**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/aso. 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) 496-6132 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | For out-of-network providers **$2,000** individual/ **$5,000** family | 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?** | No. | You don't have to meet deductibles for specific services. |
| **What is the out-of-pocket limit for this plan?** | For out-of-network providers **$10,000** individual/ **$25,000** family | 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, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| **What is not included in the out-of-pocket limit?** | Premiums, balance-billing charges, and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the out-of-pocket limit. |
| **Will you pay less if you use a network provider?** | Yes, POS. See www.empireblue.com or call (800) 496-6132 for a list of network providers. | You pay the least if you use a provider in Catholic Hospitals. You pay more if you use a provider in In-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 |
|---|---|---|---|---|---|
| | | CHS Provider (You will pay the least) | Empire Tier In-Network Provider (You will pay more) | 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 | $20/visit | $20/visit | 40% coinsurance | Well child care covered up to age 19. $40 copay for in-network providers outside Nassau & Suffolk Counties |
| | Specialist visit | $20/visit | $20/visit | 40% coinsurance | |
| | Preventive care/screening/ immunization | $20/visit | $20/visit | 40% coinsurance | Well child care covered up to age 19. $40 copay for in-network providers outside Nassau & Suffolk Counties |
| **If you have a test** | Diagnostic test (x-ray, blood work) | No charge | No charge | 40% coinsurance | --------none-------- |
| | Imaging (CT/PET scans, MRIs) | No charge | No charge | 40% coinsurance | --------none-------- |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at www.envisionrx.com. | Tier 1 - Typically Generic | $10 | $10 | Not covered | Clinical rules may apply; Copays are up to 30 day supply; Up to 90 day supply maintenance drugs available at 2x retail copay (MyCHSRx or Envision Rx mail order). For more information contact the MyCHSRx Pharmacy at 516-207-7007 or EnvisionRxOptions at 800-361-4542. |
| | Tier 2 - Typically Preferred Brand | $20 | $20 | Not covered | |
| | Tier 3 - Typically Non-Preferred Brand | $35 | $35 | Not covered | |
| | Tier 4 - Typically Specialty (brand and generic) | Same as above | Same as above | Not covered | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | No charge | $75 | 40% coinsurance | Failure to obtain preauthorization may result in non-coverage or reduced coverage. |
| | Physician/surgeon fees | No charge | No charge | 40% coinsurance | --------none-------- |

* For more information about limitations and exceptions, see **plan** or policy document at https://eoc.empireblue.com/eocdps/aso.

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | CHS Provider (You will pay the least) | Empire Tier In-Network Provider (You will pay more) | Out-of-Network Provider (You will pay the most) | |
| **If you need immediate medical attention** | Emergency room care | $50/visit | $50/visit | $50/visit | Copay waived if admitted within 24 hours. |
| | Emergency medical transportation | No charge | No charge | No charge | --------none-------- |
| | Urgent care | There is no unique benefit for Urgent Care. It will be billed as either an office or ER cost share. | There is no unique benefit for Urgent Care. It will be billed as either an office or ER cost share. | There is no unique benefit for Urgent Care. It will be billed as either an office or ER cost share. | --------none-------- |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | No charge | $125/$500 per day/ max per confinement per person for facilities in Nassau or Suffolk County | 40% coinsurance | $125/$1,000 per day/max per confinement per person at facilities outside Nassau & Suffolk Counties. Failure to obtain preauthorization may result in non-coverage or reduced coverage |
| | Physician/surgeon fees | No charge | No charge | 40% coinsurance | --------none-------- |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $20 | $20 | 40% coinsurance | $40 copay for in-network providers outside Nassau & Suffolk Counties |
| | Inpatient services | No charge | $125/$500 per day/ max per confinement per person for facilities in Nassau or Suffolk County | 50% coinsurance | $125/$1,000 per day/max per confinement per person at facilities outside Nassau & Suffolk Counties. Failure to obtain preauthorization may result in non-coverage or reduced coverage |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | CHS Provider (You will pay the least) | Empire Tier In-Network Provider (You will pay more) | Out-of-Network Provider (You will pay the most) | |
| **If you are pregnant** | Office visits | $20/visit first visit | $20/visit first visit | 40% coinsurance | $40 copay for in-network providers outside Nassau & Suffolk Counties<br>Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).<br>Failure to obtain preauthorization may result in non-coverage or reduced coverage. |
| | Childbirth/delivery professional services | No charge | No charge | 40% coinsurance | |
| | Childbirth/delivery facility services | No charge | $125/$500 per day/ max per confinement per person for facilities in Nassau or Suffolk County | 40% coinsurance | |
| **If you need help recovering or have other special health needs** | Home health care | $20/visit | $20/visit | 40% coinsurance deductible does not apply | $40 copay for in-network providers outside Nassau & Suffolk Counties<br>200 days limit/benefit period for CHS Provider, Empire Tier In-Network Providers and Out-of-Network Provider combined. Failure to obtain preauthorization may result in non-coverage or reduced coverage. |
| | Rehabilitation services | $20/visit | $20/visit | 40% coinsurance | $40 copay for in-network providers outside Nassau & Suffolk Counties. PT covered up to 20 visits per calendar year, speech/language/OT and vision therapy covered up to 20 visits combined per calendar year. |
| | Habilitation services | $20/visit | $20/visit | 40% coinsurance | $40 copay for in-network providers outside Nassau & Suffolk Counties |

* For more information about limitations and exceptions, see **plan** or policy document at https://eoc.empireblue.com/eocdps/aso.

