Limited to 210 days per lifetime.
If your child needs dental or eye care	Children's eye exam	No charge	Up to $100 per year reimbursement.	Limited to one exam per year.
	Children's glasses	No charge for one basic pair of glasses per year		There may be a charge for contact lenses, bi- or tri-focals, transitional lenses, tinted lenses, or brand name frames.
	Children's dental check-up	No charge	Balance billing	Non-essential dental benefits are limited to $2,000 per child per year.

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.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Habilitation services
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Weight loss programs

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

- Chiropractic care
- Dental care (Limited to $2,000 per adult per year)
- Infertility treatment
- Most coverage provided outside the United States. See www.bcbs.com/bluecardworldwide
- Routine eye care (Adult)
- Routine foot care (if associated with disease affecting the lower limbs, such as severe diabetes, which requires care of a podiatrist or a physician)

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: The Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or the U.S. department of Health and Human Services at 1-877-267-2323 x61565 or 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 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: the Department of Labor's Employee Benefits Security Administration, 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or the Publishers' – Pressmen's Welfare Fund, 1501 Broadway, Suite 1724, New York, NY 10036 at (212) 869-5994.

Additionally, a consumer assistance program can help you file your appeal. Contact: Community Service Society of New York, Community Health Advocates, 105 East 22nd Street, 8th floor New York, NY 10010 at (888) 614-5400 or htpp://www.communityhealthadvocates.org/.

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.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-212-869-5994.

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 plan's overall deductible	$0
Specialist copayment	$35
Hospital (facility) coinsurance	0%
Other copayment	$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:

Cost Sharing	
Deductibles	$20
Copayments	$70
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$150**

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

The plan's overall deductible	$0
Specialist copayment	$35
Hospital (facility) coinsurance	0%
Other copayment	$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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$50
Copayments	$600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$710**

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

The plan's overall deductible	$0
Specialist copayment	$35
Hospital (facility) coinsurance	0%
Other copayment	$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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$400**

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