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, visit www.cs.ny.gov or call 1-877-7-NYSHIP (1-877-769-7447). 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 1-877-7-NYSHIP (1-877-769-7447) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$1,500** per enrollee, per spouse/domestic partner, and per all dependent children combined. This **deductible** only applies to the Basic Medical Program. The **deductible** only applies when you seek out-of-network services.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services that are not provided at a network facility or by a participating provider. The **deductible** renews each year. See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there services covered before you meet your deductible?	Yes. The **deductible** does not apply to care rendered at a network facility or by a participating provider, preventive care services as defined by the federal Patient Protection and Affordable Care Act (PPACA), hearing aids, prosthetic wigs, modified solid food products, second opinion for cancer diagnosis, external mastectomy prostheses, emergency services, emergency ambulance services, or prescription drugs.	Most services rendered by a participating provider or at a network facility require only a copayment and do not count toward the Basic Medical Program **deductible**. The **deductible** only applies when you seek out-of-network services.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
What is the out-of-pocket limit for this plan?	In-Network Max: Individual **$9,450**/Family **$18,900**. Out-of-Network Coinsurance Max: **$4,750** per enrollee, per spouse/domestic partner, and per all dependent children combined for the Basic Medical Program and non-network outpatient Mental Health and Substance Use Program.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, and health care this plan does not cover do not count toward either **out-of-pocket limit**. In-Network Max excludes non-network expenses and ancillary charges. Out-of-Network Coinsurance Max excludes facility copays, penalties, and expenses incurred under the Prescription Drug Program, Managed Physical Medicine Program services or Home Care Advocacy Program.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See www.cs.ny.gov/employee-benefits **or call 1-877-7-NYSHIP** and select the appropriate program for a list of participating providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the terms in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting below for how this plan pays different kinds of **providers**.
Do you need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.

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	$35 copayment/visit	20% coinsurance	——————none——————
	Specialist visit	$35 copayment/visit	20% coinsurance	
	Preventive care/screening/ immunization	No charge	Most services not covered	Certain services are covered when rendered by a non-participating provider, including well-care services for children.
If you have a test	Diagnostic test (x-ray, blood work)	$35 copayment/office visit; $85 copayment/outpatient hospital	20% coinsurance in an office; no coverage in a hospital	——————none——————
	Imaging (CT/PET scans, MRIs)	$80 copayment/office visit	20% coinsurance in an office; no coverage in a hospital	Precertification required if not an emergency or an inpatient procedure. If not precertified, the cost will be greater. The test or procedure is not covered if determined not to be medically necessary.

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.cs.ny.gov	Level 1 or for most Generic Drugs	$10 for 1-30 day supply; $30 for 31-90 day supply from a Network Pharmacy; $25 for 31-90 day supply from a Mail Service or Specialty Pharmacy	Claims for your out-of-pocket costs may be eligible for partial reimbursement.	Certain medications require prior authorization for coverage. Copayment waived at a network pharmacy for: • Oral chemotherapy drugs when used to treat cancer; tamoxifen, raloxifene, anastrozole and exemestane when prescribed for the primary prevention of breast cancer • Generic oral contraceptive drugs/devices or brand-name contraceptive drugs/devices without a generic equivalent (single-source brand-name drugs/devices) • Medications used for emergency contraception and pregnancy termination • Adult immunizations and certain prescription drugs and over-the-counter medications that are considered preventive under the Patient Protection and Affordable Care Act (PPACA). To learn more, go to www.hhs.gov/healthcare/about-the-aca/preventive-care/index.html There is an ancillary charge for covered brand-name drugs that have a generic equivalent in addition to the Level 3 copayment.
	Level 2, Preferred Drugs or Compound Drugs	$45 for 1-30 day supply; $100 for 31-90 day supply from a Network Pharmacy; $100 for 31-90 day supply from a Mail Service or Specialty Pharmacy		
	Level 3 or Non-preferred Drugs	$85 for 1-30 day supply; $200 for 31-90 day supply from a Network Pharmacy; $200 for 31-90 day supply from a Mail Service or Specialty Pharmacy		
	Specialty drugs	Applicable copayment based on the drug copayment level		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$35 copayment/office visit; $95 copayment/non-hospital outpatient surgery; $130 copayment/outpatient hospital surgery	20% coinsurance in an office; No coverage in a hospital setting	Provider fee in addition to facility fee applies only if the provider bills separately from the facility.
	Physician/ surgeon fees	$35 copayment/surgery	20% coinsurance in an office setting	

