Your summary of benefits

Empire BlueCross

HFM Boces

Your Plan: Empire EPO with HSA

Your Network: Blue Access

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.

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.*	$2,000 person / $4,000 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.*	$4,000 person / $8,000 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 Visit to treat an injury or illness**	Covered in full after deductible is met	Not covered
Specialist Care Visit	Covered in full after deductible is met	Not covered

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Prenatal and Post-natal Care *In-Network preventive prenatal and postnatal services are covered at 100%.*	Covered in full after deductible is met	Not covered
Other Practitioner Visits:		
Retail Health Clinic	Covered in full after deductible is met	Not covered
On-line Visit	Covered in full after deductible is met	Not covered
Chiropractic	Covered in full after deductible is met	Not covered
Acupuncture	Covered in full after deductible is met	Not covered
Other Services in an Office:		
Allergy Testing Performed by a Primary Care Physician	Covered in full after deductible is met	Not covered
Allergy Testing Performed by a Specialist	Covered in full after deductible is met	Not covered
Chemo/Radiation Therapy Performed by a Primary Care Physician	Covered in full after deductible is met	Not covered
Chemo/Radiation Therapy Performed by a Specialist	Covered in full after deductible is met	Not covered
Hemodialysis Performed by a Primary Care Physician	Covered in full after deductible is met	Not covered
Hemodialysis Performed by a Specialist	Covered in full after deductible is	Not covered

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	met	
Prescription Drugs Administered in an Office by a Primary Care Physician *For the drugs itself dispensed in the office through infusion/injection.*	Covered in full after deductible is met	Not covered
Prescription Drugs Administered in an Office by a Specialist *For the drugs itself dispensed in the office through infusion/injection.*	Covered in full after deductible is met	Not covered
Diagnostic Services		
Lab:		
Office Performed by a Primary Care Physician	Covered in full after deductible is met	Not Applicable
Office Performed by a Specialist	Covered in full after deductible is met	Not Applicable
Freestanding Lab/Reference 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.*	Covered in full after deductible is met	Not Applicable
Outpatient Hospital	Covered in full after deductible is met	Not covered
X-Ray:		
Office Performed by a Primary Care Physician	Covered in full after deductible is met	Not covered
Office Performed by a Specialist	Covered in full after deductible is met	Not covered
Freestanding Radiology Center	Covered in full after deductible is met	Not covered

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Outpatient Hospital	Covered in full after deductible is met	Not covered
Advanced Diagnostic Imaging (for example, MRI/PET/CAT scans):		
Office	Covered in full after deductible is met	Not covered
Freestanding Radiology Center	Covered in full after deductible is met	Not covered
Outpatient Hospital	Covered in full after deductible is met	Not covered
Emergency and Urgent Care		
Urgent Care (Office Setting)	Covered in full after deductible is met	Covered as In-Network
Emergency Room Facility Services *Copay waived if admitted.*	Covered in full after deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services	Covered in full after deductible is met	Covered as In-Network
Ambulance (Air and Ground)	Covered in full after deductible is met	Covered as In-Network
Outpatient Mental/Behavioral Health and Substance Abuse		
Doctor Office Visit *Family counseling related to Substance Abuse is limited to 20 visits per year.*	Covered in full after deductible is met	Not covered
Facility visit:		

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Facility Fees	Covered in full after deductible is met	Not covered
Doctor Services	Covered in full after deductible is met	Not covered
Outpatient Surgery		
Facility Fees:		
Hospital	Covered in full after deductible is met	Not covered
Freestanding Surgical Center	Covered in full after deductible is met	Not covered
Doctor and Other Services:		
Surgery Performed by a Primary Care Physician	Covered in full after deductible is met	Not covered
Surgery Performed by a Specialist	Covered in full after deductible is met	Not covered
Freestanding Surgical Center	Covered in full after deductible is met	Not covered
Hospital Stay (all inpatient stays including Maternity, Mental / Behavioral Health, and Substance Abuse)		
Facility fees (for example, room & board) *Coverage for Inpatient Rehabilitation is limited to 30 days per year. Applies to In-Network.*	Covered in full after deductible is met	Not covered
Doctor and other services	Covered in full after deductible is met	Not covered

