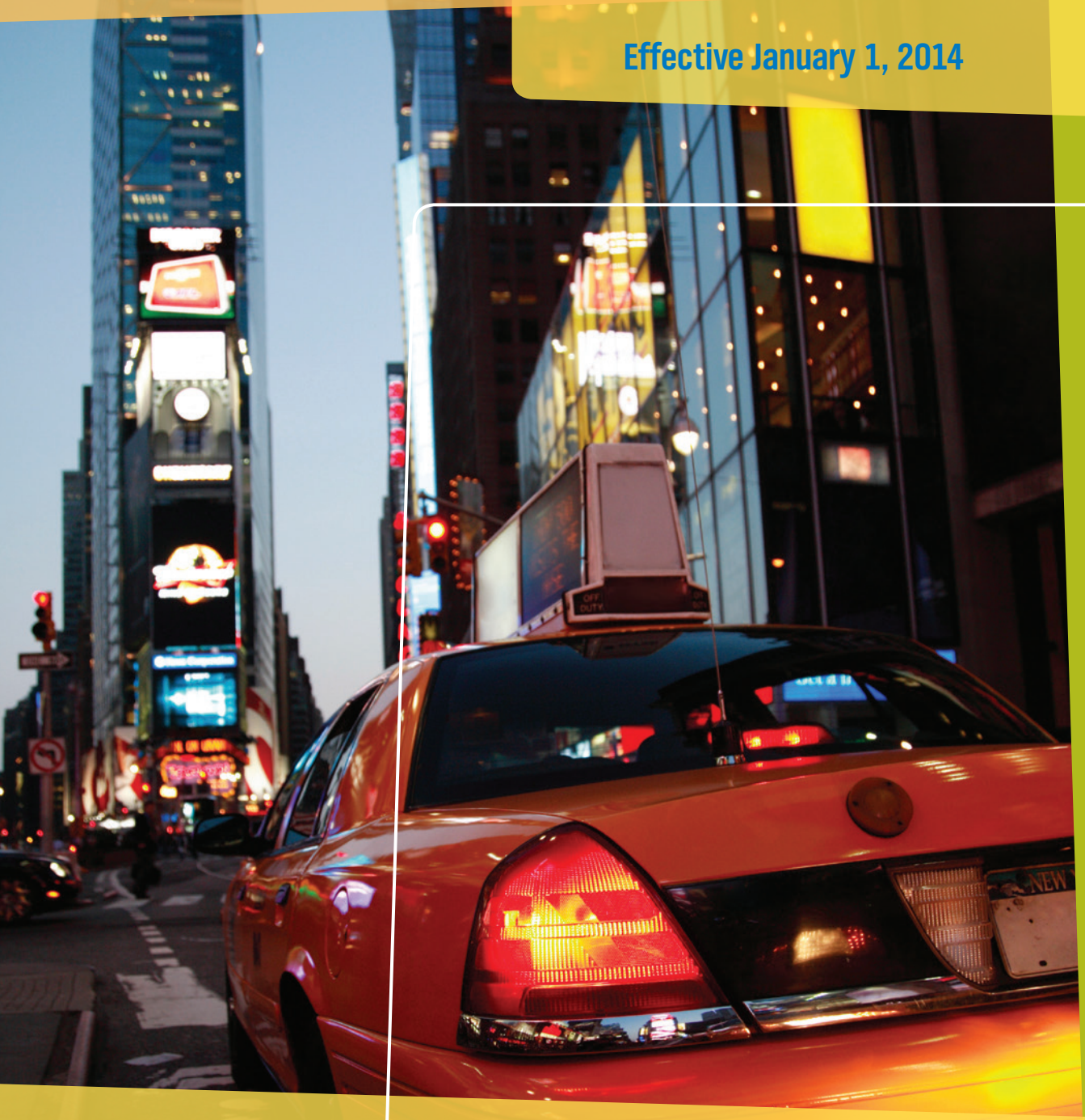
Empire BlueCross BlueShield

Empire Plan Guide
for the individual market

Effective January 1, 2014



This brochure is intended for broker use only and should not be distributed to consumers or employer groups.

Note: The plans described here are available for effective dates starting January 1, 2014. They can be purchased from Empire directly or on the NY State of Health, The Official Health Plan Marketplace. Open Enrollment begins October 1, 2013 and ends March 31, 2014.

This document contains a brief summary of certain benefits and services covered under Empire policies. It is important to consult the Evidence of Coverage issued by Empire for complete coverage details. It contains important exclusions, limits and other coverage terms that are not contained here and impact on eligibility and coverage availability.

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Empire On-Exchange Individual Plans

