

Your summary of benefits



Greene County

Your Plan: PPO Deductible Plan

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 <i>See notes section to understand how your deductible works. Your plan may also have a separate Prescription Drug Deductible. See Prescription Drug Coverage section.</i>	\$400 person / \$800 family	\$1,000 person \$2,000 family
Out-of-Pocket Limit <i>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.</i>	Medical: \$1,000 person \$2,000 family RX: \$5,350 person / \$10,700 family	\$2,000 person/ \$4,000 family
Preventive care/screening/immunization <i>In-network preventive care is not subject to deductible, if your plan has a deductible.</i>	No charge	40% coinsurance after deductible is met
Doctor Home and Office Services Primary care visit to treat an injury or illness <i>Pediatric visits for children up to age 19 covered in full</i>	\$20 copay per visit deductible does not apply	40% coinsurance after deductible is met
Specialist care visit	\$20 copay per visit deductible does not apply	40% coinsurance after deductible is met
Prenatal and Post-natal Care	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Other practitioner visits: Retail health clinic	\$20 copay per visit deductible does not apply	40% coinsurance after deductible is met

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<p>On-line Visit <i>Live Health Online</i> (www.livehealthonline.com)</p> <p>Chiropractor services</p> <p>Acupuncture</p>	<p>\$0 copay per visit deductible does not apply</p> <p>\$20 copay per visit deductible does not apply</p> <p>\$20 copay per visit deductible does not apply</p>	<p>N/A</p> <p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p>
<p>Other services in an office:</p> <p>Allergy testing performed by a Primary Care Physician</p> <p>Allergy testing performed by a Specialist</p> <p>Chemo/radiation therapy performed by a Primary Care Physician</p> <p>Chemo/radiation therapy performed by a Specialist</p> <p>Hemodialysis performed by a Primary Care Physician</p> <p>Hemodialysis performed by a Specialist</p> <p>Prescription drugs administered in an office by a Primary Care Physician <i>For the drugs itself dispensed in the office through infusion/injection</i></p> <p>Prescription drugs administered in an office by a Specialist <i>For the drugs itself dispensed in the office through infusion/injection</i></p>	<p>No Charge</p> <p>No Charge</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p>
<p>Diagnostic Services</p> <p>Lab:</p> <p>Office performed by a Primary Care Physician</p>	<p>\$20 copay per visit deductible does not apply</p>	<p>40% coinsurance after deductible is met</p>

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Office performed by a Specialist	\$20 copay per visit deductible does not apply	40% coinsurance after deductible is met
Freestanding Lab	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
X-ray:		
Office performed by a Primary Care Physician	\$20 copay per visit deductible does not apply	40% coinsurance after deductible is met
Office performed by a Specialist	\$20 copay per visit deductible does not apply	40% coinsurance after deductible is met
Freestanding Radiology Center	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Advanced diagnostic imaging (for example, MRI/PET/CAT scans):		
Office	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Freestanding Radiology Center	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Emergency and Urgent Care		
Emergency room facility services <i>Cost share except deductible waived if admitted.</i>	\$35 copay per visit deductible does not apply	\$35 copay per visit deductible does not apply

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Emergency room doctor and other services	No charge	No charge
Ambulance (air and ground)	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Urgent Care (office setting)	\$20 copay per visit deductible does not apply	40% coinsurance after deductible is met
Outpatient Mental/Behavioral Health and Substance Abuse		
Doctor office visit	No Charge	40% coinsurance after deductible is met
Facility visit:		
Facility fees	No Charge	40% coinsurance after deductible is met
Doctor Services	No Charge	40% coinsurance after deductible is met
Outpatient Surgery		
Facility fees:		
Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Freestanding Surgical Center	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Doctor and other services		
Surgery performed by a Primary Care Physician	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Surgery performed by a Specialist	20% coinsurance after deductible is met	40% coinsurance after deductible is met

