Your summary of benefits

Empire BlueCross BlueShield

An Anthem Company

Empire BlueCross BlueShield

Your Contract Code: 3JMK

Your Plan: Empire Silver EPO 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 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	Not covered
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	Not covered
Preventive care/screening/immunization *In-network preventive care is not subject to deductible, if your plan has a deductible.*	No charge	Not covered
Doctor Home and Office Services		
Primary Care Office Visit to treat an injury or illness *Hospital clinics are not covered.*	$25 copay per visit after deductible is met	Not covered
Specialist Care Office Visit	$50 copay per visit after deductible is met	Not covered
Prenatal and Post-natal Care *In-Network preventive prenatal services are covered at 100%.*	No charge	Not covered
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	Not covered
On-line Medical Visit *Live Health Online is the preferred telehealth solution (www.livehealthonline.com)*	0% coinsurance after deductible is met	Not covered
Chiropractic Services	$50 copay per visit after deductible is met	Not covered
Acupuncture	$50 copay per visit after deductible is met	Not covered
Other Services in an Office:		
Allergy Testing	$25 copay per visit after deductible is met	Not covered
Chemo/Radiation Therapy	$50 copay per visit after deductible is met	Not covered
Hemodialysis	$50 copay per visit after deductible is met	Not covered
Prescription Drugs *For the drug itself dispensed in the office through infusion/injection.*	$50 copay per visit after deductible is met	Not covered
Diagnostic Services		
Lab:		
Office *Office Cost Share applies only when Freestanding/Reference Labs are not used.*	$25 copay per visit after deductible is met	Not covered
Freestanding Laboratory Facility *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	Not covered

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Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Outpatient Hospital	$200 copay per visit after deductible is met	Not covered
X-Ray:		
Office	$25 copay per visit after deductible is met	Not covered
Freestanding Radiology Center	$200 copay per visit after deductible is met	Not covered
Outpatient Hospital	$200 copay per visit after deductible is met	Not covered
Advanced Diagnostic Imaging (for example, MRI/PET/CAT scans):		
Office	$50 copay per visit after deductible is met	Not covered
Freestanding Radiology Center	$200 copay per visit after deductible is met	Not covered
Outpatient Hospital	$200 copay per visit after deductible is met	Not covered
Emergency and Urgent Care		
Urgent Care Center Office Visit	$50 copay per visit after deductible is met	Covered as In-Network
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

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Ambulance Transportation	$300 copay per trip after deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Use Disorder		
Doctor Office Visit and Online Visit	$50 copay per visit after deductible is met	Not covered
Facility visit:		
Facility Fees	$50 copay per visit after deductible is met	Not covered
Doctor Services	$50 copay per visit after deductible is met	Not covered
Outpatient Surgery		
Facility Fees:		
Hospital	$200 copay per visit after deductible is met	Not covered
Freestanding Surgical Center	$200 copay per visit after deductible is met	Not covered
Doctor and Other Services:		
Hospital	0% coinsurance after deductible is met	Not covered
Freestanding Surgical Center	0% coinsurance after deductible is met	Not covered

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Hospital Stay (all Inpatient stays including Maternity, Mental and Substance Use Disorder):		
Facility fees (for example, room & board)	$500 copay per day to a maximum of $2,000 per admission after deductible is met	Not covered
Doctor and other services	0% coinsurance after deductible is met	Not covered
Recovery & Rehabilitation		
Home Health Care *Coverage is limited to 40 visits per benefit period. Applies to In-Network Providers. Limit does not apply to separate Physical or Occupational or Speech Therapy limits, when performed as part of Home Health.*	$50 copay per visit after deductible is met	Not covered
Rehabilitation services (for example, physical/speech/occupational therapy):		
Office *Coverage for physical therapy, occupational therapy and speech therapy is limited to 60 visits combined per benefit period. Applies to In-Network Providers. Visit limits are combined both across outpatient and other professional visits. Benefit limit does not apply when performed as part of Home Health care visits.*	$50 copay per visit after deductible is met	Not covered
Outpatient Hospital *Coverage for physical therapy, occupational therapy and speech therapy is limited to 60 visits combined per benefit period. Applies to In-Network Providers. Visit limits are combined both across outpatient and other professional visits. Benefit limit does not apply when performed as part of Home Health care visits.*	$50 copay per visit after deductible is met	Not covered
Habilitation services (for example, physical/speech/occupational therapy):		
Office *Coverage for physical therapy, occupational therapy and speech therapy is limited to 60 visits combined per benefit period. Applies to In-Network Providers. Visit limits are combined both across outpatient*	$50 copay per visit after deductible is met	Not covered

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
and other professional visits. Benefit limit does not apply when performed as part of Home Health care visits.		
Outpatient Hospital *Coverage for physical therapy, occupational therapy and speech therapy is limited to 60 visits combined per benefit period. Applies to In-Network Providers. Visit limits are combined both across outpatient and other professional visits. Benefit limit does not apply when performed as part of Home Health care visits.*	$50 copay per visit after deductible is met	Not covered
Cardiac rehabilitation		
Office	$50 copay per visit after deductible is met	Not covered
Outpatient Hospital	$50 copay per visit after deductible is met	Not covered
Skilled Nursing Care (in a facility)	$500 copay per day to a maximum of $2,000 per admission after deductible is met	Not covered
Hospice	0% coinsurance after deductible is met	Not covered
Durable Medical Equipment *Wearable hearing aids limited to a single purchase for one or both ears (including repair/replacement) once every 3 years. Applies to In-Network Providers.*	0% coinsurance after deductible is met	Not covered
Prosthetic Devices	0% coinsurance after deductible is met	Not covered

