This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at https://www.cs.ny.gov/employee-benefits or by calling 1-877-7-NYSHIP (1-877-769-7447).

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$100** per covered individual. Does not apply to care rendered by a network provider or by a network facility, non-network inpatient hospital care or mental health treatment, non-network routine well-child care, external mastectomy prostheses, ambulance services, non-network inpatient hospital, Managed Physical Medicine Program or prescription drugs.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. **$100** for non-network chiropractic and physical therapy services. There are no other specific **deductibles**.	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.
Is there an out–of–pocket limit on my expenses?	Yes. In-Network Max: Individual **$6,600**/Family **$13,200**.	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.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See https://www.cs.ny.gov/employee-benefits **or call 1-877-7-NYSHIP** 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 term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I 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.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

Questions: Call 1-877-7-NYSHIP or visit us at https://www.cs.ny.gov/employee-benefits**.** If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at https://www.cs.ny.gov/sbc or call 1-877-7-NYSHIP and select the Medical Program to request a copy.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use network **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use		Limitations & Exceptions
		Network Coverage	Non-network Coverage	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10 co-payment/visit plus $10 co-payment for radiology/lab services	20% co-insurance	Coverage for up to 15 visits per person per calendar year to a network provider. Non-network coverage applies for visit 16 and beyond. Dialysis, chemotherapy and radiation therapy, well-child care, prenatal and postnatal office visits included in your provider's delivery charge, diagnostic laboratory tests and radiology not performed during an office visit (including interpretation of mammograms and analysis of cervical cytology screening), and visits to a participating Urgent Care Center and visits for preventive care services do not count toward the 15-visit per person limit.
	Specialist visit	$10 co-payment/visit plus $10 co-payment for radiology/lab services	20% co-insurance	
	Other practitioner office visit	$10 co-payment/visit plus $10 co-payment for radiology/lab services	20% co-insurance	
	Preventive care/ screening/ immunization	No charge for preventive services	20% co-insurance	No charge for certain preventive care services in accordance with Patient Protection and Affordable Care Act (PPACA).
If you have a test	Diagnostic test (x-ray, blood work)	$10 co-payment/office visit; $15 co-payment/hospital outpatient setting	20% co-insurance	Non-network coverage applies for visit 16 and beyond.
	Imaging (CT/PET scans, MRIs)	$10 co-payment/office visit; $15 co-payment/hospital outpatient setting	20% co-insurance	Precertification required or penalty of up to $250 may be applied.

Common Medical Event	Services You May Need	Your cost if you use		Limitations & Exceptions
		Network Coverage	Non-network Coverage	
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	30-day supply: $5; Mail Service or Specialty Pharmacy 31-90 day supply: $5	Claims for your out-of-pocket costs may be eligible for partial reimbursement.	Certain medications require prior authorization for coverage. Co-payment waived for oral chemotherapy drugs, most Level 1 contraceptives, and Tamoxifen and Raloxifene prescribed for breast cancer prevention. At certain SUNY Campus Student Health Centers, SEHP enrollees may fill prescriptions for up to a 30-day supply for a $7 co-pay.
	Level 2, Preferred Drugs or Compound Drugs	30-day supply: $25; Mail Service or Specialty Pharmacy 31-90 day supply: $50		
	Level 3 or Non-preferred Drugs	30-day supply: $45; Mail Service or Specialty Pharmacy 31-90 day supply: $90		
	Specialty drugs	Applicable co-payment based on the drug co-payment level		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$10 co-payment/office visit or ambulatory surgical center visit; $15 co-payment/hospital outpatient setting (facility, extension clinic, outpatient surgical locations)	20% co-insurance	Non-network coverage applies in an office setting for visit 16 and beyond. Co-payment for Ambulatory Surgical Center covers facility, same-day on-site testing and anesthesiology charges. Provider fee in addition to facility fee applies only if the provider bills separately from the facility.
	Physician/surgeon fees	$10 co-payment/visit	20% co-insurance	
If you need immediate medical attention	Emergency room services	$25 co-payment/visit	$25 co-payment/visit	If admitted, emergency room co-payment is waived and only the inpatient co-payment applies.
	Emergency medical transportation	$15 co-payment/trip	$15 co-payment/trip	Covered when the service is provided by a licensed ambulance service to the nearest hospital where emergency care can be performed and ambulance transportation is required because of an emergency condition.
	Urgent care	$10 co-payment/office visit; $15 co-payment/hospital outpatient setting; additional $10 co-payment for radiology/lab services	20% co-insurance	Not subject to 15-visit per person annual limit in-network. If you receive services in addition to urgent care, additional co-payments, deductibles or co-insurance may apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	$200 co-payment/inpatient stay	$200 co-payment plus 20% co-insurance	Precertification required; if hospitalization is not precertified you pay the $200 co-payment plus 50% co-insurance.