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<p>Hospital Stay (all inpatient stays including maternity, mental / behavioral health, and substance abuse)</p> <p>Facility fees (for example, room & board) <i>Coverage for Inpatient physical medicine and rehabilitation including day rehabilitation programs In-Network Provider and Non-Network Provider combined is limited to 60 days per benefit period.</i></p> <p>Doctor and other services</p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p>
<p>Recovery & Rehabilitation</p> <p>Home health care <i>Coverage for In-Network Provider and Non-Network Provider combined is limited to 200 visits per benefit period.</i></p>	<p>No Charge</p>	<p>40% coinsurance after deductible is met</p>
<p>Rehabilitation services (for example, physical/speech/occupational therapy):</p> <p>Office <i>Coverage for physical therapy and occupational therapy and Speech Therapy is limited to 90 combined visits per benefit period.</i></p> <p>Outpatient hospital <i>Coverage for physical therapy and occupational therapy and Speech Therapy is limited to 90 combined visits per benefit period.</i></p> <p>Habilitation services (for example, physical/speech/occupational therapy):</p> <p>Office <i>Habilitation and Rehabilitation visits count towards your Rehabilitation limit.</i></p> <p>Outpatient hospital <i>Habilitation and Rehabilitation visits count towards your Rehabilitation limit.</i></p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p>
<p>Cardiac rehabilitation</p> <p>Office</p>	<p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p>

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Outpatient hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Skilled nursing care (in a facility) <i>Coverage for In-Network Provider and Non-Network Provider combined is limited to 120 days per benefit period.</i>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Hospice	No charge	40% coinsurance after deductible is met
Durable Medical Equipment	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Prosthetic Devices	20% coinsurance	40% coinsurance after deductible is met

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Covered Prescription Drug Benefits Network: Base Network Drug List: National Direct Plus	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Pharmacy Deductible	Not Applicable	Not Applicable
Pharmacy Out of Pocket	\$5,350 person / \$10,700 family	Combined with medical out of pocket
Prescription Drug Coverage <i>**Mandatory mail order applies after 2 retail fills of maintenance medication</i>		
Tier 1 - Typically Generic <i>Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program).</i>	\$10 copay per prescription (retail only) and \$20 copay per prescription (home delivery only)	Not covered
Tier 2 - Typically Preferred / Brand <i>Covers up to a 30 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.</i>	\$30 copay per prescription (retail only) and \$60 copay per prescription (home delivery only)	Not covered
Tier 3 - Typically Non-Preferred / Specialty Drugs <i>Covers up to a 30 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.</i>	\$45 copay per prescription (retail only) and \$90 copay per prescription (home delivery only)	Not covered
Tier 4 - Typically Specialty Drugs	Not Applicable	Not Applicable

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Notes:

- 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.
- 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.
- Our Preauthorization is required before You receive certain Covered Services. You are responsible for requesting Preauthorization for the following services: All inpatient admissions, including maternity admissions and admissions for illness or injury to newborns; Inpatient Mental Health Care, Substance Abuse Care and Alcohol Detoxification; Skilled Nursing Facility; Outpatient/Ambulatory Surgical Treatments (certain procedures); Chiropractic Care (after the 5th visit); Physical, Occupational, and Speech Therapy; Diagnostics; Outpatient Treatments; Air Ambulance; High tech radiology services: MRI, MRA, PET, CAT, Nuclear Technology services; Durable Medical Equipment; Prosthetics and Orthotics; Assistive Communication Devices.
- 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.

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) 241-7087.

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) 241-7087.

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) 241-7087:

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) 241-7087。

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) 241-7087 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) 241-7087.

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) 241-7087.

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) 241-7087.

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) 241-7087 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) 241-7087 로 문의하십시오.

Navajo (Diné): Dú naaltsoos biká'ígíí lahgo bina'idíilkidgo ná bohónéedzá dóó bee ahóót'i' t'áá ni nizaad k'ehjí bee níí hodoonih t'áadoo bą́ąh ilínígóó. Ata' halne'ígíí la' bich'í' hadeesdzih nínizingo koj' hodiilnih (844) 241-7087.

Language Access Services:

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) 241-7087.

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) 241-7087 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) 241-7087.

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 (844) 241-7087.

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) 241-7087.

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) 241-7087.

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>.