Your Summary of Benefits

Alternate PPO

Empire BlueCross

An Anthem Company

WSWHE Counties Health Insurance Consortium Trust

Benefit	In-Network [1]	Out-of-Network [2,3]
Deductible	N/A	$200/$500
Coinsurance	N/A	20%
Out-of-Pocket Maximum	$5,080 / $12,700 (All In-Network Medical & RX Cost Shares)	$5,000/$12,500 Coinsurance Stop Loss / $1,200 / $3,000 Out-of-Pocket Maximum
Lifetime Maximum	Unlimited	Unlimited
Dependent Children (covered to the end of the month of the dependent's birthday)	Dependents to age 26	Dependents to age 26
Covered Preventive Care[4]	**Member Pays In-Network**	**Member Pays Out-of-Network**
Covered Adult Preventive Care	$0	Deductible and Coinsurance
Annual Physical Exam	$0	Covered in-network only
Well-Child Care (Up to age 19; including necessary covered immunizations)	$0	Deductible and Coinsurance
Preventive Well-Woman Care	$0	Deductible and Coinsurance
Home/Office/Outpatient Care [12]	**Member Pays In-Network**	**Member Pays Out-of-Network**
Home/Office Visits / Online Visits	$30/$50 copayment	Deductible and Coinsurance
Urgent Care Center	$50 copayment	$50 copayment
Emergency Room/Facility (initial visit per occurrence)	$200 copayment (Waived if admitted within 24 hours)	$200 copayment (Waived if admitted within 24 hours)
Surgery[5], Presurgical Testing, Anesthesia	$0	Deductible and Coinsurance
Chemotherapy, Radiation Therapy	$0	Deductible and Coinsurance
Routine Maternity Care	$0	Deductible and Coinsurance
Laboratory Tests, X-rays	$0	Deductible and Coinsurance
MRI/MRA[6], CAT Scan[7], PET[7] & Nuclear Cardiology[7]	$0	Deductible and Coinsurance
Allergy Routine Testing and Treatment (Allergy Injections/Immunotherapy)	$30/$50 copayment (Waived for treatment)	Deductible and Coinsurance
Chiropractic Care[9]	$30 copayment	Deductible and Coinsurance
Home Healthcare (Up to 200 visits per calendar year)	$0	Coinsurance (no deductible)
Home Infusion Therapy	$0	Covered in-network only
Hospice Care (Unlimited days combined IP & OP per lifetime)	$0	Covered in-network only
Physical Therapy[5] (Up to 90 visits per calendar year combined in home, office or outpatient facility)	$30/$50 copayment	Covered in-network only
Other Short-Term Rehabilitative Therapies – Speech/Language[5], Occupational[5], Vision (Up to 30 visits per calendar year combined in home, office or outpatient facility)	$30/$50 copayment	Covered in-network only

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Benefit	In-Network[1]	Out-of-Network [2,3]
Cardiac Rehabilitation	$50 copayment	Deductible and Coinsurance
Second Surgical Opinion	$30/$50 copayment	Deductible and Coinsurance
Kidney Dialysis	$0	Deductible and Coinsurance
Inpatient Care[5]	**Member Pays In-Network**	**Member Pays Out-of-Network**
Inpatient Hospital (As many days as is medically necessary; semiprivate room and board)	$0	Deductible and Coinsurance
Surgery, Covered Surgical Assistant, Anesthesia	$0	Deductible and Coinsurance
Physical Therapy, Physical Medicine, or Rehabilitation (Up to 90 inpatient days per calendar year)	$0	Deductible and Coinsurance
Skilled Nursing Facility (Up to 120 days per calendar year)	$0	Covered in-network only
Mental Health	**Member Pays In-Network**	
Outpatient Visits in Office	$30 copayment	Deductible and Coinsurance
Outpatient Visits in Facility	$0	Deductible and Coinsurance
Inpatient Care[8] (As many days as medically necessary; semiprivate room and board)	$0	Deductible and Coinsurance
Alcohol/Substance Abuse	**Member Pays In-Network**	**Member Pays Out-of-Network**
Outpatient Visits in Office	$30 copayment	Deductible and Coinsurance
Outpatient Visits in Facility	$0	Deductible and Coinsurance
Inpatient Detoxification[8] (As many days as medically necessary; semiprivate room and board)	$0	Deductible and Coinsurance
Inpatient Rehabilitation[8]	$0	Deductible and Coinsurance
Other	**Member Pays In-Network**	**Member Pays Out-of-Network**
Medical Supplies	$0 when obtained through Empire's medical supplies vendor	In-network benefits apply
Durable Medical Equipment[6]	$0	Covered in-network only
Prosthetics & Orthotics[6]	$0	Covered in-network only
Ambulance (air ambulance)	$0	In-network benefits apply
Prescription Drugs[10]		Covered in-network only
Retail Program – One copayment required for up to a 30-day supply	$0 Deductible per person per calendar year $10 copay for Tier 1 $25 copay for Tier 2 $50 copay for Tier 3 Includes Contraceptives (Retail & Mail-Order)	
Mail-Order Program[11] – Only two copayments required for a 90-day supply	$0 Deductible The Mail-Order Program has the same copayments as the Retail Program listed above.	
Routine Vision Benefits through Blue View Vision Must use the BVV -Insight Network (Every 24 months)	$5 copay for exam $115 allowance for frames, $10 copay for lenses $75 allowance for contact lenses	Up to $30 reimbursement for exams Up to $64 reimbursement for frames Up to $25 reimbursement for Single vision lenses, $35 for bifocal lenses, and $45 for trifocal lenses. Up to $75 reimbursement for Contact lenses.

