Your summary of benefits

Empire BlueCross BlueShield

An Anthem Company

Empire BlueCross BlueShield

Hudson Valley Credit Union

Your Plan: Empire EPO HDHP

Your Network: PPO/EPO

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	$2,800 person / $5,600 family	Not covered
Overall Out-of-Pocket Limit	$5,000 person / $10,000 family	Not covered
The family deductible and out-of-pocket limit are embedded, meaning the cost shares of one family member will be applied to the per person deductible and per person out-of-pocket limit; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket limit. No one member will pay more than the per person deductible or per person out-of-pocket limit. Your copays, coinsurance and deductible count toward your out of pocket limit(s).		
Doctor Visits (virtual and office) *You are encouraged to select a Primary Care Physician (PCP).*		
Medical Chats and Virtual Visits for Primary Care *from our Online Provider K Health, through its affiliated Provider groups are covered at No charge after deductible is met.*		
Virtual Visits from online provider LiveHealth Online *for urgent/acute medical and mental health and substance abuse care via www.livehealthonline.com are covered at 30% coinsurance after deductible is met.*		
Primary Care (PCP) and Mental Health and Substance Abuse Care *virtual and office*	30% coinsurance after deductible is met	Not covered
Specialist Care *virtual and office*	30% coinsurance after deductible is met	Not covered
Other Practitioner Visits		
Routine Maternity Care (Prenatal and Postnatal)	30% coinsurance after deductible is met	Not covered

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Retail Health Clinic *for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.*	30% coinsurance after deductible is met	Not covered
Chiropractic Services	30% coinsurance after deductible is met	Not covered
Acupuncture *Coverage is limited to 20 visits per benefit period.*	30% coinsurance after deductible is met	Not covered
Other Services in an Office		
Allergy Testing	30% coinsurance after deductible is met	Not covered
Prescription Drugs *Dispensed in the office*	30% coinsurance after deductible is met	Not covered
Surgery	30% coinsurance after deductible is met	Not covered
Preventive care / screenings / immunizations	No charge	Not covered
Preventive Care for Chronic Conditions *per IRS guidelines*	No charge	Not covered
Diagnostic Services **Lab**		
Office	30% coinsurance after deductible is met	Not covered
Freestanding Lab/Reference Lab	30% coinsurance after deductible is met	Not covered
Outpatient Hospital	30% coinsurance after deductible is met	Not covered
X-Ray		
Office	30% coinsurance after deductible is met	Not covered
Outpatient Hospital	30% coinsurance after deductible is met	Not covered
Advanced Diagnostic Imaging *for example: MRI, PET and CAT scans*		
Office	30% coinsurance after deductible is met	Not covered
Outpatient Hospital	30% coinsurance after deductible is met	Not covered

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Emergency and Urgent Care		
Urgent Care	30% coinsurance after deductible is met	Covered as In-Network
Emergency Room Facility Services *Copay waived if admitted.*	30% coinsurance after deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services	30% coinsurance after deductible is met	Covered as In-Network
Ambulance	30% coinsurance after deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Abuse Care at a Facility		
Facility Fees	30% coinsurance after deductible is met	Not covered
Doctor Services	30% coinsurance after deductible is met	Not covered
Outpatient Surgery		
Facility Fees		
Hospital	30% coinsurance after deductible is met	Not covered
Ambulatory Surgical Center	30% coinsurance after deductible is met	Not covered
Doctor and Other Services		
Hospital	30% coinsurance after deductible is met	Not covered
Ambulatory Surgical Center	30% coinsurance after deductible is met	Not covered
Hospital (Including Maternity, Mental Health and Substance Abuse)		
Facility Fees *Coverage for Inpatient Rehabilitation is limited to 60 days per benefit period.*	30% coinsurance after deductible is met	Not covered
Physician and other services *including surgeon fees*	30% coinsurance after deductible is met	Not covered
Home Health Care *Coverage is limited to 100 visits per benefit period. Limits are combined for all home health services.*	30% coinsurance after deductible is met	Not covered

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Rehabilitation and Habilitation services *including physical, occupational and speech therapies.* *Coverage for physical and occupational therapies is limited to 30 visits combined per benefit period. Coverage for speech therapy is limited to 30 visits per benefit period.*		
Office	30% coinsurance after deductible is met	Not covered
Outpatient Hospital	30% coinsurance after deductible is met	Not covered
Pulmonary rehabilitation *office and outpatient hospital*	30% coinsurance after deductible is met	Not covered
Cardiac rehabilitation *office and outpatient hospital* *Coverage is limited to 36 visits per benefit period.*	30% coinsurance after deductible is met	Not covered
Dialysis/Hemodialysis *office and outpatient hospital* *Coverage is limited to 10 visits per benefit period. Applies to Non Network.*	30% coinsurance after deductible is met	Covered as In-Network
Chemo/Radiation Therapy *office and outpatient hospital*	30% coinsurance after deductible is met	Not covered
Skilled Nursing Care (facility) *Coverage is limited to 60 days per benefit period.*	30% coinsurance after deductible is met	Not covered
Inpatient Hospice	30% coinsurance after deductible is met	Not covered
Durable Medical Equipment	30% coinsurance after deductible is met	Not covered
Prosthetic Devices	30% coinsurance after deductible is met	Not covered

Notes:

- If you have an office visit with your Primary Care Physician or Specialist at an Outpatient Facility (e.g., Hospital or Ambulatory Surgical Facility), benefits for Covered Services will be paid under "Outpatient Facility Services".
- Costs may vary by the site of service. Other cost shares may apply depending on services provided. Check your Certificate of Coverage for details.

This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This summary does not reflect each and every benefit, exclusion and limitation which may apply to the coverage. For more details, important limitations and exclusions, please review the formal Evidence of Coverage (EOC). If there is a difference between this summary and the Evidence of Coverage (EOC), the Evidence of Coverage (EOC), will prevail.

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Language Access Services:

Get help in your language

Curious to know what all this says? We would be too. Here's the English version:
If you have any questions about this document, you have the right to get help and information in your language at no cost. To talk to an interpreter, call (844) 241-7085

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 customer service telephone number on the back of your ID card.

(TTY/TDD: 711)

Arabic (العربية): إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (844) 241-7085 .

Armenian (հայերեն). Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (844) 241-7085:

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Haitian Creole (Kreyòl Ayisyen): Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (844) 241-7085.

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Japanese (日本語):この文書についてなにかご不明な点があれば、あなたにはあなたの言語で無料で支援を受け情報を得る権利があります。 通訳と話すには、(844) 241-7085 にお電話ください。

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Language Access Services:

Navajo (Diné): Díí naaltsoos biká'ígíí łahgo bina'idiłkidgo ná bohónéedzą dóó bee ahóót'i' t'áá ni nizaad k'ehjí bee nił hodoonih t'áadoo bą́ą́h ílínígóó. Ata' halne'ígíí łą' bich'į' hadeesdzih ninízingo kojį' hodíilnih (844) 241-7085.

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Spanish (Español): Si tiene preguntas acerca de este documento, tiene derecho a recibir ayuda e información en su idioma, sin costos. Para hablar con un intérprete, llame al (844) 241-7085.

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Vietnamese (Tiếng Việt): Nếu quý vị có bất kỳ thắc mắc nào về tài liệu này, quý vị có quyền nhận sự trợ giúp và thông tin bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Để trao đổi với một thông dịch viên, hãy gọi (844) 241-7085.

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