Your summary of benefits

Empire BlueCross

An Anthem Company

Empire BlueCross

Your Contract Code: 2XJH

Your Plan: Empire Silver PPO 3000/0%/5250 w/HSA

Your Network: PPO/EPO

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 Certificate of Insurance or Evidence of Coverage (EOC). If there is a difference between this summary and the Certificate of Insurance or Evidence of Coverage (EOC), the Certificate of Insurance or Evidence of Coverage (EOC), will prevail.

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible *See notes section to understand how your deductible works. Your plan may also have a separate Prescription Drug Deductible. See Prescription Drug Coverage section.*	$3,000 person / $6,000 family	$6,000 person / $12,000 family
Out-of-Pocket Limit *When you meet your out-of-pocket limit, you will no longer have to pay cost-shares during the remainder of your benefit period. See notes section for additional information regarding your out of pocket maximum.*	$5,250 person / $10,500 family	$10,500 person / $21,000 family
Preventive care/screening/immunization *In-network preventive care is not subject to deductible, if your plan has a deductible.*	No charge	30% coinsurance after medical deductible is met
Doctor Home and Office Services		
Primary care visit to treat an injury or illness *Hospital clinics are not covered.*	$25 copay per visit after deductible is met	30% coinsurance after medical deductible is met
Specialist care visit	$50 copay per visit after deductible is met	30% coinsurance after medical deductible is met
Prenatal and Post-natal Care *In-Network preventative prenatal services are covered at 100%*	No charge	30% coinsurance after medical deductible is met
Other practitioner visits:		

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Retail health clinic	$25 copay per visit after deductible is met	30% coinsurance after medical deductible is met
On-line Visit *Live Health Online is the preferred telehealth solutions (www.livehealthonline.com)*	$10 copay per visit after deductible is met	30% coinsurance after medical deductible is met
Chiropractic	$50 copay per visit after deductible is met	30% coinsurance after medical deductible is met
Acupuncture	$50 copay per visit after deductible is met	30% coinsurance after medical deductible is met
Other services in an office:		
Allergy testing	$25 copay per visit after deductible is met	30% coinsurance after medical deductible is met
Chemo/radiation therapy	$50 copay per visit after deductible is met	30% coinsurance after medical deductible is met
Hemodialysis *Coverage for Non-Network Providers is limited to 10 visits per benefit period.*	$50 copay per visit after deductible is met	30% coinsurance after medical deductible is met
Prescription drugs *For the drugs itself dispensed in the office thru infusion/injection*	$50 copay per visit after deductible is met	30% coinsurance after medical deductible is met
Diagnostic Services		
Lab:		
Office	$25 copay per visit after deductible is met	30% coinsurance after medical deductible is met
Freestanding Lab *Empire's participating Freestanding Labs are Laboratory Corporation of America or Quest Diagnostics. Please check Provider Finder for additional participating Freestanding Labs in your area.*	$25 copay per visit after deductible is met	30% coinsurance after medical deductible is met

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Outpatient Hospital	$200 copay per admission after deductible is met	30% coinsurance after medical deductible is met
X-ray:		
Office	$25 copay per visit after deductible is met	30% coinsurance after medical deductible is met
Freestanding Radiology Center	$200 copay per admission after deductible is met	30% coinsurance after medical deductible is met
Outpatient Hospital	$200 copay per admission after deductible is met	30% coinsurance after medical deductible is met
Advanced diagnostic imaging (for example, MRI/PET/CAT scans):		
Office	$50 copay per visit after deductible is met	30% coinsurance after medical deductible is met
Freestanding Radiology Center	$200 copay per admission after deductible is met	30% coinsurance after medical deductible is met
Outpatient Hospital	$200 copay per admission after deductible is met	30% coinsurance after medical deductible is met
Emergency and Urgent Care		
Emergency room facility services *Copay waived if admitted.*	$300 copay per visit after deductible is met	Covered as In-Network
Emergency room doctor and other services	0% coinsurance after deductible is met	Covered as In-Network
Ambulance (air and ground)	$300 copay per trip after deductible is met	Covered as In-Network