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | CHS Provider (You will pay the least) | Empire Tier In-Network Provider (You will pay more) | Out-of-Network Provider (You will pay the most) | |
| | | | | | Limited to 20 institutional /professional visits per calendar year for in-network and out-of-network combined. All rehabilitation and habilitation visits count toward your rehabilitation visit limit. |
| | Skilled nursing care | No charge | No charge | 40% coinsurance | Failure to obtain preauthorization may result in non-coverage or reduced coverage |
| | Durable medical equipment | No charge | No charge | 40% coinsurance | --------none-------- |
| | Hospice services | No charge | No charge | 40% coinsurance | 210 days limit/lifetime for CHS Provider, Empire Tier In-Network Providers and Out-of-Network Providers combined. Failure to obtain preauthorization may result in non-coverage or reduced coverage. |
| **If your child needs dental or eye care** | Children's eye exam | Covered | Covered | Not covered | $5 copay for 1 exam every 24 months plus discounts on frames and lenses |
| | Children's glasses | Not covered | Not covered | Not covered | |
| | Children's dental check-up | Not covered | Not covered | Not covered | --------none-------- |

## 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.)**

- Elective termination of pregnancy
- Cosmetic surgery
- Infertility treatment
- Routine foot care
- Sterilization
- Dental care (adult)
- Long- term care
- Weight loss programs
- Contraceptive Services
- Hearing aids
- Private-duty nursing
- Any services that do not comply with the ethical and religious directives of the Catholic Church

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

- Chiropractic care
- Most coverage provided outside the United States. See www.bcbsglobalcore.com
- Routine eye care (adult) 1 exam every 24 months

**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, Employee Benefits Security Administration, (866) 444-EBSA (3272), 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

**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.empireblue.com/eocdps/aso.

## 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* | $20 |
| ■ Hospital (facility) *copay* | $125/day, $500 max |
| ■ Other *coinsurance* | 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 | $12,840 |
|---|---|

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $600 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$660** |

### 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* | $20 |
| ■ Hospital (facility) *copay* | $125/day, $500 max |
| ■ Other *coinsurance* | 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 | $7,460 |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $850 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Joe would pay is** | **$910** |

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

| | |
|---|---|
| ■ The plan's overall deductible | $0 |
| ■ Specialist *copayment* | $20 |
| ■ Hospital (facility) *copay* | $125/day, $500 max |
| ■ Other *coinsurance* | 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 | $2,010 |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $140 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$140** |

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) 496-6132

**Amharic (አማርኛ):-** ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በነጻ የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር (800) 496-6132 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) 496-6132.

**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) 496-6132:

**Bassa (Bǎsɔ̀ɔ̀ Wùdù):** M̀ dyi dyi-diè-dɛ̀ bě bédé bá céè-dɛ̀ nìà kɛ dyí ní, ɔ mɔ̀ nì dyí-bɛ̀dɛ̀ìn-dɛ̀ bɛ́ m̀ ké gbo-kpá-kpá kè bɔ̌ kpɔ̃ dɛ́ m̀ bídí-wùdùŭn bó pídyi. Bɛ́ m̀ ké wudu-zììn-nyɔ̀ dò gbo wùdù kɛ, dá (800) 496-6132.

**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) 496-6132 -তে কল করুন।

**Burmese (မြန်မာ):** ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အခမဲ့အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖုန် (800) 496-6132 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) 496-6132。

**Dinka (Dinka):** Na nɔŋ thiëëc në ke de yä thorë, ke yin nɔŋ loŋ bë yi kuony ku wɛr alëu bë gɛɛr yic yin ne thoŋ du ke cin wëu tääuë ke piny. Te kɔr yin ba jam wënë ran ye thok geryic, ke yin cɔl (800) 496-6132.

**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) 496-6132.

## Language Access Services:

**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 (800) 496-6132 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) 496-6132.

**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) 496-6132.

**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) 496-6132.

**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) 496-6132.

**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) 496-6132.

**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) 496-6132 ।

**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) 496-6132.

**Igbo (Igbo):** Ọ bụr ụ na ị nwere ajụjụ 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 (800) 496-6132.

**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) 496-6132.

## Language Access Services:

**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) 496-6132.

**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) 496-6132

**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) 496-6132 にお電話ください。

**Khmer (ខ្មែរ):** បើអ្នកមានសំណួរផ្សេងទៀតអំពីឯកសារនេះ អ្នកមានសិទ្ធិទទួលជំនួយនិងព័ត៌មានជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។ ដើម្បីជជែកជាមួយអ្នកបកប្រែ សូមហៅ (800) 496-6132 ។

**Kirundi (Kirundi):** Ugize ikibazo ico arico cose kuri iyi nyandiko, ufise uburenganzira bwo kuronka ubufasha mu rurimi rwawe ata giciro. Kugira uvugishe umusemuzi, akura (800) 496-6132.

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**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) 496-6132

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