

Your Summary of Benefits



EPO

Research Foundation of the City University New York

Benefit	In-Network ¹
Deductible	\$0/\$0
Coinsurance	10%
Coinsurance Stop Loss / Total Out-of-Pocket Maximum	\$10,000/\$25,000 / (\$1,000/\$2,500 out-of-pocket maximum)
Lifetime Maximum	Unlimited
Dependent Children	Dependents to Age 26
Covered Preventive Care	Member Pays In-Network¹
Covered Adult Preventive Care	\$25/\$35 copay
Annual Physical Exam	\$25/\$35 copay
Well-Child Care (to age 19; including covered immunizations)	\$0
Preventive Well-Woman Care	\$25/\$35 copay
Home/Office/Outpatient Care	Member Pays In-Network¹
Home/Office Visits ¹	\$25/\$35 copay
Emergency Room (initial visit per occurrence)	\$50 copayment (Waived if admitted within 24 hours)
Routine Maternity Care	Coinsurance
Allergy Care	
- Office Visit	\$25/\$35 copay
- Testing	Coinsurance
- Treatment	\$0
Home Healthcare (Up to 200 visits per calendar year)	Coinsurance (no deductible)
Home Infusion Therapy	Coinsurance
Hospice Care (Up to 210 days per lifetime)	Coinsurance
Surgery ⁴ , Presurgical Testing, Anesthesia	
Chemotherapy, Radiation Therapy	
Infertility Care	
Laboratory Tests, X-rays	
MRI ⁴ , MRA ⁴ , CAT Scan ⁴ , PET ⁵ & Nuclear Cardiology ⁵	
Chiropractic Care ⁵	
Cardiac Rehabilitation	
Second Surgical Opinion	
Kidney Dialysis	
Physical Therapy ⁴ (Up to 30 visits per calendar year combined in home, office or outpatient facility)	
Other Short-Term Rehabilitative Therapies – Speech/Language ² , Occupational ² , Vision (Up to 30 visits per calendar year combined in home, office or outpatient facility)	
	\$25/\$35 copay will apply to visit services (examinations and evaluations); other services performed will be subject to in-network cost-share.

- (1) A network provider must deliver all care. The in-network office co-payment applies to examinations and evaluations only. Other services performed at the office setting may be subject to coinsurance. There is no out-of-network option for this product. The following practitioners receive the (lower) primary copay for services provided in an office: PCP, obstetricians, gynecologists, certified nurse midwives, chiropractors, and physical therapist. The (higher) specialist copay will apply for all other specialist when a copay is required, and for services received in an outpatient facility for physical and other speech, language, occupational and vision therapies.
- (2) You are responsible for obtaining precertification from Empire's Medical Management Program for these services. Your provider may call for you, but you will be responsible for penalties applied if precertification is not obtained. For ambulatory surgery, precertification is required for reconstructive surgery, outpatient transplants and ophthalmological or eye-related procedures. Precertification is also required for cosmetic surgery, an excluded benefit except when medically necessary.
- (3) Precertification is required by Empire's Behavioral Healthcare Management Programs.
- (4) For services received from an Empire network provider, the provider must precertify in-network services or services may be denied; Empire's network providers cannot bill members beyond the co-payments for "examinations and evaluations" services and the in-network coinsurance for other covered services (for services subject to in-network cost share). Outside Empire's network area, you must obtain precertification from Empire's Medical Management Program for services from in-network BlueCard® PPO providers (with the exception of MRI, MRA, PET, CAT and Nuclear Cardiology services, which do not require precertification for services rendered from in-network BlueCard® PPO providers outside of Empire's network area). The BlueCard® PPO provider may call for you for services that do require precertification, but you will be responsible for penalties applied if precertification is not obtained.

