

Your summary of benefits



An Anthem Company

CEWW Health Insurance Consortium

Your Plan: Bronze

Your Network: PPO/EPO

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	\$6,550 person / \$13,100 family	\$13,100 person / \$26,200 family
Out-of-Pocket Limit	\$6,550 person / \$13,100 family	\$13,100 person / \$26,200 family
<p>The family deductible and out-of-pocket maximum are embedded, meaning the cost shares of one family member will be applied to both per person deductible and per person out-of-pocket maximum; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket maximum. No one member will pay more than the per person deductible or per person out-of-pocket maximum.</p> <p>Your copays, coinsurance, deductible, and prescription drugs count toward your out of pocket amount(s).</p>		
Preventive Care / Screening / Immunization	No charge	0% coinsurance after deductible is met
Preventive Care for Chronic Conditions <i>per IRS guidelines</i>	No charge	0% coinsurance after deductible is met
<p><u>Virtual Care (Telemedicine / Telehealth Visits)</u></p> <p>Virtual Visits - Online visits with Doctors who also provide services in person</p>		
Primary Care (PCP)	0% coinsurance after deductible is met	0% coinsurance after deductible is met
Mental Health and Substance Abuse care	0% coinsurance after deductible is met	0% coinsurance after deductible is met
Specialist	0% coinsurance after deductible is met	0% coinsurance after deductible is met

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

Questions: Visit us at www.empireblue.com

NY/LG/CEWW Health Insurance Consortium/07-01-2023

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Medical Chats and Virtual (Video) Visits for Primary Care from our Online Provider K Health, through its affiliated Provider groups	0% coinsurance after deductible is met	
Virtual Visits from Online Provider LiveHealth Online via www.livehealthonline.com ; our mobile app, website or Empire-enabled device Primary Care (PCP) and Mental Health and Substance Abuse Specialist Care (Sleep Study)	0% coinsurance after deductible is met 0% coinsurance after deductible is met	
<u>Visits in an Office</u> Primary Care (PCP) Specialist Care	0% coinsurance after deductible is met 0% coinsurance after deductible is met	0% coinsurance after deductible is met 0% coinsurance after deductible is met
<u>Other Practitioner Visits</u> Routine Maternity Care (Prenatal and Postnatal) <i>In-Network preventive prenatal and postnatal services are covered at 100%.</i> Retail Health Clinic Chiropractic Services Acupuncture	0% coinsurance after deductible is met 0% coinsurance after deductible is met 0% coinsurance after deductible is met 0% coinsurance after deductible is met	0% coinsurance after deductible is met 0% coinsurance after deductible is met 0% coinsurance after deductible is met 0% coinsurance after deductible is met
<u>Other Services in an Office</u> Allergy Testing Chemo/Radiation Therapy Dialysis/Hemodialysis Prescription Drugs <i>Dispensed in the office</i> Surgery	0% coinsurance after deductible is met 0% coinsurance after deductible is met 0% coinsurance after deductible is met 0% coinsurance after deductible is met	0% coinsurance after deductible is met 0% coinsurance after deductible is met 0% coinsurance after deductible is met 0% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><u>Diagnostic Services</u> Lab</p> <p>Office</p> <p>Freestanding Lab/Reference Lab</p> <p>Outpatient Hospital</p>	<p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p>	<p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p>
<p>X-Ray</p> <p>Office</p> <p>Outpatient Hospital</p>	<p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p>	<p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p>
<p>Advanced Diagnostic Imaging <i>for example: MRI, PET and CAT scans</i></p> <p>Office</p> <p>Outpatient Hospital</p>	<p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p>	<p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p>
<p><u>Emergency and Urgent Care</u></p> <p>Urgent Care</p> <p>Emergency Room Facility Services <i>Coinsurance waived if admitted.</i></p> <p>Emergency Room Doctor and Other Services</p> <p>Ambulance</p>	<p>0% coinsurance after deductible is met</p>	<p>Covered as In-Network</p> <p>Covered as In-Network</p> <p>Covered as In-Network</p> <p>Covered as In-Network</p>
<p><u>Outpatient Mental Health and Substance Abuse</u></p> <p>Doctor Office Visit <i>Family counseling related to Substance Abuse is limited to 20 visits per year.</i></p> <p>Facility Visit</p> <p>Facility Fees</p>	<p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p>	<p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Doctor Services	0% coinsurance after deductible is met	0% coinsurance after deductible is met
<p><u>Outpatient Surgery</u></p> <p>Facility Fees</p> <p>Hospital</p> <p>Freestanding Surgical Center</p> <p>Doctor and Other Services</p> <p>Hospital</p> <p>Freestanding Surgical Center</p>	<p>0% coinsurance after deductible is met</p>	<p>0% coinsurance after deductible is met</p>
<p><u>Hospital (Including Maternity, Mental Health and Substance Abuse)</u></p> <p>Facility Fees <i>Coverage for Inpatient Rehabilitation is limited to 60 days per year.</i></p> <p>Doctor and other services</p>	<p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p>	<p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p>
<p><u>Recovery & Rehabilitation</u></p> <p>Home Health Care <i>Unlimited visits per year.</i></p>	<p>0% coinsurance after deductible is met</p>	<p>0% coinsurance after deductible is met</p>
<p>Rehabilitation services <i>Coverage for rehabilitative and habilitative physical therapy is limited to 45 visits per year. Coverage for rehabilitative and habilitative occupational therapy is limited to 45 visits per year. 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.</i></p> <p>Office</p> <p>Outpatient Hospital</p>	<p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p>	<p>Not covered</p> <p>Not covered</p>
<p>Cardiac rehabilitation</p> <p>Office</p>	<p>0% coinsurance after deductible is met</p>	<p>0% coinsurance after deductible is met</p>