	Empire Bronze Guided Access with HSA cacm (OSU5)	Empire Bronze Guided Access cabs (OSU8)	Empire Bronze Guided Access caat (OSU6)
Network Name	Pathway X Enhanced	Pathway X Enhanced	Pathway X Enhanced
Individual Deductible (Family is 2 x Individual amount)	$3,000	$4,000	$5,800
Individual OOP Limit (Includes deductible, copays, coinsurance & Rx. Family is 2 x Individual amount)	$6,350	$6,350	$6,350
Coinsurance	50%	40%	20%
Office Visit: PCP	**50% coinsurance** after deductible	**$35 copay** per visit for first 3 office visits, then deductible and **40% coinsurance** applies	**$45 copay** per visit for first 2 office visits, then deductible and **20% coinsurance** applies
Office Visit: Specialist	**50% coinsurance** after deductible	**40% coinsurance** after deductible	**20% coinsurance** after deductible
Outpatient Diagnostic Tests (Examples: X-ray, EKG)	**50% coinsurance** after deductible	**40% coinsurance** after deductible	**20% coinsurance** after deductible
Outpatient Advanced Diagnostic Tests (Examples: MRI, CT scan)	**50% coinsurance** after deductible	**40% coinsurance** after deductible	**20% coinsurance** after deductible
Covered Preventive Care	No cost to you	No cost to you	No cost to you
Urgent Care	**50% coinsurance** after deductible	**$50 copay** then deductible and **40% coinsurance** applies	**$50 copay** then deductible and **20% coinsurance** applies
Emergency Room Care	**50% coinsurance** after deductible	**$200 copay** then deductible and **40% coinsurance** applies	**$200 copay** then deductible and **20% coinsurance** applies
Hospital: Inpatient Admission	**50% coinsurance** after deductible	**$1,000 copay** then deductible then **40% coinsurance** applies	**$1,000 copay** then deductible then **20% coinsurance** applies
Hospital: Outpatient Surgery Hospital Facility	**50% coinsurance** after deductible	**40% coinsurance** after deductible	**20% coinsurance** after deductible
RX Tier 1 (Retail)	**$10 copay** after deductible	**40% coinsurance** after deductible	**20% coinsurance** after deductible
RX Tier 2 (Retail)	**$35 copay** after deductible	**40% coinsurance** after deductible	**20% coinsurance** after deductible
RX Tier 3 (Retail)	**$70 copay** after deductible	**40% coinsurance** after deductible	**20% coinsurance** after deductible
RX Tier 4 (Retail)	n/a	n/a	n/a
Dental: Pediatric Routine Dental Care Adult Routine Dental Care	Not covered	Not covered	Not covered
Vision	Pediatric Vision: **$50 copay** for exam after deductible Adult Vision: Not covered	Pediatric Eye Exam and Lenses: no charge after deductible Adult not covered	Pediatric Eye Exam and Lenses: no charge after deductible Adult not covered
Maternity	**50% coinsurance** for inpatient facility after deductible and **50% coinsurance** for maternity delivery after deductible	**$1,000 copay** for inpatient facility and then deductible and **40% coinsurance** applies	**$1,000 copay** for inpatient facility and then deductible and **20% coinsurance** applies
Mental Health	**50% coinsurance** after deductible	**40% coinsurance** after deductible	**20% coinsurance** after deductible
Substance Abuse	**50% coinsurance** after deductible	**40% coinsurance** after deductible	**20% coinsurance** after deductible
Chiropractic	**50% coinsurance** after deductible	**40% coinsurance** after deductible	**20% coinsurance** after deductible
Physical Therapy	**50% coinsurance** after deductible (60 visits per condition per year, PT/OT/ST combined)	**40% coinsurance** after deductible (60 visits per condition per year, PT/OT/ST combined)	**20% coinsurance** after deductible (60 visits per condition per year, PT/OT/ST combined)

Note: Benefits listed are for in-network services

Empire Silver Guided Access cbnw (OSUV)	**Empire Silver Guided Access** cbjw (OSUZ)	**Empire Silver Guided Access with HSA** cdib (OSV4)	**Empire Gold Guided Access** ccav (OSWN)
Pathway X Enhanced	Pathway X Enhanced	Pathway X Enhanced	Pathway X Enhanced
$2,000	$2,250	$2,450	$600
$5,500	$5,800	$6,350	$4,000
n/a	25%	10%	n/a
$30 copay after deductible	**$30 copay**, unlimited	**10% coinsurance** after deductible	**$25 copay** after deductible
$50 copay after deductible	**25% coinsurance** after deductible	**10% coinsurance** after deductible	**$40 copay** after deductible
$50 copay after deductible	**25% coinsurance** after deductible	**10% coinsurance** after deductible	**$40 copay** after deductible
$50 copay after deductible	**25% coinsurance** after deductible	**10% coinsurance** after deductible	**$40 copay** after deductible
No cost to you	No cost to you	No cost to you	No cost to you
$70 urgent care copay after deductible, in urgent care facility setting **$0 copay** per visit for physician charges in a free standing urgent care center	**$50 copay** then deductible and **25% coinsurance** applies	**$50 copay** after deductible plus **10% coinsurance** applies	**$60 urgent care copay** after deductible, in urgent care facility setting **$0 copay** per visit for physician charges in a free standing urgent care center
$150 copay after deductible	**$200 copay** then deductible and **25% coinsurance** applies	**$200** after deductible and **10% coinsurance** applies	**$150 copay** after deductible
$1,500 copay after deductible	**$1,000 copay** then deductible then **25% coinsurance** applies	**$1,000 copay** after deductible and **10% coinsurance** applies	**$1,000 copay** after deductible
$100 copay after deductible	**25% coinsurance** after deductible	**10% coinsurance** after deductible	**$100 copay** after deductible
$10 copay	**25% coinsurance** after deductible	**10% coinsurance** after deductible	**$10 copay**
$35 copay	**25% coinsurance** after deductible	**10% coinsurance** after deductible	**$35 copay**
$70 copay	**25% coinsurance** after deductible	**10% coinsurance** after deductible	**$70 copay**
n/a	n/a	n/a	n/a
Not covered	Not covered	Not covered	Not covered
Pediatric Vision: **$30 copay** for exam after deductible **30% coinsurance** for eyewear after deductible Adult not covered	Pediatric Eye Exam and Lenses: no charge after deductible Adult not covered	Pediatric Eye Exam and Lenses: no charge after deductible Adult not covered	Pediatric Vision: **$25 copay** for exam after deductible **20% coinsurance** for eyewear after deductible Adult not covered
$1,500 copay after deductible for inpatient facility and **$100 surgeon copay** for maternity delivery after deductible	**$1,000 copay** for inpatient facility and then deductible and **25% coinsurance** applies	**$1,000 copay** after deductible for inpatient facility and **10% coinsurance** applies	**$1,000 copay** after deductible for inpatient facility and **$100 surgeon copay** for maternity delivery after deductible
$30 copay after deductible	**25% coinsurance** after deductible	**10% coinsurance** after deductible	**$25 copay** after deductible
$30 copay after deductible	**25% coinsurance** after deductible	**10% coinsurance** after deductible	**$25 copay** after deductible
$50 copay after deductible	**25% coinsurance** after deductible	**10% coinsurance** after deductible	**$40 copay** after deductible
$30 copay per visit after deductible (60 visits per condition per year, PT/OT/ST combined)	**25% coinsurance** after deductible (60 visits per condition per year, PT/OT/ST combined)	**10% coinsurance** after deductible (60 visits per condition per year, PT/OT/ST combined)	**$30 copay** after deductible (60 visits per condition per year, PT/OT/ST combined)