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

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Benefit	In-Network ¹
Inpatient Care²	Member Pays In-Network¹
Inpatient Hospital (As many days as is medically necessary; semiprivate room and board)	Coinsurance
Physical Therapy, Physical Medicine or Rehabilitation (Up to 30 inpatient days per calendar year)	Coinsurance
Surgery, Surgical Assistant, Anesthesia	Coinsurance
Skilled Nursing Facility (Up to 60 days per calendar year)	Coinsurance
Birth Centers	Coinsurance
Mental Health³	
Outpatient Visits in Office	\$25 copay will apply to visit services (examinations and evaluations) in an office; other services performed will be subject to in-network coinsurance (no deductible).
Outpatient Visits in Facility	Coinsurance (no deductible)
Inpatient Care (As many days as is medically necessary; semiprivate room and board)	Coinsurance
Alcohol/Substance Abuse³	
Outpatient Visits in Office	\$25 copay will apply to visit services (examinations and evaluations) in an office; other services performed will be subject to in-network coinsurance (no deductible).
Outpatient Visits in Facility	Coinsurance (no deductible)
Inpatient Detoxification (As many days as is medically necessary; semiprivate room and board)	Coinsurance
Inpatient Rehabilitation	Coinsurance
Other	
Medical Supplies	Coinsurance
Durable Medical Equipment ⁴	Coinsurance
Prosthetics & Orthotics ⁴	Coinsurance
Ambulance (air ambulance)	Coinsurance
Prescription Drugs ⁵	
Retail Program – One copay required for up to a 30-day supply	\$100 Deductible per person per calendar year Tier 1/Tier 2/Tier 3 \$5/\$25/\$50 copay Includes Contraceptives (Retail & Mail-Order)
Mail-Order Program ⁷ – 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.

(5) 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 evaluations" services and the in-network coinsurance for other covered services (for services subject to in-network cost share). Authorization is not required for services rendered from in-network BlueCard® PPO providers outside of Empire's network area.

(6) This prescription drug coverage meets the Centers for Medicare and Medicaid Services (CMS) standard for Creditable Coverage under the Medicare Modernization Act of 2003.

(7) To receive a 90-day supply of prescription drugs through Empire's Mail-Order Program, the prescription must be written specifically for a 90-day supply.

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Empire believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that this plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections of the Affordable Care Act apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to Empire at the telephone number printed on the back of your member identification card, or contact your group benefits administrator if you do not have an identification card. For ERISA plans, you may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This Web site has a table summarizing which protections do and do not apply to grandfathered health plans. For nonfederal governmental plans, you may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

Your Summary of Benefits



DSPOS

Research Foundation of the City University of New York

Benefit	In-Network ¹	Out-of-Network ²
Deductible	N/A	\$500/\$1,250
Coinsurance	N/A	30%
Coinsurance Stop Loss	N/A	\$6,000/\$12,500 (\$1,500/\$3,750 out-of-pocket)
Lifetime Maximum	Unlimited	Unlimited
Dependent Children	Dependents to Age 26	Dependents to Age 26
Covered Preventive Care	Member Pays	Member Pays
Covered Adult Preventive Care	\$10	Deductible and coinsurance
Annual Physical Exam	\$10	Deductible and coinsurance
Well-Child Care (Up to age 19; including covered immunizations)	\$0	Deductible and coinsurance
Preventive Well-Woman Care	\$10	Deductible and coinsurance
Home/Office/Outpatient Care	Member Pays	Member Pays
Home/Office/Outpatient Visits Copayment	\$10 copay	Deductible and coinsurance
webVisit ³	\$5 copay per online consultation	Covered in-network only
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 ^{4,5}	\$0	Deductible and coinsurance
Presurgical Testing, Anesthesia	\$0	Deductible and coinsurance
Chemotherapy, Radiation Therapy	\$0	Deductible and coinsurance
Routine Maternity Care	\$0	Deductible and coinsurance
Laboratory Tests, X-rays, MRI/MRA ³ , CAT Scan ⁵ , PET ⁵ and Nuclear Cardiology ⁶	\$0	Deductible and coinsurance
Allergy Testing & Treatment	\$10 copay (Waived for treatment)	Deductible and coinsurance
Chiropractic Care ⁷	\$10 copay	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
Physical Therapy ⁴ (Up to 30 visits per calendar year combined in home, office or outpatient facility)	\$10 copay	Deductible and coinsurance
Speech/Language ⁴ Occupational ⁴ , Vision Therapies (Up to 30 visits per calendar year combined in home, office or outpatient facility)	\$10 copay	Deductible and coinsurance
Outpatient Cardiac Rehabilitation	\$10 copay	Deductible and coinsurance
Second Surgical Opinion	\$10 copay	Deductible and coinsurance
Kidney Dialysis	\$0	Deductible and coinsurance

