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/ebd or by calling 1-877-7-NYSHIP (1-877-769-7447).

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$417** (**$322** for DC-37) per enrollee, per spouse/domestic partner and per all dependent children combined. Does not apply to care rendered by a participating provider or by a network facility, hearing aids, prosthetic wigs, external mastectomy prostheses, emergency ambulance services, 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. **$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.
Is there an out–of–pocket limit on my expenses?	Yes. **$919** (**$690** for DC-37; **$300** for DC-37 Grade 6 and below; **$1,148** for UUP) per enrollee, per spouse/domestic partner and per all dependent children combined for the Basic Medical Program, non-network Hospital and non-network Mental Health and Substance Abuse.	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, co-pays paid to hospital facilities or for prescription drugs, Managed Physical Medicine Program, Home Care Advocacy Program (HCAP) services/supplies, balance billed charges, pre-authorization penalties and health care this plan doesn't cover.	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/ebd **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**.

- **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 participating and 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/ Participating Provider	Non-network Coverage	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 co-payment/visit plus $20 co-payment for radiology/lab services	20% co-insurance	none
	Specialist visit	$20 co-payment/visit plus $20 co-payment for radiology/lab services	20% co-insurance	none
	Other practitioner office visit	$20 co-payment/visit plus $20 co-payment for radiology/lab services	50% co-insurance	Applies to chiropractic treatment and physical therapy under the Managed Physical Medicine Program (Managed Physical Medicine Program).
	Preventive care/ screening/ immunization	$20 co-payment/visit; $20 co-payment for adult immunizations	20% co-insurance	Well child care paid-in-full when provider is participating.
If you have a test	Diagnostic test (x-ray, blood work)	$20 co-payment/office visit; $40 co-payment/outpatient hospital visit	20% co-insurance in an office; 10% co-insurance or $75 (whichever is greater) for outpatient hospital	none
	Imaging (CT/PET scans, MRIs)	$20 co-payment/office visit; $40 co-payment/outpatient hospital visit	20% co-insurance in an office; 10% co-insurance or $75 (whichever is greater) for outpatient hospital	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/ Participating Provider	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; network pharmacy 31-90 day supply: $10; Mail Service or Specialty Pharmacy 31-90 day supply: $5	Claims for your out-of-pocket costs may be eligible for partial reimbursement.	Covered prescription drugs may be assigned to any co-payment level based on clinical judgment and value to the Plan. Check Plan materials before filling any prescription to determine the cost to you based on the drug co-payment level. A drug may be placed on a different level mid-year when such changes are advantageous to the Plan. Certain medications require prior authorization for coverage. Medicare primary dependents are covered for up to a 31-day supply or 32-90 day supply under the same drug level structure. Copayments for Medicare primary enrollees are different, see your plan material for additional information.
	Level 2, Preferred Drugs or Compound Drugs	30-day supply: $15; network pharmacy 31-90 day supply: $30; Mail Service or Specialty Pharmacy 31-90 day supply: $20		
	Level 3 or Non-preferred Drugs	30-day supply: $40; network pharmacy 31-90 day supply: $70; Mail Service or Specialty Pharmacy 31-90 day supply: $65		
	Specialty drugs	Applicable co-payment based on the drug co-payment level		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$20 co-payment/office surgery; $30 co-payment/non-hospital outpatient surgery; $60 co-payment/outpatient hospital surgery	20% co-insurance in an office setting; 10% co-insurance or $75 (whichever is greater) for outpatient hospital	Separate physician/surgeon fee in addition to facility fee if the physician/surgeon is not affiliated with the facility where the surgery is performed.
	Physician/ surgeon fees	$20 co-payment/surgery	20% co-insurance in an office setting	
If you need immediate medical attention	Emergency room services	$70 co-payment/visit	$70 co-payment/visit	Co-payment waived if admitted
	Emergency medical transportation	$35 co-payment/trip	$35 co-payment/trip	Not subject to deductible or co-insurance. No charge for Mental Health and Substance Abuse ambulance services.
	Urgent care	$20 co-payment/office visit; $40 co-payment/outpatient hospital visit; Additional $20 co-payment for radiology/lab services	20% co-insurance in an office; 10% co-insurance or $75 (whichever is greater) in a hospital	——none——