Empire On-Exchange Individual Plans

	Empire Gold Guided Access cecb (OSWP)	Empire Platinum Guided Access ceaf (OSX4)	Empire Platinum Guided Access cazd (OSX5)
Network Name	Pathway X Enhanced	Pathway X Enhanced	Pathway X Enhanced
Individual Deductible (Family is 2 x Individual amount)	$1,000	$0	$200
Individual OOP Limit (Includes deductible, copays, coinsurance & Rx. Family is 2 x Individual amount)	$6,250	$2,000	$3,400
Coinsurance	10%	n/a	5%
Office Visit: PCP	**$30 copay**, unlimited	**$15 copay**	**$25 copay**, unlimited
Office Visit: Specialist	**10% coinsurance** after deductible	**$35 copay**	**5% coinsurance** after deductible
Outpatient Diagnostic Tests (Examples: X-ray, EKG)	**10% coinsurance** after deductible	**$35 copay**	**5% coinsurance** after deductible
Outpatient Advanced Diagnostic Tests (Examples: MRI, CT scan)	**10% coinsurance** after deductible	**$35 copay**	**5% coinsurance** after deductible
Covered Preventive Care	No cost to you	No cost to you	No cost to you
Urgent Care	**$50 copay** then deductible then **10% coinsurance**	**$55 urgent care copay** in urgent care facility setting **$0 copay** per visit for physician charges in a free standing urgent care center	**$50 copay** then deductible and **5% coinsurance** applies
Emergency Room Care	**$200 copay** then deductible then **10% coinsurance**	**$100 copay**	**$200 copay** then deductible and **5% coinsurance** applies
Hospital: Inpatient Admission	**$1,000 copay** then deductible then **10% coinsurance**	**$500 copay**	**$500 copay** then deductible and **5% coinsurance** applies
Hospital: Outpatient Surgery Hospital Facility	**10% coinsurance** after deductible	**$100 copay**	**5% coinsurance** after deductible
RX Tier 1 (Retail)	**$15 copay**	**$10 copay**	**$15 copay**
RX Tier 2 (Retail)	**$40 copay**	**$30 copay**	**$40 copay**
RX Tier 3 (Retail)	**10% coinsurance** after deductible	**$60 copay**	**5% coinsurance** after deductible
RX Tier 4 (Retail)	n/a	n/a	n/a
Dental: Pediatric Routine Dental Care Adult Routine Dental Care	Not covered	Not covered	Not covered
Vision	Pediatric Eye Exam and Lenses: no charge after deductible Adult not covered	Pediatric eye visits **$15 copay** Pediatric eyewear **10% coinsurance** Adult not covered	Pediatric Eye Exam and Lenses: no charge after deductible Adult not covered
Maternity	**$1,000 copay** for inpatient facility and then deductible and **10% coinsurance** applies	**$500 copay** for inpatient facility and **$100 surgeon copay** for maternity delivery	**$500 copay** for inpatient facility and then deductible and **5% coinsurance** applies
Mental Health	**10% coinsurance** after deductible	**$15 copay**	**5% coinsurance** after deductible
Substance Abuse	**10% coinsurance** after deductible	**$15 copay**	**5% coinsurance** after deductible
Chiropractic	**10% coinsurance** after deductible	**$35 copay**	**5% coinsurance** after deductible
Physical Therapy	**10% coinsurance** after deductible (60 visits per condition per lifetime, PT/OT/ST combined)	**$25 copay** (60 visits per condition per year, PT/OT/ST combined)	**5% coinsurance** after deductible (60 visits per condition per lifetime, PT/OT/ST combined)