- (1) In-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 Empire 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) A webVisit enables you to receive a covered medical consultation for a non-urgent matter from a participating provider who has agreed to provide webVisits to Empire members online. Confirm your provider's participation by contacting your provider or his/her office staff. Visit our website or call for more details.
- (4) Empire's or Anthem's, CT network provider must precertify INN services or services may be denied; Empire or Anthem, CT network providers cannot bill members beyond INN copayment (if applicable) for covered services. 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.
- (5) 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.
- (6) Empire's or Anthem's, CT network provider must precertify INN services or services may be denied; Empire or Anthem, CT network providers cannot bill members for covered services. Precertification is not necessary for out-of-network services.
- (7) 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 in-network copayment for covered services. Authorization is not required for out-of-network services.
- (8) Precertification must be obtained from the Behavioral Healthcare Manager, or penalties apply.

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Your Summary of Benefits



DSPOS

Benefit	In-Network ¹	Out-of-Network ²
Inpatient Care⁴		
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 Health⁵		
Outpatient Visits in Office	\$10 copay	Deductible and coinsurance
Outpatient Visits in Facility	\$0	Deductible and coinsurance
Inpatient Care ⁶ (As many days as is medically necessary; semiprivate room and board)	\$250/\$625 per admission/maximum per calendar year per contract	Deductible and coinsurance
Alcohol/Substance Abuse⁸		
Outpatient Visits in Office	\$10 copay	Deductible and coinsurance
Outpatient Visits in Facility	\$0	Deductible and coinsurance
Inpatient Detoxification (As many days as is medically Necessary; semiprivate room and board)	\$250/\$625 per admission/maximum per calendar year per contract	Deductible and coinsurance
Inpatient Rehabilitation	\$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 ⁷	\$0	Deductible and coinsurance
Prosthetics & Orthotics ⁷	\$0	Deductible and coinsurance
Ambulance (air ambulance)	\$0	Deductible and coinsurance
Prescription Drugs ⁹		Covered in-network only
Retail Program – One copay required for up to a 30-day supply	\$0 Deductible per person per calendar year Tier 1/Tier 2/Tier 3 \$5/\$15/\$25 copay Includes Contraceptives (Retail & Mail-Order)	
Mail-Order Program ¹⁰ – 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.	

(9) This prescription drug coverage meets the CMS standard for Creditable Coverage under the Medicare Modernization Act of 2003.

(10) To receive a 90-day supply through Empire's Mail-Order Program, the prescription must be written specifically for a 90-day supply.

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Empire believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that this plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections of the Affordable Care Act apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to Empire at the telephone number printed on the back of your member identification card, or contact your group benefits administrator if you do not have an identification card. For ERISA plans, you may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This Web site has a table summarizing which protections do and do not apply to grandfathered health plans. For nonfederal governmental plans, you may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

