

Benefits

SUMMARY

TOTAL BLUE™

For Groups with 51 Plus Contracts with Health Savings Account (HSA)*

Base Plan #	Combined INN & OON Deductible	In-Network					Out-of-Network				
		Deductible	Coinsurance	Coin Stop Loss Max	Coin OOP Max	Annual OOP Max	Deductible	Coinsurance	Coin Stop Loss Max	Coin OOP Max	Annual OOP Max
1-HSA	No	\$1,250	90%	\$15,000	\$1,500	\$2,750	\$2,500	70%	\$15,000	\$4,500	\$7,000
2-HSA	Yes	\$1,500	90%	\$20,000	\$2,000	\$3,500	\$1,500	70%	\$20,000	\$6,000	\$7,500
3-HSA	No	\$1,500	90%	\$20,000	\$2,000	\$3,500	\$3,000	70%	\$20,000	\$6,000	\$9,000
4-HSA	Yes	\$2,000	90%	\$20,000	\$2,000	\$4,000	\$2,000	70%	\$20,000	\$6,000	\$8,000
5-HSA	No	\$2,000	90%	\$20,000	\$2,000	\$4,000	\$3,500	70%	\$20,000	\$6,000	\$9,500
6-HSA	Yes	\$2,000	80%	\$10,000	\$2,000	\$4,000	\$2,000	60%	\$17,500	\$7,000	\$9,000
7-HSA	No	\$2,000	80%	\$10,000	\$2,000	\$4,000	\$3,500	60%	\$17,500	\$7,000	\$10,500
8-HSA	Yes	\$2,500	80%	\$12,500	\$2,500	\$5,000	\$2,500	60%	\$20,000	\$8,000	\$10,500
9-HSA	No	\$2,500	80%	\$12,500	\$2,500	\$5,000	\$4,500	60%	\$20,000	\$8,000	\$12,500
10-HSA	Yes	\$3,000	80%	\$10,000	\$2,000	\$5,000	\$3,000	60%	\$25,000	\$10,000	\$13,000
11-HSA	No	\$3,000	80%	\$10,000	\$2,000	\$5,000	\$5,000	60%	\$25,000	\$10,000	\$15,000
12-HSA	No	\$3,000	100%	N/A	N/A	\$3,000	\$4,000	70%	\$20,000	\$6,000	\$10,000

*Family coverage is 2.0 times the individual coverage amount; even numbered options have one deductible for INN & OON.

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

Preventive Care ⁴	Member Pays	Member Pays
Adult Preventive Care	\$0 (covered 100%)	Deductible and coinsurance
Annual Physical Exam	\$0	Deductible and coinsurance
Well-Child Care (up to age 19; including necessary immunizations)	\$0	Deductible and coinsurance
Well-Woman Care	\$0	Deductible and coinsurance

Home/Office/Outpatient Care	In-Network	Out-of-Network
Home/Office Visits/Outpatient	Deductible and coinsurance	Deductible and coinsurance
Emergency Room/Facility	Deductible and coinsurance	Deductible and coinsurance
Surgery, ^{5,9} Presurgical Testing, Anesthesia	Deductible and coinsurance	Deductible and coinsurance
Chemotherapy, Radiation Therapy	Deductible and coinsurance	Deductible and coinsurance
Maternity Care	Deductible and coinsurance	Deductible and coinsurance
Mammograms ⁴	Deductible and coinsurance	Deductible and coinsurance
Cervical Cancer Screenings ⁴	Deductible and coinsurance	Deductible and coinsurance
Laboratory Tests, ⁴ X-rays ⁴	Deductible and coinsurance	Deductible and coinsurance
Cardiac Rehabilitation ^{5,9}	Deductible and coinsurance	Deductible and coinsurance
Second Surgical Opinion	Deductible and coinsurance	Deductible and coinsurance
Kidney Dialysis	Deductible and coinsurance	Deductible and coinsurance
MRI ⁶ /MRA, ⁶ CAT Scans, ⁷ PET ⁷ and Nuclear Cardiology ⁷	Deductible and coinsurance	Deductible and coinsurance
Allergy Testing & Treatment	Deductible and coinsurance	Deductible and coinsurance
Chiropractic Care ¹⁰	Deductible and coinsurance	Deductible and coinsurance

- (1) Network provider delivers care.
- (2) Subject to balance billing over allowed amount.
- (3) Out-of-network services (except Mental Health and Alcohol/Substance Abuse) are those from a provider that does not participate with Empire or another Blue Cross and Blue Shield Plan through the BlueCard PPO Program. (This does not apply to emergency benefits.) See (8) for Mental Health and Alcohol/Substance Abuse Services.
- (4) The following benefits, if provided in-network for preventive care, are not subject to the deductible and coinsurance: mammography screenings, cervical cancer screenings, colorectal cancer screenings, prostate cancer screenings, hypercholesterolemia screenings, diabetes screenings for pregnant women, bone density testing, annual physical examinations and up to two annual obstetric and gynecological examinations.
- (5) You are responsible for obtaining precertification from Empire's Medical Management Program for these services. 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.
- (6) Empire's network provider must precertify in-network services or services may be denied; Empire network providers cannot bill members beyond in-network Deductible and Coinsurance for covered services. You are responsible for obtaining precertification from Empire's Medical Management Program for out-of-network services. Your provider may call for you, but you will be responsible for penalties applied if precertification is not obtained.
- (7) Empire's network provider must precertify in-network services or services may be denied; Empire network providers cannot bill members beyond in-network Deductible and Coinsurance for covered services. Precertification is not required for services rendered from in-network BlueCard PPO providers outside of Empire's network area.
- (8) 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.
- (9) You are responsible for obtaining precertification for services received from an out-of-area BlueCard PPO provider. Your provider may call for you but you will be responsible for penalties applied if precertification is not obtained.
- (10) Empire's network provider must obtain authorization for clinical/medical necessity for in-network services, or services may be denied; 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 Empire's Medical Management or Behavioral Healthcare Management Program requirements could result in benefit reductions.