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(1) Network provider delivers care.
(2) Out-of-network services (except Mental Health and Alcohol/Substance Abuse) are those from a provider that does not participate in Empire's PPO network, or with another Blue Cross and Blue Shield Plan through the BlueCard® PPO Program. (This does not apply to emergency benefits.) See (8) for Mental Health and Alcohol/Substance Abuse Services.
(3) Out-of-network (O-O-N) providers – those who do not participate in Empire's PPO network, or with another Blue Cross and Blue Shield Plan through the BlueCard® PPO Program. Out-of-network providers who do not participate with Empire or with another Blue Cross and Blue Shield Plan, may balance bill over Empire's allowed amount.
(4) Preventive Care benefits not subject to copayment, 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.
(5) You are responsible for obtaining precertification from Empire's Medical Management Program for these services. Your provider may call for you, but you will be responsible for penalties applied if precertification is not obtained. For ambulatory surgery, precertification is required for reconstructive surgery, outpatient transplants and ophthalmological or eye-related procedures. Precertification is also required for cosmetic surgery, an excluded benefit except when medically necessary.
(6) For services received from an Empire PPO provider, the provider must precertify in-network services; Empire PPO providers cannot bill members beyond the copayment for covered services. Outside Empire's network area, you must obtain precertification from Empire's Medical Management Program for services from in-network BlueCard® PPO providers. You are responsible for obtaining precertification from Empire's Medical Management Program for in-area and out-of-area out-of-network services. Your provider may call for you, but you will be responsible for penalties applied if precertification is not obtained.
(7) Empire's network provider must precertify in-network services; Empire network providers cannot bill members beyond the co-payment for covered services. Precertification is not required for out-of-network services, nor for out-of-area in-network BlueCard® PPO provider services.
(8) You are responsible for obtaining precertification from the Behavioral Healthcare Manager for these services. Your provider may call for you, but you will be responsible for penalties applied if precertification is not obtained.
(9) Empire's network provider must obtain authorization for clinical/medical necessity for in-network services; Empire network providers cannot bill members beyond the in-network deductible and coinsurance for covered services. Authorization is not required for out-of-network services or for services rendered from in-network BlueCard® PPO providers outside of Empire's network area.
(10) This prescription drug coverage meets the CMS standard for Creditable Coverage under the Medicare Modernization Act of 2003.
(11) 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.
(12) The following practitioners receive the lower (primary) copay for services provided in an office: Patient's PCP, obstetrics, gynecologists, certified nurse midwives, chiropractors, and physical, occupational, speech and vision therapists. The higher (specialist) copay will apply for all other specialists when a Copay is required, and for services received in an outpatient facility for physical and other speech, language, occupational, vision and cardiac therapy.

