Your summary of benefits

Empire BlueCross
An Anthem Company

CEWW Health Insurance Consortium

Your Plan: Bronze

Your Network: PPO/EPO

This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This summary does not reflect each and every benefit, exclusion and limitation which may apply to the coverage. For more details, important limitations and exclusions, please review the formal Evidence of Coverage (EOC). If there is a difference between this summary and the Evidence of Coverage (EOC), the Evidence of Coverage (EOC), will prevail.

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible *The entire family annual deductible must be met before copay or coinsurance is applied for any individual family member.*	$6,550 person / $13,100 family	$13,100 person / $26,200 family
Out-of-Pocket Limit *The out-of-pocket maximum per person cap includes the deductible, coinsurance, copays and prescription drugs. If a member under a family contract meets the out-of-pocket maximum per person cap amount, the individual will no longer pay for covered services and claims will be paid at 100% of the allowable amount by the health plan for the remainder of the plan year. The remaining annual out-of-pocket maximum still needs to be met by any combination of family members on the contract before claims are paid at 100% for the whole family.*	$6,550 person / $13,100 family	$13,100 person / $26,200 family
Preventive care/screening/immunization *In-network preventive care is not subject to deductible, if your plan has a deductible.*	No charge	0% coinsurance after deductible is met
Doctor Home and Office Services		
Primary Care Visit to treat an injury or illness	0% coinsurance after deductible is met	0% coinsurance after deductible is met
Specialist Care Visit	0% coinsurance after deductible is met	0% coinsurance after deductible is met

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Prenatal and Post-natal Care *In-Network preventive prenatal and postnatal services are covered at 100%.*	0% coinsurance after deductible is met	0% coinsurance after deductible is met
Other Practitioner Visits:		
Retail Health Clinic	0% coinsurance after deductible is met	0% coinsurance after deductible is met
On-line Visit	0% coinsurance after deductible is met	0% coinsurance after deductible is met
Chiropractic	0% coinsurance after deductible is met	0% coinsurance after deductible is met
Acupuncture	0% coinsurance after deductible is met	0% coinsurance after deductible is met
Other Services in an Office:		
Allergy Testing Performed by a Primary Care Physician	0% coinsurance after deductible is met	0% coinsurance after deductible is met
Allergy Testing Performed by a Specialist	0% coinsurance after deductible is met	0% coinsurance after deductible is met
Chemo/Radiation Therapy Performed by a Primary Care Physician	0% coinsurance after deductible is met	0% coinsurance after deductible is met
Chemo/Radiation Therapy Performed by a Specialist	0% coinsurance after deductible is met	0% coinsurance after deductible is met
Hemodialysis Performed by a Primary Care Physician	0% coinsurance after deductible is met	0% coinsurance after deductible is met
Hemodialysis Performed by a Specialist	0% coinsurance after deductible is met	0% coinsurance after deductible is met

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Prescription Drugs Administered in an Office by a Primary Care Physician *For the drugs itself dispensed in the office through infusion/injection.*	0% coinsurance after deductible is met	0% coinsurance after deductible is met
Prescription Drugs Administered in an Office by a Specialist *For the drugs itself dispensed in the office through infusion/injection.*	0% coinsurance after deductible is met	0% coinsurance after deductible is met
Diagnostic Services		
Lab:		
Office Performed by a Primary Care Physician	0% coinsurance after deductible is met	0% coinsurance after deductible is met
Office Performed by a Specialist	0% coinsurance after deductible is met	0% coinsurance after deductible is met
Freestanding Lab/Reference Lab *Empire's participating Freestanding Labs are Laboratory Corporation of America or Quest Diagnostics. Please check Provider Finder for additional participating Freestanding Labs in your area.*	0% coinsurance after deductible is met	Not Applicable
Outpatient Hospital	0% coinsurance after deductible is met	0% coinsurance after deductible is met
X-Ray:		
Office Performed by a Primary Care Physician	0% coinsurance after deductible is met	0% coinsurance after deductible is met
Office Performed by a Specialist	0% coinsurance after deductible is met	0% coinsurance after deductible is met
Freestanding Radiology Center	0% coinsurance after deductible is met	0% coinsurance after deductible is met