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 immediate medical attention	Emergency room care	$130 copayment/visit	$130 copayment/visit	If admitted, emergency copayment is waived and only the inpatient copayment applies.
	Emergency medical transportation	$70 copayment/trip	$70 copayment/trip	Not subject to deductible or coinsurance.
	Urgent care	$40 copayment/office visit; $85 copayment/visit to a hospital-owned urgent care center	20% coinsurance	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 copayment/inpatient stay	No coverage	Precertification required; $200 penalty if hospitalization is not precertified. Maximum of four inpatient hospital copayments per year, per enrollee, per spouse/domestic partner, and per all dependent children combined each calendar year. Separate provider fee in addition to facility fee if the provider is not affiliated with the facility where the surgery is performed.
	Physician/ surgeon fees	$50 copayment/service for radiology, anesthesiology and pathology; No charge for other services	$85 per service. You pay the first $50 for radiology, anesthesiology and pathology; 20% coinsurance for other services	
If you need mental health, behavioral health, or substance use services	Outpatient services	$35 copayment/visit	20% coinsurance	Precertification is required for some mental health care and substance use care.
	Inpatient services	$250 copayment/inpatient stay	No coverage	Maximum of four inpatient copayments per enrollee, per spouse/domestic partner, and per all dependent children combined each calendar year. Precertification is required for some mental health care and substance use care.
If you are pregnant	Office visits	No charge for routine prenatal and postnatal care	20% coinsurance	Routine obstetrical ultrasounds may be subject to a $35 copayment.
	Childbirth/delivery professional services	No charge	20% coinsurance	——————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)	
	Childbirth/delivery facility services	$250 copayment/visit	No coverage	Although precertification is not required, it is recommended that you notify the Hospital Program if you and/or your baby are in the hospital for more than 48 hours if your baby was delivered vaginally or 96 hours if your baby was delivered by c-section.
If you need help recovering or have other special health needs	Home health care	No charge	50% coinsurance	No charge when precertified; non-network benefits apply if not precertified. No non-network coverage for the first 48 hours of home-based nursing care.
	Rehabilitation services	$35 copayment/visit	No coverage	Covered under Managed Physical Medicine Program for office visits; outpatient hospital rehabilitation services covered when medically necessary following a related hospitalization/surgery.
If you need help recovering or have other special health needs	Habilitation services	$35 copayment/visit	No coverage	Covered services through Managed Physical Medicine Program only.
	Skilled nursing care	No charge	50% coinsurance for covered services at home; no coverage in a skilled nursing facility	Precertification required; non-network benefits apply if home care is not precertified. No non-network coverage for the first 48 hours. No coverage for Medicare-primary enrollees.
	Durable medical equipment	No charge	50% coinsurance	Precertification required; non-network benefits apply if not precertified. Diabetic supplies are covered with no cost to you if you use a Home Care Advocacy Program (HCAP) provider. Non-network benefits apply if you use a non-network provider. No out-of-pocket limit for non-network benefits.
	Hospice services	No charge	No coverage	——————none——————
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	——————none——————
	Children's glasses	Not covered	Not covered	——————none——————
	Children's dental check-up	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.)

- Hearing aids
- Weight loss programs
- Long-term care
- Dental care (adult & child), except for the correction of damage caused by an accident
- Custodial Care
- Routine eye care (adult & child)
- Non-emergency care when traveling outside the U.S.
- Non-network hospital, skilled nursing facility or hospice care, except in an emergency, when there is no network facility within 30 miles of your residence or when no facility within 30 miles of your residence can provide the service you require
- Cosmetic surgery[1]
- Routine foot care
- Services that are experimental or investigational, or not medically necessary
- Non-network habilitation and rehabilitation services under the Managed Physical Medicine Program

[1] With the exception of a diagnosis of gender dysphoria and determination of medical necessity

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

- Acupuncture
- Bariatric surgery (with limitations)
- Chiropractic care
- Infertility treatment (with limitations)
- Diabetic shoes
- Telehealth

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 at 1-800-342-3736 or www.dfs.ny.gov, U.S. Department of Health and Human Services at 1-877-267-2323 x1565 or www.cciio.cms.gov, U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 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:

- The Empire Plan at 1-877-7-NYSHIP (1-877-769-7447) and choose the appropriate program
- The New York State Department of Civil Service, Employee Benefits Division at 518-457-5754 or 1-800-833-4344
- The New York State Department of Financial Services at 518-474-6600 or 1-800-342-3736
- Additionally, a consumer assistance program can help you file your appeal. Contact Community Service Society of New York, Community Health Advocates at 888-614-5400 or www.communityhealthadvocates.org

Does this plan provide Minimum Essential Coverage? **Yes**

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 1-877-769-7447.

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) copayment	$250
Other copayment	$35

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	$0
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$460**

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) copayment	$0
Other copayment	$35

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:

Cost Sharing	
Deductibles	$0
Copayments	$1,000
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,020**

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

The plan's overall deductible	$0
Specialist copayment	$35
Hospital (facility) copayment	$130
Other copayment	$35

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:

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.