NOTE: This is a benefits summary only and is subject to the terms, conditions, limitations and exclusions set forth in your Certificate of Coverage, Schedule of Benefits, and any additional Riders or Contracts your group has purchased. Be sure to consult your benefit Contract or Certificate for full details about your coverage. To the extent that there is a conflict between this Summary and your benefit Contract or Certificate, the terms of the Contract or Certificate will control. Failure to comply with Empire's Medical Management or Behavioral Healthcare Management Program requirements could result in benefit reductions.

This summary of benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits.

Included are preventive care services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits.

Prepared on 3.22.18 NG

Summary of Benefits and Coverage: What this **Plan** Covers & What You Pay For Covered Services **Coverage Period: 07/01/2021 – 06/30/2022**
Empire BlueCross: WSWHE Counties Health Insurance Consortium Trust **Coverage for:** Individual + Family | **Plan Type: PPO**
Alternate PPO

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?	**$0**/individual or **$0**/family for In-Network Providers. **$200**/ individual or **$500**/family for Out-of-Network Providers.	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?	**$5,080**/ individual or **$12,700**/family for In-Network Providers. **$1,200**/ individual or **$3,000**/family for Out-of-Network Providers.	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, Blue Card PPO. See www.empireblue.com or call (800) 342-9816 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	No.	You can see the specialist you choose without a referral.

to see a specialist?		

⚠ 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	$30/visit	20% coinsurance	--------none--------
	Specialist visit	$50/visit	20% coinsurance	--------none--------
	Preventive care/screening/ immunization	No charge	20% coinsurance	Annual physical exams: Not covered for Out-of-Network Providers. 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	--------none--------
	Imaging (CT/PET scans, MRIs)	No charge	20% coinsurance	--------none--------
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.empireblue.com/learnmore National	Tier 1 - Typically Generic	$10/prescription (retail) and $20/prescription (home delivery)	Not covered	*See Prescription Drug section
	Tier 2 - Typically Preferred / Brand	$25/prescription (retail) and $50/prescription (home delivery)	Not covered	
	Tier 3 - Typically Non-Preferred / Specialty Drugs	$50/prescription (retail) and $100/prescription (home delivery)	Not covered	
	Tier 4 - Typically Specialty (brand and generic)	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20% coinsurance	--------none--------
	Physician/surgeon fees	No charge	20% coinsurance	--------none--------
	Emergency room care	$200/visit	Covered as In-Network	Copay waived if admitted within 24 hours.

* 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	Emergency medical transportation	No charge	Covered as In-Network	--------none--------
	Urgent care	$50/visit	Covered as In-Network	--------none--------
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	20% coinsurance	--------none--------
	Physician/surgeon fees	No charge	20% coinsurance	--------none--------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit $30/visit Other Outpatient No charge	Office Visit 20% coinsurance Other Outpatient 20% coinsurance	Office Visit --------none-------- Other Outpatient --------none--------
	Inpatient services	No charge	20% coinsurance	--------none--------
If you are pregnant	Office visits	No charge	20% coinsurance	Cost sharing 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	20% coinsurance	
	Childbirth/delivery facility services	No charge	20% coinsurance	
If you need help recovering or have other special health needs	Home health care	No charge	20% coinsurance deductible does not apply	200 visits/benefit period.
	Rehabilitation services	$30/visit	Not covered	*See Therapy Services section
	Habilitation services	$30/visit	Not covered	
	Skilled nursing care	No charge	Not covered	120 days limit/benefit period for In-Network Providers.
	Durable medical equipment	No charge	Not covered	--------none--------
	Hospice services	No charge	Not covered	210 days limit/lifetime for In-Network Providers.
If your child needs dental or eye care	Children's eye exam	$5/visit	$30 allowance	*See Vision Services section
	Children's glasses	$115 allowance	$64 allowance	
	Children's dental check-up	Not covered	Not covered	*See Dental Services section

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

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Chiropractic care	• Infertility treatment	• Routine eye care (adult)
• Acupuncture		• 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: 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 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

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 a premium tax credit.

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	$0
Specialist *copayment*	$50
Hospital (facility) *coinsurance*	0%
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	$60
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$120**

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*	$50
Hospital (facility) *coinsurance*	0%
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	$340
Coinsurance	$0
What isn't covered	
Limits or exclusions	$21
The total Joe would pay is	**$361**

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

The plan's overall deductible	$0
Specialist *copayment*	$50
Hospital (facility) *coinsurance*	0%
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	$870
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$870**

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