Common Medical Event	Services You May Need	Your cost if you use		Limitations & Exceptions
		Network Coverage/ Participating Provider	Non-network Coverage	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	10% co-insurance	Precertification required; $200 penalty if hospitalization is not precertified
	Physician/ surgeon fee	No charge	20% co-insurance	Separate physician/surgeon fee in addition to facility fee if the physician/surgeon is not affiliated with the facility where the surgery is performed.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$20 co-payment/visit	20% co-insurance	Psychological testing must be reviewed for medical necessity.
	Mental/Behavioral health inpatient services	No charge	10% co-insurance	No coverage for non-network Residential Treatment Facilities, Halfway Houses or Group Homes.
	Substance use disorder outpatient services	$20 co-payment/visit	20% co-insurance	Psychological testing must be reviewed for medical necessity.
	Substance use disorder inpatient services	No charge	10% co-insurance	No coverage for non-network Residential Treatment Facilities, Halfway Houses or Group Homes.
If you are pregnant	Prenatal and postnatal care	No charge for routine pre and post natal care	20% co-insurance	——none——
	Delivery and all inpatient services	No charge	10% co-insurance; 20% co-insurance for provider services not billed by hospital	Precertification required; $200 penalty if hospitalization is not precertified.
If you need help recovering or have other special health needs	Home health care	No charge	50% co-insurance	Precertification required; non-network benefits apply if not precertified. No non-network coverage for the first 48 hours of home based nursing care.

Common Medical Event	Services You May Need	Your cost if you use		Limitations & Exceptions
		Network Coverage/ Participating Provider	Non-network Coverage	
If you need help recovering or have other special health needs (cont.)	Rehabilitation services	$20 co-payment/visit	50% co-insurance for office visits under Managed Physical Medicine Program; 10% co-insurance or $75 (whichever is greater) for outpatient hospital	Outpatient hospital physical therapy or rehabilitation services covered when medically necessary following a related hospitalization or surgery.
	Habilitation services	$20 co-payment/visit	50% co-insurance	HCAP or Managed Physical Medicine Program network allowance depending on the service. No charge when precertified if service is covered under HCAP. No co-insurance maximum for Managed Physical Medicine Program services.
	Skilled nursing care	No charge	50% co-insurance for covered services at home; 10% co-insurance in a skilled nursing facility	Limitations and exceptions apply to skilled nursing facility coverage. Precertification required; $200 penalty if admission is not precertified. 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% co-insurance	Diabetic shoes are covered up to $500 when precertified. Allowance for diabetic shoes purchased at a non-network provider is one pair up to 75% of the network allowance. Precertification required; non-network benefits apply if not precertified.
	Hospice service	No charge	10% co-insurance or $75 (whichever is greater)	Precertification required; $200 penalty if hospitalization is not precertified.
If your child needs dental or eye care	Eye exam	Not covered	Not covered	none
	Glasses	Not covered	Not covered	none
	Dental check-up	Not covered	Not covered	none

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
- Dental care (adult & child), except for the correction of damaged caused by an accident
- Long-term care
- Non-network Residential Treatment Facilities, Halfway Houses or Group Homes
- Routine eye care (adult & child)
- Routine foot care
- Services that are not medically necessary
- 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 (provided by a doctor, with limitations)
- Bariatric surgery (with limitations)
- Chiropractic care
- Hearing aids (with limitations)
- Infertility treatment (with limitations)
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing (covered under HCAP only)

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 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

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al [1-877-769-7447].]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [1-877-769-7447].]

[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 [1-877-769-7447].]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' [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** $6940
- **You pay** $600

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	$400
Co-insurance	$0
Limits or exclusions	$200
Total	**$600**

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

- **Amount owed to providers:** $5400
- **Plan pays** $4760
- **You pay** $640

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	$600
Co-insurance	$0
Limits or exclusions	$40
Total	**$640**

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.