The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, contact the District's Employee Benefit Supervisor 631-874-1995. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 631-874-1995 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$1,000/Individual or $1,000/family Deductible - $1000 Individual $1000 Spouse, Domestic Partner, Sponsored Dependent. $1000 All Dependent Children Combined	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care and primary care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. $250 per enrollee, per spouse/domestic partner and per all dependent children combined for non-network Managed Physical Medicine Program.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	For network providers $7,150 individual / $14,300 family. INN does include copays, deductible and coinsurance (if applicable). for out-of-network providers $3,000 individual / $3,000 family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Copayments for certain services, premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.empireblue.com or call (800) 435-1385 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No, You don't need a referral to see a specialist	This plan will pay some or all of the costs to see a specialist for covered services.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/office visit deductible does not apply	20% coinsurance	None
	Specialist visit	$20 copay/visit	20% coinsurance	Preauthorization is NOT required.
	Preventive care/screening/ immunization	No charge	20% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	$20 copay/test	20% coinsurance	Precertification required if not an emergency or an inpatient procedure. If not precertified, the cost will be greater. The test of procedure is not covered if determined not to be medically necessary.
	Imaging (CT/PET scans, MRIs)	$20 copay/test	20% coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.[insert].com	Level 1 or for most Generic Drugs	30-day supply: $5; Network pharmacy 31-90 day supply: $10; Mail Service or Specialty Pharmacy 31-90 day supply: $5	Not Covered	Certain medications require prior authorization for coverage. Copayment waived, at a network pharmacy for: • oral chemotherapy drugs when used to treat cancer, generic oral contraceptive drugs and devices • brand-name contraceptive drugs/devices without a generic equivalent (singlesource brand-name drugs/devices) • Tamoxifen and Raloxifene when prescribed for the primary prevention of breast cancer There is an ancillary charge for covered brand name drugs that have a generic equivalent in addition to the Level 3 copayment.
	Level 2, Preferred Drugs or Compound Drugs	30-day supply: $25; network pharmacy 31-90 day supply: $50; Mail Service or Specialty Pharmacy 31-90 day supply: $50	Not Covered	
	Level 3 or Nonpreferred Drugs	30-day supply: $45; network pharmacy 31-90 day supply: $90; Mail Service or Specialty Pharmacy 31-90 day supply:	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
		$90		
	Specialty drugs	Applicable copayment based on the drug copayment level		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$30 copay	20% coinsurance	Outpatient surgery- subject to medical necessity- Precertification for transplant
	Physician/surgeon fees	$30 copay	20% coinsurance	
If you need immediate medical attention	Emergency room care	$70 copay	$70 copay	Copayment is waived if admitted
	Emergency medical transportation	$35 copay	$35 copay	
	Urgent care	$20 copay	20% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	10% coinsurance	Preauthorization is required. If you don't get preauthorization, $200 penalty applied.
	Physician/surgeon fees	No Charge	20% coinsurance	Provider fee in addition to facility fee applies only if the provider bills separately from the facility.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay	20% coinsurance	Preauthorization is required for some mental health and substance abuse services.
	Inpatient services	$0 copay	10% coinsurance	
If you are pregnant	Office visits	$20 copay	20% coinsurance	Preauthorization is required. If you don't get preauthorization, $200 penalty applied. Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply.
	Childbirth/delivery professional services	No Charge	10% coinsurance; 20% coinsurance for provider services not billed by hospital	
	Childbirth/delivery facility services	No Charge	10% coinsurance; 20% coinsurance for provider services not billed by hospital	
If you need help recovering or have other special health needs	Home health care	No Charge	50% coinsurance	Limited to 4 hours per day, Preauthorization is required; non-network benefits apply if not precertified. No non-network coverage for the first 48 hours of home nursing. Custodial Care is not covered.
	Rehabilitation services	$20 copay	50% coinsurance for office	Outpatient hospital rehabilitation services

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
			visits under Managed Physical Medicine Program; 10% coinsurance or $75 (whichever is greater) for outpatient hospital	covered when medically necessary following a related hospitalization or surgery.
	Habilitation services	20% copay	50% coinsurance	
	Skilled nursing care	No Charge	50% coinsurance; 10% coinsurance in a skilled nursing facility	Limitations and exceptions apply to skilled nursing facility coverage. Precertification required; $200 penalty if admission is not precertified. Non-network benefits apply if skilled nursing at home is not precertified. No non-network coverage for the first 48 hours. No coverage for Medicareprimary enrollees.
	Durable medical equipment	No Charge	50% coinsurance	Diabetic shoes are covered up to $500 when precertified. Allowance for diabetic shoes purchased at a non-network provider is one pair up to 75% of the network allowance. Precertification required; non-network benefits apply if not precertified.
	Hospice services	No Charge	50% coinsurance	None
If your child needs dental or eye care	Children's eye exam	Not Covered	Not covered	None
	Children's glasses	Not Covered	Not covered	None
	Children's dental check-up	Not Covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic Surgery
- Dental Care
- Custodial care
- Infertility Treatment
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Private Duty Nursing
- Routine eye care (Adult & Child)
- Routine Foot Care
- Services that are not medically necessary
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture (if prescribed for rehabilitation purposes)
- Chiropractic Care
- Hearing Aids
- Prescription Drugs

- Bariatric Surgery
- Infertility Treatment

Your Rights to Continue Coverage: If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay under the plan. Other limitations on your rights to continue coverage may also apply. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Contract District's Employee Benefit Supervisor 631-874-1995.

Does this plan provide Minimum Essential Coverage? Yes.
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? Yes.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
[Spanish (Español): Para obtener asistencia en Español, llame al [insert telephone number].]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [insert telephone number].]
[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 [insert telephone number].]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' [insert telephone number].]

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$1000
Specialist copayment	$20
Hospital (facility) coinsurance	10%
Other coinsurance	20%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing In-Network	
Deductibles	$0
Copayments	$120
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$120.00**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$1000
Specialist copayment	$20
Hospital (facility) coinsurance	10%
Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing In-Network	
Deductibles*	$0
Copayments	$60
Prescription Drugs	$300
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$360.00**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$1000
Specialist copayment	$20
Hospital (facility) coinsurance	10%
Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing In-Network	
Deductibles*	$0
Copayments ER / Therapy	$160
Durable medical equipment *(crutches)*	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$160.00**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.