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Outpatient Hospital	0% coinsurance after deductible is met	0% coinsurance after deductible is met
Advanced Diagnostic Imaging (for example, MRI/PET/CAT scans):		
Office	0% coinsurance after deductible is met	0% coinsurance after deductible is met
Freestanding Radiology Center	0% coinsurance after deductible is met	0% coinsurance after deductible is met
Outpatient Hospital	0% coinsurance after deductible is met	0% coinsurance after deductible is met
Emergency and Urgent Care		
Urgent Care (Office Setting)	0% coinsurance after deductible is met	Covered as In-Network
Emergency Room Facility Services *Copay waived if admitted.*	0% coinsurance after deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services	0% coinsurance after deductible is met	Covered as In-Network
Ambulance (Air and Ground)	0% coinsurance after deductible is met	Covered as In-Network
Outpatient Mental/Behavioral Health and Substance Abuse		
Doctor Office Visit *Family counseling related to Substance Abuse is limited to 20 visits per year.*	0% coinsurance after deductible is met	0% coinsurance after deductible is met
Facility visit:		

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Facility Fees	0% coinsurance after deductible is met	0% coinsurance after deductible is met
Doctor Services	0% coinsurance after deductible is met	0% coinsurance after deductible is met
Outpatient Surgery		
Facility Fees:		
Hospital	0% coinsurance after deductible is met	0% coinsurance after deductible is met
Freestanding Surgical Center	0% coinsurance after deductible is met	0% coinsurance after deductible is met
Doctor and Other Services:		
Surgery Performed by a Primary Care Physician	0% coinsurance after deductible is met	0% coinsurance after deductible is met
Surgery Performed by a Specialist	0% coinsurance after deductible is met	0% coinsurance after deductible is met
Freestanding Surgical Center	0% coinsurance after deductible is met	0% coinsurance after deductible is met
Hospital Stay (all inpatient stays including Maternity, Mental / Behavioral Health, and Substance Abuse)		
Facility fees (for example, room & board) *Coverage for Inpatient Rehabilitation is limited to 60 days per year. Limit is combined In-Network and Non-Network.*	0% coinsurance after deductible is met	0% coinsurance after deductible is met
Doctor and other services	0% coinsurance after deductible is met	0% coinsurance after deductible is met

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Recovery & Rehabilitation		
Home Health Care *Coverage has unlimited visits per year. Limit is combined In-Network and Non-Network.*	0% coinsurance after deductible is met	0% coinsurance after deductible is met
Rehabilitation services (for example, physical/speech/occupational therapy):		
Office *Coverage for rehabilitative and habilitative physical therapy and occupational therapy combined is limited to 45 visits per year. Applies to In-Network. Visit limits are combined both across outpatient and other professional visits. Coverage for rehabilitative and habilitative speech therapy is limited to 45 visits per year. Visit limits are combined both across outpatient and other professional visits. Applies to In-Network.*	0% coinsurance after deductible is met	Not covered
Outpatient Hospital *Coverage for rehabilitative and habilitative physical therapy and occupational therapy combined is limited to 45 visits per year. Applies to In-Network. Visit limits are combined both across outpatient and other professional visits. Coverage for rehabilitative and habilitative speech therapy is limited to 45 visits per year. Visit limits are combined both across outpatient and other professional visits. Applies to In-Network.*	0% coinsurance after deductible is met	Not covered
Habilitation services (for example, physical/speech/occupational therapy):		
Office *Coverage for rehabilitative and habilitative physical therapy and occupational therapy combined is limited to 45 visits per year. Visit limits are combined both across outpatient and other professional visits. Coverage for rehabilitative and habilitative speech therapy is limited to 45 visits per year. Visit limits are combined both across outpatient and other professional visits.*	0% coinsurance after deductible is met	Not covered
Outpatient Hospital *Coverage for rehabilitative and habilitative physical therapy and occupational therapy combined is limited to 45 visits combined per year. Visit limits are combined both across outpatient and other professional visits. Coverage for rehabilitative and habilitative speech therapy is limited to 30 visits per year. Visit limits are combined both across outpatient and other professional visits.*	0% coinsurance after deductible is met	Not covered

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Cardiac rehabilitation		
Office	0% coinsurance after deductible is met	0% coinsurance after deductible is met
Outpatient Hospital	0% coinsurance after deductible is met	0% coinsurance after deductible is met
Skilled Nursing Care (in a facility) *Coverage is limited to 45 days per year. Limit is combined In-Network and Non-Network.*	0% coinsurance after deductible is met	0% coinsurance after deductible is met
Hospice	0% coinsurance after deductible is met	0% coinsurance after deductible is met
Durable Medical Equipment	0% coinsurance after deductible is met	0% coinsurance after deductible is met
Prosthetic Devices	0% coinsurance after deductible is met	0% coinsurance after deductible is met