DS PCS CO REV Sept 2010

Prepared on 10/4/10

Your Summary of Benefits



PPO

Research Foundation of the City University New York

Benefit	In-Network ¹	Out-of-Network ^{2,3}
Deductible	N/A	\$750/\$1,875
Coinsurance	N/A	30%
Coinsurance Stop Loss	N/A	\$10,000/\$25,000 / (\$3,000/\$7,500 out-of-pocket)
Lifetime Maximum	Unlimited	Unlimited
Dependent Children	Dependents to age 26	Dependents to age 26
Covered Preventive Care:	Member Pays In-Network	Member Pays Out-of-Network
Covered Adult Preventive Care	\$25/\$35	Deductible and Coinsurance
Annual Physical Exam	\$25/\$35	Covered in-network only
Well-Child Care (Up to age 19; including necessary covered immunizations)	\$0	Deductible and Coinsurance
Preventive Well-Woman Care	\$25/\$35	Deductible and Coinsurance
Home/Office/Outpatient Care:	Member Pays In-Network	Member Pays Out-of-Network
Home/Office Visits ¹	\$25/\$35 copay	Deductible and Coinsurance
Emergency Room/Facility (initial visit per occurrence)	\$50 copayment (Waived if admitted within 24 hours)	\$50 copayment (Waived if admitted within 24 hours)
Surgery ⁴ , Presurgical Testing, Anesthesia	\$0	Deductible and Coinsurance
Chemotherapy, Radiation Therapy	\$0	Deductible and Coinsurance
Routine Maternity Care	\$0	Deductible and Coinsurance
Laboratory Tests, X-rays	\$0	Deductible and Coinsurance
MRI/MRA ⁵ , CAT Scan ⁶ , PET ⁶ & Nuclear Cardiology ⁶	\$0	Deductible and Coinsurance
Allergy Testing & Treatment	\$25/\$35 copay (Waived for treatment)	Deductible and Coinsurance
Chiropractic Care ⁸	\$25/\$35 copay	Deductible and Coinsurance
Home Healthcare (Up to 200 visits per calendar year)	\$0	Coinsurance (no deductible)
Home Infusion Therapy	\$0	Covered in-network only
Hospice Care (Up to 210 days per lifetime)	\$0	Covered in-network only
Physical Therapy ⁴ (Up to 30 visits per calendar year combined in home, office or outpatient facility)	\$25/\$35 copay	Covered in-network only
Other Short-Term Rehabilitative Therapies – Speech/Language ¹ , Occupational ¹ , Vision (Up to 30 visits per calendar year combined in home, office or outpatient facility)	\$25/\$35 copay	Covered in-network only

- The following practitioners receive the lower (primary) copay for services provided in an office: patient's PCP, obstetricians, gynecologists, certified nurse, midwives, chiropractors and physical therapists. The higher (specialist) copay will apply for all other specialists when a copay is required, and for services received in an outpatient facility for physical and other speech, language, occupational and vision therapies.
- Out-of-network services (except Mental Health and Alcohol/Substance Abuse) are those from a provider that does not participate in Empire's PPO network, or with another Blue Cross and Blue Shield Plan through the BlueCard® PPO Program. (This does not apply to emergency benefits.) See (7) for Mental Health and Alcohol/Substance Abuse Services.
- Out-of-network (O-O-N) providers -- those who do not participate in Empire's PPO network, or with another Blue Cross and Blue Shield Plan through the BlueCard® PPO Program. Out-of-network providers who do not participate with Empire or with another Blue Cross and Blue Shield Plan, may balance bill over Empire's allowed amount.
- You are responsible for obtaining precertification from Empire's Medical Management Program for these services provided in-area and out-of-area, in-network and out-of-network. Your provider may call for you, but you will be responsible for penalties applied if precertification is not obtained. For ambulatory surgery, precertification is required for reconstructive surgery, outpatient transplants and ophthalmological or eye-related procedures. Precertification is also required for cosmetic surgery, an excluded benefit except when medically necessary.
- For services received from an Empire PPO provider, the provider must precertify in-network services; Empire PPO providers cannot bill members beyond the copayment for covered services. Outside Empire's network area, you must obtain precertification from Empire's Medical Management Program for services from in-network BlueCard® PPO providers. You are responsible for obtaining precertification from Empire's Medical Management Program for in-area and out-of-area out-of-network services. Your provider may call for you, but you will be responsible for penalties applied if precertification is not obtained.
- Empire's network provider must precertify in-network services; Empire network providers cannot bill members beyond the co-payment for covered services. Precertification is not required for out-of-network services, nor for out-of-area in-network BlueCard® PPO provider services.
- You are responsible for obtaining precertification from the Behavioral Healthcare Manager for these services. Your provider may call for you, but you will be responsible for penalties applied if precertification is not obtained.

