2017 Plan Year: Individual and Family

Your Health Plan Guide

Bronze, Silver, Gold, Platinum and Catastrophic plans offered by Empire on the NY State of Health Marketplace

Empire BlueCross BlueShield

An Anthem Company

Note: The plans described here are available for effective dates starting January 1, 2017. They can be purchased from Empire directly or through the NY State of Health Marketplace during the annual open enrollment period from November 1, 2016 through January 31, 2017. This document is a summary and does not contain all terms about referenced covered benefits and services. Benefit plans have exclusions, limitations and terms that apply. For more complete details on what's covered and what isn't, review the Contract and Summary of Benefits and Coverage (SBC). To access an SBC, please visit sbc.empireblue.com and select Member.

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Why Empire?

Health plans don't have to be complicated.

We understand that every individual and family is unique. That's why we offer many affordable plan options for different health care needs and budgets. Our goal is not just to be there when you're sick, but also to help you stay well – at every stage of life.

With Empire BlueCross BlueShield (Empire), you can count on:

- A strong network with access to major hospital systems.
- Dedicated customer service.
- All your benefits, including dental and vision, from one source.
- Convenient online tools, including 24/7 access to doctors through LiveHealth Online.
- A simple enrollment process.
- Coordinated care that can connect your doctors and other health care providers.
- Resources to support your health care goals.

Empire is right there with you.

It's time to expect more from health care plans.

- Local presence where you live and work
- A brand you can trust.

You want the best value your health care dollars can buy. And in New York, that's our goal — through our networks and our experience.

* Based on Internal Data, 2016.

Table of Contents

Quick clicks

Get the info you want now. Just choose a topic to take you right to that section.

- Medical plans
- Networks
- Find a Doctor
- Prescriptions

What we cover

All our plan options have one major goal — to help you stay healthy and provide the quality coverage you need, when you need it.That's why, no matter which plan you choose, you're covered from preventive care to emergencies and plenty in between!

Built in benefits

Our plans include the essential health benefits (EHBs) under the Affordable Care Act (ACA):

- Ambulatory patient services (outpatient care you get without being admitted to a hospital)
- Emergency services (going to the emergency room, also known as the ER) or urgent care center, when medically necessary
- Hospitalization and inpatient services (such as surgery)
- Laboratory and radiology services (includes blood work, screenings and X-rays)
- Mental health and substance use disorder services
- Pediatric dental and vision coverage for children up to age 19†

Take care of yourself with no-cost, in-network preventive care

With Empire, you pay no copay, no coinsurance and no deductible for covered **in-network** preventive services. So you can stay on top of your health care and your finances!*

- Pregnancy, maternity and newborn care
- Prescriptions
- Rehabilitative and habilitative services and devices (hospital beds, crutches, oxygen tanks)
- Visits to doctors in your plan for preventive care services* (wellness exams, shots, screenings) and chronic disease management

* Nationally recommended preventive care services from in-network providers have no copay, no coinsurance and no deductible requirement. Preventive and wellness services consist of certain services, including well-child care, immunizations, prostate-specific antigen (PSA) screenings, Pap tests, mammograms and more, recommended by the United States Preventive Services Task Force.
† Embedded dental benefits only include in-network benefits. Remember, you save money when using in-network providers no matter which type of medical plan you choose.

Pharmacy

Getting the most out of your pharmacy benefits can help keep you healthy and save you money. Here's what you need to know:

About our covered drug list

Empire's pharmacy plans have a formulary/drug list, which is a list of covered prescription drugs that includes hundreds of brand name and generic medicines. Our individual and family plans use the Select Drug List, which offers drugs in every category and class that meet or exceed ACA requirements. The list tells you what tier your drug is in and provides guidance on how your cost shares are affected. Cost shares go up the higher the drug tier. Talk to your doctor about possible lower-cost options if your drug is in a higher tier.

Access all of your pharmacy information at empireblue.com

- Find out if your medication is covered. Check out our Select Drug List at empireblue.com/pharmacyinformation and click on the link, **Select Drug List (Searchable)**.
- See if your preferred pharmacy is in the plan's network. Visit empireblue.com/pharmacyinformation and select the **Rx Networks** tab.
- Learn more about using your pharmacy benefits, your drug list and get answers to questions about prior authorization and step therapy. See our list of FAQs located on the **Customer Support** tab.

Together with medical – better and easier than ever

With our combined pharmacy and medical programs, your doctor has a better picture of your health which can help result in:

- Better overall health
- A simplified experience
- Fewer hospital stays and reduced medical costs*
- Improved medication compliance
- Increased cost savings for prescriptions*

Save with prescription drug benefits

Empire wants to help lower the cost to you for prescription drugs, improve your overall health and deliver top-notch customer service. Here's how:

Multi-level pharmacy coverage with some of our plans helps provide savings and access

Level 1

Visiting CVS, Target, Wal-Mart, or any of our nearly 25,000 national Level 1 in-network pharmacies give you the lowest out-of-pocket costs for your prescriptions.

Level 2

You can also visit one of our 50,000+ national Level 2 in-network pharmacies, and your prescriptions will be covered for an additional cost.†

Save with Home Delivery Choice

We offer home delivery of your medicines right to your door. With the Home Delivery Choice program, you must choose how you want to get the medicines you take for ongoing conditions like indigestion, high blood pressure, high cholesterol or diabetes — at your local pharmacy or delivered to your doorstep.

We'll contact you by phone and mail to tell you about the program and its benefits. You can use a retail pharmacy for two fills, but after the second fill, your medicines will no longer be covered at your pharmacy until you make a final decision.

Using home delivery may help you save money. And it makes it easy for you to get your medicine quickly and safely.

* Outcomes based on 2014 integrated analysis. Results do not represent a guarantee of outcomes, group-specific results and cost savings will vary.
† Additional $20 copayment or 15% coinsurance may apply.

How to choose a plan

Networks...why choosing a doctor in your plan matters

One thing to think about when shopping for a health plan is your health plan's network of participating providers.

When Empire sets up medical, dental and vision networks, we negotiate with doctors, hospitals and labs on the cost of services. For example, a doctor may normally charge $150 for an X-ray for a patient without medical benefits. We may negotiate with that same doctor to discount the rate for our Empire members down to $100. Once this agreement is made, the doctor becomes part of our network of health care providers.

Bottom line: If you have a favorite doctor, hospital or other health care provider, you should always check to see if that provider is in our network, so you can get the benefit of the discounted or in-network rate.

Providers in your plan may include:

- Doctors, mental health providers and other health care professionals
- Hospitals and outpatient facilities
- Pharmacies
- ERs and urgent care centers
- Labs and radiology centers
- Durable medical equipment providers for things like hospital beds, crutches, wheelchairs and oxygen tanks (retail and online stores)

Our Find a Doctor tool — it's quick and easy

Go to **empireblue.com/findadoctor** and search for the plans described in this brochure using the plan/network (**Pathway X Enhanced**) you're considering.

You'll get a list of providers, including detailed information about them like location, gender, specialty, certifications, availability and much more.

It's a good idea to check with providers to confirm if they're in our network.

For searches on the go, download our **Empire Anywhere** mobile app to your mobile device.

Network details: HMO

- **Health maintenance organization (HMO):** With an HMO, you have to choose a primary care doctor to manage your care needs — including getting referrals to see other in-network doctors. HMOs don't offer out-of-network benefits, except for emergency care or when a service is preapproved. If you go outside the network for any other reason, you're not covered and will be responsible for the provider payment.

Travel coverage

Our plans cover medically necessary emergency care in all 50 states.

Whether you're traveling for work or on vacation, going to the ER is probably the last thing you want to worry about. The good news is you don't have to! With the Blue Cross and Blue Shield Association's BlueCard® program, you can access emergency care no matter where you are in the United States (U.S.).

Some differences between doctors in the plan and doctors outside the plan

Doctors in the plan: Doctors and other health care providers who contract with us to provide care at discounted rates.

Doctors outside the plan: Doctors and other health care providers who are not contracted with the health plan.

If you choose to go to a doctor not in your plan, you may not be covered and will pay more out of pocket.

What do you need?

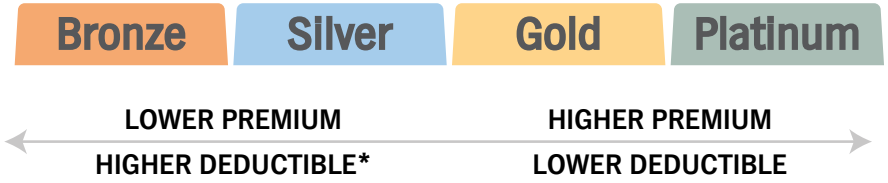
Choosing the right health care plan can be challenging. To help you decide, consider the questions below.

What matters most to you?

- **Does the plan meet your coverage needs?** How often do you see doctors and specialists? What prescription medications do you take regularly? Are you planning any necessary procedures this year?
- **Do you have a certain doctor you like to see?** If you answered yes, then you can use our Find a Doctor tool at **empireblue.com/findadoctor** to check if your doctor is in the plan you're considering.
- **Do you need to know if your medication is covered?** Check out our drug list at **empireblue.com/pharmacyinformation** and click on the link, **Select Drug List (Searchable)**.
- **Is a Catastrophic plan an option?** If you're under age 30 or are 30 or older with an approved hardship exemption from the NY State of Health Marketplace (your state's Marketplace) you may qualify for a high deductible, low monthly payment, Catastrophic plan. Catastrophic plans can help protect you from worst-case scenarios like serious accidents or illnesses.

Plan choices

Plans based on Metal Levels



Health savings account (HSA)

If you like the idea of lowering your health care costs and your taxes, a health savings account (HSA) could be a good option for you.

- **What is it?**
  It's a savings account you can open when you have a qualified high-deductible health plan (HDHP). You set up the HSA through a bank and fund it with your post tax dollars.
- **Why choose it?**
  It can help you pay for health care expenses, including prescriptions. Plus, you can claim your HSA contributions as tax deductions, earn interest on your money and roll over the year-end balance.
- **How can you learn more?**
  Check with your tax advisor to see if an HSA plan is right for you. For more information on HSAs, review our HSA flier included with this brochure.

* This does not apply to Silver cost-share reduction /subsidy plans. Silver cost-share reduction plans / subsidy plans are only available for Qualified Health Plans purchased through the NY State of Health Marketplace. Empire HealthChoice HMO, Inc. is a Qualified Health Plan issuer that offers such plans through the NY State of Health Marketplace. Only your state exchange can determine eligibility for financial help.

How your plan might work

With most health care plans, you pay a monthly fee called a premium; then, you share some of the cost of covered services you receive with your health insurance company. **With Empire, you choose the level of cost sharing that works for you.**

Here's an example: *Meet Jason*

To show you how your health plan might work, we'd like to introduce you to "Jason." The cost-share amounts used in this example may not apply to the plan you choose. This is just an example. Be sure to look at the actual benefits for each plan when you're deciding.

Jason's story

After injuring his knee in a soccer game, Jason chooses a doctor in our Pathway X Enhanced network to be sure the services he needs will be covered. Jason pays a copay or coinsurance based on Empire negotiated rates because he uses doctors in our network. **Below, see how Jason's benefits work, his treatment costs and why it's important to have health insurance:**

Jason's health plan has the following benefits:

- $2,000 deductible
- 30% coinsurance
- $5,000 out-of-pocket limit
- $35 copay for primary care doctor visits

Definitions

Copay

On some plans, you pay a fixed-dollar amount or copay for certain services. For example, you may have a $35 copay for in-network primary care doctor visits.

Deductible

This is generally the dollar amount you pay in a plan year before your plan will begin paying for covered services. Your deductible always resets January 1 and runs through December 31.

Examples of covered services that apply to the deductible include lab work, X-rays, anesthesia and surgeon fees.

Let's take a closer look at Jason's doctor visit:

- *Doctor visit cost (without insurance):* $200
- *Empire's negotiated rate:* $140
- *Empire pays:* $105
- ***Jason paid:*** **$35**

  (This is his plan's copay for primary care doctor office visits.)

Here's what happens when Jason's doctor orders an approved magnetic resonance imaging (MRI) of the knee and recommends surgery:

MRI

- *MRI cost (without insurance):* $1,500
- *Empire's negotiated rate:* $1,000
- ***Jason paid:*** **$1,000**

  (Jason's payment counts toward his plan's $2,000 deductible.)

Surgery

- *Hospital/surgery costs (without insurance):* $50,000
- *Empire's negotiated rate:* $35,000
- ***Jason paid:*** **$1,000**

  (Jason's payment satisfies the remaining $1,000 deductible.)
- *Remaining cost of surgery:* $34,000

Coinsurance (your percentage of the cost)

Once you've met your deductible, Empire starts paying a portion of your claims for covered services (Covered in-network preventive services are paid in full). Then, you and Empire share responsibility for your health care bills. Your coinsurance is the percentage that you pay for certain covered services. Having met his deductible, Jason begins to pay coinsurance on covered services that require it.

