Benefits Summary Empire PPO

For Groups with 2-50 Eligible Employees

Cost Sharing Options	In-Network Copay		In-Network Inpatient	Deductible		Coinsurance % (Member Responsibility)		Total annual Out-of-Pocket Maximum (Includes Deductibles)	
	PCP	Specialist		In-Network	Out-of- Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Option 1	$45	$60	Deductible and Coinsurance	$1,000 / $2,500	$2,500 / $6,250	10%	30%	$3,000/$7,500	$7,500/$18,750
Option 2	PCP	Specialist	Deductible and Coinsurance	$1,500 / $3,750	$3,000 / $7,500	20%	40%	$4,500/$11,250	$9,000/$22,500
	$45	$60							

* Family coverage is 2.5 times the individual coverage amount.

Benefit	In-Network[1]	Out-of-Network[2,3]	Options
Lifetime Maximum	Unlimited	Unlimited	
Dependent Children (covered to the end of the month)	To age 26	Same as in-network	Dependents through Age 29 (Covered to the end of the month of Dependent's 30th birthday. Dependent must live, work or reside in New York State and meet other eligibility requirements)
Covered Preventive Care[4]	**Member Pays In-Network**	**Member Pays Out-of-Network**	**Options**
Covered Adult Preventive Care	$0	Not Covered	
Annual Physical Exam	$0	Not Covered	
Well-Child Care (up to age 19; including covered immunizations)	$0	Not Covered	
Preventive Well-Woman Care	$0	Not Covered	
Home/Office/Outpatient Care[1]	**Member Pays In-Network**	**Member Pays Out-of-Network**	**Options**
Home/Office Visits Copayment	Copayment option selected	Deductible and Coinsurance	
Emergency Room/Facility (waived if admitted within 24 hrs)	$150 Copayment	$150 Copayment	
Ambulatory[5] / Outpatient Surgery	Deductible and Coinsurance	Deductible and Coinsurance	
Cardiac, Rehab, Chemotherapy, Dialysis Therapy, Radiation Therapy (Office or Outpatient)	Deductible and Coinsurance	Deductible and Coinsurance	
Routine Maternity Care	Office Visit Copayment for Pre-Post Natal Visits - Inpatient Hospital cost-share applies to Delivery.	Deductible and Coinsurance	
Allergy Care - Office Visit - Testing - Treatment	Copayment option selected Deductible and Coinsurance $0	Deductible and Coinsurance	

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Home/Office/Outpatient Care	Member Pays In-Network	Member Pays Out-of-Network	Options
Laboratory Tests, X-Rays	$0 for Lab work Office Visit Copay for all Radiology	Deductible and Coinsurance	
MRI[6]/MRA[6], CAT Scan[7], PET[7] and Nuclear Cardiology[7]	Office Visit Copay for all Radiology	Deductible and Coinsurance	
Chiropractic care[9]	Deductible and Coinsurance	Not Covered	
Physical Therapy[5] (Up to 30 visits combined in home, office or outpatient facility per calendar/plan year)	Deductible and Coinsurance	Not Covered	
Other Short-Term Rehabilitative Therapies – Speech/Language[5], Occupational[5] (Up to 30 visits combined in home, office or outpatient facility per calendar/plan year)	Deductible and Coinsurance	Not Covered	
Second Surgical Opinion	The copayment will apply to visit services (examinations and evaluations); other services performed will be subject to in-network cost-share	Deductible and Coinsurance	
Home Health Care (Up to 100 visits per calendar/plan year)	$0	Deductible and Coinsurance	
Home Infusion Therapy	$0	Not Covered	
Hospice Care (Unlimited)	$0	Deductible and Coinsurance	

Inpatient Care[5]	Member Pays In-Network	Member Pays Out-of-Network	Options
Inpatient Hospital	Deductible and Coinsurance	Deductible and Coinsurance	
Surgery, Covered Surgical Assistant, Anesthesia	Deductible and Coinsurance	Deductible and Coinsurance	
Physical Therapy, Physical Medicine or Rehabilitation (Up to 30 inpatient days per calendar/plan year)	Deductible and Coinsurance	Deductible and Coinsurance	
Skilled Nursing Facility (Up to 60 days per calendar/plan year)	Deductible and Coinsurance	Not Covered	

