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 nyship.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 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?	**$1,250** per enrollee, per spouse/domestic partner, and per all dependent children combined. 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 you use 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, mastectomy bras, emergency services, emergency ambulance services, services under the 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 receive out-of-network services.
Are there other deductibles for specific services?	Yes. **$250** per enrollee, per spouse/domestic partner, and per all dependent children combined for non-network Managed Physical Medicine Program. 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 Max: Individual **$4,120**/Family **$8,240**.* Out-of-Network Coinsurance Max: **$3,750** per enrollee, per spouse/domestic partner, and per all dependent children combined. *In-network Drug OOP Limit does not apply to Empire Plan Medicare Rx enrollees.	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 copayments, 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 nyship.ny.gov **or call 1-877-7-NYSHIP** and choose 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	$25 copayment/visit	20% coinsurance	——————none——————
	Specialist visit	$25 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)	$25 copayment/office visit; $50 copayment/hospital outpatient setting	20% coinsurance in an office; 10% coinsurance or $75 (whichever is greater) for outpatient hospital	——————none——————
	Imaging (CT/PET scans, MRIs)	$25 copayment/office visit; $50 copayment/hospital outpatient setting	20% coinsurance in an office; 10% coinsurance or $75 (whichever is greater) for outpatient 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 nyship.ny.gov	Level 1 or for most Generic Drugs	$5 for 1-30 day supply; $10 for 31-90 day supply from a network pharmacy; $5 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 (for patients age 35 and over), 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 hhs.gov/healthcare/about-the-aca/preventive-care/index.html There is an ancillary charge for covered, non-preferred, brand-name drugs that have a generic equivalent in addition to the Level 3 copayment.
	Level 2, Preferred Drugs or Compound Drugs	$30 for 1-30 day supply; $60 for 31-90 day supply from a network pharmacy; $55 for 31-90 day supply from a mail service or specialty pharmacy		
	Level 3 or Non-preferred Drugs	$60 for 1-30 day supply; $120 for 31-90 day supply from a network pharmacy; $110 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)	$25 copayment/office surgery; $50 copayment/non-hospital outpatient surgery; $95 copayment/outpatient hospital surgery	20% coinsurance in an office or ambulatory surgery center setting; 10% coinsurance or $75 (whichever is greater) for outpatient hospital	Provider fee in addition to facility fee applies only if the provider bills separately from the facility.
	Physician/surgeon fees	$25 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	$100 copayment/visit	$100 copayment/visit	Copayment waived if admitted as inpatient directly from the Emergency Department.
	Emergency medical transportation	$70 copayment/trip	$70 copayment/trip	Not subject to deductible or coinsurance.
	Urgent care	$30 copayment/visit to a freestanding urgent care center; $50 copayment/visit to a hospital-owned urgent care center	20% coinsurance in a freestanding urgent care center; 10% coinsurance or $75 (whichever is greater) for a hospital-owned urgent care center	Up to two copayments per service date may apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	10% coinsurance	Precertification required; $200 penalty if hospitalization is not precertified.
	Physician/surgeon fees	No charge	20% coinsurance	Provider fee in addition to facility fee applies only if the provider bills separately from the facility.
If you need mental health, behavioral health, or substance use services	Outpatient services	$25 copayment/visit	20% coinsurance	Precertification is required for some mental health care and substance use care.
	Inpatient services	No charge	10% coinsurance	
If you are pregnant	Office visits	No charge for routine prenatal and postnatal care	20% coinsurance	Routine obstetrical ultrasounds may be subject to a $25 copayment when using a network provider.
	Childbirth/delivery professional services	No charge	20% coinsurance	——————none——————
	Childbirth/delivery facility services	No charge	10% coinsurance	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.

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 help recovering or have other special health needs	Home health care	No charge	50% coinsurance	Precertification required; non-network benefits apply if not precertified. No non-network coverage for the first 48 hours of home nursing.
	Rehabilitation services	$25 copayment/visit	50% coinsurance for office visits under Managed Physical Medicine Program; 10% coinsurance or $75 (whichever is greater) for outpatient hospital	Outpatient hospital rehabilitation services covered when medically necessary following a related hospitalization or surgery.
	Habilitation services	$25 copayment/visit	50% coinsurance	Home Care Advocacy Program (HCAP) or Managed Physical Medicine Program (MPMP) network allowance depending on the service. No charge when precertified if service is covered under HCAP. No coinsurance maximum for MPMP or HCAP services.
	Skilled nursing care	No charge	50% coinsurance; 10% coinsurance in a skilled nursing facility	Limitations and exceptions apply to skilled nursing facility coverage. Precertification required; $200 penalty if admission is not precertified. No coverage for Medicare-primary enrollees. Non-network benefits apply if skilled nursing at home is not precertified. No non-network coverage for the first 48 hours.
	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.
	Hospice services	No charge	Inpatient: 10% coinsurance; Outpatient: 10% coinsurance or $75, whichever is greater	——————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.)

- Cosmetic surgery[1]
- Custodial care
- Dental care (adult & child), except for the correction of damage caused by an accident
- Long-term care
- Routine eye care (adult & child)
- Services that are experimental or investigational, or not medically necessary
- Routine foot care
- Weight loss programs

[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
- Chiropractic care
- Hearing aids
- Infertility treatment
- Non-emergency care when traveling outside the U.S.
- 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 dfs.ny.gov, U.S. Department of Health and Human Services at 1-877-267-2323 x1565 or cciio.cms.gov, U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or 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 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 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 prenatal care and a hospital delivery)

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

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	$100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$160**

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	$25
Hospital (facility) copayment	$0
Other copayment	$25

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	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$420**

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

The plan's overall deductible	$0
Specialist copayment	$25
Hospital (facility) copayment	$100
Other copayment	$25

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	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$300**

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