Note: Benefits listed are for in-network services

Empire Catastrophic Guided Access (OSXQ)	**Empire Bronze Guided Access for Child Only with HSA** cadc (OSXS)	**Empire Silver Guided Access for Child Only** cade (OTMJ)	**Empire Gold Guided Access for Child Only** cadd (OTMX)	**Empire Platinum Guided Access for Child Only** caed (OTN3)
Pathway X Enhanced	Pathway X Enhanced	Pathway X Enhanced	Pathway X Enhanced	Pathway X Enhanced
$6,350	$3,000	$2,000	$600	$0
$6,350	$6,350	$5,500	$4,000	$2,000
0%	50%	n/a	n/a	n/a
3 PCP visits per year at no charge then deductible then **0% coinsurance**	**50% coinsurance** after deductible	**$30 copay** after deductible	**$25 copay** after deductible	**$15 copay**
0% coinsurance after deductible	**50% coinsurance** after deductible	**$50 copay** after deductible	**$40 copay** after deductible	**$35 copay**
0% coinsurance after deductible	**50% coinsurance** after deductible	**$50 copay** after deductible	**$40 copay** after deductible	**$35 copay**
0% coinsurance after deductible	**50% coinsurance** after deductible	**$50 copay** after deductible	**$40 copay** after deductible	**$35 copay**
No cost to you	No cost to you	No cost to you	No cost to you	No cost to you
0% coinsurance after deductible	**50% coinsurance** after deductible	**$70 urgent care copay** after deductible in urgent care facility setting **$0 copay** per visit for physician charges in a free standing urgent care center	**$60 urgent care copay** after deductible in urgent care facility setting **$0 copay** per visit for physician charges in a free standing urgent care center	**$55 urgent care copay** in urgent care facility setting **$0 copay** per visit for physician charges in a free standing urgent care center
0% coinsurance after deductible	**50% coinsurance** after deductible	**$150 copay** after deductible	**$150 copay** after deductible	**$100 copay**
0% coinsurance after deductible	**50% coinsurance** after deductible	**$1,500 copay** after deductible	**$1,000 copay** after deductible	**$500 copay**
0% coinsurance after deductible	**50% coinsurance** after deductible	**$100 copay** after deductible	**$100 copay** after deductible	**$100 copay**
0% coinsurance after deductible	**$10 copay** after deductible	**$10 copay**	**$10 copay**	**$10 copay**
0% coinsurance after deductible	**$35 copay** after deductible	**$35 copay**	**$35 copay**	**$30 copay**
0% coinsurance after deductible	**$70 copay** after deductible	**$70 copay**	**$70 copay**	**$60 copay**
n/a	n/a	n/a	n/a	n/a
Not covered	Not covered	Not covered	Not covered	Not covered
Pediatric covered: **0% coinsurance** after deductible Adult not covered	Pediatric covered: **$50 copay** for exam after deductible Adult not covered	Pediatric Vision: **$30 copay** for exam after deductible **30% coinsurance** for eyewear after deductible Adult not covered	Pediatric Vision: **$25 copay** for exam after deductible **20% coinsurance** for eyewear after deductible Adult not covered	Pediatric eye visits **$15 copay** Pediatric eyewear **10% coinsurance** Adult not covered
0% coinsurance after deductible	**50% coinsurance** for inpatient facility after deductible and **50% coinsurance** for maternity delivery after deductible	**$1,500 copay** after deductible for inpatient facility and **$100 surgeon copay** for maternity delivery after deductible	**$1,000 copay** after deductible for inpatient facility and **$100 surgeon copay** for maternity delivery after deductible	**$500 copay** for inpatient facility and **$100 surgeon copay** for maternity delivery
0% coinsurance after deductible	**50% coinsurance** after deductible	**$30 copay** after deductible	**$25 copay** after deductible	**$15 copay**
0% coinsurance after deductible	**50% coinsurance** after deductible	**$30 copay** after deductible	**$25 copay** after deductible	**$15 copay**
0% coinsurance after deductible	**50% coinsurance** after deductible	**$50 copay** after deductible	**$40 copay** after deductible	**$35 copay**
0% coinsurance after deductible (60 visits per condition per lifetime, PT/OT/ST combined)	**50% coinsurance** after deductible (60 visits per condition per lifetime, PT/OT/ST combined)	**$30 copay** after deductible (60 visits per condition per lifetime, PT/OT/ST combined)	**$30 copay** after deductible (60 visits per condition per lifetime, PT/OT/ST combined)	**$25 copay** (60 visits per condition per lifetime, PT/OT/ST combined)

