Your summary of benefits

Empire BlueCross BlueShield

An Anthem Company

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Premium Plan

Your Plan: Empire EPO Copay With Deductible

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	$1,000 person / $2,000 family	Not covered
Overall Out-of-Pocket Limit	$2,500 person / $5,000 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 per visit deductible does not apply.*		
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 $10 copay per visit deductible does not apply.*		
Primary Care (PCP) and Mental Health and Substance Abuse Care *virtual and office*	$35 copay per visit deductible does not apply	Not covered
Specialist Care *virtual and office*	$50 copay per visit deductible does not apply	Not covered
Other Practitioner Visits		

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Routine Maternity Care (Prenatal and Postnatal)	20% coinsurance after deductible is met	Not covered
Retail Health Clinic *for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.*	$35 copay per visit deductible does not apply	Not covered
Chiropractic Services	$50 copay per visit deductible does not apply	Not covered
Acupuncture *Coverage is limited to 20 visits per benefit period.*	$50 copay per visit deductible does not apply	Not covered
Other Services in an Office		
Allergy Testing	20% coinsurance after deductible is met	Not covered
Prescription Drugs *Dispensed in the office*	20% coinsurance after deductible is met	Not covered
Surgery	20% 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	20% coinsurance after deductible is met	Not covered
Freestanding Lab/Reference Lab	20% coinsurance after deductible is met	Not covered
Outpatient Hospital	20% coinsurance after deductible is met	Not covered
X-Ray		
Office	20% coinsurance after deductible is met	Not covered
Outpatient Hospital	20% 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
Advanced Diagnostic Imaging *for example: MRI, PET and CAT scans*		
Office	$250 copay per visit deductible does not apply	Not covered
Outpatient Hospital	$250 copay per visit deductible does not apply	Not covered
Emergency and Urgent Care		
Urgent Care	$50 copay per visit deductible does not apply	Covered as In-Network
Emergency Room Facility Services *Copay waived if admitted.*	$350 copay per visit deductible does not apply	Covered as In-Network
Emergency Room Doctor and Other Services	No charge	Covered as In-Network
Ambulance	20% coinsurance after deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Abuse Care at a Facility		
Facility Fees	20% coinsurance after deductible is met	Not covered
Doctor Services	No charge	Not covered
Outpatient Surgery		
Facility Fees		
Hospital	20% coinsurance after deductible is met	Not covered
Ambulatory Surgical Center	20% coinsurance after deductible is met	Not covered
Doctor and Other Services		
Hospital	20% coinsurance after deductible is met	Not covered
Ambulatory Surgical Center	20% coinsurance after deductible is met	Not covered
Hospital (Including Maternity, Mental Health and Substance Abuse)		
Facility Fees	20% 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
Coverage for Inpatient Rehabilitation is limited to 60 days per benefit period. **Physician and other services** *including surgeon fees*	20% 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.*	20% coinsurance deductible does not apply	Not covered
Rehabilitation and Habilitation services *Coverage for physical therapy is limited to 60 visits per benefit period. Coverage for speech and occupational therapies is limited to 60 visits combined per benefit period.*		
Physical Therapy Office and Outpatient Hospital	$35 copay per visit deductible does not apply	Not covered
Speech Therapy and Occupational Therapy Office	$35 copay per visit deductible does not apply	Not covered
Outpatient Hospital	20% coinsurance after deductible is met	Not covered
Pulmonary rehabilitation		
Office	$50 copay per visit deductible does not apply	Not covered
Outpatient Hospital	20% coinsurance after deductible is met	Not covered
Cardiac rehabilitation		
Office	$50 copay per visit deductible does not apply	Not covered
Outpatient Hospital	20% coinsurance after deductible is met	Not covered
Dialysis/Hemodialysis *office and outpatient hospital*	20% coinsurance after deductible is met	Not covered
Chemo/Radiation Therapy *office and outpatient hospital*	20% 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
Skilled Nursing Care (facility) *Coverage is limited to 60 days per benefit period.*	20% coinsurance after deductible is met	Not covered
Inpatient Hospice	20% coinsurance after deductible is met	Not covered
Durable Medical Equipment	20% coinsurance after deductible is met	Not covered
Prosthetic Devices	20% 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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French (Français) : Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (844) 241-7085.

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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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 ła' 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.

Tagalog (Tagalog): Kung mayroon kang anumang katanungan tungkol sa dokumentong ito, may karapatan kang humingi ng tulong at impormasyon sa iyong wika nang walang bayad. Makipag-usap sa isang tagapagpaliwanag, tawagan ang (844) 241-7085.

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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