Let's check in to see Jason's final costs for surgery:

- *Coinsurance* (30% of $34,000): $10,200
- ***Jason paid:*** **$2,965**
  (Jason's payment satisfies the remainder of his $5,000 out-of-pocket limit. Even though Jason's coinsurance is 30% or $10,200, he only has to pay a portion of that to meet his $5,000 out-of-pocket limit.)

Out-of-pocket limit

This is the most you pay during a calendar year for covered services. Your combined deductible, coinsurance and copay costs typically make up your out-of-pocket limit. Once you meet this limit, your health insurance covers 100% (of the maximum allowed amount) of covered services for the rest of the calendar year.

Jason has met his out-of-pocket limit and the remaining surgery costs and all other covered services Jason receives in-network for the rest of the year are paid by Empire (up to the maximum allowed amount):

- *Empire pays:* $31,035
- *Jason's out-of-pocket limit:* $5,000

Summary

Jason saved money because he had health care coverage and stayed in our network. If Jason had used a doctor outside our network, he wouldn't have been covered unless it was an emergency.

Keep in mind our plans don't include coverage for out-of-network benefits, and you'll pay the full cost for services from doctors not in our network with the exception of medically necessary emergency and urgent care.

Let's check in to see Jason's final costs:

- *Total for the doctor visit, MRI and surgery (without health insurance):* $51,700
- *Total Empire paid after discounts:* $31,140
- ***Total Jason paid:*** **$5,000**
  ($35 office visit + $2,000 deductible + $2,965 coinsurance = $5,000)

Call your Empire representative for more information.

You can also visit **empireblue.com** or **nystateofhealth.ny.gov** to view and compare different plans.

Qualify for financial help?

With the Affordable Care Act (ACA), most people have to get health care coverage unless they qualify for an exemption. But you may be eligible for financial help to pay for your insurance.

Your medical plan may not cost as much as you think

Depending on your income and family size, you may qualify for an advance premium tax credit (APTC) on any metal level plan, excluding Catastrophic plans, when you buy a plan through the NY State of Health Marketplace. If you qualify, you may be able to enroll in certain Silver plans available on the NY State of Health Marketplace that offer a reduction in the deductible, copays and out-of-pocket costs charged under that plan. This is called a cost-share reduction (CSR) plan (also called cost-sharing subsidy). These options are shown in the chart below as CSR 1, CSR 2 and CSR 3.

Use the chart below to see if you qualify for a cost-share reduction.

1. Find your family size. Then, figure out your yearly income and move across the row to find the income range that applies to your household.

2. Look at the percentage at the top of the chart to see where you fall on the Federal Poverty Level (FPL).

3. Go to the second row to find the plan you qualify for.* Then, check out our Silver cost-share reduction plans for details.

2017 Federal Poverty Level

	Less than 138%		138% - 150%	151% - 200%	201% - 250%
You qualify for	Medicaid Eligible		CSR 3	CSR 2†	CSR 1†
Family Size					
1	$11,880	$16,394	$16,395-$17,820	$17,821-$23,760	$23,761-$29,700
2	$16,020	$22,108	$22,109-$24,030	$24,031-$32,040	$32,041-$40,050
3	$20,160	$27,821	$27,822-$30,240	$30,241-$40,320	$40,321-$50,400
4	$24,300	$33,534	$33,535-$36,450	$36,451-$48,600	$48,601-$60,750
5	$28,440	$39,247	$39,248-$42,660	$42,661-$56,880	$56,881-$71,100
6	$32,580	$44,960	$44,961-$48,870	$48,871-$65,160	$65,161-$81,450
7	$36,730	$50,687	$50,688-$55,095	$55,096-$73,460	$73,461-$91,825
8	$40,890	$56,428	$56,429-$61,335	$61,336-$81,780	$81,781-$102,225

Source: Calculations based on data from the U.S. Department of Health and Human Services, www.federalregister.gov/documents/2016/01/25/2016-01450/annual-update-of-the-hhs-poverty-guidelines.

* Other metal level plans are available, but are not eligible for a cost-share reduction.

† Available for the individuals that are not eligible for Essential Plan coverage offered via the NY State of Health Marketplace, over 65 years old and not eligible for Medicare coverage.

Avoid tax penalties

If you don't enroll in a medical plan, you may have to pay a penalty – unless you qualify for an exemption. Penalties are based on your income and increase each year for inflation. To learn how tax penalties could affect you, contact a tax advisor.

Cost-sharing subsidies can make Silver metal level plans ineligible for an HSA.

If you qualify for a CSR plan, you may not be able to enroll in an HSA. Since cost-sharing subsidies lower your deductible and out-of-pocket costs, sometimes these amounts drop below the federal government's minimum deductible threshold for HSA eligibility. If this is the case, you won't qualify for the HSA feature. You'll then be automatically enrolled in the base plan without the HSA.

What does it mean to shop on or off the Marketplace?

The medical plans you see in this brochure are only available on the NY State of Health Marketplace (your state's Marketplace). If you don't qualify for an APTC or a Silver CSR plan, you may want to shop off the Marketplace at **empireblue.com**. We have lots of plan options that may suit your needs.

Does the chart show you qualify for a Silver CSR plan? Then, you'll need to shop on the NY State of Health Marketplace. You can still buy an Empire plan at **nystateofhealth.ny.gov**, where you can take advantage of an APTC or Silver CSR plan, if you qualify.

Whether you shop on or off the Marketplace, you can compare plans and get a quote on the plan that fits your needs.

Overview of plans

Understanding insurance terms

In-network preventive care is covered at no additional cost to you!*

Insurance terms can be confusing. Here's a quick look at some commonly used health insurance terms.

Take a look at the following pages to see the individual and family medical plan choices offered by Empire, including a sample of commonly used benefits and how they're covered under each plan. **Cost-share and benefit information shown is for *in-network* services only.**

For more information, you can view and compare plans on empireblue.com.

Plan name	Plan name and contract code are found in the first row of the medical plan charts. Look for this when you're applying for a plan. The contract code is in parentheses after the plan name.
Plan includes out-of-network coverage?	Indicates whether the plan includes coverage for out-of-network benefits. Our individual and family plans don't include out-of-network benefits, except in cases of emergency. **In-network** refers to doctors who are part of the plan's network. **Out-of-network** refers to doctors who don't participate in the network.
Deductible	The **deductible** is a set amount that you pay out of pocket each year before your plan starts paying for covered services, except for in-network preventive services.* *For example:* If your deductible is $5,000, your plan won't pay anything until you've met your $5,000 deductible for non-preventive covered services. Some plans may cover certain services, such as non-preventive doctor office visits, before you meet the deductible. Our plans have embedded family deductibles, where each covered family member only needs to satisfy his or her individual deductible, not the entire family deductible, before receiving plan benefits. No one family member pays more than the individual deductible. The medical plan charts display the individual deductible. Family deductibles are two (2) times the individual amount for most plans and three (3) times the individual amount for some Silver, Gold and Platinum plans. **Note:** You must meet your deductible every calendar year (January 1 through December 31), even if your effective date (the date your coverage begins) is later than January 1.
Out-of-pocket limit	The **out-of-pocket** limit is the most you pay during a policy period (each calendar year) before your health insurance or plan pays 100% of the maximum allowed amount for covered services. *For example:* If your out-of-pocket limit is $6,850, you will continue to pay your coinsurance and copays, if applicable, until you've met your $6,850 out-of-pocket limit. Once you have met your out-of-pocket limit, your plan pays 100% of the maximum allowed amount for covered services for the rest of that calendar year. This limit never includes your monthly payment (premium) or the costs of services your plan doesn't cover. The amount includes deductible, copays, coinsurance and covered pharmacy costs. Our plans have embedded family out-of-pocket limits where each covered family member only needs to satisfy his or her individual out-of-pocket limit, not the entire family out-of-pocket limit, before the plan pays 100% of the maximum allowed amount for services. No one family member pays more than the individual out-of-pocket limit. The medical plan charts display the individual out-of-pocket limit. Family out-of-pocket limits are two (2) times the individual amount and three (3) times the individual amount for some Silver, Gold and Platinum plans.
Coinsurance	**Your percentage of the cost (Coinsurance)** is the amount you pay for covered health care services. It's a percentage of the cost of services after the deductible has been paid. *For example:* A health plan pays 80% of the maximum allowed amount for a service and you pay the remaining 20%. All medical plans have coinsurance for some services (others require a copay), but the percentage may vary by health care service.
Copay	A **copay** is a fixed dollar amount that you pay for each visit to an in-network provider for services that require a copay. *For example:* If your copay is $50, then you pay $50 when you see your in-network doctor — usually at the time you receive treatment and the health plan pays the rest, up to the maximum allowed amount. The amount of your copay may depend on the type of health care service you receive. For instance, an office visit to your primary care doctor may be $30 and an office visit to a specialist may be $50. The actual copay amounts will be listed in your Contract.

* Nationally recommended preventive care services from in-network providers have no copay, no coinsurance and no deductible requirement. Preventive and wellness services consist of certain services, including well-child care, immunizations, prostate-specific antigen (PSA) screenings, Pap tests, mammograms and more, recommended by the United States Preventive Services Task Force.

Medical plans

The benefit information shown here is for in-network services received from providers in Empire's **Pathway X Enhanced** network. These plans don't include coverage for out-of-network benefits except for emergency care or urgent care as described in the Contract.

When reviewing our medical plans, keep in mind that you must meet your **full annual deductible every calendar year.** Even if you started your coverage after January 1, you pay the full annual deductible. The calendar year runs from January 1 through December 31.

	Empire HMO 5500 X, for HSA, Bronze, ST, INN, Pediatric Dental, Dep 25 (1H14)	**Empire HMO 6350 X, Bronze, NS, INN, Pediatric Dental, Dep 25 (1H1D)**	**Empire HMO 6750 X, Bronze, NS, INN, Pediatric Dental, Dep 25 (2EBK)**
Network name	Pathway X Enhanced	Pathway X Enhanced	Pathway X Enhanced
Plan includes out-of-network coverage?	No	No	No
Available optional riders?	Dep 29 (1H15), Child Only (1H16)	Dep 29 (1H1E)	Dep 29 (2EBL)
Individual deductible[1]	$5,500	$6,350	$6,750
Individual out-of-pocket limit[1]	$6,550	$7,150	$7,150
Coinsurance (percentage may vary for some covered services)	50%	20%	40%
Preventive care[2]	No additional cost to you.	No additional cost to you.	No additional cost to you.
Office visit: primary care physician (PCP) (Other office services may be subject to deductible and plan coinsurance)	Deductible, then 50% coinsurance	$0 copay per visit for the first 3 visits, then deductible and 20% coinsurance	Deductible, then 40% coinsurance
Office visit: specialist (Other office services may be subject to deductible and plan coinsurance)	Deductible, then 50% coinsurance	Deductible, then 20% coinsurance	Deductible, then 40% coinsurance
Outpatient diagnostic tests (Ex. X-ray, EKG)	Deductible, then 50% coinsurance	Deductible, then 20% coinsurance	Deductible, then 40% coinsurance
Outpatient advanced diagnostic tests (Ex. MRI, CT scan)	Deductible, then 50% coinsurance	Deductible, then $100 copay and 20% coinsurance	Deductible, then 40% coinsurance
Urgent care	Deductible, then 50% coinsurance	Deductible, then $75 copay and 20% coinsurance	Deductible, then 40% coinsurance
Emergency room care (Copay waived if admitted into the hospital from the emergency room.)	Deductible, then 50% coinsurance	Deductible, then $750 copay and 20% coinsurance	Deductible, then 40% coinsurance
Hospital: inpatient admission (includes maternity, mental health / substance use)	Deductible, then 50% coinsurance	Deductible, then $800 copay	Deductible, then 40% coinsurance
Hospital: outpatient surgery hospital facility (includes maternity, mental health / substance use)	Deductible, then 50% coinsurance	Deductible, then 20% coinsurance	Deductible, then 40% coinsurance
Pharmacy deductible (for tiers with deductible, cost share applies after deductible)	Tier 1, 2, 3: Medical deductible applies	Level 1 / Level 2 Pharmacy Tier 1, 2, 3: Medical deductible applies	Level 1 / Level 2 Pharmacy Tier 1, 2, 3: Medical deductible applies
Retail pharmacy tier 1[3]**: level 1 / level 2**	$10 copay	$15 copay / $25 copay	25% coinsurance / 35% coinsurance
Retail pharmacy tier 2[3]**: level 1 / level 2**	$35 copay	$40 copay / $50 copay	35% coinsurance / 45% coinsurance
Retail pharmacy tier 3[3]**: level 1 / level 2**	$70 copay	40% coinsurance / 50% coinsurance	45% coinsurance / 50% coinsurance
Physical and occupational therapy (limits apply)	Deductible, then 50% coinsurance	Deductible, then 20% coinsurance	Deductible, then 40% coinsurance
Speech therapy (limits apply)	Deductible, then 50% coinsurance	Deductible, then 20% coinsurance	Deductible, then 40% coinsurance
Mental health / substance use: outpatient facility & services	Deductible, then 50% coinsurance	Deductible, then 20% coinsurance	Deductible, then 40% coinsurance

Please see Medical and Silver cost-share reduction plans footnotes on page 21.

Medical plans

The benefit information shown here is for in-network services received from providers in Empire's **Pathway X Enhanced** network. These plans don't include coverage for out-of-network benefits except for emergency care or urgent care as described in the Contract.

When reviewing our medical plans, keep in mind that you must meet your **full annual deductible every calendar year.** Even if you started your coverage after January 1, you pay the full annual deductible. The calendar year runs from January 1 through December 31.

	Empire HMO 2000 X, Silver, ST, INN, Pediatric Dental, Dep 25 (1H1R)	**Empire HMO 2250 X, Silver, NS, INN, Pediatric Dental, Dep 25 (1H2M)**	**Empire BlueCross BlueShield HMO 2800 X, for HSA, Silver, NS, INN, Pediatric Dental, Dep 25, a Multi-State Plan (1H0Q)**
Network name	Pathway X Enhanced	Pathway X Enhanced	Pathway X Enhanced
Plan includes out-of-network coverage?	No	No	No
Available optional riders?	Dep 29 (1H1S), Child Only (1H1T)	Dep 29 (1H2N)	Dep 29 (1H0R)
Individual deductible[1]	$2,000	$2,250	$2,800
Individual out-of-pocket limit[1]	$6,750	$7,150	$6,550
Coinsurance (percentage may vary for some covered services)	30%	25%	15%
Preventive care[2]	No additional cost to you.	No additional cost to you.	No additional cost to you.
Office visit: primary care physician (PCP) (Other office services may be subject to deductible and plan coinsurance)	Deductible, then $30 copay	$0 copay per visit for the first 5 visits, then deductible and 25% coinsurance	Deductible, then 15% coinsurance
Office visit: specialist (Other office services may be subject to deductible and plan coinsurance)	Deductible, then $50 copay	Deductible, then $50 copay and 25% coinsurance	Deductible, then $30 copay and 15% coinsurance
Outpatient diagnostic tests (Ex. X-ray, EKG)	Deductible, then $50 copay	Deductible, then 25% coinsurance	Deductible, then 15% coinsurance
Outpatient advanced diagnostic tests (Ex. MRI, CT scan)	Deductible, then $50 copay	Deductible, then 25% coinsurance and $100 copay	Deductible, then $100 copay and 15% coinsurance
Urgent care	Deductible, then $70 copay	Deductible, then $50 copay and 25% coinsurance	Deductible, then $50 copay and 15% coinsurance
Emergency room care (Copay waived if admitted into the hospital from the emergency room.)	Deductible, then $250 copay	Deductible, then $200 copay and 25% coinsurance	Deductible, then $500 copay and 15% coinsurance
Hospital: inpatient admission (includes maternity, mental health / substance use)	Deductible, then $1,500 copay	Deductible, then $2,000 copay and 25% coinsurance	Deductible, then $1,100 copay and 50% coinsurance
Hospital: outpatient surgery hospital facility (includes maternity, mental health / substance use)	Deductible, then $100 copay	Deductible, then $200 copay and 25% coinsurance	Deductible, then 15% coinsurance
Pharmacy deductible (for tiers with deductible, cost share applies after deductible)	Tier 1, 2, 3: No deductible	Level 1 / Level 2 Pharmacy Tier 1, 2, 3: Medical deductible applies	Level 1 / Level 2 Pharmacy Tier 1, 2, 3: Medical deductible applies
Retail Pharmacy tier 1[3]**: level 1 / level 2**	$10 copay	$10 copay / $15 copay	10% coinsurance / 15% coinsurance
Retail pharmacy tier 2[3]**: level 1 / level 2**	$35 copay	$30 copay / $40 copay	10% coinsurance / 15% coinsurance
Retail pharmacy tier 3[3]**: level 1 / level 2**	$70 copay	40% coinsurance / 50% coinsurance	40% coinsurance / 50% coinsurance
Physical and occupational therapy (limits apply)	Deductible, then $30 copay	Deductible, then 25% coinsurance	Deductible, then 15% coinsurance
Speech therapy (limits apply)	Deductible, then $30 copay	Deductible, then 25% coinsurance	Deductible, then 15% coinsurance
Mental health / substance use: outpatient facility & services	Deductible, then $30 copay	Deductible, then 25% coinsurance	Deductible, then 15% coinsurance

Please see Medical and Silver cost-share reduction plans footnotes on page 21.

Medical plans

The benefit information shown here is for in-network services received from providers in Empire's **Pathway X Enhanced** network. These plans don't include coverage for out-of-network benefits except for emergency care or urgent care as described in the Contract.

When reviewing our medical plans, keep in mind that you must meet your **full annual deductible every calendar year.** Even if you started your coverage after January 1, you pay the full annual deductible. The calendar year runs from January 1 through December 31.

	Empire HMO 5250 X, Silver, NS, INN, Pediatric Dental, Dep 25 (2EB9)	**Empire BlueCross BlueShield HMO 1000 X, Gold, NS, INN, Pediatric Dental, Dep 25, a Multi-State Plan (1H0Y)**	**Empire HMO 1000 X, Gold, NS, INN, Pediatric Dental, Dep 25 (1H3C)**
Network name	Pathway X Enhanced	Pathway X Enhanced	Pathway X Enhanced
Plan includes out-of-network coverage?	No	No	No
Available optional riders?	Dep 29 (2EBD)	Dep 29 (1H0Z)	Dep 29 (1H3D)
Individual deductible[1]	$5,250	$1,000	$1,000
Individual out-of-pocket limit[1]	$6,500	$7,150	$7,150
Coinsurance (percentage may vary for some covered services)	25%	10%	10%
Preventive care[2]	No additional cost to you.	No additional cost to you.	No additional cost to you.
Office visit: primary care physician (PCP) (Other office services may be subject to deductible and plan coinsurance)	$35 copay	$30 copay	$30 copay
Office visit: specialist (Other office services may be subject to deductible and plan coinsurance)	Deductible, then 25% coinsurance	Deductible, then 10% coinsurance	Deductible, then 10% coinsurance
Outpatient diagnostic tests (Ex. X-ray, EKG)	Deductible, then 25% coinsurance	Deductible, then 10% coinsurance	Deductible, then 10% coinsurance
Outpatient advanced diagnostic tests (Ex. MRI, CT scan)	Deductible, then 25% coinsurance	Deductible, then $100 copay and 10% coinsurance	Deductible, then $100 copay and 10% coinsurance
Urgent care	Deductible, then $50 copay	Deductible, then $50 copay and 10% coinsurance	Deductible, then $50 copay and 10% coinsurance
Emergency room care (Copay waived if admitted into the hospital from the emergency room.)	Deductible, then 25% coinsurance	Deductible, then $500 copay and 10% coinsurance	Deductible, then $500 copay and 10% coinsurance
Hospital: inpatient admission (includes maternity, mental health / substance use)	Deductible, then 25% coinsurance	Deductible, then $1,000 copay and 10% coinsurance	Deductible, then $1,000 copay and 10% coinsurance
Hospital: outpatient surgery hospital facility (includes maternity, mental health / substance use)	Deductible, then 25% coinsurance	Deductible, then 10% coinsurance	Deductible, then 10% coinsurance
Pharmacy deductible (for tiers with deductible, cost share applies after deductible)	Level 1 / Level 2 Pharmacy Tier 1, 2: No deductible Tier 3: Medical deductible applies	Level 1 / Level 2 Pharmacy Tier 1: No deductible Tier 2, 3: Medical deductible applies	Level 1 / Level 2 Pharmacy Tier 1: No deductible Tier 2, 3: Medical deductible applies
Retail pharmacy tier 1[3]**: level 1 / level 2**	$5 copay / $20 copay	$15 copay / $25 copay	$15 copay / $25 copay
Retail pharmacy tier 2[3]**: level 1 / level 2**	$40 copay / $50 copay	$40 copay / $50 copay	$40 copay / $50 copay
Retail pharmacy tier 3[3]**: level 1 / level 2**	35% coinsurance / 50% coinsurance	40% coinsurance / 50% coinsurance	40% coinsurance / 50% coinsurance
Physical and occupational therapy (limits apply)	Deductible, then 25% coinsurance	Deductible, then 10% coinsurance	Deductible, then 10% coinsurance
Speech therapy (limits apply)	Deductible, then 25% coinsurance	Deductible, then 10% coinsurance	Deductible, then 10% coinsurance
Mental health / substance use: outpatient facility & services	Deductible, then 25% coinsurance	Deductible, then 10% coinsurance	Deductible, then 10% coinsurance

Please see Medical and Silver cost-share reduction plans footnotes on page 21.

Medical plans

The benefit information shown here is for in-network services received from providers in Empire's **Pathway X Enhanced** network. These plans don't include coverage for out-of-network benefits except for emergency care or urgent care as described in the Contract.

When reviewing our medical plans, keep in mind that you must meet your **full annual deductible every calendar year.** Even if you started your coverage after January 1, you pay the full annual deductible. The calendar year runs from January 1 through December 31.

	Empire HMO 600 X, Gold, ST, INN, Pediatric Dental, Dep 25 (1H33)	**Empire HMO 0 X, Platinum, ST, INN, Pediatric Dental, Dep 25 (1H3N)**	**Empire HMO 300 X, Platinum, NS, INN, Pediatric Dental, Dep 25 (1H44)**
Network name	Pathway X Enhanced	Pathway X Enhanced	Pathway X Enhanced
Plan includes out-of-network coverage?	No	No	No
Available optional riders?	Dep 29 (1H34), Child Only (1H35)	Dep 29 (1H3P), Child Only (1H3Q)	Dep 29 (1H43)
Individual deductible[1]	$600	$0	$300
Individual out-of-pocket limit[1]	$4,000	$2,000	$4,500
Coinsurance (percentage may vary for some covered services)	20%	10%	5%
Preventive care[2]	No additional cost to you.	No additional cost to you.	No additional cost to you.
Office visit: primary care physician (PCP) (Other office services may be subject to deductible and plan coinsurance)	Deductible, then $25 copay	$15 copay	$15 copay
Office visit: specialist (Other office services may be subject to deductible and plan coinsurance)	Deductible, then $40 copay	$35 copay	Deductible, then $30 copay
Outpatient diagnostic tests (Ex. X-ray, EKG)	Deductible, then $40 copay	$35 copay	Deductible, then 5% coinsurance
Outpatient advanced diagnostic tests (Ex. MRI, CT scan)	Deductible, then $40 copay	$35 copay	Deductible, then $100 copay and 5% coinsurance
Urgent care	Deductible, then $60 copay	$55 copay	Deductible, then $50 copay and 5% coinsurance
Emergency room care (Copay waived if admitted into the hospital from the emergency room.)	Deductible, then $150 copay	$100 copay	Deductible, then $150 copay and 5% coinsurance
Hospital: inpatient admission (includes maternity, mental health / substance use)	Deductible, then $1,000 copay	$500 copay	Deductible, then $500 copay and 5% coinsurance
Hospital: outpatient surgery hospital facility (includes maternity, mental health / substance use)	Deductible, then $100 copay	$100 copay	Deductible, then 5% coinsurance
Pharmacy deductible (for tiers with deductible, cost share applies after deductible)	Tier 1, 2, 3: No deductible	Tier 1, 2, 3: No deductible	Level 1 / Level 2 Pharmacy Tier 1: No deductible Tier 2, 3: Medical deductible applies
Retail pharmacy tier 1[3]**: level 1 / level 2**	$10 copay	$10 copay	$10 copay / $20 copay
Retail pharmacy tier 2[3]**: level 1 / level 2**	$35 copay	$30 copay	$30 copay / $40 copay
Retail pharmacy tier 3[3]**: level 1 / level 2**	$70 copay	$60 copay	40% coinsurance / 50% coinsurance
Physical and occupational therapy (limits apply)	Deductible, then $30 copay	$25 copay	Deductible, then 5% coinsurance
Speech therapy (limits apply)	Deductible, then $30 copay	$25 copay	Deductible, then 5% coinsurance
Mental health / substance use: outpatient facility & services	Deductible, then $25 copay	$15 copay	Deductible, then 5% coinsurance

Please see Medical and Silver cost-share reduction plans footnotes on page 21.

Medical plans

The benefit information shown here is for in-network services received from providers in Empire's **Pathway X Enhanced** network. These plans don't include coverage for out-of-network benefits except for emergency care or urgent care as described in the Contract.

When reviewing our medical plans, keep in mind that you must meet your **full annual deductible every calendar year.** Even if you started your coverage after January 1, you pay the full annual deductible. The calendar year runs from January 1 through December 31.

	Empire HMO 7150 X, Catastrophic, ST, INN, Pediatric Dental (1H49)
Network name	Pathway X Enhanced
Plan includes out-of-network coverage?	No
Available optional riders?	NA
Individual deductible[1]	$7,150
Individual out-of-pocket limit[1]	$7,150
Coinsurance (percentage may vary for some covered services)	0%
Preventive care[2]	No additional cost to you.
Office visit: primary care physician (PCP) (Other office services may be subject to deductible and plan coinsurance)	$0 copay per visit for the first 3 visits, then deductible and 0% coinsurance
Office visit: specialist (Other office services may be subject to deductible and plan coinsurance)	Deductible, then 0% coinsurance
Outpatient diagnostic tests (Ex. X-ray, EKG)	Deductible, then 0% coinsurance
Outpatient advanced diagnostic tests (Ex. MRI, CT scan)	Deductible, then 0% coinsurance
Urgent care	Deductible, then 0% coinsurance
Emergency room care (Copay waived if admitted into the hospital from the emergency room.)	Deductible, then 0% coinsurance
Hospital: inpatient admission (includes maternity, mental health / substance use)	Deductible, then 0% coinsurance
Hospital: outpatient surgery hospital facility (includes maternity, mental health / substance use)	Deductible, then 0% coinsurance
Pharmacy deductible (for tiers with deductible, cost share applies after deductible)	Tier 1, 2, 3: Medical deductible applies
Retail pharmacy tier 1[3]**: level 1 / level 2**	0% coinsurance
Retail pharmacy tier 2[3]**: level 1 / level 2**	0% coinsurance
Retail pharmacy tier 3[3]**: level 1 / level 2**	0% coinsurance
Physical and occupational therapy (limits apply)	Deductible, then 0% coinsurance
Speech therapy (limits apply)	Deductible, then 0% coinsurance
Mental health / substance use: outpatient facility & services	Deductible, then 0% coinsurance

Please see Medical and Silver cost-share reduction plans footnotes on page 21.

Silver cost-share reduction (CSR) plans

These plans are available if you qualify for a tax credit subsidy or cost share reduction on Silver plans you buy on the NY State of Health Marketplace. Have questions? Call your Empire representative.

	Empire HMO 2000 X, Silver CSR 1, ST, INN, Pediatric Dental, Dep 25 (1H1U)	**Empire HMO 2000 X, Silver CSR 2, ST, INN, Pediatric Dental, Dep 25 (1H1X)**	**Empire HMO 2000 X, Silver CSR 3, ST, INN, Pediatric Dental, Dep 25 (1H20)**
Network name	Pathway X Enhanced	Pathway X Enhanced	Pathway X Enhanced
Plan includes out-of-network coverage?	No	No	No
Available optional riders?	Dep 29 (1H1V), Child Only (1H1W)	Dep 29 (1H1Y), Child Only (1H1Z)	Dep 29 (1H21), Child Only (1H22)
Individual deductible[1]	$1,650	$300	$0
Individual out-of-pocket limit[1]	$5,700	$2,350	$1,000
Coinsurance (percentage may vary for some covered services)	25%	10%	5%
Preventive care[2]	No additional cost to you.	No additional cost to you.	No additional cost to you.
Office visit: primary care physician (PCP) (Other office services may be subject to deductible and plan coinsurance)	Deductible, then $30 copay	Deductible, then $15 copay	$10 copay
Office visit: specialist (Other office services may be subject to deductible and plan coinsurance)	Deductible, then $50 copay	Deductible, then $35 copay	$20 copay
Outpatient diagnostic tests (Ex. X-ray, EKG)	Deductible, then $50 copay	Deductible, then $35 copay	$20 copay
Outpatient advanced diagnostic tests (Ex. MRI, CT scan)	Deductible, then $50 copay	Deductible, then $35 copay	$20 copay
Urgent care	Deductible, then $70 copay	Deductible, then $50 copay	$30 copay
Emergency room care (Copay waived if admitted into the hospital from the emergency room.)	Deductible, then $250 copay	Deductible, then $75 copay	$50 copay
Hospital: inpatient admission (includes maternity, mental health / substance use)	Deductible, then $1,500 copay	Deductible, then $250 copay	$100 copay
Hospital: outpatient surgery hospital facility (includes maternity, mental health / substance use)	Deductible, then $100 copay	Deductible, then $75 copay	$25 copay
Pharmacy deductible (for tiers with deductible, cost share applies after deductible)	Tier 1, 2, 3: No deductible	Tier 1, 2, 3: No deductible	Tier 1, 2, 3: No deductible
Retail pharmacy tier 1[3]**: level 1 / level 2**	$10 copay	$9 copay	$6 copay
Retail pharmacy tier 2[3]**: level 1 / level 2**	$35 copay	$20 copay	$15 copay
Retail pharmacy tier 3[3]**: level 1 / level 2**	$70 copay	$40 copay	$30 copay
Physical and occupational therapy (limits apply)	Deductible, then $30 copay	Deductible, then $25 copay	$15 copay
Speech therapy (limits apply)	Deductible, then $30 copay	Deductible, then $25 copay	$15 copay
Mental health / substance use: outpatient facility & services	Deductible, then $30 copay	Deductible, then $15 copay	$10 copay

Please see Medical and Silver cost-share reduction plans footnotes on page 21.

Silver cost-share reduction (CSR) plans

These plans are available if you qualify for a tax credit subsidy or cost share reduction on Silver plans you buy on the NY State of Health Marketplace. Have questions? Call your Empire representative.

	Empire HMO 2250 X, Silver CSR 1, NS, INN, Pediatric Dental, Dep 25 (1H2P)	**Empire HMO 2250 X, Silver CSR 2, NS, INN, Pediatric Dental, Dep 25 (1H2R)**	**Empire HMO 2250 X, Silver CSR 3, NS, INN, Pediatric Dental, Dep 25 (1H2T)**
Network name	Pathway X Enhanced	Pathway X Enhanced	Pathway X Enhanced
Plan includes out-of-network coverage?	No	No	No
Available optional riders?	Dep 29 (1H2Q)	Dep 29 (1H2S)	Dep 29 (1H2U)
Individual deductible[1]	$2,100	$450	$0
Individual out-of-pocket limit[1]	$5,700	$2,350	$1,450
Coinsurance (percentage may vary for some covered services)	20%	15%	10%
Preventive care[2]	No additional cost to you.	No additional cost to you.	No additional cost to you.
Office visit: primary care physician (PCP) (Other office services may be subject to deductible and plan coinsurance)	$0 copay per visit for the first 5 visits, then deductible and 20% coinsurance	$0 copay per visit for the first 5 visits, then deductible and 15% coinsurance	$0 copay per visit for the first 5 visits, then 10% coinsurance
Office visit: specialist (Other office services may be subject to deductible and plan coinsurance)	Deductible, then $50 copay and 20% coinsurance	Deductible, then $25 copay and 15% coinsurance	$15 copay, then 10% coinsurance
Outpatient diagnostic tests (Ex. X-ray, EKG)	Deductible, then 20% coinsurance	Deductible, then 15% coinsurance	10% coinsurance
Outpatient advanced diagnostic tests (Ex. MRI, CT scan)	Deductible, then 20% coinsurance and $100 copay	Deductible, then 15% coinsurance	10% coinsurance
Urgent care	Deductible, then $50 copay and 20% coinsurance	Deductible, then $30 copay and 15% coinsurance	$25 copay, then 10% coinsurance
Emergency room care (Copay waived if admitted into the hospital from the emergency room.)	Deductible, then $200 copay and 20% coinsurance	Deductible, then $100 copay and 15% coinsurance	$50 copay, then 10% coinsurance
Hospital: inpatient admission (includes maternity, mental health / substance use)	Deductible, then $1,500 copay and 20% coinsurance	Deductible, then $250 copay and 15% coinsurance	$100 copay, then 10% coinsurance
Hospital: outpatient surgery hospital facility (includes maternity, mental health / substance use)	Deductible, then $100 copay and 20% coinsurance	Deductible, then 15% coinsurance	10% coinsurance
Pharmacy deductible (for tiers with deductible, cost share applies after deductible)	Level 1 / Level 2 Pharmacy Tier 1, 2, 3: Medical deductible applies	Level 1 / Level 2 Pharmacy Tier 1, 2, 3: Medical deductible applies	Level 1 / Level 2 Pharmacy Tier 1, 2, 3: Medical deductible applies
Retail pharmacy tier 1[3]**: level 1 / level 2**	$5 copay / $10 copay	$5 copay / $10 copay	$5 copay / $10 copay
Retail pharmacy tier 2[3]**: level 1 / level 2**	$20 copay / $40 copay	$20 copay / $40 copay	$15 copay / $30 copay
Retail pharmacy tier 3[3]**: level 1 / level 2**	40% coinsurance / 50% coinsurance	30% coinsurance / 40% coinsurance	30% coinsurance / 40% coinsurance
Physical and occupational therapy (limits apply)	Deductible, then 20% coinsurance	Deductible, then 15% coinsurance	10% coinsurance
Speech therapy (limits apply)	Deductible, then 20% coinsurance	Deductible, then 15% coinsurance	10% coinsurance
Mental health / substance use: outpatient facility & services	Deductible, then 20% coinsurance	Deductible, then 15% coinsurance	10% coinsurance

Please see Medical and Silver cost-share reduction plans footnotes on page 21.

Silver cost-share reduction (CSR) plans

These plans are available if you qualify for a tax credit subsidy or cost share reduction on Silver plans you buy on the NY State of Health Marketplace. Have questions? Call your Empire representative.

	Empire BlueCross BlueShield HMO 2800 X, Silver CSR 1, NS, INN, Pediatric Dental, Dep 25, a Multi-State Plan (2828)	**Empire BlueCross BlueShield HMO 2800 X, Silver CSR 2, NS, INN, Pediatric Dental, Dep 25, a Multi-State Plan (1H0U)**	**Empire BlueCross BlueShield HMO 2800 X, Silver CSR 3, NS, INN, Pediatric Dental, Dep 25, a Multi-State Plan (1H0W)**
Network name	Pathway X Enhanced	Pathway X Enhanced	Pathway X Enhanced
Plan includes out-of-network coverage?	No	No	No
Available optional riders?	Dep 29 (2829)	Dep 29 (1H0V)	Dep 29 (1H0X)
Individual deductible[1]	$2,400	$1,200	$475
Individual out-of-pocket limit[1]	$4,500	$1,200	$475
Coinsurance (percentage may vary for some covered services)	15%	0%	0%
Preventive care[2]	No additional cost to you.	No additional cost to you.	No additional cost to you.
Office visit: primary care physician (PCP) (Other office services may be subject to deductible and plan coinsurance)	Deductible, then 15% coinsurance	Deductible, then 0% coinsurance	Deductible, then 0% coinsurance
Office visit: specialist (Other office services may be subject to deductible and plan coinsurance)	Deductible, then $30 copay and 15% coinsurance	Deductible, then 0% coinsurance	Deductible, then 0% coinsurance
Outpatient diagnostic tests (Ex. X-ray, EKG)	Deductible, then 15% coinsurance	Deductible, then 0% coinsurance	Deductible, then 0% coinsurance
Outpatient advanced diagnostic tests (Ex. MRI, CT scan)	Deductible, then $100 copay and 15% coinsurance	Deductible, then 0% coinsurance	Deductible, then 0% coinsurance
Urgent care	Deductible, then $50 copay and 15% coinsurance	Deductible, then 0% coinsurance	Deductible, then 0% coinsurance
Emergency room care (Copay waived if admitted into the hospital from the emergency room.)	Deductible, then $500 copay and 15% coinsurance	Deductible, then 0% coinsurance	Deductible, then 0% coinsurance
Hospital: inpatient admission (includes maternity, mental health / substance use)	Deductible, then $500 copay and 50% coinsurance	Deductible, then 0% coinsurance	Deductible, then 0% coinsurance
Hospital: outpatient surgery hospital facility (includes maternity, mental health / substance use)	Deductible, then 15% coinsurance	Deductible, then 0% coinsurance	Deductible, then 0% coinsurance
Pharmacy deductible (for tiers with deductible, cost share applies after deductible)	Level 1 / Level 2 Pharmacy Tier 1, 2, 3: Medical deductible applies	Tier 1, 2, 3: Medical deductible applies	Tier 1, 2, 3: Medical deductible applies
Retail pharmacy tier 1[3]**: level 1 / level 2**	10% coinsurance / 15% coinsurance	0% coinsurance	0% coinsurance
Retail pharmacy tier 2[3]**: level 1 / level 2**	10% coinsurance / 15% coinsurance	0% coinsurance	0% coinsurance
Retail pharmacy tier 3[3]**: level 1 / level 2**	40% coinsurance / 50% coinsurance	0% coinsurance	0% coinsurance
Physical and occupational therapy (limits apply)	Deductible, then 15% coinsurance	Deductible, then 0% coinsurance	Deductible, then 0% coinsurance
Speech therapy (limits apply)	Deductible, then 15% coinsurance	Deductible, then 0% coinsurance	Deductible, then 0% coinsurance
Mental health / substance use: outpatient facility & services	Deductible, then 15% coinsurance	Deductible, then 0% coinsurance	Deductible, then 0% coinsurance

Please see Medical and Silver cost-share reduction plans footnotes on page 21.

Silver cost-share reduction (CSR) plans

These plans are available if you qualify for a tax credit subsidy or cost share reduction on Silver plans you buy on the NY State of Health Marketplace. Have questions? Call your Empire representative.

	Empire HMO 5250 X, Silver CSR 1, NS, INN, Pediatric Dental, Dep 25 (2EBA)	**Empire HMO 5250 X, Silver CSR 2, NS, INN, Pediatric Dental, Dep 25 (2EBB)**	**Empire HMO 5250 X, Silver CSR 3, NS, INN, Pediatric Dental, Dep 25 (2EBC)**
Network name	Pathway X Enhanced	Pathway X Enhanced	Pathway X Enhanced
Plan includes out-of-network coverage?	No	No	No
Available optional riders?	Dep 29 (2EBE)	Dep 29 (2EBF)	Dep 29 (2EBG)
Individual deductible[1]	$3,700	$900	$150
Individual out-of-pocket limit[1]	$5,200	$1,800	$750
Coinsurance (percentage may vary for some covered services)	25%	25%	25%
Preventive care[2]	No additional cost to you.	No additional cost to you.	No additional cost to you.
Office visit: primary care physician (PCP) (Other office services may be subject to deductible and plan coinsurance)	$30 copay	$25 copay	$15 copay
Office visit: specialist (Other office services may be subject to deductible and plan coinsurance)	Deductible, then 25% coinsurance	Deductible, then 25% coinsurance	Deductible, then 25% coinsurance
Outpatient diagnostic tests (Ex. X-ray, EKG)	Deductible, then 25% coinsurance	Deductible, then 25% coinsurance	Deductible, then 25% coinsurance
Outpatient advanced diagnostic tests (Ex. MRI, CT scan)	Deductible, then 25% coinsurance	Deductible, then 25% coinsurance	Deductible, then 25% coinsurance
Urgent care	Deductible, then $50 copay	Deductible, then $50 copay	Deductible, then $50 copay
Emergency room care (Copay waived if admitted into the hospital from the emergency room.)	Deductible, then 25% coinsurance	Deductible, then 25% coinsurance	Deductible, then 25% coinsurance
Hospital: inpatient admission (includes maternity, mental health / substance use)	Deductible, then 25% coinsurance	Deductible, then 25% coinsurance	Deductible, then 25% coinsurance
Hospital: outpatient surgery hospital facility (includes maternity, mental health / substance use)	Deductible, then 25% coinsurance	Deductible, then 25% coinsurance	Deductible, then 25% coinsurance
Pharmacy deductible (for tiers with deductible, cost share applies after deductible)	Level 1 / Level 2 Pharmacy Tier 1, 2: No deductible Tier 3: Medical deductible applies	Level 1 / Level 2 Pharmacy Tier 1, 2: No deductible Tier 3: Medical deductible applies	Level 1 / Level 2 Pharmacy Tier 1, 2: No deductible Tier 3: Medical deductible applies
Retail pharmacy tier 1[3]**: level 1 / level 2**	$5 copay / $20 copay	$5 copay / $20 copay	$5 copay / $20 copay
Retail pharmacy tier 2[3]**: level 1 / level 2**	$40 copay / $50 copay	$30 copay / $40 copay	$30 copay / $40 copay
Retail pharmacy tier 3[3]**: level 1 / level 2**	35% coinsurance / 50% coinsurance	35% coinsurance / 50% coinsurance	35% coinsurance / 50% coinsurance
Physical and occupational therapy (limits apply)	Deductible, then 25% coinsurance	Deductible, then 25% coinsurance	Deductible, then 25% coinsurance
Speech therapy (limits apply)	Deductible, then 25% coinsurance	Deductible, then 25% coinsurance	Deductible, then 25% coinsurance
Mental health / substance use: outpatient facility & services	Deductible, then 25% coinsurance	Deductible, then 25% coinsurance	Deductible, then 25% coinsurance

Please see Medical and Silver cost-share reduction plans footnotes on page 21.

Medical and Silver cost-share reduction plans benefit footnotes

1 The family **deductible** for the following plans is three (3) times the individual deductible: Empire HMO 2250 X, Silver CSR 1, NS, INN, Pediatric Dental, Dep 25 (1H2P), Empire HMO 2250 X, Silver CSR 2, NS, INN, Pediatric Dental, Dep 25 (1H2R), Empire HMO 2250 X, Silver, NS, INN, Pediatric Dental, Dep 25 (1H2M), Empire BlueCross BlueShield HMO 1000 X, Gold, NS, INN, Pediatric Dental, Dep 25, a Multi-State Plan (1H0Y), Empire HMO 1000 X, Gold, NS, INN, Pediatric Dental, Dep 25 (1H3C) and Empire HMO 300 X, Platinum, NS, INN, Pediatric Dental, Dep 25 (1H44). The family **out-of-pocket limit** for the following plan is three (3) times the individual out-of-pocket limit: Empire HMO 300 X, Platinum, NS, INN, Pediatric Dental, Dep 25 (1H44).
2 Nationally recommended **preventive care services** from in-network providers have no copay, no coinsurance and no deductible requirement. Preventive and wellness services consist of certain services, including well-child care, immunizations, prostate-specific antigen (PSA) screenings, Pap tests, mammograms and more, provided in accordance with the comprehensive guidelines supported by the Health Resources and Services Administration, or if the items or services have an “A” or “B” rating from the U.S. Preventive Services Task Force, or if the immunizations are recommended by the Advisory Committee on Immunization Practices.
3 **Home delivery pharmacy** cost shares for all plans containing “**NS**” in the plan name are 2.5 times the retail copay for Tier 1 drugs and 3 times the retail copy for Tier 2 and Tier 3 drugs when the plan has retail pharmacy copays. **Home delivery pharmacy** cost shares for all plans containing “**ST**” in the plan name are 2.5 times the retail copay for Tier 1, Tier 2 and Tier 3 drugs when the plan has retail pharmacy copays. Cost savings don't apply to coinsurance plans.

NOTE: Multi-State Plans are overseen by the U.S. Office of Personnel Management (OPM) and are similar to the other Qualified Health Plan products offered on the Marketplace. Generally, all of the same requirements that apply to other products also apply to these Multi-State Plan products. The name “Multi-State Plan” does NOT mean that consumers have health plan coverage for non-urgent care in multiple states.

Dental

We offer a variety of individual and family dental plans to fit your health care needs and budget:

- Empire Dental Family Value
- Empire Dental Family
- Empire Dental Family Enhanced

Empire can help you get access to the dental care you need for your overall health. Many of our dental plans cover you 100% for exams, cleanings and X-rays. Plus, we have one of the largest dental preferred provider organization (PPO) networks in the country. To see more of what we cover, take a look at the **Dental stand-alone plans** on the next page.

Tools that put a smile on your face

We offer some great online tools to help you better understand your dental health. Once you're a member, log in to the web address on your ID card to access:

Ask a Hygienist

Email questions to licensed dental professionals and get quick, private personalized advice at no extra cost.

Dental Cost Estimator

Help estimate your costs for certain dental procedures and services in the ZIP code where you get care.

Dental Health Assessment

Get feedback based on your unique responses to a few questions to help you keep a healthy smile.

The medical + dental advantage

Coordinating medical and dental plans can result in better care – delivered sooner and at a lower cost. Plus, you enjoy the convenience of having only one ID card and one bill when you purchase all your coverage from Empire.

Dental stand-alone plans

	Empire Dental Family Value (Dependents age 18 and younger)	**Empire Dental Family Value** (Adults age 19+)	**Empire Dental Family** (Dependents age 18 and younger)	**Empire Dental Family** (Adults age 19+)	**Empire Dental Family Enhanced** (Dependents age 18 and younger)	**Empire Dental Family Enhanced** (Adults age 19+)
	In-network / Out-of-network	**In-network / Out-of-network**	**In-network / Out-of-network**	**In-network / Out-of-network**	**In-network / Out-of-network**	**In-network / Out-of-network**
Dental network	Dental Prime	Dental Prime	Dental Prime	Dental Prime	Dental Prime	Dental Prime
Deductible (per person, all services)	$25	$50	$25	$50	None	$50
Annual Maximum (per person)	None	$750	None	$750	None	$1,000
Annual out-of-pocket limit	$350[1] / None	None	$350[1] / None	None	$350[1] / None	None
Pediatric benefits	No waiting period	n/a	No waiting period	n/a	No waiting period	n/a
Emergency dental care	0% / 0% coinsurance	n/a	0% / 0% coinsurance	n/a	0% / 0% coinsurance	n/a
Preventive dental care	25% / 25% coinsurance	n/a	25% / 25% coinsurance	n/a	0% / 0% coinsurance	n/a
Routine dental care	25% / 25% coinsurance	n/a	25% / 25% coinsurance	n/a	20% / 20% coinsurance	n/a
Endodontic and prosthodontic services	50% / 50% coinsurance	n/a	50% / 50% coinsurance	n/a	20% / 20% coinsurance	n/a
Medically necessary orthodontia	50% / 50% coinsurance	n/a	50% / 50% coinsurance	n/a	50% / 50% coinsurance	n/a
Diagnostic and preventive	No waiting period	No waiting period	No waiting period	No waiting period	No waiting period	No waiting period
Cleaning, exams and x-rays	n/a	0% / 50% coinsurance	n/a	0% / 50% coinsurance	n/a	0% / 50% coinsurance
Extra cleaning	n/a	Not covered	n/a	Not covered	n/a	Not covered
Basic services	n/a	6-month waiting period	n/a	6-month waiting period	n/a	6-month waiting period
Fillings	n/a	50% / 50% coinsurance	n/a	50% / 50% coinsurance	n/a	20% / 50% coinsurance
Brush biopsy	n/a	Covered	n/a	Covered	n/a	Covered
Complex & major services	n/a	Not covered	n/a	12-month waiting period	n/a	12-month waiting period
Endodontic/periodontic/oral surgery	n/a	Not covered	n/a	50% / 50% coinsurance	n/a	50% / 50% coinsurance
Major restorative and prosthodontic	n/a	Not covered	n/a	50% / 50% coinsurance	n/a	50% / 50% coinsurance
Cosmetic orthodontia	Not covered	Not covered	Not covered	Not covered	50% / 50% coinsurance[2]	Not covered
International emergency dental program	Included	Included	Included	Included	Included	Included

Note: This is only a brief description of some plan benefits. Please refer to the Contract for more complete details including benefits, limitations and exclusions.

Please see Dental stand-alone plans footnotes on page 24.

Dental stand-alone plans footnotes

1 Per child, up to $700 per family.

2 $1,000 lifetime maximum and 12-month waiting period for **Cosmetic orthodontia**.

Our plans' built-in extras

At Empire, we want to be more than your health benefits plan — we want to help you meet your day-to-day health and wellness goals. That's why we offer a variety of programs, discounts and tools to support you being your healthy best.

Health and wellness resources

Whether you're looking for one-on-one coaching or pregnancy support, we're here to give you the guidance you need, when you need it — at no extra cost. **Here's how:**

24/7 Nurseline — is staffed with registered nurses who are just a phone call away at any time. Nurses can answer questions about a medical concern or help you choose the right level of care. Plus, you can call the same phone line and listen to hundreds of health topics in the AudioHealth Library.

Care Support — gives you the extra care and support you need for your ongoing or complex health issues. A case manager may call you to see how we can help keep your condition in check and give you information as well as emotional support services.

And don't forget about those regular checkups! Your yearly exams, flu shots and other preventive care services are covered 100% when you visit in-network providers. These services can give you extra support in managing your health or a specific health condition.

MyHealth Advantage — helps keep you healthier. We review your incoming health claims and remind you if you've missed a routine test or checkup. We also check the medications you take in the event your doctor needs to be alerted of possible drug interactions or if you could save money. If we find something that can help you, we'll mail you a confidential MyHealth Note. Or, download the Empire Anywhere app and choose to receive your personalized, secure health messages on-the-go through the Mobile Inbox.

SpecialOffers℠

SpecialOffers℠ (SpecialOffers) is our member discount program for health- and wellness-related products and services.

Through the program, members can enjoy discounts on:

- Vitamins
- Health and beauty products
- Massage therapy
- LASIK eye surgery
- Eyeglass frames and contact lenses
- Hearing aids and services
- Jenny Craig® and Weight Watchers® weight-loss programs*
- Smoking cessation programs

To view all our SpecialOffers discounts, log in to **empireblue.com** and select **Discounts**.

* WEIGHT WATCHERS and PointsPlus are the registered trademarks of Weight Watchers International, Inc. Trademarks used under license by WeightWatchers.com, Inc.

Gym Membership Reimbursement program

When it comes to your health, regular exercise is key. To help you get moving, we reimburse you and your covered spouse or domestic partner for joining a gym. Here's how the Gym Membership Reimbursement program works:

- You must be an active member of one of our recognized facilities.
- We pay for part of your membership cost when you complete 50 visits in a six-month period.
- The facility must keep equipment and programs that promote heart health.
- Reimbursement is either $200 for you and $100 for your covered spouse or domestic partner, or the actual cost of the membership per six-month period — whichever is less.

Enhanced Personal Health Care

Enhanced Personal Health Care (EHPC) is a kind of doctor-patient relationship created just for Empire members!

We put members in a circle of care, making them the central focus of a team approach to their overall health.

Enhanced Personal Health Care — a program that:

- Aims to improve your patient experience with access to a primary care doctor who cares for the "whole person" and becomes your health care champion and helps you navigate the health care system.
- Gives doctors added support with the right tools and strategies to help strengthen your doctor-patient relationship, so doctors can spend more time with you and coordinate your care with other doctors.

To find out if your primary care doctor is in the EPHC program, go to **empireblue.com/findadoctor**. If your doctor is in the program, you'll see Quality Snapshot within the doctor's listing and the EPHC designation (a heart symbol with a plus sign) under Other Certifications.

Together, you and your doctor work to make the right choices for your health care.

Online Tools

From our website and mobile app to cost and quality comparison tools, we want to make sure you have the information you need to make informed health care decisions for you and your family.

Our secure website:

- Get a breakdown of what is and isn't covered by your plan through a benefit summary.
- See your recent claims and coverage details.
- Pay your premium online.
- Estimate your costs before having certain procedures.
- Manage your prescription benefits and search the drug list that applies to your benefit plan.

Our Empire Anywhere app:


Find a doctor, hospital or pharmacy


Get a virtual ID card


Compare doctor costs and quality


Manage prescription benefits


View claims

Cost and quality information with Estimate Your Cost

With our Estimate Your Cost tool, you can save time and money by comparing the cost of common procedures at health care facilities in your area. You'll also get to see the quality and safety ratings for those facilities.

* LiveHealth Online is the trade name of the Health Management Corporation.
† Appointments subject to availability of a therapist. Psychologists or therapists using LiveHealth Online cannot prescribe medications.
‡ Depending on your coverage, the cost may be similar to what you would pay for an office visit, considering your benefits, copay or coinsurance.

LiveHealth® ONLINE

Now you can have a private video visit with a doctor or therapist on your smartphone, tablet or computer. LiveHealth Online* is an easy and convenient way to get the care you need from the comfort and privacy of home.

All you have to do is sign up at **livehealthonline.com** to use it!

- Get medical advice, diagnoses, proper treatment and even prescriptions, 24/7 in about 10 minutes or less
- Quickly address common health problems, like allergies, colds, rashes, fever and more

Now, you can talk to a licensed therapist or psychologist at home. If you're feeling stressed, worried or having a tough time, we're here to help.

- See a therapist in four days or less†
- Choose a time that's convenient for you - seven days a week from 7 a.m. to 11 p.m.

Doctors typically charge $49 or less per visit and therapists usually cost the same as what you'd pay for an office therapy visit, depending on your medical plan.‡

Register at empireblue.com for online access.

Once you're a member, register at **empireblue.com** to access your benefits online. And don't forget to download the **Empire Anywhere** mobile app, so you can manage your benefits at home or on the go.

Ready to enroll? Let's get started.

If you're ready to take the next step and enroll, we're here to help you.

To get started, you'll need to have the following information handy:

1. **Employer and income details** (for example, pay stubs and W-2 forms) for every member of your household who needs coverage
2. **Policy numbers and insurer names** for any current health insurance plans covering members of your household
3. **Name of every job-based health insurance plan** for which you or someone in your household is eligible

Then, you can:

4. **Call your Empire representative** to enroll or learn more about our health care plans; or
5. **Visit our website** at empireblue.com; or
6. **Find our plans** on the NY State of Health Marketplace at nystateofhealth.ny.gov.

Generally, plans can be purchased once a year through an open enrollment period. For 2017, the open enrollment period runs from November 1, 2016 through January 31, 2017. Be sure to enroll by December 15, 2016, to start coverage effective January 1, 2017.

There are special qualifying events that may allow you to change your health coverage outside of the open enrollment period. Check with your Empire representative to see if you qualify or if you have other questions about open enrollment.

Your Empire representative can help you enroll.

Simplified payments

You can set up a recurring payment using electronic funds transfer (EFT) or bank draft, which means your premium will automatically be paid from your bank account each month.

You can also use WebPay to make your monthly payments. This payment program allows you to enroll in automatic recurring payments with a Visa or MasterCard debit or credit card.

If you choose to make regular credit card payments, make sure your card's expiration date and other account information stays up to date.

We want you to be satisfied

When you enroll in one of our plans, you'll have access to a *Contract and Schedule of Benefits* that explains the terms and conditions of coverage, including exclusions and limitations. You'll have 10 days to examine your *Contract's* features. If you change your mind during that time, you may cancel your coverage and your premium will be refunded, minus any claims that were already paid.

This document does not contain all terms about our covered benefits and services. Our plans have exclusions, limitations and terms under which the *Contract* may be continued in force or discontinued. For more complete details on what's covered and what isn't:

- Review the *Contract and Schedule of Benefits*.
- Call your Empire representative.
- Go to **empireblue.com**.
- Check the provider network and prescription drug list to see if your doctor and prescription drugs are listed.

To access a ***Summary of Benefits and Coverage (SBC)***, please visit **sbc.empireblue.com** and select **Member**.

Empire HealthChoice HMO, Inc., dba Empire BlueCross BlueShield, is a Qualified Health Plan issuer that offers individual health plans through the NY State of Health Marketplace.

In compliance with the ACA, the following plan changes may occur annually on January 1:

- Benefits
- Premiums
- Deductibles, copays, coinsurance and out-of-pocket limits

There may also be changes to our prescription formulary/drug list, and pharmacy and provider networks during the year.

Still have questions?

Please reach out to your Empire representative. We know there's a great plan out there just for you!

Important information

Before choosing a health benefit plan, please review the following information along with the other materials enclosed.

Who is Covered Under the Contract

The subscriber to whom the Contract is issued, is covered under the Contract. The subscriber must live or reside in Empire's service area to be covered under the Contract. If you are eligible for Medicare, you are not eligible to purchase a Contract. Members of your family may also be covered depending on the type of coverage you select.

NOTE: In order to be eligible for a **catastrophic** plan, you must also be:

- Under the age of 30 at the beginning of the plan year; or
- Exempt from the individual mandate because you cannot afford minimum essential coverage or are eligible for a hardship exception.

If you select one of the following types of coverage, members of your family may also be covered on a catastrophic plan if the family member is:

- Under the age of 30 at the beginning of the plan year; or
- Exempt from the individual mandate because you cannot afford minimum essential coverage or are eligible for a hardship exception.

Types of Coverage

In addition to individual coverage, Empire offers the following types of coverage:

- Individual and spouse - If you select individual and spouse coverage, then you and your spouse will be covered.
- Parent and Child/Children – If you select parent and child/children coverage, then you and your child or children, as described below, will be covered.
- Family – If you select family coverage, then you, your spouse and your children, as described below, will be covered.

Open Enrollment

You can enroll during the annual open enrollment period that runs from November 1, 2016 through January 31, 2017. If the NY State of Health Marketplace receives your selection on or before December 15, 2016, your coverage will begin on January 1, 2017, as long as the applicable premium payment is received by then. If the NY State of Health Marketplace receives your selection between December 16, 2016, through January 15, 2017, your coverage will begin on February 1, 2017, as long as the applicable premium payment is received by then. If the NY State of Health Marketplace receives your selection between January 16, 2017, through January 31, 2017, your coverage will begin on March 1, 2017, as long as the applicable premium payment is received by then.

If you don't enroll during open enrollment or during a special enrollment period as described below, you must wait until the next annual open enrollment period to enroll.

Special Enrollment Periods

Outside of the annual open enrollment period, you, your spouse, or child, can enroll for coverage within 60 days prior to or after the occurrence of one of the following events:

1. You, your spouse or child involuntarily loses minimum essential coverage, including COBRA or state continuation coverage; including if you are enrolled in a non-calendar year group health plan or individual health insurance coverage, even if you have the option to renew the coverage;
2. You, your spouse or child are determined newly eligible for advance payments of the premium tax credit because the coverage you are enrolled in will no longer be employer-sponsored minimum essential coverage, including as a result of your employer discontinuing or changing available coverage within the next 60 days, provided that you are allowed to terminate existing coverage;
3. You, your spouse or child loses eligibility for Medicaid coverage, including Medicaid coverage for pregnancy-related services and Medicaid coverage for the medically needy, but not including other Medicaid programs that don't provide coverage for primary and specialty care; or
4. You, your spouse or child move and become eligible for new qualified health plans because of a permanent move and you, your spouse or child either had minimum essential coverage for one (1) or more days during the 60 days before the move or were living outside the United States or a United States territory at the time of the move.

Outside of the annual open enrollment period, you, your spouse, or child can enroll for coverage within 60 days after the occurrence of one of the following events:

1. You, your spouse or child's enrollment or non-enrollment in another qualified health plan was unintentional, inadvertent or erroneous and was the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the NY State of Health Marketplace as evaluated and determined by the NY State of Health Marketplace;
2. You, your spouse or child adequately demonstrate to the NY State of Health Marketplacethat another qualified health plan in which you were enrolled substantially violated a material provision of its contract;
3. You gain a dependent or become a dependent through marriage, birth, adoption or placement for adoption or foster care, however, foster children are not covered under the Contract;
4. You lose a dependent or are no longer considered a dependent through divorce, legal separation, or upon the death of you or your dependents;
5. If you are an Indian, as defined in 25 U.S.C. 450b(d), you may enroll in a qualified health plan or change from one qualified health plan to another one time per month;
6. You, your spouse or child demonstrate to the NY State of Health Marketplace that you meet other exceptional circumstances as the NY State of Health Marketplace may provide;
7. You, your spouse or child were not previously a citizen, national, or lawfully present individual and you gain such status;
8. You, your spouse or child are determined newly eligible or newly ineligible for advance payments of the premium tax credit or have a change in eligibility for cost-sharing reductions.

The NY State of Health Marketplace must receive notice and Empire must receive premium payment within 60 days of one of these events.

If you, your spouse or child enroll because you are losing minimum essential coverage within the next 60 days, you are are determined newly eligible for advance payments of the premium tax credit because the coverage you are enrolled in will no longer be employer-sponsored

minimum essential coverage; or you gain access to new qualified health plans because you are moving and your selection is made on or before the triggering event, then your coverage will begin on the first day of the month following your loss of coverage.

If you, your spouse or child enroll because you got married, your coverage will begin on the first day of the month following your selection of coverage. If you, your spouse or child enroll because you gain a dependent through adoption or placement for adoption, your coverage will begin on the date of the adoption or placement for adoption. If you, your spouse or child enroll because of a court order, your coverage will begin on the date the court order is effective.

If you have a newborn or adopted newborn child and the NY State of Health Marketplace receives notice of such birth within 60 days thereafter, coverage for your newborn starts at the moment of birth; otherwise coverage begins on the date on which the NY State of Health Marketplace receives notice. Your adopted newborn child will be covered from the moment of birth if you take physical custody of the infant as soon as the infant is released from the hospital after birth and you file a petition pursuant to section 115-c of the New York Domestic Relations Law within 60 days of the infant's birth; and provided further that no notice of revocation to the adoption has been filed pursuant to section 115-b of the New York Domestic Relations Law, and consent to the adoption has not been revoked. However, Empire will not provide hospital benefits for the adopted newborn's initial hospital stay if one of the infant's natural parents has coverage for the newborn's initial hospital stay. If you have individual or individual and spouse coverage, you must also notify the NY State of Health Marketplace of your desire to switch to parent and child/children or family coverage and pay any additional premium within 60 days of the birth or adoption in order for coverage to start at the moment of birth. Otherwise, coverage begins on the date on which the NY State of Health Marketplace receives notice and Empire receives the premium payment.

Advance payments of any premium tax credit and cost-sharing reductions are not effective until the first day of the following month, unless the birth, adoption, or placement for adoption occurs on the first day of the month.

In all other cases, the effective date of your coverage will depend on when the NY State of Health Marketplace receives your selection. If your selection is received between the first and fifteenth day of the month, your coverage will begin on the first day of the following month, as long as your applicable premium payment is received by then. If your selection is received between the sixteenth day and the last day of the month, your coverage will begin on the first day of the second month, as long as your applicable premium payment is received by then.

Grievances

Our grievance procedure applies to any issue not relating to a medical necessity or experimental or investigational determination by us. For example, it applies to contractual benefit denials or issues or concerns you have regarding our administrative policies or access to providers.

Filing a Grievance. You can contact us by phone at the number on your ID card or in writing to file a grievance. You may submit an oral grievance in connection with a denial of a referral or a covered benefit determination. You or your designee has up to 180 calendar days from when you received the decision you are asking us to review to file the grievance.

When we receive your grievance, we will mail an acknowledgement letter within 15 business days. The acknowledgement letter will include the name, address, and telephone number of the person handling your grievance, and indicate what additional information, if any, must be provided.

We keep all requests and discussions confidential and we will take no discriminatory action because of your issue. We have a process for both standard and expedited grievances, depending on the nature of your inquiry. See the Contract for further details.

Requesting Approval for Benefits

Utilization Review

We review health services to determine whether the services are or were medically necessary or experimental or investigational ("medically necessary"). This process is called Utilization Review (UR). Utilization Review includes all review activities, whether they take place prior to the service being performed (Preauthorization); when the service is being performed (Concurrent); or after the service is performed (Post-service).

All determinations that services are not medically necessary will be made by 1) licensed physicians or 2) licensed, certified, registered or credentialed health care professionals who are in the same profession and same or similar specialty as the provider who typically manages your medical condition or disease or provides the health care service under review or 3) with respect to substance use disorder treatment, licensed physicians or licensed, certified, registered or credentialed health care professionals who specialize in behavioral health and have experience in the delivery of substance use disorder courses of treatment. We don't compensate or provide financial incentives to our employees or reviewers for determining that services are not or were not medically necessary. We have developed guidelines and protocols to assist us in this process. Specific guidelines and protocols are available for your review upon request. For more information, you can contact Member Services or visit empireblue.com.

Preauthorization Reviews

If Empire has all the information necessary to make a determination regarding a preauthorization review, we will make a determination and provide notice to you (or your designee) and your provider, by telephone and in writing, within three (3) business days of receipt of the request.

If Empire needs additional information, we will request it within three (3) business days. You or your provider will then have 45 calendar days to submit the information. If we receive the requested information within 45 days, we will make a determination and provide notice to you (or your designee) and your provider, by telephone and in writing, within three business days of our receipt of the information. If all necessary information is not received within 45 days, we will make a determination within 15 calendar days of the end of the 45-day period.

Urgent Preauthorization Reviews. With respect to urgent Preauthorization requests, if Empire has all information necessary to make a determination, we will make a determination and provide notice to you (or your designee) and your provider, by telephone, within 72 hours of receipt of the request. Written notice will be provided within three (3) business days of receipt of the request. If we need additional information, we will request it within 24 hours. You or your provider will then have 48 hours to submit the information. Empire will make a determination and provide notice to you and your provider by telephone and in writing within 48 hours of the earlier of our receipt of the information or the end of the 48-hour time period.

Concurrent Reviews

Utilization review decisions for services during the course of care (concurrent reviews) will be made, and notice provided to you (or your designee) and your provider, by telephone and

in writing, within one (1) business day of receipt of all necessary information. If Empire needs additional information, we will request it within one (1) business day. You or your provider will then have 45 calendar days to submit the information. Empire will make a determination and provide notice to you (or your designee) and your provider, by telephone and in writing, within one (1) business day of our receipt of the information or, if we don't receive the information, within 15 calendar days of the end of the 45-day time period.

Urgent Concurrent Reviews. For concurrent reviews that involve an extension of urgent care, if the request for coverage is made at least 24 hours prior to the expiration of a previously approved treatment, we will make a determination and provide notice to you and your provider by telephone within 24 hours of receipt of the request. Written notice will be provided within one (1) business day of receipt of the request.

If the request for coverage is not made at least 24 hours prior to the expiration of a previously approved treatment, and Empire has all the information necessary to make a determination, Empire will make a determination and provide written notice to you (or your designee) and your provider within the earlier of 72 hours or one (1) business day of receipt of the request. If Empire needs additional information, we will request it within 24 hours. You or your provider will then have 48 hours to submit the information. Empire will make a determination and provide written notice to you (or your designee) and your provider within the earlier of one (1) business day or 48 hours of our receipt of information or, if we don't receive the information, within 48 hours of the end of the 48-hour time period.

Home Health Care Reviews. After receiving a request for coverage of home care services following an inpatient hospital admission, Empire will make a determination and provide notice to you (or your designee) and your provider, by telephone and in writing, within one (1) business day of receipt of the necessary information. If the day following the request falls on a weekend or holiday, we will make a determination and provide notice to you (or your designee) and your provider within 72 hours of receipt of the necessary information. When we receive a request for home care services and all necessary information prior to your discharge from an inpatient hospital admission, we will not deny coverage for home care services while our decision on the request is pending.

Inpatient Substance Use Disorder Treatment Reviews. If a request for inpatient substance use disorder treatment is submitted to us at least 24 hours prior to discharge from an inpatient substance use disorder treatment admission, we will make a determination within 24 hours of receipt of the request and we will provide coverage for the inpatient substance use disorder treatment while our determination is pending.

Retrospective Reviews

If Empire has all information necessary to make a determination regarding a retrospective claim, we will make a determination and notify you and your provider within 30 calendar days of the receipt of the request. If we need additional information, we will request it within 30 calendar days. You or your provider will then have 45 calendar days to provide the information. We will make a determination and provide notice to you and your provider in writing within 15 calendar days of the earlier of our receipt of the information or the end of the 45-day period.

Once we have all the information to make a decision, our failure to make a Utilization Review determination within the applicable time frames set forth above will be deemed an adverse determination subject to an internal appeal.

Retrospective Review of Preapproved Services

Empire may only reverse a preapproveded treatment, service or procedure on retrospective review when:

- The relevant medical information presented to us upon retrospective review is materially different from the information presented during the Preauthorization review;
- The relevant medical information presented to us upon retrospective review existed at the time of the Preauthorization but was withheld or not made available to us;
- We were not aware of the existence of such information at the time of the Preauthorization review; and
- Had we been aware of such information, the treatment, service or procedure being requested would not have been authorized. The determination is made using the same specific standards, criteria or procedures as used during the Preauthorization review.

Utilization Review Internal Appeals

Members may request an internal appeal of an adverse determination, either by phone, in person, or in writing. You have the right to appeal the denial of a Preauthorization request for an out-of-network health service when we determine that the out-of-network health service is not materially different from an available in-network health service. A denial of an out-of-network health service is a service provided by a non-participating provider, but only when the service is not available from a participating provider. You are not eligible for a Utilization Review Appeal if the service you request is available from a participating provider, even if the non-participating provider has more experience in diagnosing or treating your condition. (This type of appeal will be treated as a grievance.)

You also have the right to appeal the denial of a request for a referral; an authorization to a non-participating provider when we determine that we have a participating provider with the appropriate training and experience to meet your particular health care needs who is able to provide the requested health care service.

You have up to 180 calendar days after you receive notice of the adverse determination to file an appeal. We will acknowledge your request for an internal appeal within 15 calendar days of receipt. This acknowledgment will include the name, address, and phone number of the person handling your appeal and, if necessary, inform you of any additional information needed before a decision can be made. A clinical peer reviewer who is a physician or a health care professional in the same or similar specialty as the provider who typically manages the disease or condition at issue and who is not subordinate to the clinical peer reviewer who made the initial adverse determination will perform the appeal.

Standard Appeal. If your appeal relates to a Preauthorization request, we will decide the appeal within 30 calendar days of receipt of the appeal request. Written notice of the determination will be provided to you (or your designee) and where appropriate your provider within two business days after the determination is made, but no later than 30 calendar days after receipt of the appeal request. If your appeal relates to a retrospective claim, we will decide the appeal within 60 calendar days of receipt of the appeal request. Written notice of the determination will be provided to you (or your designee) and where appropriate your provider within two business days after the determination is made, but no later than 60 calendar days after receipt of the appeal request.

Expedited Appeals. An appeal of a review of continued or extended health care services, additional services rendered in the course of continued treatment, home health care services following discharge from an inpatient hospital admission, services in which a provider requests an immediate review, or any other urgent matter will be handled on an expedited basis.

Expedited appeals are not available for retrospective reviews. For expedited appeals, your provider will have reasonable access to the clinical peer reviewer assigned to the appeal within one (1) business day of receipt of the request for an appeal. Your provider and a clinical peer reviewer may exchange information by telephone or fax. Expedited appeals will be determined within the earlier of 72 hours from receipt of the appeal or two (2) business days of receipt of the information necessary to conduct the appeal.

Substance Use Appeal. If we deny a request for inpatient substance use disorder treatment that was submitted at least 24 hours prior to discharge from an inpatient admission, and you or your provider file an expedited internal appeal of our adverse determination, we will decide the appeal within 24 hours of receipt of the appeal request. If you or your rrovider file the expedited internal appeal and an expedited external appeal within 24 hours of receipt of our adverse determination, We will also provide coverage for the inpatient substance use disorder treatment while a determination on the internal appeal and external appeal is pending.

Our failure to render a determination of your appeal within 60 calendar days of receipt of the necessary information for a standard appeal or within two (2) business days of receipt of the necessary information for an expedited appeal will be deemed a reversal of the initial adverse determination.

External Appeals

In some cases, you have a right to an external appeal of a denial of coverage. If we have denied coverage on the basis that a service does not meet our requirements for medical necessity (including appropriateness, health care setting, level of care, or effectiveness of a covered benefit) or is an experimental or investigational treatment (including clinical trials and treatments for rare diseases), or is an out-of-network treatment, you may appeal that decision to an external appeal agent, an independent third party certified by the State to conduct these appeals.

In order for you to be eligible for an external appeal, you must meet the following two requirements:

- The service, procedure, or treatment must otherwise be a covered service under the Contract; and
- In general, you must have received a final adverse determination through our internal appeal process. But, you can file an external appeal even though you have not received a final adverse determination through our internal appeal process if:
  - We agree in writing to waive the internal appeal. We are not required to agree to your request to waive the internal appeal; or
  - You file an external appeal at the same time as you apply for an expedited internal appeal; or
  - We fail to adhere to Utilization Review claim processing requirements (other than a minor violation that is not likely to cause prejudice or harm to you, and we demonstrate that the violation was for good cause or due to matters beyond our control and the violation occurred during an ongoing, good faith exchange of information between you and us).

Your Right to Appeal a Determination that a Service is not Medically Necessary. If we have denied coverage on the basis that the service does not meet our requirements for medical necessity, you may appeal to an external appeal agent if you meet the requirements for an external appeal outlined above.

Your Right to Appeal a Determination that a Service is Experimental or Investigational. If we have denied coverage on the basis that the service is an experimental or investigational treatment, you must satisfy the two requirements for an external appeal outlined above and your attending physician must provide additional information and the service, procedure or treatment recommended by your doctor must meet certain criteria.

Your Right to Appeal a Determination that a Service is Out-of-Network. If we have denied coverage of an out-of-network treatment because it is not materially different than the health service available in-network, you may appeal to an external appeal agent if you meet the two requirements for an external appeal outlined above, and you have requested preauthorization for the out-of-network treatment. In addition, your attending physician must provide certain certifications and information.

You don't have a right to an external appeal for a denial of a referral to an out-of-network provider on the basis that a health care provider is available in-network to provide the particular health service requested by you.

Your Right to Appeal an Out-of-Network Referral Denial. If we have denied coverage of a request for a referral to a non-participating provider because we determine we have a participating provider with the appropriate training and experience to meet your particular health care needs who is able to provide the requested health care service, you may appeal to an external appeal agent if you meet the two requirements for an external appeal outlined above. In addition, your attending physician must provide certain certifications and information.

External Appeal Process. You have four (4) months from receipt of a final adverse determination or from receipt of a waiver of the internal appeal process to file a written request for an external appeal. If you are filing an external appeal based on our failure to adhere to claim processing requirements, you have four (4) months from such failure to file a written request for an external appeal. Please see the Contract for additional details about the external appeal application and documentation process, response timeframes and other details.