Empire Off-Exchange Individual Plans

	Empire Core Guided Access cabs (OSU9)	**Empire Core Guided Access with Child Dental** cdbs (OSUE)	**Empire Core Guided Access** caat (OSU7)	**Empire Core Guided Access with Child Dental** cdat (OSUC)	**Empire Essential Guided Access** cbjw (OSV0)
Network Name	Pathway Enhanced	Pathway Enhanced	Pathway Enhanced	Pathway Enhanced	Pathway Enhanced
Individual Deductible (Family is 2 x Individual amount)	$4,000	$4,000	$5,800	$5,800	$2,250
Individual OOP Limit (Includes deductible, copays, coinsurance & Rx. Family is 2 x Individual amount)	$6,350	$6,350	$6,350	$6,350	$5,800
Coinsurance	40%	40%	20%	20%	25%
Office Visit: PCP	**$35 copay** per visit for first 3 office visits, then deductible and **40% coinsurance** applies	**$35 copay** per visit for first 3 office visits, then deductible and **40% coinsurance** applies	**$45 copay** per visit for first 2 office visits, then deductible and **20% coinsurance** applies	**$45 copay** per visit for first 2 office visits, then deductible and **20% coinsurance** applies	**$30 copay**, unlimited
Office Visit: Specialist	**40% coinsurance** after deductible	**40% coinsurance** after deductible	**20% coinsurance** after deductible	**20% coinsurance** after deductible	**25% coinsurance** after deductible
Outpatient Diagnostic Tests (Examples: X-ray, EKG)	**40% coinsurance** after deductible	**40% coinsurance** after deductible	**20% coinsurance** after deductible	**20% coinsurance** after deductible	**25% coinsurance** after deductible
Outpatient Advanced Diagnostic Tests (Examples: MRI, CT scan)	**40% coinsurance** after deductible	**40% coinsurance** after deductible	**20% coinsurance** after deductible	**20% coinsurance** after deductible	**25% coinsurance** after deductible
Covered Preventive Care	No cost to you	No cost to you	No cost to you	No cost to you	No cost to you
Urgent Care	**$50 copay** then deductible and **40% coinsurance** applies	**$50 copay** then deductible and **40% coinsurance** applies	**$50 copay** then deductible and **20% coinsurance** applies	**$50 copay** then deductible and **40% coinsurance** applies	**$50 copay** then deductible and **25% coinsurance** applies
Emergency Room Care	**$200 copay** then deductible and **40% coinsurance** applies	**$200 copay** then deductible and **40% coinsurance** applies	**$200 copay** then deductible and **20% coinsurance** applies	**$200 copay** then deductible and **40% coinsurance** applies	**$200 copay** then deductible and **25% coinsurance** applies
Hospital: Inpatient Admission	**$1,000 copay** then deductible then **40% coinsurance** applies	**$1,000 copay** then deductible then **40% coinsurance** applies	**$1,000 copay** then deductible then **20% coinsurance** applies	**$1,000 copay** then deductible then **20% coinsurance** applies	**$1,000 copay** then deductible then **25% coinsurance** applies
Hospital: Outpatient Surgery Hospital Facility	**40% coinsurance** after deductible	**40% coinsurance** after deductible	**20% coinsurance** after deductible	**20% coinsurance** after deductible	**25% coinsurance** after deductible
RX Tier 1 (Retail)	**40% coinsurance** after deductible	**40% coinsurance** after deductible	**20% coinsurance** after deductible	**20% coinsurance** after deductible	**25% coinsurance** after deductible
RX Tier 2 (Retail)	**40% coinsurance** after deductible	**40% coinsurance** after deductible	**20% coinsurance** after deductible	**20% coinsurance** after deductible	**25% coinsurance** after deductible
RX Tier 3 (Retail)	**40% coinsurance** after deductible	**40% coinsurance** after deductible	**20% coinsurance** after deductible	**20% coinsurance** after deductible	**25% coinsurance** after deductible
RX Tier 4 (Retail)	n/a	n/a	n/a	n/a	n/a
Dental: Pediatric Routine Dental Care Adult Routine Dental Care	Not covered	Pediatric Routine Dental Care: **25% coinsurance** after deductible Adult Routine Dental Care: not covered	Not covered	Pediatric Routine Dental Care: **25% coinsurance** after deductible Adult Routine Dental Care: not covered	Not covered
Vision	Pediatric Eye Exam and Lenses: no charge after deductible Adult not covered	Pediatric Eye Exam and Lenses: no charge after deductible Adult not covered	Pediatric Eye Exam and Lenses: no charge after deductible Adult not covered	Pediatric Eye Exam and Lenses: no charge after deductible Adult not covered	Pediatric Eye Exam and Lenses: no charge after deductible Adult not covered
Maternity	**$1,000 copay** for inpatient facility and then deductible and **40% coinsurance** applies	**$1,000 copay** for inpatient facility and then deductible and **40% coinsurance** applies	**$1,000 copay** for inpatient facility and then deductible and **20% coinsurance** applies	**$1,000 copay** for inpatient facility and then deductible and **20% coinsurance** applies	**$1,000 copay** for inpatient facility and then deductible and **25% coinsurance** applies
Mental Health	**40% coinsurance** after deductible	**40% coinsurance** after deductible	**20% coinsurance** after deductible	**20% coinsurance** after deductible	**25% coinsurance** after deductible
Substance Abuse	**40% coinsurance** after deductible	**40% coinsurance** after deductible	**20% coinsurance** after deductible	**20% coinsurance** after deductible	**25% coinsurance** after deductible
Chiropractic	**40% coinsurance** after deductible	**40% coinsurance** after deductible	**20% coinsurance** after deductible	**20% coinsurance** after deductible	**25% coinsurance** after deductible
Physical Therapy	**40% coinsurance** after deductible (60 visits per condition per year, PT/OT/ST combined)	**40% coinsurance** after deductible (limit 60 visits per condition per lifetime, PT/OT/ST combined)	**20% coinsurance** after deductible (60 visits per condition per year, PT/OT/ST combined)	**20% coinsurance** after deductible (limit 60 visits per condition per lifetime, PT/OT/ST combined)	**25% coinsurance** after deductible (limit 60 visits per condition per lifetime, PT/OT/ST combined)