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Urgent Care (office setting)	$50 copay per visit after deductible is met	Covered as In-Network
Outpatient Mental/Behavioral Health and Substance Abuse		
Doctor office visit	$50 copay per visit after deductible is met	30% coinsurance after medical deductible is met
Facility visit:		
Facility fees	$50 copay per admission after deductible is met	30% coinsurance after medical deductible is met
Doctor Services	$50 copay per visit after deductible is met	30% coinsurance after medical deductible is met
Outpatient Surgery		
Facility fees:		
Hospital	$200 copay per admission after deductible is met	30% coinsurance after medical deductible is met
Freestanding Surgical Center	$200 copay per admission after deductible is met	30% coinsurance after medical deductible is met
Doctor and other services:		
Hospital	0% coinsurance after deductible is met	30% coinsurance after medical deductible is met
Freestanding Surgical Center	0% coinsurance after deductible is met	30% coinsurance after medical deductible is met
Hospital Stay (all inpatient stays including maternity, mental / behavioral health, and substance abuse)		

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Facility fees (for example, room & board) *Coverage for Inpatient physical medicine and rehabilitation including day rehabilitation programs In-Network Providers and Non-Network Providers combined is limited to 60 days per benefit period.*	$500 per admission up to 4 days per admission after deductible is met	30% coinsurance after medical deductible is met
Doctor and other services	0% coinsurance after deductible is met	30% coinsurance after medical deductible is met
Recovery & Rehabilitation		
Home health care *Coverage for In-Network Providers and Non-Network Providers combined is limited to 40 visits per benefit period.*	$50 copay per visit after deductible is met	25% coinsurance after medical deductible is met
Rehabilitation services (for example, physical/speech/occupational therapy):		
Office *Coverage for physical therapy, occupational therapy and speech therapy combined In-Network Providers and Non-Network Providers combined is limited to 60 visits per benefit period. Visit limits are combined both across outpatient and other professional visits.*	$50 copay per visit after deductible is met	30% coinsurance after medical deductible is met
Outpatient hospital *Coverage for physical therapy, occupational therapy and speech therapy combined In-Network Providers and Non-Network Providers combined is limited to 60 visits per benefit period. Visit limits are combined both across outpatient and other professional visits.*	$50 copay per admission after deductible is met	30% coinsurance after medical deductible is met
Habilitation services (for example, physical/speech/occupational therapy):		
Office *Coverage for physical therapy, occupational therapy and speech therapy combined In-Network Providers and Non-Network Providers combined is limited to 60 visits per benefit period. Visit limits are combined both across outpatient and other professional visits.*	$50 copay per visit after deductible is met	30% coinsurance after medical deductible is met
Outpatient hospital *Coverage for physical therapy, occupational therapy and speech therapy combined is limited to 60 visits per benefit period and physical therapy, occupational therapy and speech therapy combined is limited to 60 visits per benefit period. Apply to In-Network Providers and Non-Network*	$50 copay per admission after deductible is met	30% coinsurance after medical deductible is met

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Providers combined. Visit limits are combined both across outpatient and other professional visits.		
Cardiac rehabilitation		
Office	$50 copay per visit after deductible is met	30% coinsurance after medical deductible is met
Outpatient hospital	$50 copay per admission after deductible is met	30% coinsurance after medical deductible is met
Skilled nursing care (in a facility) *Coverage for In-Network Providers and Non-Network Providers combined is limited to 200 days per benefit period.*	$500 per admission up to 4 days per admission after deductible is met	30% coinsurance after medical deductible is met
Hospice	0% coinsurance after deductible is met	30% coinsurance after medical deductible is met
Durable Medical Equipment *Coverage for hearing aids services left ear is limited to 1 unit every 36 months and right ear is limited to 1 unit every 36 months. Apply to In-Network and Non-Network Providers.*	0% coinsurance after deductible is met	30% coinsurance after medical deductible is met
Prosthetic Devices *Coverage for wigs and scalp hair prosthetics In-Network and Non-Network Providers is limited to 1 unit per lifetime.*	0% coinsurance after deductible is met	30% coinsurance after medical deductible is met

