Your summary of benefits

Empire BlueCross BlueShield

HDHP Plan

Your Plan: Empire EPO with HRA Deductible and Coinsurance

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
Out-of-Pocket Limit	$5,000 person / $10,000 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**	30% coinsurance after deductible is met	Not covered
Specialist Care Visit	30% coinsurance after deductible is met	Not covered
Prenatal and Post-natal Care	30% coinsurance after deductible is met	Not covered
Other Practitioner Visits:		
Retail Health Clinic	30% coinsurance after deductible is met	Not covered
On-line Visit *Includes Mental/Behavioral Health and Substance Abuse*	30% coinsurance after deductible is met	Not covered
Manipulation Therapy	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
Acupuncture	30% coinsurance after deductible is met	Not covered
Other Services in an Office:		
Allergy Testing	30% coinsurance after deductible is met	Not covered
Chemo/Radiation Therapy - PCP	30% coinsurance after deductible is met	Not covered
Chemo/Radiation Therapy - Specialist	30% coinsurance after deductible is met	Not covered
Dialysis/Hemodialysis	30% coinsurance after deductible is met	Not covered
Prescription Drugs - *Dispensed in the office*	30% coinsurance after deductible is met	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:		
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/Behavioral Health and Substance Abuse		
Doctor Office Visit	30% coinsurance after deductible is met	Not covered
Facility Visit:		
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
Freestanding Surgical Center	30% coinsurance after deductible is met	Not covered
Doctor and Other Services:		
Hospital	30% coinsurance after deductible is met	Not covered
Freestanding Surgical Center	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
Hospital (Including Maternity, Mental / Behavioral Health, Substance Abuse):		
Facility Fees	30% coinsurance after deductible is met	Not covered
Doctor and other services	30% coinsurance after deductible is met	Not covered
Recovery & Rehabilitation		
Home Health Care *Coverage is limited to 100 visits per year.*	30% coinsurance after deductible is met	Not covered
Rehabilitation services:		
Office *Coverage for rehabilitative and habilitative physical therapy and occupational therapy combined is limited to 30 visits per year. Coverage for rehabilitative and habilitative speech therapy is limited to 30 visits per year.*	30% coinsurance after deductible is met	Not covered
Outpatient Hospital *Coverage for rehabilitative and habilitative physical therapy and occupational therapy combined is limited to 30 visits per year. Coverage for rehabilitative and habilitative speech therapy is limited to 30 visits per year.*	30% coinsurance after deductible is met	Not covered
Cardiac rehabilitation		
Office *Coverage is limited to 36 visits per year.*	30% coinsurance after deductible is met	Not covered
Outpatient Hospital *Coverage is limited to 36 visits per year.*	30% coinsurance after deductible is met	Not covered
Skilled Nursing Care (facility) *Coverage is limited to 60 days per year.*	30% coinsurance after deductible is met	Not covered
Hospice	30% coinsurance after deductible is met	Not covered
Durable Medical Equipment	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
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" 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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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 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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