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?	**$100** per covered individual. 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 January 1st. 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?	The **deductible** does not apply to care rendered at a network facility, by a participating provider, preventive care services as defined by the federal Patient Protection and Affordable Care Act (PPACA), external mastectomy prostheses, second opinion for cancer diagnosis, emergency services, emergency ambulance services, Managed Physical Medicine Program, 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?	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.
What is the out-of-pocket limit for this plan?	In-Network **out-of-pocket limit**: Individual **$7,350**/Family **$14,700**.	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**.
Will you pay less if you use a network provider?	Yes. See 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 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	$10 copayment/visit plus $10 copayment for radiology/lab services	20% coinsurance	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 copayment/visit plus $10 copayment for radiology/lab services	20% coinsurance	
	Preventive care/screening/ immunization	No charge for preventive services in accordance with the Patient Protection and Affordable Care Act (PPACA).	20% coinsurance; no coverage for adult immunizations	
If you have a test	Diagnostic test (x-ray, blood work)	$10 copayment/office visit; $15 copayment/hospital outpatient setting	20% coinsurance	Non-network coverage applies for visit 16 and beyond.
	Imaging (CT/PET scans, MRIs)	$10 copayment/office visit; $15 copayment/hospital outpatient setting	20% coinsurance	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.
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	1-30 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. Copayment waived, at a network pharmacy, for: • Oral chemotherapy drugs when used to treat cancer • Generic oral contraceptive drugs and devices or brand-name contraceptive drugs/devices without a generic equivalent (single-source brand-name drugs/devices) • Tamoxifen and Raloxifene when prescribed for the primary prevention of breast cancer At certain SUNY Campus Student Health Centers, SEHP enrollees may fill prescriptions for up to a 30-day supply for a $7 copay. 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	1-30 day supply: $25; Mail Service or Specialty Pharmacy 31-90 day supply: $50		
	Level 3 or Non-preferred Drugs	1-30 day supply: $45; Mail Service or Specialty Pharmacy 31-90 day supply: $90		
	Specialty drugs	Applicable copayment based on the drug copayment level		

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 outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$10 copayment/office visit or ambulatory surgical center visit; $15 copayment/hospital outpatient setting (facility, extension clinic, outpatient surgical locations)	20% coinsurance	Non-network coverage applies in an office setting for visit 16 and beyond. Copayment 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 copayment/visit	20% coinsurance	
If you need immediate medical attention	Emergency room care	$25 copayment/visit	$25 copayment/visit	Copayment waived if admitted as inpatient directly from the Emergency Department and only the inpatient copayment applies.
	Emergency medical transportation	$15 copayment/trip	$15 copayment/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 copayment/office visit; $15 copayment/hospital outpatient setting; additional $10 copayment for radiology/lab services	20% coinsurance	Not subject to 15-visit per person annual limit in-network. If you receive services in addition to urgent care, additional copayments, deductibles or coinsurance may apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	$200 copayment/inpatient stay	$200 copayment plus 20% coinsurance	Precertification required; if hospitalization is not precertified you pay the $200 copayment plus 50% coinsurance.
	Physician/surgeon fees	$10 copayment/surgery	20% coinsurance	Provider fee in addition to facility fee applies only if the provider bills separately from the facility.

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 mental health, behavioral health, or substance abuse services	Outpatient services	$10 copayment/visit	20% coinsurance	Coverage for up to 15 visits per person per calendar year to a network provider. Non-network coverage applies for visit 16 and beyond. Precertification is required for some mental health care and substance use care.
	Inpatient services	$200 copayment/inpatient stay	$200 copayment plus 20% coinsurance	Approved facilities only. Length of stay limited by the type of facility and treatment. 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	Not subject to 15-visit per person annual limit for network coverage.
	Childbirth/delivery professional services	No charge	20% coinsurance	Provider fee in addition to facility fee applies only if the provider bills separately from the facility.
	Childbirth/delivery facility services	$200 copayment/inpatient stay	$200 copayment plus 20% coinsurance	Precertification required; if hospitalization is not precertified you pay the $200 copayment plus 50% coinsurance.
If you need help recovering or have other special health needs	Home health care	No charge	20% coinsurance	Precertification required, no coverage if not precertified. Covered only in lieu of hospitalization.
	Rehabilitation services	$10 copayment/visit	20% coinsurance	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 copayment/visit	20% coinsurance	
	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	Not covered	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 coinsurance.
	Hospice services	No charge	No charge	Coverage for up to 210 days in an approved hospice program.

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 your child needs dental or eye care	Children's eye exam	$10 copayment/visit	Not covered	Routine eye exam covered once in a 24-month period
	Children's glasses	No charge	Not covered	Limited selection at the time and place of an eye exam; once in a 24-month period.
	Children's dental check-up	$20 copayment/visit	Not covered	Up to two visits for covered services and up to two fillings per 12-months, additional $10 copay/filling

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.)

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

- Acupuncture
- Bariatric surgery (with limitations)
- Chiropractic care
- Private-duty nursing (covered under HCAP only)
- Infertility treatment (with limitations)
- Non-emergency care when traveling outside the U.S.
- Dental care (adult & child)
- Routine eye care (adult & child)

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/contactEBSA/consumerassistance.html 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

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 1-877-769-7447.

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 prenatal care and a hospital delivery)

The plan's overall deductible	$0
Specialist copayment	$10
Hospital (facility) copayment	$250
Other copayment	$10

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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$360**

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	$10
Hospital (facility) copayment	$0
Other copayment	$10

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	$0
Copayments	$600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$620**

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

The plan's overall deductible	$0
Specialist copayment	$10
Hospital (facility) copayment	$25
Other copayment	$10

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	$90
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$90**

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