Your summary of benefits

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Pharmacy Deductible	Combined with medical deductible	Not Applicable
Pharmacy Out of Pocket	Combined with medical out of pocket	Combined with medical out of pocket
Prescription Drug Coverage *Traditional Open Drug List* *This product has a 90-day Retail Pharmacy Network available. A 90 day supply is available at most retail pharmacies.*		
Preventive Drugs *Preventive Rx Plus: Deductible is waived for certain drugs for diabetes, asthma, heart health, high blood pressure, high cholesterol, stroke, and osteoporosis.*		
Tier 1 - Typically Generic	$10 copay per prescription (retail only). $25 copay per prescription (home delivery only).	Not covered
Tier 2 - Typically Preferred Brand & Non-Preferred Generic Drugs	$40 copay per prescription (retail only). $100 copay per prescription (home delivery only).	Not covered
Other Drug Coverage		
Tier 1 - Typically Generic *Covers up to a 90 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program).*	$10 copay per prescription, after deductible is met (retail only). $25 copay per prescription, after deductible is met	Not covered

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
	(home delivery only).	
Tier 2 - Typically Preferred Brand & Non-Preferred Generic Drugs *Covers up to a 90 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). If you select a brand name drug when a generic drug is available, additional cost sharing amounts may apply.*	$40 copay per prescription, after deductible is met (retail only). $100 copay per prescription, after deductible is met (home delivery only).	Not covered
Tier 3 - Typically Non-Preferred Brand and Generic drugs *Covers up to a 90 day supply (retail pharmacy). Covers up to a 30 day supply for Specialty Drugs (home delivery program). If you select a brand name drug when a generic drug is available, additional cost sharing amounts may apply.*	$80 copay per prescription, after deductible is met (retail only). $200 copay per prescription, after deductible is met (home delivery only).	Not covered
Tier 4 - Typically Specialty (brand and generic)	Not Applicable	Not Applicable

Your summary of benefits

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
This is a brief outline of your vision coverage. Not all cost shares for covered services are shown below. For a full list, including benefits, exclusions and limitations, see the combined Evidence of Coverage/Disclosure form/Certificate. If there is a difference between this summary and either Evidence of Coverage/Disclosure form/Certificate, the Evidence of Coverage/Disclosure form/Certificate will prevail. *Only children's vision services count towards your out of pocket limit.*		
Children's Vision Essential Health Benefits		
Child Vision Deductible	$0 person	$0 person
Vision exam *Coverage for In-Network Providers and Non-Network Providers combined is limited to 1 exam per benefit period.*	No charge	Amount above $30 reimbursement
Frames *Coverage for In-Network Providers and Non-Network Providers combined is limited to 1 unit per benefit period.*	No charge	Amount above $45 reimbursement
Lenses *Coverage for In-Network Providers and Non-Network Providers combined is limited to 1 unit per benefit period.*	No charge	Amount above $55 reimbursement
Elective contact lenses *Coverage for In-Network Providers and Non-Network Providers combined is limited to 1 unit per benefit period.*	No charge	Amount above $60 reimbursement
Non-Elective Contact Lenses *Coverage for In-Network Providers and Non-Network Providers combined is limited to 1 unit per benefit period.*	No charge	Amount above $210 reimbursement
Adult Vision		
Adult Vision Deductible	$0 person	$0 person
Vision exam *Coverage for In-Network Providers and Non-Network Providers combined is limited to 1 exam per benefit period.*	$20 copay per visit	Amount above $30 reimbursement
Frames *Coverage for In-Network Providers and Non-Network Providers combined is limited to 1 unit every 2 years. Coverage for In-Network Providers is limited to $130 maximum benefit per occurrence.*	No charge	Amount above $45 reimbursement