Note: Benefits listed are for in-network services

Empire Essential Guided Access with Child Dental cdce (OSVE)	**Empire Essential Guided Access with HSA** cdib (OSV5)	**Empire Essential Guided Access with HSA and Child Dental** cdmb (OSVK)	**Empire Preferred Guided Access** cecb (OSWQ)	**Empire Preferred Guided Access with Child Dental** cdgd (OSWT)	**Empire Premier Guided Access** cazd (OSX6)
Pathway Enhanced	Pathway Enhanced	Pathway Enhanced	Pathway Enhanced	Pathway Enhanced	Pathway Enhanced
$2,250	$2,450	$2,450	$1,000	$1,000	$200
$5,800	$6,350	$6,350	$6,250	$6,250	$3,400
25%	10%	10%	10%	10%	5%
$30 copay, unlimited	**10% coinsurance** after deductible	**10% coinsurance** after deductible	**$30 copay**, unlimited	**$30 copay**, unlimited	**$25 copay**, unlimited
25% coinsurance after deductible	**10% coinsurance** after deductible	**10% coinsurance** after deductible	**10% coinsurance** after deductible	**10% coinsurance** after deductible	**5% coinsurance** after deductible
25% coinsurance after deductible	**10% coinsurance** after deductible	**10% coinsurance** after deductible	**10% coinsurance** after deductible	**10% coinsurance** after deductible	**5% coinsurance** after deductible
25% coinsurance after deductible	**10% coinsurance** after deductible	**10% coinsurance** after deductible	**10% coinsurance** after deductible	**10% coinsurance** after deductible	**5% coinsurance** after deductible
No cost to you	No cost to you	No cost to you	No cost to you	No cost to you	No cost to you
$50 copay then deductible and **25% coinsurance** applies	**$50 copay** after deductible and **10% coinsurance** applies	**$50 copay** after deductible and **10% coinsurance** applies	**$50 copay** then deductible and **10% coinsurance** applies	**$50 copay** then deductible and **10% coinsurance** applies	**$50 copay** then deductible and **5% coinsurance** applies
$200 copay then deductible and **25% coinsurance** applies	**$200 copay** after deductible and **10% coinsurance** applies	**$200 copay** after deductible and **10% coinsurance** applies	**$200 copay** then deductible then **10% coinsurance**	**$200 copay** then deductible then **10% coinsurance**	**$200 copay** then deductible and **5% coinsurance** applies
$1,000 copay then deductible then **25% coinsurance** applies	**$1,000 copay** after deductible and **10% coinsurance** applies	**$1,000 copay** after deductible and **10% coinsurance** applies	**$1,000 copay** then deductible then **10% coinsurance**	**$1,000 copay** then deductible then **10% coinsurance**	**$500 copay** then deductible and **5% coinsurance** applies
25% coinsurance after deductible	**10% coinsurance** after deductible	**10% coinsurance** after deductible	**10% coinsurance** after deductible	**10% coinsurance** after deductible	**5% coinsurance** after deductible
25% coinsurance after deductible	**10% coinsurance** after deductible	**10% coinsurance** after deductible	**$15 copay**	**$15 copay**	**$15 copay**
25% coinsurance after deductible	**10% coinsurance** after deductible	**10% coinsurance** after deductible	**$40 copay**	**$40 copay**	**$40 copay**
25% coinsurance after deductible	**10% coinsurance** after deductible	**10% coinsurance** after deductible	**10% coinsurance** after deductible	**10% coinsurance** after deductible	**5% coinsurance** after deductible
n/a	n/a	n/a	n/a	n/a	n/a
Pediatric Routine Dental Care: **25% coinsurance** after deductible Adult Routine Dental Care: not covered	Not covered	Pediatric Routine Dental Care: **25% coinsurance** after deductible Adult Routine Dental Care: not covered	Not covered	Pediatric Routine Dental Care: **25% coinsurance** after deductible Adult Routine Dental Care: not covered	Not covered
Pediatric Eye Exam and Lenses: no charge after deductible Adult not covered	Pediatric Eye Exam and Lenses: no charge after deductible Adult not covered	Pediatric Eye Exam and Lenses: no charge after deductible Adult not covered	Pediatric Eye Exam and Lenses: no charge after deductible Adult not covered	Pediatric Eye Exam and Lenses: no charge after deductible Adult not covered	Pediatric Eye Exam and Lenses: no charge after deductible Adult not covered
$1,000 copay for inpatient facility and then deductible and **25% coinsurance** applies	**$1,000 copay** after deductible and **10% coinsurance** applies	**$1,000 copay** after deductible and **10% coinsurance** applies	**$1,000 copay** for inpatient facility and then deductible and **10% coinsurance** applies	**$1,000 copay** for inpatient facility and then deductible and **10% coinsurance** applies	**$500 copay** for inpatient facility and then deductible and **5% coinsurance** applies
25% coinsurance after deductible	**10% coinsurance** after deductible	**10% coinsurance** after deductible	**10% coinsurance** after deductible	**10% coinsurance** after deductible	**5% coinsurance** after deductible
25% coinsurance after deductible	**10% coinsurance** after deductible	**10% coinsurance** after deductible	**10% coinsurance** after deductible	**10% coinsurance** after deductible	**5% coinsurance** after deductible
25% coinsurance after deductible	**10% coinsurance** after deductible	**10% coinsurance** after deductible	**10% coinsurance** after deductible	**10% coinsurance** after deductible	**5% coinsurance** after deductible
25% coinsurance after deductible (limit 60 visits per condition per lifetime, PT/OT/ST combined)	**10% coinsurance** after deductible (limit 60 visits per condition per lifetime, PT/OT/ST combined)	**10% coinsurance** after deductible (limit 60 visits per condition per lifetime, PT/OT/ST combined)	**10% coinsurance** after deductible (60 visits per condition per lifetime, PT/OT/ST combined)	**10% coinsurance** after deductible (limit 60 visits per condition per lifetime, PT/OT/ST combined)	**5% coinsurance** after deductible (limit 60 visits per condition per lifetime, PT/OT/ST combined)

Empire Off-Exchange Individual Plans

	Empire Premier Guided Access with Child Dental cdwc (OSX9)	Empire Core Guided Access for Child Only with HSA cadc (OSXT)	Empire Core Guided Access for Child Only with Child Dental cdea (OTMF)	Empire Essential Guided Access for Child Only cade (OTMK)
Network Name	Pathway Enhanced	Pathway Enhanced	Pathway Enhanced	Pathway Enhanced
Individual Deductible (Family is 2 x Individual amount)	$200	$3,000	$3,000	$2,000
Individual OOP Limit (Includes deductible, copays, coinsurance & Rx. Family is 2 x Individual amount)	$3,400	$6,350	$6,350	$5,500
Coinsurance	5%	50%	50%	n/a
Office Visit: PCP	**$25 copay**, unlimited	**50% coinsurance** after deductible	**50% coinsurance** after deductible	**$30 copay** after deductible
Office Visit: Specialist	**5% coinsurance** after deductible	**50% coinsurance** after deductible	**50% coinsurance** after deductible	**$50 copay** after deductible
Outpatient Diagnostic Tests (Examples: X-ray, EKG)	**5% coinsurance** after deductible	**50% coinsurance** after deductible	**50% coinsurance** after deductible	**$50 copay** after deductible
Outpatient Advanced Diagnostic Tests (Examples: MRI, CT scan)	**5% coinsurance** after deductible	**50% coinsurance** after deductible	**50% coinsurance** after deductible	**$50 copay** after deductible
Covered Preventive Care	No cost to you	No cost to you	No cost to you	No cost to you
Urgent Care	**$50 copay** then deductible and **5% coinsurance** applies	**50% coinsurance** after deductible	**50% coinsurance** after deductible	**$70 urgent care copay** after deductible in urgent care facility setting **$0 copay** per visit for physician charges in a free standing urgent care center
Emergency Room Care	**$200 copay** then deductible and **5% coinsurance** applies	**50% coinsurance** after deductible	**50% coinsurance** after deductible	**$150 copay** after deductible
Hospital: Inpatient Admission	**$500 copay** then deductible and **5% coinsurance** applies	**50% coinsurance** after deductible	**50% coinsurance** after deductible	**$1,500 copay** after deductible
Hospital: Outpatient Surgery Hospital Facility	**5% coinsurance** after deductible	**50% coinsurance** after deductible	**50% coinsurance** after deductible	**$100 copay** after deductible
RX Tier 1 (Retail)	**$15 copay**	**$10 copay** after deductible	**$10 copay** after deductible	**$10 copay**
RX Tier 2 (Retail)	**$40 copay**	**$35 copay** after deductible	**$35 copay** after deductible	**$35 copay**
RX Tier 3 (Retail)	**5% coinsurance** after deductible	**$70 copay** after deductible	**$70 copay** after deductible	**$70 copay**
RX Tier 4 (Retail)	n/a	n/a	n/a	n/a
Dental: Pediatric Routine Dental Care Adult Routine Dental Care	Pediatric Routine Dental Care: **25% coinsurance** after deductible Adult Routine Dental Care: not covered	Not covered	Pediatric Routine Dental Care: **50% coinsurance** after deductible Adult Routine Dental Care: not covered	Not covered
Vision	Pediatric Eye Exam and Lenses: no charge after deductible Adult not covered	Pediatric covered: **$50 copay** for exam after deductible Adult not covered	Pediatric covered: **$50 copay** for exam after deductible Adult not covered	Pediatric Vision: **$30 copay** for exam after deductible **30% coinsurance** for eyewear after deductible Adult not covered
Maternity	**$500 copay** for inpatient facility and then deductible and **5% coinsurance** applies	**50% coinsurance** for inpatient facility after deductible and **50% coinsurance** for maternity delivery after deductible	**50% coinsurance** for inpatient facility after deductible and **50% coinsurance** for maternity delivery after deductible	**$1,500 copay** after deductible for inpatient facility and **$100 surgeon copay** for maternity delivery after deductible
Mental Health	**5% coinsurance** after deductible	**50% coinsurance** after deductible	**50% coinsurance** after deductible	**$30 copay** after deductible
Substance Abuse	**5% coinsurance** after deductible	**50% coinsurance** after deductible	**50% coinsurance** after deductible	**$30 copay** after deductible
Chiropractic	**5% coinsurance** after deductible	**50% coinsurance** after deductible	**50% coinsurance** after deductible	**$50 copay** after deductible
Physical Therapy	**5% coinsurance** after deductible (limit 60 visits per condition per lifetime, PT/OT/ST combined)	**50% coinsurance** after deductible (limit 60 visits per condition per lifetime, PT/OT/ST combined)	Deductible then **50% coinsurance** applies (limit 60 visits per condition per lifetime, PT/OT/ST combined)	**$30 copay** after deductible (limit 60 visits per condition per lifetime, PT/OT/ST combined)

Note: Benefits listed are for in-network services

Empire Essential Guided Access for Child Only with Child Dental cdbb (OTMQ)	**Empire Preferred Guided Access for Child Only** cadd (OTMY)	**Empire Preferred Guided Access for Child Only with Child Dental** cdha (OTNO)	**Empire Premier Guided Access for Child Only** caed (OTN4)	**Empire Premier Guided Access for Child Only with Child Dental** cdja (OTN6)
Pathway Enhanced	Pathway Enhanced	Pathway Enhanced	Pathway Enhanced	Pathway Enhanced
$2,000	$600	$600	$0	$0
$5,500	$4,000	$4,000	$2,000	$2,000
n/a	n/a	n/a	n/a	n/a
$30 copay after deductible	**$25 copay** after deductible	**$25 copay** after deductible	**$15 copay**	**$15 copay**
$50 copay after deductible	**$40 copay** after deductible	**$40 copay** after deductible	**$35 copay**	**$35 copay**
$50 copay after deductible	**$40 copay** after deductible	**$40 copay** after deductible	**$35 copay**	**$35 copay**
$50 copay after deductible	**$40 copay** after deductible	**$40 copay** after deductible	**$35 copay**	**$35 copay**
No cost to you	No cost to you	No cost to you	No cost to you	No cost to you
$70 urgent care copay after deductible in urgent care facility setting **$0 copay** per visit for physician charges in a free standing urgent care center	**$60 urgent care copay** after deductible in urgent care facility setting **$0 copay** per visit for physician charges in a free standing urgent care center	**$60 urgent care copay** after deductible in urgent care facility setting **$0 copay** per visit for physician charges in a free standing urgent care center	**$55 urgent care copay** in urgent care facility setting **$0 copay** per visit for physician charges in a free standing urgent care center	**$55 urgent care copay** in urgent care facility setting **$0 copay** per visit for physician charges in a free standing urgent care center
$150 copay after deductible	**$150 copay** after deductible	**$150 copay** after deductible	**$100 copay**	**$100 copay**
$1,500 copay after deductible	**$1,000 copay** after deductible	**$1,000 copay** after deductible	**$500 copay** after deductible	**$500 copay**
$100 copay after deductible	**$100 copay** after deductible	**$100 copay** after deductible	**$100 copay**	**$100 copay**
$10 copay	**$10 copay**	**$10 copay**	**$10 copay**	**$10 copay**
$35 copay	**$35 copay**	**$35 copay**	**$30 copay**	**$30 copay**
$70 copay	**$70 copay**	**$70 copay**	**$60 copay**	**$60 copay**
n/a	n/a	n/a	n/a	n/a
Pediatric Routine Dental Care: **$30 copay** after deductible Adult Routine Dental Care: not covered	Not covered	Pediatric Routine Dental Care: **$25 copay** after deductible Adult Routine Dental Care: not covered	Not covered	Pediatric Routine Dental Care: **$30 copay** Adult Routine Dental Care: not covered
Pediatric Vision: **$30 copay** for exam after deductible **30% coinsurance** for eyewear after deductible Adult not covered	Pediatric Vision: **$25 copay** for exam after deductible **20% coinsurance** for eyewear after deductible Adult not covered	Pediatric Vision: **$25 copay** for exam after deductible **20% coinsurance** for eyewear after deductible Adult not covered	Pediatric eye visits **$15 copay** Pediatric eyewear **10% coinsurance** Adult not covered	Pediatric eye visits **$15 copay** Pediatric eyewear **10% coinsurance** Adult not covered
$1,500 copay after deductible for inpatient facility and **$100 surgeon copay** for maternity delivery after deductible	**$1,000 copay** after deductible for inpatient facility and **$100 surgeon copay** for maternity delivery after deductible	**$1,000 copay** after deductible for inpatient facility and **$100 surgeon copay** for maternity delivery after deductible	**$500 copay** for inpatient facility and **$100 surgeon copay** for maternity delivery	**$500 copay** for inpatient facility and **$100 surgeon copay** for maternity delivery
$30 copay after deductible	**$25 copay** after deductible	**$25 copay** after deductible	**$15 copay**	**$15 copay**
$30 copay after deductible	**$25 copay** after deductible	**$25 copay** after deductible	**$15 copay**	**$15 copay**
$50 copay after deductible	**$40 copay** after deductible	**$40 copay** after deductible	**$35 copay**	**$35 copay**
$30 copay after deductible (limit 60 visits per condition per lifetime, PT/OT/ST combined)	**$30 copay** after deductible (limit 60 visits per condition per lifetime, PT/OT/ST combined)	**$30 copay** after deductible (limit 60 visits per condition per lifetime, PT/OT/ST combined)	**$25 copay** (limit 60 visits per condition per lifetime, PT/OT/ST combined)	**$25 copay** (limit 60 visits per condition per lifetime, PT/OT/ST combined)

Exclusions and Limitations

Exclusions

This list includes some of the more common services not covered by these plans:

- Benefits covered by Medicare or a governmental program (except Medicaid)
- Convalescent and custodial care
- Cosmetic services except as stated in your Contract
- Coverage outside of the United States, Canada or Mexico, except emergency
- Dental services except as stated in your Contract
- Experimental or investigative treatment (subject to external appeal right)
- Services needed to treat any condition due to participation in a felony, riot or insurrection
- Foot care excepted as listed in your Contract
- Treatment provided in a hospital owned or operated by the federal, state or other government entity
- Not medically necessary services
- Services needed to treat any condition due to military service
- Services to the extent covered by no-fault automobile insurance
- Services separately billed by hospital or lab employees
- Services provided by a family member
- Services with no charge
- Services not listed in your Contract
- Vision services except as stated in your Contract
- Services covered by workers' compensation or similar laws
- Services needed to treat any condition due to war
- Services arising out of aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline

Benefit Limits

Covered services may be subject to limits as described in the Benefit Contract, including without limitation:

- Autism – Applied behavioral analysis – subject to maximum hour limit per year
- Hearing aids – limited to a single purchase (including repair/replacement) every three years
- Home health care – 40 visits per plan year
- Hospice – 210 days per plan year, inpatient and outpatient combined
- Exercise Facility Reimbursement – reimbursed the lesser of $200 for the Subscriber and $100 for the Subscriber's spouse or the actual cost of the membership per six-month period (eligibility requirements apply)
- External Prosthetic device – 1 device per limb per lifetime
- Skilled nursing facility – 200 days per plan year
- Therapy services – 60 visits per condition, per lifetime combined
  - Physical therapy
  - Occupational therapy
  - Speech therapy

This document is only a brief summary of benefits and services. Consult the Evidence of Coverage for complete coverage details including important exclusions, limitations and terms.

Coverage is not guaranteed up to the stated limits. Covered services must meet criteria as medically necessary services under the benefit plan.

Preventive care services consist of services recommended by the United States Preventive Services Task Force, including well-child care, immunizations, PSA screenings, Pap tests, mammograms and more.

These plans are available with optional coverage for dependents through age 29. If you would like to include this coverage, please be sure to choose a plan that includes the words "dependent age 29" in the plan name on the application.

Services provided by Empire HealthChoice HMO, Inc. and/or Empire HealthChoice Assurance, Inc., licensees of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans.

Note: The plans described here are available for effective dates starting January 1, 2014.
They can be purchased from Empire directly or on the NY State of Health, The Official Health Plan Marketplace. Open Enrollment begins October 1, 2013 and ends March 31, 2014.

This document contains a brief summary of certain benefits and services covered under Empire policies.
It is important to consult the Evidence of Coverage issued by Empire for complete coverage details.
It contains important exclusions, limits and other coverage terms that are not contained here and impact on eligibility and coverage availability.

Empire BlueCross BlueShield