

Benefits

SUMMARY



For Groups with 2–50 Contracts

Out-of-Network (OON) Cost ¹	Deductible	Coinsurance (Member Responsibility)	Coinsurance Stop-Loss
Option 1	\$500/\$1,250	30%	\$5,000 (\$1,500 out-of-pocket)
Option 2	\$500/\$1,250	30%	\$10,000 (\$3,000 out-of-pocket)
Option 3	\$750/\$1,875	30%	\$15,000 (\$4,500 out-of-pocket)
Option 4	\$1,000/\$2,500	30%	\$25,000 (\$7,500 out-of-pocket) Family limit x 2.5

Benefit	In-Network ¹	Out-of-Network ^{2,3}	Options
Lifetime Maximum	Unlimited	\$1,000,000	
Dependent Children	To age 19; full-time	Same as In-network students to age 23	Dependent children to age 23; Full-time students to age 25

Home/Office/Outpatient Care	Member Pays	Member Pays	Options
Co-Payment Options	\$12, \$20, \$30	Does not apply	
Home/Office Visits Co-payment	Co-payment option selected	Deductible and coinsurance	O-O-N cost-sharing options 1–4
Annual Physical Exam	Co-payment option selected	Covered in-network	
Well-Child Care (up to age 19; including covered immunizations)	\$0	Deductible and coinsurance	O-O-N cost-sharing options 1–4
Well-Woman Care	Co-payment option selected	Deductible and coinsurance	O-O-N cost-sharing options 1–4
Emergency Room/Facility (initial visit per occurrence)	\$35 co-pay (waived if admitted within 24 hours)	\$35 co-pay (waived if admitted within 24 hours)	
Surgery, ⁴ Presurgical Testing, Anesthesia	\$0	Deductible and coinsurance	O-O-N cost-sharing options 1–4
Chemotherapy, Radiation Therapy	\$0	Deductible and coinsurance	O-O-N cost-sharing options 1–4
Maternity Care	\$0	Deductible and coinsurance	O-O-N cost-sharing options 1–4
Mammograms	\$0	Deductible and coinsurance	O-O-N cost-sharing options 1–4
Cervical Cancer Screenings	\$0	Deductible and coinsurance	O-O-N cost-sharing options 1–4
Laboratory Tests, X-rays	\$0	Deductible and coinsurance	
MRI ⁵ /MRA, ⁵ CAT Scan, ⁶ PET, ⁶ and Nuclear Cardiology ⁶	\$0	Deductible and coinsurance	
Allergy Testing & Treatment	Co-payment option selected (waived for treatments)	Deductible and coinsurance	O-O-N cost-sharing options 1–4
Chiropractic Care ⁸	Co-payment option selected	Deductible and coinsurance	O-O-N cost-sharing options 1–4
Home Healthcare ⁵ (up to 200 visits per calendar year)	\$0	Coinsurance (no deductible)	O-O-N cost-sharing options 1–4
Home Infusion Therapy ⁵	\$0	Covered in-network	
Hospice Care ⁴ (up to 210 days per lifetime)	\$0	Covered in-network	
Physical Therapy ⁴ (up to 30 visits per calendar year combined in home, office or outpatient facility)	Co-payment option selected	Covered in-network	
Other Short-term Rehabilitative Therapies ⁴ — Speech/Language, Occupational, Vision (up to 30 visits per calendar year combined in home, office or outpatient facility)	Co-payment option selected	Covered in-network	

(1) Network provider delivers care. The in-network office co-payment applies to evaluation and consultations only. Other services performed at the office setting may be subject to in-network deductible and coinsurance.

(2) Out-of-network services (except Mental Health and Alcohol/Substance Abuse) are those from a provider that does not participate in Empire's PPO network, or with another Blue Cross and Blue Shield Plan through the BlueCard[®] PPO Program. (This does not apply to emergency benefits.) See (7) for Mental Health and Alcohol/Substance Abuse Services.

(3) Out-of-network (O-O-N) providers – those who do not participate in Empire's PPO network, or with another Blue Cross and Blue Shield Plan through the BlueCard[®] PPO Program. Out-of-network providers who do not participate with Empire or with another BlueCross and BlueShield Plan, may balance bill over Empire's allowed amount.

(4) You are responsible for obtaining precertification from Empire's Medical Management Program for these services provided in-area and out-of-area, in-network and out-of-network. Your provider may call for you, but you will be responsible for penalties applied if precertification is not obtained. For ambulatory surgery, precertification is required for reconstructive surgery, outpatient transplants and ophthalmological or eye-related procedures. Precertification is also required for cosmetic surgery, an excluded benefit except when medically necessary.