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
Skilled Nursing Care (facility) <i>Coverage is limited to 45 days per year.</i>	0% coinsurance after deductible is met	0% coinsurance after deductible is met
Inpatient 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

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Pharmacy Deductible	Combined with In-Network medical deductible	Not covered
Pharmacy Out-of-Pocket Limit	Combined with In-Network medical out-of-pocket limit	Not covered

Prescription Drug Coverage *Cost shares for drugs included on the National drug list appear below. Your plan uses the Base Network. You may receive up to a 90 day supply of medication at most retail pharmacies.*

Preventive Drugs *Your Pharmacy cost share is reduced for drugs included on the PreventiveRX Plus drug list, a designated list of drugs for the treatment of diabetes, asthma, depression, heart health, high blood pressure, high cholesterol, and osteoporosis.*

Tier 1 Preventive - Typically Generic <i>Per 30 day supply (retail pharmacy). Per 90 day supply (home delivery).</i>	No charge (retail and home delivery)	Not covered
Tier 2 Preventive - Typically Preferred Brand <i>Per 30 day supply (retail pharmacy). Per 90 day supply (home delivery).</i>	No charge (retail and home delivery)	Not covered

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Tier 1 - Typically Generic <i>Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program).</i>	No charge after deductible is met (retail and home delivery)	Not covered
Tier 2 – Typically Preferred Brand <i>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.</i>	No charge after deductible is met (retail and home delivery)	Not covered
Tier 3 - Typically Non-Preferred Brand/Specialty Drugs <i>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.</i>	No charge after deductible is met (retail and home delivery)	Not covered

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.

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.

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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:

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Haitian Creole (Kreyòl Ayisyen): Si ou gen nempòt 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.

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Language Access Services:

Navajo (Diné): Dii naaltsoos biká'ígíí lahgo bina'idiikidgo ná bohónéedzǎ dóó bee ahóót'i' t'áá ni nizaad k'ehǫ́ bee nił hodoonih t'áadoo bááh ilínígóó. Ata' halne'ígíí la' bich'í' hadeesdzih ninizingo kojí' hodíílnih (844) 241-7085.

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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>.