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Mental Health[8]	Member Pays In-Network	Member Pays Out-of-Network	Options
Outpatient Visits in Office or Facility (Up to 20 visits per calendar/plan year)	Specialist Copayment	Deductible and Coinsurance	
Inpatient Care[8] (Up to 30 days per calendar/plan year combined In-Network and Out-of-Network)	Deductible and Coinsurance	Deductible and Coinsurance	
Alcohol/Substance Abuse[8]	**Member Pays In-Network**	**Member Pays Out-of-Network**	**Options**
Outpatient Visits (Up to 60 visits per calendar/plan year which includes 20 family counseling visits)	Deductible and Coinsurance	Deductible and Coinsurance	
Inpatient Rehabilitation	Rider Available	Rider Available	
Inpatient Detoxification (Up to 7 days per calendar/plan year combined In-Network and Out-of-Network)	Deductible and Coinsurance	Deductible and Coinsurance	
Other	**Member Pays In-Network**	**Member Pays Out-of-Network**	**Options**
Medical Supplies	Deductible and Coinsurance	In-Network Benefits apply	
Durable Medical Equipment[6]	50% Coinsurance (Does not apply to Deductible or OOP Max)	Not Covered	
Prosthetics and Orthotics[6]	50% Coinsurance (Does not apply to Deductible or OOP Max)	Not Covered	
Ambulance (Includes Air)	$150 Copayment (In addition to ER Copay)	$150 Copayment (In addition to ER Copay)	
Gym Membership Reimbursement[11] Up to $400 annual reimbursement per contract; 50 visits required semi annually. Reimbursed Up to $200 for the first 6 months and Up to $200 for the second 6 months.			
Prescription Drugs[10]			Retail Program: (Tier 1/Tier 2/Tier 3) 1) $10/$35/35%; $50 Deductible with Preferred Generic[12, 13] 2) $10/35%/50%; $100 Deductible with Preferred Generic[12, 13] 3) $10 Generic only, no deductible – 50% coverage for mandated brands (without a generic equivalent) For Rx Options 1 & 2, Deductible does not apply to Tier 1 Generic drugs. Mail Service: Drug deductible is waived for mail order. Prescriptions filled through mail order only require two copayments for a three-month supply.

Benefits Summary Empire PPO

For Groups with 2-50 Eligible Employees

Other	Member Pays In-Network	Member Pays Out-of-Network	Options
Vision Care			Contact Empire for more information about the options available

[1] *Network provider delivers care.*

[2] *Out–of-network services (except Mental Health and Alcohol/Substance Abuse) are those from a provider who 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 (8) 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 Blue Cross and Blue Shield Plan may balance bill over Empire's allowed amount.*

[4] *The following benefits, if provided in-network for preventive care, are not subject to copayment; mammography screenings, cervical cancer screening, colorectal cancer screenings, prostate cancer screenings, hypercholesterol 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 is 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] *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. You are responsible for obtaining precertification from Empire's Medical Management Program for in-area and out-of-area 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; Empire network providers cannot bill members beyond the copayment for covered services. Precertification is not required for out-of-network services, not for out-of-area in-network BlueCard® PPO provider service.*

[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] *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*

[10] *Prescription Options 1 & 2 listed on this Benefits Summary meets the Centers for Medicare and Medicaid Services (CMS) standard for Creditable Coverage under the Medicare Modernization Act of 2003*

[11] *You must submit a receipt to show that you have paid in full for the fitness club or exercise center membership. Reimbursement payments will be issued twice annually each contract year. Covered Members are required to exercise at the club or center no less than fifty (50) visits during each six (6) month period of the contract year. If the fitness club or exercise center does not provide proof written of member visits, a logbook will be provided to the Covered Member. The Covered Member can request that the fitness club or exercise center representative sign the logbook to satisfy the visit requirement. See our website or your membership materials for the mailing address and further directions on how to request reimbursement.*

[12] *You may request, or your physician may order, the brand name drug. However, if a generic drug is available, you will be responsible for the difference in price between Empire's cost of the generic drug and Empire's cost of the brand name drug, in addition to the applicable tiered Copayment amount of the generic drug, as listed on the attached Schedule of Benefits.*

[13] *There is a $350 coinsurance maximum per prescription for Retail up to a 30 day supply on the 35% and 50% coinsurance tiers. There is a $700 coinsurance maximum per prescription for Mail Rx up to a 90 day supply on the 35% and 50% coinsurance tiers.*

IMPORTANT NOTE: This is a benefits summary only and is subject to the terms, conditions and limitations and exclusions set forth in your Certificate of Coverage, Schedule of Benefits, and any additional Riders or Contracts your group has purchased. Be sure to consult your benefit Contract or Certificate for full details about your coverage. To the extent there is a conflict between this Summary and your benefit Contract or Certificate, the terms of the Contract or Certificate will control. Failure to comply with Empire's Medical Management or Behavioral Healthcare Management Program requirements could result in benefit reductions.

This summary of benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits.

Included are preventive care services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits.