Empire BlueCross BlueShield

www.empireblue.com

Benefits SUMMARY

DirectShare POS

Grants Plus

Benefit	In-Network[1]	Out-of-Network[2,3]
Deductible	N/A	$500/$1,250
Coinsurance	N/A	70% / 30%
Coinsurance Stop Loss	N/A`	$5,000/$12,500 ($1,500/$3,750 (Out-of-pocket)
Lifetime Maximum	Unlimited	$1,000,000
Dependent Children	To age 23; full-time students to age 23	To age 23; full-time students to age 23
Home/Office/Outpatient Care	**Member Pays In-Network**	**Member Pays Out-of-Network**
Home/Office/Outpatient Visits	$10 copay	Deductible and Coinsurance
Emergency Room/Facility (initial visit per occurrence)	$50 copay (Waived if admitted within 24 hours)	$50 copay (Waived if admitted within 24 hours)
Ambulatory/Outpatient Surgery[4]	$0	Deductible and Coinsurance
Well-Child Care (Up to age 19; including covered immunizations)	$0	Deductible and Coinsurance
Maternity Care	$0	Deductible and Coinsurance
Allergy Care		
- Office Visit	$10 copay	Deductible and Coinsurance
- Testing	$0	Deductible and Coinsurance
- Treatment (i.e. shots)	$0	Deductible and Coinsurance
Home Healthcare (Up to 200 visits per calendar year)	$0	Coinsurance (no deductible)
Home Infusion Therapy	$0	Deductible and Coinsurance
Hospice Care (Up to 210 days per lifetime)	$0	Deductible and Coinsurance
Annual Physical Exam	$10 copay will apply to visit services (examinations and evaluations)	Deductible and Coinsurance
Well-Woman Care		Deductible and Coinsurance
Surgery, Presurgical Testing, Anesthesia		Deductible and Coinsurance
Chemotherapy, Radiation Therapy		Deductible and Coinsurance
Mammograms		Deductible and Coinsurance
Cervical Cancer Screenings		Deductible and Coinsurance
Infertility Care		Deductible and Coinsurance
Laboratory Tests, X-rays		Deductible and Coinsurance
MRI[3]/MRA[3]/PET[3]/CAT Scans[3]/Nuclear Cardiology[3]		Deductible and Coinsurance
Physical Therapy[3] (Up to 30 visits per calendar year combined in home, office or outpatient facility)		Deductible and Coinsurance
Speech/Language, Occupational and Vision Therapies[3] (Up to 30 visits per calendar year combined in home, office or outpatient facility)		Deductible and Coinsurance

(1) Network provider delivers care. In-network providers are in Empire's POS network and in our affiliate POS network in Connecticut, Anthem Blue Cross and Blue Shield.
(2) Out-of-network providers are providers who are not in Empire's POS network or our affiliate network in Connecticut, Anthem Blue Cross and Blue Shield. Out-of-Network services rendered by providers who do not participate with Emprie or with another Blue Cross Blue Shield plan through the BlueCard Program are subject to balance billing over the allowed amount. (This does not apply to emergency benefits.)
(3) Empire's or Anthem's, CT network provider must precertify in-network services or services may be denied; Empire or Anthem, CT network providers cannot bill members beyond the co-payments for examinations and evaluation services and the in-network deductible and coinsurance for other covered services (for services subject to in-network cost share). You are responsible for obtaining precertification for out-of-network services. Your provider may call for you, but you will be responsible for penalties applied to out-of-network claims if precertification is not obtained.
(4) For ambulatory surgery, precertification is required for reconstructive surgery, outpatient transplants and ophthalmological or eye-related procedures. Precertification is also required for proposed cosmetic surgery, an excluded benefit except when medically necessary.
(5) Precertification must be obtained from the Behavioral Healthcare Manager, or penalties apply.
(6) Empire's network provider must obtain authorization for clinical/medical necessity for in-network services, or services may be denied; Empire network providers cannot bill members beyond the co-payments for examinations and evaluation services and the in-network deductible and coinsurance for other covered services (for services subject to in-network cost share.) Authorization is not required for out-of-network services.

Benefit	In-Network[1]	Out-of-Network [2,3]
Home/Office/Outpatient Care (continued)	**Member Pays**	**Member Pays**
Chiropractic Care[6]	$10 copay will apply to visit services (examinations and evaluations)	Deductible and Coinsurance
Cardiac Rehabilitation		Deductible and Coinsurance
Second Surgical Opinion		Deductible and Coinsurance
Kidney Dialysis		Deductible and Coinsurance
Inpatient Care[3]		
Inpatient Hospital (As many days as is medically necessary; semiprivate room and board)	$250/$625 per admission/maximum per calendar year per contract	Deductible and Coinsurance
Surgery, Surgical Assistant, Anesthesia	$0	Deductible and Coinsurance
Physical Therapy, Physical Medicine or Rehabilitation (Up to 30 inpatient days per calendar year)	$250/$625 per admission/maximum per calendar year per contract	Deductible and Coinsurance
Skilled Nursing Facility (Up to 30 days per calendar year)	$250/$625 per admission/maximum per calendar year per contract	Deductible and Coinsurance
Mental Health		
Outpatient Visits in Office or Facility (Up to 20 outpatient visits per calendar year)	$10 copay[5]	Deductible and Coinsurance
Inpatient Care[5] (Up to 30 inpatient days per calendar year)	$250/$625 per admission/maximum per calendar year per contract	Deductible and Coinsurance
Biologically-based mental illness and serious emotional disturbances in children with certain risks/behaviors will be treated the same as any other illness once the visit limits have been exhausted.		
Alcohol/Substance Abuse[5]		
Outpatient Visits (Up to 60 outpatient visits, which include 20 family counseling visits, per calendar year)	$0	Deductible and Coinsurance
Inpatient Detoxification (Up to 7 days detox per calendar year)	$250/$625 per admission/maximum per calendar year per contract	Deductible and Coinsurance
Other		
Medical Supplies	$0 when obtained through Empire's medical supplies vendor	Deductible and Coinsurance
Durable Medical Equipment[3]	$0	Deductible and Coinsurance
Prosthetics & Orthotics[3]	$0	Deductible and Coinsurance
Emergency Ambulance (air ambulance)	$0	Deductible and Coinsurance
Prescription Drugs[7] Retail Program – One copay required for up to a 30-day supply	$0 Deductible per person per calendar year $5 copay for generic $15 copay for brand $25 copay for non-formularyIncludes Contraceptives (Retail & Mail-Order)	Covered in-network only
Mail-Order Program[8] – Only two copays required for a 90-day supply	$0 Deductible The Mail-Order Program has the same copayments as the Retail Program listed above.	
Routine Vision Care (Through Davis Vision network of providers at 1-800-999-5431)	$5 copay for 1 exam every 24 months $10 copay for frames/contacts $0 additional copay on designer frames $35 allowance for nonplan eyewear purchases	Covered in-network only

(7) This prescription drug coverage meets the CMS standard for Creditable Coverage under the Medicare Modernization Act of 2003.
(8) To receive a 90-day supply of prescription drugs through our Mail-Order Program, the prescription must be written specifically for a 90-day supply.

NOTE: This is a benefits summary only and is subject to the terms, conditions, limitations and exclusions set forth in the certificate of coverage or contract. Failure to comply with our Medical Management or Mental and Behavioral Healthcare Management Program requirements may result in benefit reductions.

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