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 covered
Pharmacy Out of Pocket	Combined with medical out of pocket maximum	Not covered
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 deductible does not apply (retail only).	Not covered
Tier 2 - Typically Preferred Brand	$40 copay per Prescription deductible does not apply (retail only).	Not covered
Tier 1 - Typically Generic *Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). Covers up to 90 day supply (retail maintenance pharmacy). If you select a brand name drug when a generic drug is available, additional cost sharing amounts may apply.*	$10 copay per prescription after deductible is met (retail only). $25 copay per prescription after deductible is met (home delivery only).	Not covered
Tier 2 – Typically Preferred Brand *Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). Covers up to 90 day supply (retail maintenance pharmacy). 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).	Not covered

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
	$100 copay per prescription after deductible is met (home delivery only).	
Tier 3 - Typically Non-Preferred Brand/Specialty Drugs *Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). Covers up to 90 day supply (retail maintenance pharmacy). 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

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. Benefits include coverage for member's choice of eyeglass lenses or contact lenses, but not both. 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.		
Children's Vision Essential Health Benefits (up to age 19)		
Child Vision Deductible	$0 person	Not covered
Vision exam *Coverage for In-Network Providers is limited to 1 exam per benefit period.*	No charge	Not covered
Frames *Coverage for In-Network Providers is limited to 1 unit per benefit period.*	No charge	Not covered
Lenses *Coverage for In-Network Providers is limited to 1 unit per benefit period.*	No charge	Not covered
Elective contact lenses *Coverage for In-Network Providers is limited to 1 unit per benefit period.*	No charge	Not covered
Non-Elective Contact Lenses *Coverage for In-Network Providers is limited to 1 unit per benefit period.*	No charge	Not covered
Adult Vision (age 19 and older)		
Adult Vision Deductible	$0 person	Not covered
Vision exam *Coverage for In-Network Providers is limited to 1 exam per benefit period.*	$20 copay per visit	Not covered
Frames	Not covered	Not covered
Lenses	Not covered	Not covered
Elective contact lenses	Not covered	Not covered
Non-Elective Contact Lenses	Not covered	Not covered

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 is limited to 2 visits per 12 months.*	0% coinsurance after deductible is met	Not covered
Basic services	0% coinsurance after deductible is met	Not covered
Major services	50% coinsurance after deductible is met	Not covered
Medically Necessary Orthodontia services	50% coinsurance after deductible is met	Not covered
Cosmetic Orthodontia services	Not covered	Not covered
Deductible	Combined with medical deductible	Not covered
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 covered
Annual maximum	Not covered	Not covered

Your summary of benefits

Your plan also includes the following Reward features.

To see your rewards and additional information log into the Anthem website at www.empireblue.com or call the customer service number on your member ID card.

- *Additional rules and limitations may apply to incentives such as requiring completion of multiple activities in order to earn the rewards.*

Living Healthy	Subscriber and spouse/domestic partner may earn rewards for participating in this program. If you participate, you will earn points by completing designated steps and milestones. The points will be redeemed for rewards.	Up to $150 per member per year.
Processed Claim: Annual Flu Shot	Subscriber and spouse/domestic partner may earn a reward if you get your annual flu shot and it is verified by an Anthem claim. This activity requires completion of the Adult Wellness Exam in order to earn the rewards.	Up to $50 per member per year.
Processed Claim: Adult Wellness Exam	Subscriber and spouse/domestic partner may earn a reward if you complete an annual preventive wellness exam and it is verified by an Anthem claim. This activity requires completion of the Annual Flu Shot in order to earn the rewards.	Up to $50 per member per year.
Tobacco Certification Program	Subscriber and spouse/domestic partner may earn a reward when you confirm you're tobacco free. It will be only for the current year of your employer's program; you will need to confirm this each year to receive your reward. In some cases, this activity may require the completion of the Health Assessment in order to earn the rewards.	Up to $50 per member per year.
NY Gym Reimbursement Extra	Subscriber, spouse, and dependents age 18 and over can get money back for using a gym. Fitness membership dues, up to $400, are covered if you're a member of this plan. Work out 50 times at a qualifying fitness center for each six-month period within your benefit plan year. Benefit plan year is the yearly period of coverage that starts at the effective date of coverage.	

Your summary of benefits

Notes:

- Human Organ and Tissues Transplants require precertification and are covered as any other service in your summary of benefits.
- Empire's Service Area: Albany, Bronx, Clinton, Columbia, Delaware, Dutchess, Essex, Fulton, Green, Kings, Montgomery, Nassau, New York, Orange, Putnam, Queens, Rensselaer, Richmond, Rockland, Saratoga, Schenectady, Schoharie, Suffolk, Sullivan, Ulster, Warren, Washington and Westchester.
- The family deductible and out-of-pocket maximum are embedded indicating the cost shares of one family member will be applied to both the individual deductible and individual out-of-pocket maximum; additionally, 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.
- 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.
- For additional information on this plan, please visit www.sbc.empireblue.com to obtain a "Summary of Benefit 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 (855) 330-1105 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 (855) 330-1105.

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 (855) 330-1105.

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 (855) 330-1105.

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Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면(855) 330-1105로 문의하십시오.

Navajo (Diné): Díí naaltsoos biká'ígíí łahgo bína'ídíłkidgo ná bohónéedzą dóó bee ahóót'i' t'áá ni nizaad k'ehjí bee nił

Language Access Services:

hodoonih t'áadoo bą́ą́h ílínígóó. Ata' halne'ígíí ła' bich'į' hadeesdzih nínízingo koj̨ą' 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।

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. (855) 330-1105.

Spanish (Español): Si tiene preguntas acerca de este documento, tiene derecho a recibir ayuda e información en su idioma, sin costos. Para hablar con un intérprete, llame al (855) 330-1105.

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.

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 (855) 330-1105.

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