

Your summary of benefits



An Anthem Company

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
<p>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.</p>		
Preventive Care / Screening / Immunization	No Charge	Not covered
<u>Doctor Home and Office Services</u>		
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
<u>Other Practitioner Visits:</u>		
Retail Health Clinic	30% coinsurance after deductible is met	Not covered
On-line Visit <i>Includes Mental/Behavioral Health and Substance Abuse</i>	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 <i>Coverage is limited to 20 visits per year.</i>	30% coinsurance after deductible is met	Not covered
<u>Other Services in an Office:</u> Allergy Testing Chemo/Radiation Therapy - PCP Chemo/Radiation Therapy - Specialist Dialysis/Hemodialysis Prescription Drugs - <i>Dispensed in the office</i>	30% coinsurance after deductible is met 30% coinsurance after deductible is met 30% coinsurance after deductible is met 30% coinsurance after deductible is met 30% coinsurance after deductible is met	Not covered Not covered Not covered Not covered Not covered
<u>Diagnostic Services</u> Lab: Office Freestanding Lab/Reference Lab Outpatient Hospital	30% coinsurance after deductible is met 30% coinsurance after deductible is met 30% coinsurance after deductible is met	Not covered Not covered Not covered
X-Ray: Office Outpatient Hospital	30% coinsurance after deductible is met 30% coinsurance after deductible is met	Not covered Not covered
Advanced Diagnostic Imaging: Office Outpatient Hospital	30% coinsurance after deductible is met 30% coinsurance after deductible is met	Not covered Not covered

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<u>Emergency and Urgent Care</u> Urgent Care	30% coinsurance after deductible is met	Covered as In-Network
Emergency Room Facility Services <i>Copay waived if admitted.</i> Emergency Room Doctor and Other Services	30% coinsurance after deductible is met	Covered as In-Network
<u>Ambulance</u>	30% coinsurance after deductible is met	Covered as In-Network
<u>Outpatient Mental/Behavioral Health and Substance Abuse</u> Doctor Office Visit Facility Visit: Facility Fees Doctor Services	30% coinsurance after deductible is met	Not covered
<u>Outpatient Surgery</u> Facility Fees: Hospital Freestanding Surgical Center Doctor and Other Services: Hospital 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
<p><u>Hospital (Including Maternity, Mental / Behavioral Health, Substance Abuse):</u></p> <p>Facility Fees</p> <p>Doctor and other services</p>	<p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p>	<p>Not covered</p> <p>Not covered</p>
<p><u>Recovery & Rehabilitation</u></p> <p>Home Health Care <i>Coverage is limited to 100 visits per year.</i></p>	<p>30% coinsurance after deductible is met</p>	<p>Not covered</p>
<p>Rehabilitation services:</p> <p>Office <i>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.</i></p> <p>Outpatient Hospital <i>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.</i></p>	<p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p>	<p>Not covered</p> <p>Not covered</p>
<p>Cardiac rehabilitation</p> <p>Office <i>Coverage is limited to 36 visits per year.</i></p> <p>Outpatient Hospital <i>Coverage is limited to 36 visits per year.</i></p>	<p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p>	<p>Not covered</p> <p>Not covered</p>
<p>Skilled Nursing Care (facility) <i>Coverage is limited to 60 days per year.</i></p>	<p>30% coinsurance after deductible is met</p>	<p>Not covered</p>
<p>Hospice</p>	<p>30% coinsurance after deductible is met</p>	<p>Not covered</p>
<p>Durable Medical Equipment</p>	<p>30% coinsurance after deductible is met</p>	<p>Not covered</p>

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.

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:

Chinese(中文): 如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電(844) 241-7085。

Farsi (فارسی): در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه ای به زبان مادریتان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره (844) 241-7085 تماس بگیرید.

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.

Italian (Italiano): In caso di eventuali domande sul presente documento, ha il diritto di ricevere assistenza e informazioni nella sua lingua senza alcun costo aggiuntivo. Per parlare con un interprete, chiami il numero (844) 241-7085.

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。

Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면(844) 241-7085로 문의하십시오.

Language Access Services:

Navajo (Diné): Dii naaltsoos biká'ígíí lahgo bina'idílkidgo ná bohónéedzą dóó bee ahóót'i' t'áá ni nizaad k'ehjí bee nił hodoonih t'áadoo bąąh ilinígóó. Ata' halne'ígíí la' bich'í' hadeesdzih nínizingo koj' hodíilnih (844) 241-7085.

Polish (polski): W przypadku jakichkolwiek pytań związanych z niniejszym dokumentem masz prawo do bezpłatnego uzyskania pomocy oraz informacji w swoim języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer: (844) 241-7085.

Punjabi (ਪੰਜਾਬੀ): ਜੇ ਤੁਹਾਡੇ ਇਸ ਦਸਤਾਵੇਜ਼ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹੁੰਦੇ ਹਨ ਤਾਂ ਤੁਹਾਡੇ ਕੋਲ ਮੁਫਤ ਵਿੱਚ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੁੰਦਾ ਹੈ। ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, (844) 241-7085 ਤੇ ਕਾਲ ਕਰੋ।

Russian (Русский): если у вас есть какие-либо вопросы в отношении данного документа, вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы связаться с устным переводчиком, позвоните по тел. (844) 241-7085.

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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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<https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>. Complaint forms are available at

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