Benefit	In-Network ¹	Out-of-Network ³	Options
Home/Office/Outpatient Care	Member Pays	Member Pays	
Home Healthcare ^{6,9} (up to 200 visits per calendar year)	Deductible and coinsurance	Deductible and coinsurance	
Home Infusion Therapy ^{6,9}	Deductible and coinsurance	Deductible and coinsurance	
Hospice Care ^{5,9} (up to 210 days per lifetime)	Deductible and coinsurance	Deductible and coinsurance	
Physical Therapy ^{5,9} (up to 30 visits per calendar year combined in home, office or outpatient facility)	Deductible and coinsurance	Deductible and coinsurance	In-Network or 0-0-N visits; 60 or 90 visits (combined)
Other Short-Term Rehabilitative Therapies	Deductible and coinsurance	Deductible and coinsurance	In-Network or 0-0-N visits; 60 visits (combined)
Speech/Language, ^{5,9} Occupational, ^{5,9} Vision (up to 30 visits per calendar year combined in home, office or outpatient facility)			
Inpatient Care^{5,9}			
Inpatient Hospital (as many days as is medically necessary; semiprivate room and board)	Deductible and coinsurance	Deductible and coinsurance	
Physical Therapy, Physical Medicine or Rehabilitation (up to 30 inpatient days per calendar year)	Deductible and coinsurance	Deductible and coinsurance	60 or 90 days
Surgery, Surgical Assistant, Anesthesia	Deductible and coinsurance	Deductible and coinsurance	
Skilled Nursing Facility (up to 60 days per calendar year)	Deductible and coinsurance	Deductible and coinsurance	90, 120 or Unlimited days
Birth Centers	Deductible and coinsurance	Deductible and coinsurance	
Mental Health⁸			
Outpatient Visits in Office or Facility (up to 20 outpatient visits per calendar year)	Deductible and coinsurance	Deductible and 50% coinsurance	40/60/90/120 visits in-network; 20/40/60/90/120 visits out-of-network subject to deductible and coinsurance of either 30% or 40%
Inpatient Care (up to 30 inpatient days per calendar year)	Deductible and coinsurance	Deductible and 50% coinsurance	45/90 days in-network; 30/45/90 days out-of-network subject to deductible and coinsurance of either 30% or 40%
Alcohol/Substance Abuse⁴			
Outpatient Visits (up to 60 outpatient visits, which include 20 family counseling visits per calendar year)	Deductible and coinsurance	Deductible and coinsurance	
Inpatient Detoxification (up to 7 days detox per calendar year)	Deductible and coinsurance	Deductible and 50% coinsurance	O-O-N option subject to deductible and coinsurance of either 30% or 40%
Inpatient Rehabilitation (up to 30 days per calendar year)	Rider available	Rider available	I-N-N option subject to deductible and coinsurance O-O-N option subject to deductible and coinsurance of either 30%, 40% or 50%
Other			
Medical Supplies	Deductible and coinsurance	Deductible and coinsurance	
Durable Medical Equipment ^{6,9}	Deductible and coinsurance	Deductible and coinsurance	
Prosthetics & Orthotics ^{6,9}	Deductible and coinsurance	Deductible and coinsurance	
Ambulance (air ambulance ^{6,9})	Deductible and coinsurance	Deductible and coinsurance	
Prescription Drugs	Rider available	Covered in-network n/a	Member must meet integrated I-N-N medical Rx deductible before 3-tier co-pay structure applies Retail Program: (generic/brand/non-formulary) \$10/\$20/\$40 : \$10/\$30/\$50 : \$10/\$25/\$50 Mail-Order Program: Applies to both retail and mail-order. Prescriptions filled through mail-order only require 2 co-payments for a 3-month supply, once the deductible (integrated medical and Rx) is met. For Option 12 once the integrated deductible is met, Rx is covered at 100%.
Routine Vision Care (through a special network of providers)	Rider available	n/a	Covered in-network (1) \$5 or \$10 co-pay for 1 exam every 12 or 24 months plus discounts on frames and lenses (2) Option 1 plus \$10 co-pay for frames/contacts, \$15 additional co-pay on Designer frames, and \$25 allowance for nonplan eyewear purchases (3) Option 1 plus \$10 co-pay for frames/contacts, \$0 additional co-pay on Designer frames, and \$35 allowance for nonplan eyewear purchases