Common Medical Event	Services You May Need	Your cost if you use		Limitations & Exceptions
		Network Coverage	Non-network Coverage	
If you have a hospital stay (cont.)	Physician/surgeon fee	$10 co-payment/surgery	20% co-insurance	Provider fee in addition to facility fee applies only if the provider bills separately from the facility.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$10 co-payment/visit	20% co-insurance	Coverage for up to 15 visits per person per calendar year to a network provider. Non-network coverage applies for visit 16 and beyond. Certain services require precertification.
	Mental/Behavioral health inpatient services	$200 co-payment/inpatient stay	$200 co-payment plus 20% co-insurance	Approved facilities only. Length of stay limited by the type of facility and treatment. Precertification required; penalty for failure to precertify is $200 co-payment plus 50% coinsurance.
	Substance use disorder outpatient services	$10 co-payment/visit	20% co-insurance	Coverage for up to 15 visits per person per calendar year to a network provider. Non-network coverage applies for visit 16 and beyond. Certain services require precertification.
	Substance use disorder inpatient services	$200 co-payment/ inpatient stay	$200 co-payment plus 20% co-insurance	Precertification required; penalty for failure to precertify is $200 co-payment plus 50% coinsurance.
If you are pregnant	Prenatal and postnatal care	No charge for routine pre and post natal care	20% co-insurance	Not subject to 15-visit per person annual limit for network coverage.
	Delivery and all inpatient services	$200 co-payment/inpatient stay	$200 co-payment plus 20% co-insurance	Precertification required; if hospitalization is not precertified you pay the $200 co-payment plus 50% co-insurance.
If you need help recovering or have other special health needs	Home health care	No charge	20% co-insurance	Precertification required, no coverage if not precertified. Covered only in lieu of hospitalization.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Common Medical Event	Services You May Need	Your cost if you use		Limitations & Exceptions
		Network Coverage	Non-network Coverage	
If you need help recovering or have other special health needs (cont.)	Rehabilitation services	$10 co-payment/visit	20% co-insurance	Chiropractic treatment through Managed Physical Medicine Program only; no coverage for occupational and speech therapy. Network benefits for up to 15 chiropractic visits/person/year and for up to 60 precertified physical therapy visits/ diagnosis. Non-network benefits apply after limit.
	Habilitation services	$10 co-payment/visit	20% co-insurance	
	Skilled nursing care	No coverage in skilled nursing facilities; no charge for covered services at home	No coverage in skilled nursing facilities; 20% coinsurance for covered services at home	No coverage in skilled nursing facilities. Precertification required for services at home, no coverage if not precertified. Covered only in lieu of hospitalization.
	Durable medical equipment	No charge	Charges in excess of the allowable amount	Durable medical equipment (except diabetic equipment/supplies) is only covered in lieu of hospitalization. Precertification required; non-network benefits apply if not precertified. Diabetic equipment/supplies not subject to deductible or co-insurance.
	Hospice service	No charge	Charges in excess of the allowable amount	Coverage for up to 210 days in an approved hospice program.
If your child needs dental or eye care	Eye exam	$10 co-payment/visit	Not covered	Routine eye exam covered once in a 24-month period
	Glasses	No charge	Not covered	Limited selection at the time and place of an eye exam; once in a 24-month period.
	Dental check-up	$20 co-payment/visit	Not covered	Up to two visits for covered services and up to two fillings per 12-months, additional $10 co-pay/filling

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic surgery
- Custodial Care
- Hearing aids
- Long-term care
- Non-network dental check up
- Non-network eye exam and/or glasses
- Occupational therapy
- Routine foot care
- Services that are not medically necessary
- Skilled nursing facility care, including rehabilitation
- Speech therapy
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
• Acupuncture	• Dental care (adult & child)	• Private-duty nursing (covered under HCAP only)
• Bariatric surgery (with limitations)	• Infertility treatment (with limitations)	• Routine eye care (adult & child)
• Chiropractic care	• Non-emergency care when traveling outside the U.S.	

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-877-7-NYSHIP. You may also contact your state insurance department, the U.S. Department of Labor or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

- The Empire Plan at 1-877-7-NYSHIP (1-877-769-7447) and choose the appropriate carrier
- 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 http://www.communityhealthadvocates.org

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

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 page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care also will be different.

If other than individual coverage, the Patient Pays amount may be more.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- ☐ **Amount owed to providers:** $7540
- ☐ **Plan pays** $7140
- ☐ **You pay** $400

Sample care costs:

Hospital charges (mother)	$2700
Routine obstetric care	$2100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7540**

Patient pays:

Deductibles	$0
Co-pays	$200
Co-insurance	$0
Limits or exclusions	$200
Total	**$400**

.

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- ☐ **Amount owed to providers:** $5400
- ☐ **Plan pays** $5000
- ☐ **You pay** $400

Sample care costs:

Prescriptions	$2800
Medical Equipment & Supplies	$1300
Office Visits and Procedures	$900
Education	$200
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5400**

Patient pays:

Deductibles	$0
Co-pays	$400
Co-insurance	$0
Limits or exclusions	$0
Total	**$400**