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Recovery & Rehabilitation **Home Health Care** *Coverage is limited to 100 visits per year. Applies to In-Network.*	Covered in full after deductible is met	Not covered
Rehabilitation services (for example, physical/speech/occupational therapy): Office *Coverage for rehabilitative and habilitative physical therapy and occupational therapy combined is limited to 60 visits per year. Applies to In-Network. Visit limits are combined both across outpatient and other professional visits. Coverage for rehabilitative and habilitative speech therapy is limited to 60 visits per year. Visit limits are combined both across outpatient and other professional visits. Applies to In-Network.*	Covered in full after deductible is met	Not covered
Outpatient Hospital *Coverage for rehabilitative and habilitative physical therapy and occupational therapy combined is limited to 60 visits per year. Applies to In-Network. Visit limits are combined both across outpatient and other professional visits. Coverage for rehabilitative and habilitative speech therapy is limited to 60 visits per year. Visit limits are combined both across outpatient and other professional visits. Applies to In-Network.*	Covered in full after deductible is met	Not covered
Habilitation services (for example, physical/speech/occupational therapy): Office *Coverage for rehabilitative and habilitative physical therapy and occupational therapy combined is limited to 60 visits per year. Visit limits are combined both across outpatient and other professional visits. Coverage for rehabilitative and habilitative speech therapy is limited to 30 visits per year. Visit limits are combined both across outpatient and other professional visits.*	Covered in full after deductible is met	Not covered
Outpatient Hospital *Coverage for rehabilitative and habilitative physical therapy and occupational therapy combined is limited to 60 visits combined per year. Visit limits are combined both across outpatient and other professional visits. Coverage for rehabilitative and habilitative speech therapy is limited to 30 visits per year. Visit limits are combined both across*	Covered in full after deductible is met	Not covered

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outpatient and other professional visits.		
Cardiac rehabilitation		
Office	Covered in full after deductible is met	Not covered
Outpatient Hospital	Covered in full after deductible is met	Not covered
Skilled Nursing Care (in a facility)	Covered in full after deductible is met	Not covered
Hospice	Covered in full after deductible is met	Not covered
Durable Medical Equipment	Covered in full after deductible is met	Not covered
Prosthetic Devices	Covered in full 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
Pharmacy Deductible	Combined with medical deductible	Not covered
Pharmacy Out of Pocket	Combined with medical out of pocket maximum	Not covered
Prescription Drug Coverage *National Drug List*		
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).*	$5 copay per prescription after deductible is met (retail only). $10 copay per prescription after deductible is met (home delivery).	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).*	$20 copay per prescription after deductible is met (retail only). $40 copay per prescription after deductible is met (home delivery).	Not covered
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).*	$40 copay per prescription after deductible is met (retail only). $80 copay per prescription after deductible is met (home delivery).	Not covered

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.
- Preauthorization - You may have to pay for all or a portion of any test, equipment, service or procedure that is not preauthorized. To find out which services require Preauthorization and to be sure that Preauthorization has been given, you may contact us.
- If you seek coverage for services that require Preauthorization or notification, You or Your Provider must call Us or Our vendor at the number indicated on Your ID card.
- Preventive care benefits not subject to copay, deductible and coinsurance; when provided In-Network include: mammography screenings, cervical cancer screenings, colorectal cancer screenings, prostate cancer screenings, hypercholesterolemia screenings, diabetes screenings for pregnant women, bone density testing, annual physical examinations and annual obstetric and gynecological examinations. May also include other services as required under State and Federal Law. May be subject to age and frequency limits.
- To receive a 90-day supply of prescription drugs through Empire's Mail-Order Program, the prescription must be written specifically for a 90-day supply.

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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