(5) For services received from an Empire PPO provider, the provider must precertify in-network services; Empire PPO network providers cannot bill members beyond the co-payment for covered services. Outside Empire's network area, you must obtain precertification from Empire's Medical Management Program for services from in-network BlueCard[®] PPO providers (with the exception of MRI and MRA services which do not require precertification for services rendered from in-network BlueCard[®] PPO providers outside of Empire's network area). You are responsible for obtaining precertification from Empire's Medical Management Program for all out-of-network services in-area and out-of-area. Your provider may call for you, but you will be responsible for penalties applied if precertification is not obtained.

(6) Empire's network provider must precertify in-network services or services may be denied; Empire network providers cannot bill members beyond the co-payment for covered services. Precertification is not required for out-of-network services, nor for out-of-area in-network BlueCard[®] PPO provider services.

(7) You are responsible for obtaining precertification from the Behavioral Healthcare Manager for these services. Your provider may call for you, but you will be responsible for penalties applied if precertification is not obtained.

(8) Empire's network provider must obtain authorization for clinical/medical necessity for in-network services; Empire network providers cannot bill members beyond the in-network Deductible and Coinsurance for covered services. Authorization is not required for out-of-network services or for services rendered from in-network BlueCard[®] PPO providers outside of Empire's network area.

NOTE: This is a benefits summary only and is subject to the terms, conditions, limitations and exclusions set forth in the contract. Failure to comply with our Medical Management or Behavioral Healthcare Management Program requirements could result in benefit reductions.

Home/Office/Outpatient Care		Member Pays	Member Pays	
Benefit	In Network ¹	Out-of-Network ^{2,3}	Options	
Cardiac Rehabilitation ⁴ Second Surgical Opinion	Co-payment option selected Co-payment option selected (no co-payment applies if arranged through the Medical Management Program)	Deductible and coinsurance Deductible and coinsurance	O-O-N cost-sharing options 1-4 O-O-N cost-sharing options 1-4	
Kidney Dialysis	\$0	Deductible and coinsurance	O-O-N cost-sharing options 1-4	
Inpatient Care⁴				
Inpatient Hospital (as many days as is medically necessary; semi-private room and board)	\$0	Deductible and coinsurance	O-O-N cost-sharing options 1-4	
Surgery, Surgical Assistant, Anesthesia	\$0	Deductible and coinsurance	O-O-N cost-sharing options 1-4	
Physical Therapy, Physical Medicine or Rehabilitation (up to 30 inpatient days per calendar year)	\$0	Deductible and coinsurance	O-O-N cost-sharing options 1-4	
Skilled Nursing Facility (up to 60 days per calendar year)	\$0	Covered in-network		
Mental Health⁷				
Outpatient Visits in Office or Facility (up to 20 outpatient visits per calendar year)	\$25 co-pay per visit ⁷	Covered in-network		
Inpatient Care ⁷ (up to 30 inpatient days per calendar year)	\$0	Covered in-network		
Alcohol/Substance Abuse⁷				
Outpatient Visits (up to 60 outpatient visits, which include 20 family counseling visits per calendar year)	\$0	Deductible and coinsurance	O-O-N cost-sharing options 1-4	
Inpatient Detoxification (up to 7 days detox per calendar year)	\$0	Covered in-network		
Inpatient Rehabilitation (up to 30 days per calendar year)	Rider available	Covered in-network	30 days, inpatient rehab in-network	
Other				
Medical Supplies	\$0	Covered in-network		
Durable Medical Equipment ⁵	\$0	Covered in-network		
Prosthetics & Orthotics ⁵	\$0	Covered in-network		
Ambulance (Air Ambulance) ⁴	\$0	Covered in-network		
Prescription Drugs ⁹	Rider available	n/a		Retail Program: (generic/brand/non-formulary): \$10/\$25/\$50, \$10/\$20/\$40 Deductible options: \$0, \$50, \$100, \$150 Mail-Order Program Drug deductible is waived for mail order; prescriptions filled through mail order require only 2 co-payments for a 3-month supply. Covered in-network.
Routine Vision Care (through a special network of providers)	Rider available	n/a		(1) \$5 co-pay for 1 exam every 24 months plus discounts on frames and lenses; (2) Option (1) plus \$10 co-pay for frames, \$25 co-pay for contact lenses; plus \$35 allowance for nonplan eyewear purchase

(9) All of the prescription drug plan options listed on this Benefits Summary meet the Centers for Medicare and Medicaid Services (CMS) standard for Creditable Coverage under the Medicare Modernization Act of 2003.

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