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PPO

Benefit	In-Network ¹	Out-of-Network ^{2,3}
Cardiac Rehabilitation	\$25/\$35 copay	Deductible and Coinsurance
Second Surgical Opinion	\$25/\$35 copay (no copayment applies if arranged through the Medical Management Program)	Deductible and Coinsurance
Kidney Dialysis	\$0	Deductible and Coinsurance
Inpatient Care⁴	Member Pays In-Network	Member Pays Out-of-Network
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, Covered Surgical Assistant, Anesthesia	\$0	Deductible and Coinsurance
Physical Therapy, Physical Medicine, or Rehabilitation (Up to 90 inpatient days per calendar year)	\$250/\$625 per admission/maximum per calendar year per contract	Deductible and Coinsurance
Skilled Nursing Facility (Up to 60 days per calendar year)	\$0	Covered in-network only
Mental Health⁷	Member Pays In-Network	
Outpatient Visits in Office	\$25 copay	Deductible and Coinsurance
Outpatient Visits in Facility	\$0	Deductible and Coinsurance
Inpatient Care ⁷ (As many days as medically necessary; semiprivate room and board)	\$250/\$625 per admission/maximum per calendar year per contract	Deductible and Coinsurance
Alcohol/Substance Abuse⁷	Member Pays In-Network	Member Pays Out-of-Network
Outpatient Visits in Office	\$25 copay	Deductible and Coinsurance
Outpatient Visits in Facility	\$0	Deductible and Coinsurance
Inpatient Detoxification (As many days as medically necessary; semiprivate room and board)	\$250/\$625 per admission/maximum per calendar year per contract	Deductible and Coinsurance
Inpatient Rehabilitation	\$250/\$625 per admission/maximum per calendar year per contract	Deductible and Coinsurance
Other	Member Pays In-Network	Member Pays Out-of-Network
Medical Supplies	\$0 when obtained through Empire's medical supplies vendor	In-network benefits apply
Durable Medical Equipment ⁸	\$0	Covered in-network only
Prosthetics & Orthotics ⁸	\$0	Covered in-network only
Ambulance (air ambulance)	\$0	In-network benefits apply
Prescription Drugs ⁹		Covered in-network only
Retail Program – One copay required for up to a 30-day supply	\$0 Deductible per person per calendar year Tier 1/Tier 2/Tier 3 \$5/\$25/\$35 copay Includes Contraceptives (Retail & Mail-Order)	
Mail-Order Program ¹⁰ – 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.	

(8) Empire's network provider must obtain authorization for clinical/medical necessity for in-network services; Empire network providers cannot bill members beyond the in-network deductible and coinsurance for covered services. Authorization is not required for out-of-network services or for services rendered from in-network BlueCard[®] PPO providers outside of Empire's network area.

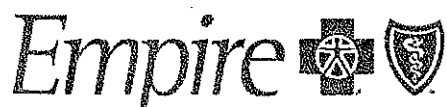
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www.empireblue.com

**Empire Dental Preferred (XPO) Benefit Summary
for
Research Foundation – CUNY
Full Time Employees**

Service	In-Network ¹	Out-of-Network ²
Diagnostic & Preventive <ul style="list-style-type: none"> • Exams • X-rays • Prophylaxis • Fluoride Treatment • Sealant 	100%	80%
Basic Restorative <ul style="list-style-type: none"> • Fillings • Endodontics • Routine Extractions 	100%	80%
Major Restorative <ul style="list-style-type: none"> • Periodontics • Oral Surgery • Prosthetics 	60%	50%
Orthodontia	50%	50%

Other Important Plan Features:

- ◆ Your annual maximum is: \$2,500
- ◆ Your in-network annual deductible is: None
- ◆ Your out-of-network annual deductible is: \$50/Individual - \$100/Family
- ◆ Dependent children are covered to the end of the calendar year in which they turn: 23
- ◆ Orthodontics are covered for dependent children to age 19 to a maximum of: \$1,750

Specific details regarding Empire Dental Preferred are available in the benefit booklet which will be available after enrollment.

¹ Percentage of in-network fee schedule covered when services are performed by an in-network provider. Members are not responsible for charges above the fee schedule for covered services.

² Percentage of out-of-network fee schedule covered when services are performed by an out-of-network provider.

