Your summary of benefits

Empire BlueCross BlueShield

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
Out-of-Pocket Limit	$2,500 person / $5,000 family	Not covered
The family deductible and out-of-pocket maximum are embedded meaning the cost shares of one family member will be applied to both the individual deductible and individual out-of-pocket maximum; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket maximum. No one member will pay more than the individual deductible and individual out-of-pocket maximum.		
Preventive Care / Screening / Immunization	No charge	Not covered
Doctor Home and Office Services **Primary Care Visit**	$35 copay per visit deductible does not apply	Not covered
Specialist Care Visit	$50 copay per visit deductible does not apply	Not covered
Prenatal and Post-natal Care	20% coinsurance after deductible is met	Not covered
Other Practitioner Visits: Retail Health Clinic	$35 copay per visit deductible does not apply	Not covered
Preferred On-line Visit *Includes Mental/Behavioral Health and Substance Abuse (Live Health On-line)*	$10 copay per visit deductible does not apply	Not covered

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Other Participating Provider On-line Visit *Includes Mental/Behavioral Health and Substance Abuse*	$35(pcp)/$50(specialist) copay per visit deductible does not apply	Not covered
Manipulation Therapy	$50 copay per visit deductible does not apply	Not covered
Acupuncture	$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
Chemo/Radiation Therapy - PCP	20% coinsurance after deductible is met	Not covered
Chemo/Radiation Therapy - Specialist	20% coinsurance after deductible is met	Not covered
Dialysis/Hemodialysis	20% coinsurance after deductible is met	Not covered
Prescription Drugs - *Dispensed in the office*	20% coinsurance after deductible is met	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

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
X-Ray:		
Office	20% coinsurance after deductible is met	Not covered
Outpatient Hospital	20% coinsurance after deductible is met	Not covered
Advanced Diagnostic Imaging:		
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/Behavioral Health and Substance Abuse		
Doctor Office Visit	$35 copay per visit deductible does not apply	Not covered
Facility Visit:		
Facility Fees	20% coinsurance deductible does not apply	Not covered
Doctor Services	No charge	Not covered

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Outpatient Surgery		
Facility Fees:		
Hospital	20% coinsurance after deductible is met	Not covered
Freestanding Surgical Center	20% coinsurance after deductible is met	Not covered
Doctor and Other Services:		
Hospital	20% coinsurance after deductible is met	Not covered
Freestanding Surgical Center	20% coinsurance after deductible is met	Not covered
Hospital (Including Maternity, Mental / Behavioral Health, Substance Abuse):		
Facility Fees	20% coinsurance after deductible is met	Not covered
Doctor and other services	20% coinsurance after deductible is met	Not covered
Recovery & Rehabilitation		
Home Health Care *Coverage is limited to 100 visits per year.*	20% coinsurance deductible does not apply	Not covered
Rehabilitation services:		
Office *Coverage for rehabilitative and habilitative physical therapy and occupational therapy combined is limited to 60 visits per year. Coverage for rehabilitative and habilitative speech therapy is limited to 60 visits per year.*	$35 copay per visit deductible does not apply	Not covered
Outpatient Hospital *Coverage for rehabilitative and habilitative physical therapy and occupational therapy combined is limited to 60 visits per year. Coverage for rehabilitative and habilitative speech therapy is limited to 60 visits per year.*	20% coinsurance after deductible is met	Not covered
Cardiac rehabilitation		

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Office *Coverage is unlimited visits per year.* Outpatient Hospital *Coverage is unlimited visits per year.*	$50 copay per visit deductible does not apply 20% coinsurance after deductible is met	Not covered Not covered
Skilled Nursing Care (facility) *Coverage is limited to 60 days per year.*	20% coinsurance after deductible is met	Not covered
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" which is generally coinsurance or coinsurance after your deductible is met.

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.

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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Language Access Services:

Navajo (Diné): Díí naaltsoos bíká'ígíí łahgo bína'idiłkidgo ná bohónéedzą́ dóó bee ahóót'i' t'áá ni nizaad k'ehjí bee nił hodoonih t'áadoo bą́ą́h ílínígóó. Ata' halne'ígíí ła' bich'į' hadeesdzih nínízingo koji' hodíilnih (844) 241-7085.

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