In-network Providers

The Contract only covers in-network benefits. To receive in-network benefits, you must receive care exclusively from participating providers in our Pathway X Enhanced network. Care covered under the Contract (including hospitalization) must be provided, arranged or authorized in advance by your primary care physician (PCP) and, when required, approved by Empire. In order to receive benefits under the Contract, you must contact your primary care physician before you obtain covered services except for services to treat an emergency condition described in the Emergency Services and Urgent Care section of the Contract. Except for care for an emergency condition described in the Emergency Services and Urgent Care section of the Contract, you will be responsible for paying the cost of all care that is provided by non-participating providers.

Laws and rights that protect you

As a member, you have rights and responsibilities. You have the right to expect the privacy of your personal health information to be protected, consistent with state and federal laws and our policies. You also have certain rights and responsibilities when receiving your health care. Visit this link to find more information on our website: http://www.empireblue.com/health-insurance/customer-care/faq.

Benefit Limits

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

- Child dental exams - One (1) exam within a six-month consecutive period
- Child vision - contacts, glasses, exam limited to one (1) item or exam per year
- External hearing aids – limited to a single purchase (including repair and/or replacement) for one or both ears once every three (3) years
- Home health care - 40 visits per plan year
- Hospice – 210 days per plan year, inpatient and outpatient combined
- External prosthetic device – 1 external prosthetic device per limb, per lifetime
- Inpatient habilitation services (physical, speech and occupational therapy) – 60 days per plan year
- Inpatient rehabilitation services (physical, speech and occupational therapy) – 60 days per plan year
- Outpatient habilitation services (physical, speech and occupational therapy) – 60 visits per condition, per plan year, all therapies combined
- Outpatient rehabilitation services (physical, speech and occupational therapy) – 60 visits per condition, per plan year, all therapies combined
- Skilled nursing facility (includes cardiac and pulmonary rehabilitation) – 200 days per plan year (applies to Standard Plans: Empire HMO 5500 X, for HSA, Bronze, ST; Empire HMO 2000 X, Silver, ST; Empire HMO 600 X, Gold, ST; Empire HMO 0 X, Platinum, ST; Empire HMO 7150 X, Catastrophic, ST)

Exclusions

The specific exclusions are spelled out in the terms of the particular plan, but some of the more common services not covered by these plans:

- Services to treat conditions arising out of aviation
- Benefits covered by Medicare or a governmental program
- Convalescent and custodial care
- Cosmetic services, except as stated in the Contract
- Coverage outside of the United States, Canada or Mexico
- Dental services, except as stated in the Contract
- Experimental or investigative treatment, except as stated in the Contract
- Felony participation - conditions resulting from your participation in a felony, riot or insurrection
- Foot care, except as stated in the Contract
- Government facility - treatment provided in a hospital owned or operated by the federal, state or other government entity
- Military service
- Services we determine aren't medically necessary
- No-fault automobile insurance
- Services separately billed by hospital employees
- Services provided by member of your family
- Services with no charge
- Services not listed in the Contract
- Vision services, except as stated in the Contract
- War - illness, treatment or medical condition due to war, declared or undeclared
- Workers' compensation

SpecialOffers is a service mark of Anthem Insurance Companies, Inc. Vendors and offers are subject to change without notice. Empire does not endorse and is not responsible for the products, services or information provided by the SpecialOffers vendors. Arrangements and discounts were negotiated between each vendor and Empirefor the benefit of our members. All other marks are the property of their respective owners. All of the offers in the SpecialOffers program are continually being evaluated and expanded so the offerings may change. Any additions or changes will be communicated on our website, empireblue.com. These arrangements have been made to add value for our members. Value-added products and services are not covered by your health plan benefit. Available discount percentages may change or be discontinued from time to time without notice. Discount is applicable to the items referenced.

A high deductible health plan is not a health savings account (HSA). An HSA is a separate arrangement between an individual and a qualified financial institution. To take advantage of tax benefits, an HSA needs to be established. This brochure provides general information only and is not intended to be a substitute for the advice of a qualified tax professional.

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.

Get help in your language

Curious to know what all this says? We would be too. Here's the English version:
If you need assistance to understand this document in an alternate language, you may request it at no additional cost by calling the Member Services number (855-748-1806). (TTY/TDD: 711)

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 Member Services telephone number on the back of your ID card.

Spanish
Si necesita ayuda para entender este documento en otro idioma, puede solicitarla sin costo adicional llamando al número de Servicios para Miembros (855-748-1806). (TTY/TDD: 711)

Albanian
Nëse ju nevojitet ndihmë për ta kuptuar këtë dokument në një gjuhë tjetër, mund ta kërkoni pa kosto shtesë duke telefonuar në numrin e shërbimeve për anëtarët (855-748-1806). (TTY/TDD: 711)

Arabic
إذا احتجت إلى المساعدة لفهم هذا المستند بلغة أخرى، فيمكنك طلب المساعدة دون تكلفة إضافية من خلال الاتصال برقم خدمات الأعضاء (855-748-1806). (TTY/TDD: 711)

Bengali
একটি বিকল্প ভাষায় এই তথ্য পুস্তিকাটি বোঝার জন্য। যদি আপনার সহায়তার প্রয়োজন হয়, তাহলে কোনো অতিরিক্ত খরচ ছাড়া সদস্য পরিষেবা নম্বর (855-748-1806)-তে কল করে আপনি এটির অনুরোধ করতে পারেন। (TTY/TDD: 711)

Chinese
如果您需要協助以便以另一種語言理解本文件，您可以撥打成員服務號碼(855-748-1806)請求免費協助。(TTY/TDD: 711)

French
Si vous avez besoin d'aide pour comprendre ce document dans une autre langue, vous pouvez en faire la demande gratuitement en appelant les Services destinés aux membres au numéro suivant : 855-748-1806. (TTY/TDD: 711)

Greek
Αν χρειαστείτε βοήθεια για να κατανοήσετε το παρόν έγγραφο σε άλλη γλώσσα, μπορείτε να τη ζητήσετε χωρίς πρόσθετο κόστος καλώντας τον αριθμό του Τμήματος Υπηρεσιών Μέλους (855-748-1806). (TTY/TDD: 711)

Haitian
Si ou bezwen èd pou konprann dokiman sa a nan yon lòt lang, ou kapab rele nimewo Manm Sèvis la pou mande asistans gratis nan nimewo (855-748-1806). (TTY/TDD: 711)

Italian
Se ha bisogno di assistenza per la comprensione del presente documento in un'altra lingua, può richiederla senza alcun costo aggiuntivo chiamando il numero dedicato ai Servizi per i membri (855-748-1806). (TTY/TDD: 711)

Korean
다른 언어로 본 문서를 이해하기 위해 도움이 필요하실 경우, 추가 비용 없이 회원 서비스 번호(855-748-1806)로 전화를 걸어 도움을 요청할 수 있습니다. (TTY/TDD: 711)

Polish
Jeśli potrzebujesz pomocy w zrozumieniu niniejszego dokumentu w innym języku, możesz ją uzyskać bez ponoszenia dodatkowych kosztów, dzwoniąc do Działu Obsługi Klienta pod numer (855-748-1806). (TTY/TDD: 711)

Russian
Если вам нужна помощь, чтобы понять содержание настоящего документа на другом языке, вы можете бесплатно запросить ее, позвонив в отдел обслуживания участников (855-748-1806). (TTY/TDD: 711)

Tagalog
Kung kailangan ninyo ng tulong upang maunawaan ang dokumentong ito sa ibang wika, maaari ninyo itong hilingin nang walang karagdagang bayad sa pamamagitan ng pagtawag sa Member Services sa numerong (855-748-1806). (TTY/TDD: 711)

Urdu
تو آپ ممبر سروس نمبر پر کال اگر اپ کو کسی دوسری زبان میں اس دستاویز کو سمجھنے کے لیے مدد کی ضرورت ہوجس کے لئے آپ پر کوئی اضافی اخراجات عائد نہیں ہوں گے نمبرکرکے اس کی درخواست کرسکتے ہیں
(855-748-1806) (TTY/TDD:711)

Yiddish
אויב איר דארפט הילף צו פארשטיין דעם דאקומענט אין אן אנדערע שפראך, קענט איר עס בעטן אהן קיין עקסטערע קאסט דורך רופן די מעמבער באדינונגען נומער
(TTY/TDD:711) (855-748-1806)

Empire BlueCross BlueShield

An Anthem Company

Get help today!

To learn more, call your Empire representative. You can also view and compare plans online at **empireblue.com**.

If you'd like a paper copy of this information by fax or mail, call your Empire representative.

Your HSA:

Enjoy the advantages of opening a Health Savings Account (HSA) from BenefitWallet®

A Health Savings Account can help you pay for health care expenses including prescriptions. Plus, you can claim your HSA contributions as tax deductions, earn interest on your money and roll over the year-end balance.

To realize your plan's full power, consider selecting a qualified high-deductible health plan with an HSA. Our partner, BenefitWallet, administers our HSA solution with The Bank of New York Mellon as the custodian. Setting up your account with BenefitWallet is easy and it comes with built-in advantages and conveniences like:

- A single Customer Service contact for the health plan and your HSA
- A single online health site to access your plan benefit information and account details
- Several payment and deposit options, including debit cards, checks and automatic fund transfers
- Ability to save your receipt images online
- Competitive interest rates and investment opportunities for the funds in your account
- iPhone®, iPad® and Android™ apps for access anywhere
- Health Topics encyclopedia of more than 1,500 ailments
- Medication Advisor for drugs and pharmacy identifier
- Treatment Cost Advisor for common medical conditions
- FDIC-insured checking account with the custodian, The Bank of New York Mellon (BNY Mellon)

Note: You also have the option of using a different financial institution to set up your Health Savings Account.

Set up is easy

Simply make the selection on your application form and we'll send you welcome materials to get you started. Account registration instructions are included. It's that simple.

Empire BlueCross BlueShield

An Anthem Company

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A closer look at your BenefitWallet HSA

BenefitWallet Welcome Materials

If you make the selection on your application form, your HSA will automatically be set up - no set-up fee required. You'll soon receive HSA welcome materials with all of the instructions for opening and using your account. A separate application for your account is only required if you choose an HSA administrator other than BenefitWallet.

Interest and investments

You'll earn interest on your HSA funds and have the chance to invest your funds as long as you keep a minimum $1,000 HSA balance. Investment options include a number of mutual fund families. Once you're ready to invest, log in to your account and select "Investments" from the Quick Links menu or contact the BenefitWallet Service Center at **866-686-4798,** Monday through Friday, from 8 a.m. to 11 p.m. ET.

Debit cards, checkbooks and online bill pay

Use your VISA debit card, your HSA checkbook or online bill pay (provided by BenefitWallet) to pay your doctor or pharmacy directly for eligible medical expenses — or to reimburse yourself for qualified medical expenses paid out of pocket.

Deposits to your account

You can make your deposits online or with a mobile app. You can also send a check and deposit slip to the address printed on your deposit slip. Deposit slips can be found at the back of the checkbook, online through the Help Center or through the BenefitWallet Service Center. In addition, you can set up an electronic funds transfer between your bank and BenefitWallet for one-time or recurring account contributions.

Account activity statement

Regularly, you'll receive an electronic statement from BenefitWallet that shows all your account activity. Your monthly statement is free if you open your account electronically. You can receive a paper statement for an additional fee of $1.25 per month. Visit empireblue.com or call your dedicated Customer Service line to learn how to elect this option. You'll also receive *IRS 1099* and *IRS 5498* forms from BNY Mellon near tax time to help with tax preparation.

BenefitWallet HSA fee and rate schedule

A *Deposit Agreement* and *Disclosure Statement,* along with a *Rate and Fee Sheet* will be made available to you by BenefitWallet. Please refer to those documents for the complete terms and conditions related to your account.

As appealing as these options may sound, you should still talk to your tax advisor when trying to maximize financial benefits for your personal situation.

Banking fees	
Monthly account fee	$2.95
First two debit cards, debit card transactions, first checkbook, check writing, online bill pay, electronic transfers	no charge
ATM transactions	$2
Card replacement Duplicate check	$5
Check reorder	$10
Nonsufficient funds	$25
Stop-check service	$25
Periodic paper statement	$1.25

This is what the IRS requires if you want to open a Health Savings Account:

- **You must be covered by an HSA-compatible, high-deductible health plan.**
- **You must be a U.S. resident, and not a resident of Puerto Rico or American Samoa.**
- **You cannot be covered by any other medical plan that is not an HSA-compatible, high-deductible health plan.**
- **You cannot be enrolled in Medicare.**
- **You cannot be claimed as a dependent on another individual's tax return.**
- **If you are a veteran, you may not have received veteran's benefits within the last three months.**
- **You cannot be active military.**
- **Your spouse cannot be enrolled in an FSA plan.**