Your summary of benefits

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Lenses *Coverage for Eye Glasses or Contact Lens In-Network Providers and Non-Network Providers combined is limited to 1 unit every 2 years.*	$20 copay per unit	Amount above $55 reimbursement
Elective contact lenses *Coverage for In-Network Providers is limited to $80 maximum benefit per occurrence. Coverage for Eye Glasses or Contact Lens In-Network Providers and Non-Network Providers combined is limited to 1 unit every 2 years.*	No charge	Amount above $60 reimbursement
Non-Elective Contact Lenses *Coverage for Eye Glasses or Contact Lens In-Network Providers and Non-Network Providers combined is limited to 1 unit every 2 years.*	No charge	Amount above $210 reimbursement

Your summary of benefits

Covered Dental Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
This is a brief outline of your dental coverage. Not all cost shares for covered services are shown below. For a full list, including benefits, exclusions and limitations, see the combined Evidence of Coverage/Disclosure form/Certificate. If there is a difference between this summary and either Evidence of Coverage/Disclosure form/Certificate, the Evidence of Coverage/Disclosure form/Certificate will prevail. *Only children's dental services count towards your out of pocket limit.*		
Children's Dental Essential Health Benefits **Diagnostic and preventive** *Coverage for In-Network Providers and Non-Network Providers combined is limited to 2 visits per 12 months.*	0% coinsurance after deductible is met	0% coinsurance after deductible is met
Basic services	0% coinsurance after deductible is met	0% coinsurance after deductible is met
Major services	50% coinsurance after deductible is met	50% coinsurance after deductible is met
Medically Necessary Orthodontia services	50% coinsurance after deductible is met	50% coinsurance after deductible is met
Cosmetic Orthodontia services	Not covered	Not covered
Deductible	Combined with medical deductible	Combined with medical deductible
Adult Dental		
Diagnostic and preventive	Not covered	Not covered
Basic services	Not covered	Not covered
Major services	Not covered	Not covered
Deductible	Not covered	Not Applicable
Annual maximum	Not covered	Not covered

Your summary of benefits

Your plan also includes the following Healthy Support & Rewards features.
To see your rewards and additional information log into the Anthem website at empireblue.com or call the customer service number on your member ID card.

QUARTERLY HEALTH WEBINARS	One hour health education seminars delivered via the web

Notes:

- The prescription drug plan listed on this Summary meets the Centers for Medicare and Medicaid Services (CMS) standard for Creditable Coverage under the Medicare Modernization Act of 2003.
- The family deductible and out-of-pocket maximum are embedded meaning the cost shares of one family member will be applied to the individual deductible and individual out-of-pocket maximum; in addition, amounts for all family members apply to 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.
- Your coinsurance, copays and deductible count toward your out of pocket amount.
- For additional information on this plan, please visit sbc.empireblue.com/dps/ to obtain a "Summary of Benefit and Coverage".

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 (855) 330-1105.

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 330-1105 (855).

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՝ (855) 330-1105:

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 (855) 330-1105。

Farsi (فارسي): 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 330-1105 (855) تماس بگیرید.

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Navajo (Diné): Díí naaltsoos biká'ígíí łahgo bína'ídíłkidgo 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 kojį' hodíílnih (855) 330-1105.

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: (855) 330-1105.

Punjabi (ਪੰਜਾਬੀ): ਜੇ ਤੁਹਾਡੇ ਇਸ ਦਸਤਾਵੇਜ਼ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹੁੰਦੇ ਹਨ ਤਾਂ ਤੁਹਾਡੇ ਕੋਲ ਮੁਫ਼ਤ ਵਿੱਚ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੁੰਦਾ ਹੈ। ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, (855) 330-1105 ਤੇ ਕਾਲ ਕਰੋ।

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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 (855) 330-1105.

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It's important we treat you fairly

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.