Your summary of benefits

Empire BlueCross BlueShield

HDHP Plan

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	$5,000 person / $10,000 family	Not covered
Out-of-Pocket Limit	$6,000 person / $12,000 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 per person deductible and per person 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 per person deductible or per person out-of-pocket maximum. Your copays, coinsurance and deductible count toward your out of pocket amount(s).		
Preventive Care / Screening / Immunization	No charge	Not covered
Preventive Care for Chronic Conditions *per IRS guidelines*	No charge	Not covered
Virtual Care (Telemedicine / Telehealth Visits) **Virtual Visits - Online visits with Doctors who also provide services in person**		
Primary Care (PCP)	20% coinsurance after deductible is met	Not covered
Mental Health and Substance Abuse care	20% coinsurance after deductible is met	Not covered
Specialist	20% coinsurance after deductible is met	Not covered
Medical Chats and Virtual (Video) Visits for Primary Care from our Online Provider K Health, through its affiliated Provider groups	0% coinsurance after deductible is met	Not Applicable

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Virtual Visits from Online Provider LiveHealth Online *via www.livehealthonline.com; our mobile app, website or Empire-enabled device*		
Primary Care (PCP) and Mental Health and Substance Abuse	20% coinsurance after deductible is met	Not Applicable
Specialist Care	20% coinsurance after deductible is met	Not covered
Visits in an Office		
Primary Care (PCP)	20% coinsurance after deductible is met	Not covered
Specialist Care	20% coinsurance after deductible is met	Not covered
Other Practitioner Visits		
Routine Maternity Care (Prenatal and Postnatal)	20% coinsurance after deductible is met	Not covered
Retail Health Clinic	20% coinsurance after deductible is met	Not covered
Chiropractic Services	20% coinsurance after deductible is met	Not covered
Acupuncture	20% coinsurance after deductible is met	Not covered
Other Services in an Office		
Allergy Testing	20% coinsurance after deductible is met	Not covered
Chemo/Radiation Therapy	20% coinsurance after deductible is met	Not covered
Dialysis/Hemodialysis *Coverage is limited to 10 visits per benefit period. Applies to Non Network.*	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

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Diagnostic Services **Lab**		
Office	20% coinsurance after deductible is met	Not covered
Freestanding Lab/Reference Lab	20% coinsurance after deductible is met	Not Applicable
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
Advanced Diagnostic Imaging *for example: MRI, PET and CAT scans*		
Office	20% coinsurance after deductible is met	Not covered
Outpatient Hospital	20% coinsurance after deductible is met	Not covered
Emergency and Urgent Care		
Urgent Care	20% coinsurance after deductible is met	Covered as In-Network
Emergency Room Facility Services *Copay waived if admitted.*	20% coinsurance after deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services	20% coinsurance after deductible is met	Covered as In-Network
Ambulance	20% coinsurance after deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Abuse		
Doctor Office Visit	20% coinsurance after deductible is met	Not covered
Facility Visit		
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
Doctor Services	20% coinsurance after deductible is met	Not covered
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 Health and 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 after deductible is met	Not covered
Rehabilitation services *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.*		
Office	20% coinsurance after deductible is met	Not covered
Outpatient Hospital	20% coinsurance after deductible is met	Not covered
Cardiac rehabilitation *Coverage is limited to 36 visits per year.*		
Office	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
Outpatient Hospital	20% coinsurance after deductible is met	Not covered
Skilled Nursing Care (facility) *Coverage is limited to 60 days per year.*	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)

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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 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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