

Benefits

summary



For Groups with 2-50 Contracts

Out Of Network (O-O-N) Cost ²	Deductible	Coinsurance (Member Responsibility)	Coinsurance Stop-Loss
Option 1	\$500/\$1,250	30%	\$5,000 (\$1,500 out-of-pocket)
Option 2	\$500/\$1,250	30%	\$10,000 (\$3,000 out-of-pocket)
Option 3	\$750/\$1,875	30%	\$15,000 (\$4,500 out-of-pocket)
Option 4	\$1,000/\$2,500	30%	\$25,000 (\$7,500 out-of-pocket)
			Family limit x 2.5

Benefit	In-Network ¹	Out-Of-Network ^{2,3}	Options
Lifetime Maximum	Unlimited	\$1,000,000	
Dependent Children	To age 19; full-time students to age 23	Same as In-network	Dependent children to age 23; full-time students to age 25

Home/Office/Outpatient Care	Member Pays	Member Pays	Options
Copayment Option	\$12, \$20, \$30	Does not apply	
Home/Office Visits	Copayment option selected	Deductible and coinsurance	0-0-N Cost sharing options 1-4
Annual Physical Exam	Copayment option selected	Covered in-network	
Well-Child Care (Up to age 19; including covered immunizations)	\$0	Deductible and coinsurance	0-0-N Cost sharing options 1-4
Well-Woman Care	Copayment option selected	Deductible and coinsurance	0-0-N Cost sharing options 1-4
Emergency Room/Facility (Initial visit per occurrence)	\$35 copay (Waived if admitted within 24 hours)	\$35 copay (Waived if admitted within 24 hours)	
Surgery ⁴ , Pre-surgical Testing, Anesthesia	\$0	Deductible and coinsurance	0-0-N Cost sharing options 1-4
Chemotherapy, Radiation Therapy	\$0	Deductible and coinsurance	0-0-N Cost sharing options 1-4
Maternity Care	\$0	Deductible and coinsurance	0-0-N Cost sharing options 1-4
Mammograms	\$0	Deductible and Coinsurance	0-0-N Cost sharing options 1-4
Cervical Cancer Screenings	\$0	Deductible and coinsurance	0-0-N Cost sharing options 1-4
Laboratory Tests, X-rays	\$0	Deductible and coinsurance	
MRI ⁴ /MRA ⁴	\$0	Deductible and coinsurance	
Allergy Testing & Treatment	Copayment option selected (Waived for treatments)	Deductible and coinsurance	0-0-N Cost sharing options 1-4
Chiropractic Care	Copayment option selected	Deductible and coinsurance	0-0-N Cost sharing options 1-4
Home Health Care ⁴ (Up to 200 visits per calendar year)	\$0	Coinsurance (no deductible)	0-0-N Cost sharing options 1-4
Home Infusion Therapy ⁴	\$0	Covered in-network	
Hospice Care ⁴ (up to 210 days per lifetime)	\$0	Covered in-network	
Physical Therapy ⁴ (Up to 30 visits per calendar year combined in home, office or outpatient facility)	Copayment option selected	Covered in-network	
Other Short-Term Rehabilitative Therapies ⁴ — Speech/Language, Occupational, Vision (Up to 30 visits per calendar year combined in home, office or outpatient facility)	Copayment option selected	Covered in-network	
These new options are available as of May 15, 2002.			

(1) Network provider delivers care
 (2) Out-of-network provider delivers care and charges are subject to balance billing over allowed amount
 (3) Out-of-network services (except Mental Health and Alcohol/Substance Abuse) are those from a provider who does not participate with Empire or another Blue Cross and/or Blue Shield Plan through the BlueCard PPO Program. (This does not apply to emergency benefits.) See (5) for Mental Health and Alcohol/Substance Abuse Services.
 (4) Precertification by our Medical Management Program is required or penalties will apply
 (5) Precertification by our Behavioral Health Care Management Program is required



Benefit	Member Pays		Options
	In Network ¹	Out-of-Network ^{2,3}	
Cardiac Rehabilitation ⁴ Second Surgical Opinion	Copayment option selected Copayment option selected (No copayment applies if arranged through the Medical Management Program)	Deductible and coinsurance Deductible and coinsurance	0-0-N Cost sharing options 1-4 0-0-N Cost sharing options 1-4
Kidney Dialysis	\$0	Deductible and coinsurance	0-0-N Cost sharing options 1-4
Inpatient Care⁴			
Inpatient Hospital (As many days as is medically necessary; semi-private room and board)	\$0	Deductible and coinsurance	0-0-N Cost sharing options 1-4
Surgery, Surgical Assistant, Anesthesia	\$0	Deductible and coinsurance	0-0-N Cost sharing options 1-4
Physical Therapy, Physical Medicine or Rehabilitation (Up to 30 inpatient days per calendar year)	\$0	Deductible and coinsurance	0-0-N Cost-sharing options 1-4
Skilled Nursing Facility (Up to 60 days per calendar year)	\$0	Covered in-network	
Mental Health⁵			
Outpatient Visits in Office or Facility (Up to 20 outpatient visits per calendar year)	\$25 copay per visit	Covered in-network	
Inpatient Care (Up to 30 inpatient days per calendar year)	\$0	Covered in-network	
Alcohol/Substance Abuse⁵			
Outpatient Visits (Up to 60 outpatient visits which include 20 family counseling visits per calendar year)	\$0	Deductible and coinsurance	0-0-N Cost sharing options 1-4
Inpatient Detoxification (Up to 7 days detox per calendar year)	\$0	Covered in-network	
Inpatient Rehabilitation (Up to 30 days per calendar year)	Rider available	Covered in-network	30 days inpatient rehab in-network
Other			
Medical Supplies	\$0	Covered in-network	
Durable Medical Equipment ⁴	\$0	Covered in-network	
Prosthetics & Orthotics ⁴	\$0	Covered in-network	
Ambulance (Air Ambulance ⁴)	\$0	Covered in-network	
Prescription Drugs (With or without oral contraceptives)	Rider available	n/a	Deductible options: \$0, \$100, \$150 Retail/Mail order program (generic/brand/non-formulary): \$10/\$25/\$50, \$10/\$20/\$40
Routine Vision Care (Through a special network of providers)	Rider available	n/a	Covered in-network (1) \$5 copay for 1 exam every 24 months plus discounts on frames and lenses (2) Option (1) plus \$10 copay for frames, \$25 copay for contact lenses, plus \$35 allowance for non-plan eyewear purchase

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NOTE: This is a benefits summary only and is subject to the terms, conditions, limitations and exclusions set forth in the contract. Failure to comply with our Medical Management or Behavioral Health Care Management Program requirements could result in benefit reductions.

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