Your summary of benefits

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Pharmacy Deductible	Combined with medical deductible	Not covered
Pharmacy Out of Pocket	Combined with medical out of pocket maximum	Not covered
Prescription Drug Coverage *National Drug List* *This product has a 90-day Retail Pharmacy Network available. A 90 day supply is available at most retail pharmacies.*		
Tier 1 - Typically Generic *Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program).*	No charge after deductible is met	Not covered
Tier 2 – Typically Preferred Brand *Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). If you select a brand name drug when a generic drug is available, additional cost sharing amounts may apply.*	No charge after deductible is met	Not covered
Tier 3 - Typically Non-Preferred Brand/Specialty Drugs *Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). If you select a brand name drug when a generic drug is available, additional cost sharing amounts may apply.*	No charge after deductible is met	Not covered

Your summary of benefits

Notes:

- The prescription drug plan listed on this Summary meets the Centers for Medicare and Medicaid Services (CMS) standard for Creditable Coverage under the Medicare Modernization Act of 2003.
- Preauthorization - You may have to pay for all or a portion of any test, equipment, service or procedure that is not preauthorized. To find out which services require Preauthorization and to be sure that Preauthorization has been given, you may contact us.
- If You seek coverage for services that require Preauthorization or notification, You or Your Provider must call Us or Our vendor at the number indicated on Your ID card.
- Preventive care benefits not subject to copay, deductible and coinsurance; when provided In-Network include: 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 annual obstetric and gynecological examinations. May also include other services as required under State and Federal Law. May be subject to age and frequency limits.
- To receive a 90-day supply of prescription drugs through Empire's Mail-Order Program, the prescription must be written specifically for a 90-day supply.

Language Access Services:

Get help in your language

Curious to know what all this says? We would be too. Here's the English version:
If you have any questions about this document, you have the right to get help and information in your language at no cost. To talk to an interpreter, call (844) 241-7085

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

(TTY/TDD: 711)

Arabic (العربية): إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (844) 241-7085 .

Armenian (հայերեն). Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (844) 241-7085:

Chinese(中文)：如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電(844) 241-7085。

Farsi (فارسي): در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه ای به زبان مادری‌تان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره (844) 241-7085 تماس بگیرید.

French (Français) : Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (844) 241-7085.

Haitian Creole (Kreyòl Ayisyen): Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (844) 241-7085.

Italian (Italiano): In caso di eventuali domande sul presente documento, ha il diritto di ricevere assistenza e informazioni nella sua lingua senza alcun costo aggiuntivo. Per parlare con un interprete, chiami il numero (844) 241-7085.

Japanese (日本語):この文書についてなにかご不明な点があれば、あなたにはあなたの言語で無料で支援を受け情報を得る権利があります。 通訳と話すには、(844) 241-7085 にお電話ください。

Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면(844) 241-7085로 문의하십시오.

Language Access Services:

Navajo (Diné): Díí naaltsoos biká'ígíí łahgo bina'idiłkidgo ná bohónéedzą dóó bee ahóót'i' t'áá ni nizaad k'ehjí bee nił hodoonih t'áadoo bą́ą́h ílínígóó. Ata' halne'ígíí ła' bich'į' hadeesdzih ninízingo kojį' hodíilnih (844) 241-7085.

Polish (polski): W przypadku jakichkolwiek pytań związanych z niniejszym dokumentem masz prawo do bezpłatnego uzyskania pomocy oraz informacji w swoim języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer: (844) 241-7085.

Punjabi (ਪੰਜਾਬੀ): ਜੇ ਤੁਹਾਡੇ ਇਸ ਦਸਤਾਵੇਜ਼ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹੁੰਦੇ ਹਨ ਤਾਂ ਤੁਹਾਡੇ ਕੋਲ ਮੁਫ਼ਤ ਵਿੱਚ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੁੰਦਾ ਹੈ। ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, (844) 241-7085 ਤੇ ਕਾਲ ਕਰੋ।

Russian (Русский): если у вас есть какие-либо вопросы в отношении данного документа, вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы связаться с устным переводчиком, позвоните по тел. (844) 241-7085.

Spanish (Español): Si tiene preguntas acerca de este documento, tiene derecho a recibir ayuda e información en su idioma, sin costos. Para hablar con un intérprete, llame al (844) 241-7085.

Tagalog (Tagalog): Kung mayroon kang anumang katanungan tungkol sa dokumentong ito, may karapatan kang humingi ng tulong at impormasyon sa iyong wika nang walang bayad. Makipag-usap sa isang tagapagpaliwanag, tawagan ang (844) 241-7085.

Vietnamese (Tiếng Việt): Nếu quý vị có bất kỳ thắc mắc nào về tài liệu này, quý vị có quyền nhận sự trợ giúp và thông tin bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Để trao đổi với một thông dịch viên, hãy gọi (844) 241-7085.

It's important we treat you fairly
That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.