Your summary of benefits

An Anthem Company

Empire BlueCross

Fulmont Health Trust

Your Plan: Empire EPO with HSA

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	$1,500 person / $3,000 family	Not covered
Overall Out-of-Pocket Limit	$6,350 person / $12,700 family	Not covered
The family deductible and out-of-pocket limit are non-embedded, meaning the cost shares of all family members apply to one family deductible and one family out-of-pocket limit. The per person deductible and per person out-of-pocket limit apply to individuals enrolled under single-only coverage. Your copays, coinsurance and deductible count toward your out of pocket limit(s).		
Doctor Visits (virtual and office) *You are encouraged to select a Primary Care Physician (PCP).*		
Medical Chats and Virtual Visits for Primary Care *from our Online Provider K Health, through its affiliated Provider groups are covered at 0% coinsurance after deductible is met.*		
Virtual Visits from online provider LiveHealth Online *for urgent/acute medical and mental health and substance abuse care via www.livehealthonline.com are covered at No charge; and $20 copay per visit after deductible is met for covered Specialist Care.*		
Primary Care (PCP) and Mental Health and Substance Abuse Care *virtual and office*	$20 copay per visit after deductible is met	Not covered
Specialist Care *virtual and office*	$20 copay per visit after deductible is met	Not covered
Other Practitioner Visits		
Routine Maternity Care (Prenatal and Postnatal)	0% coinsurance after deductible is met	Not covered
Retail Health Clinic *for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.*	$20 copay per visit 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
Chiropractic Services	$20 copay per visit after deductible is met	Not covered
Acupuncture	$20 copay per visit after deductible is met	Not covered
<u>Other Services in an Office</u>		
Allergy Testing	$20 copay per visit after deductible is met	Not covered
Prescription Drugs *Dispensed in the office*	$20 copay per visit after deductible is met	Not covered
Surgery	$20 copay per surgery after deductible is met	Not covered
Preventive care / screenings / immunizations	No charge	Not covered
Preventive Care for Chronic Conditions *per IRS guidelines*	No charge	Not covered
<u>Diagnostic Services</u> **Lab**		
Office	$20 copay per visit after deductible is met	Not covered
Freestanding Lab/Reference Lab	0% coinsurance after deductible is met	Not covered
Outpatient Hospital	0% coinsurance after deductible is met	Not covered
X-Ray		
Office	$20 copay per visit after deductible is met	Not covered
Outpatient Hospital	0% coinsurance after deductible is met	Not covered
Advanced Diagnostic Imaging *for example: MRI, PET and CAT scans*		
Office	0% coinsurance after deductible is met	Not covered
Outpatient Hospital	0% coinsurance after deductible is met	Not covered
<u>Emergency and Urgent Care</u>		
Urgent Care *includes doctor services. Additional charges may apply depending on the care provided.*	$25 copay per visit after deductible is met	Covered as In-Network

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Emergency Room Facility Services *Copay waived if admitted.*	$200 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	0% coinsurance after deductible is met	Covered as In-Network
<u>Outpatient Mental Health and Substance Abuse Care at a Facility</u>		
Facility Fees	0% coinsurance after deductible is met	Not covered
Doctor Services	0% coinsurance after deductible is met	Not covered
<u>Outpatient Surgery</u>		
Facility Fees		
Hospital	0% coinsurance after deductible is met	Not covered
Ambulatory Surgical Center	0% coinsurance after deductible is met	Not covered
Doctor and Other Services		
Hospital	$20 copay per visit after deductible is met	Not covered
Ambulatory Surgical Center	$20 copay per visit after deductible is met	Not covered
<u>Hospital (Including Maternity, Mental Health and Substance Abuse)</u>		
Facility Fees *Coverage for Inpatient Rehabilitation is limited to 30 days per per year.*	$0 copay per admission after deductible is met	Not covered
Physician and other services *including surgeon fees*	0% coinsurance after deductible is met	Not covered
Home Health Care *Coverage is limited to 200 visits per per year.*	$20 copay per visit 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
Rehabilitation and Habilitation services *including physical, occupational and speech therapies.* *Coverage for physical, occupational and speech therapies is limited to 60 visits combined per year.*		
Office	$20 copay per visit after deductible is met	Not covered
Outpatient Hospital	$20 copay per visit after deductible is met	Not covered
Pulmonary rehabilitation		
Office	$20 copay per visit after deductible is met	Not covered
Outpatient Hospital	0% coinsurance after deductible is met	Not covered
Cardiac rehabilitation		
Office	$20 copay per visit after deductible is met	Not covered
Outpatient Hospital	0% coinsurance after deductible is met	Not covered
Dialysis/Hemodialysis *office and outpatient hospital*	$20 copay per visit after deductible is met	Not covered
Chemo/Radiation Therapy *office and outpatient hospital*	$20 copay per visit after deductible is met	Not covered
Skilled Nursing Care (facility) *Coverage is limited to 120 days per per year.*	$0 copay per admission after deductible is met	Not covered
Inpatient Hospice	0% coinsurance after deductible is met	Not covered
Durable Medical Equipment	50% coinsurance after deductible is met	Not covered
Prosthetic Devices *Coverage for wigs is limited to 1 item after cancer treatment per benefit period.*	20% coinsurance after deductible is met	Not covered

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Pharmacy Deductible	Combined with In-Network medical deductible	Not covered
Pharmacy Out-of-Pocket Limit	Combined with In-Network medical out-of-pocket limit	Not covered
Prescription Drug Coverage **Network:** ***Base Network*** **Drug List:** ***National*** *If you select a brand name drug when a generic drug is available, additional cost sharing amounts may apply.*		
Day Supply Limits: **Retail Pharmacy** *30 day supply (cost shares noted below)* **Retail 90 Pharmacy** *90 day supply (3 times the 30 day supply cost share(s) charged at In-Network Retail Pharmacies noted below applies).* **Home Delivery Pharmacy** *90 day supply (maximum cost shares noted below) Maintenance medications are available through CarelonRx Mail (IngenioRx will become CarelonRx on January 1, 2023). You will need to call us on the number on your ID card to sign up when you first use the service.* **Specialty Pharmacy** *30 day supply (cost shares noted below for retail and home delivery apply). We may require certain drugs with special handling, provider coordination or patient education be filled by our designated specialty pharmacy.*		
Preventive Drugs *Your In-Network Pharmacy deductible is waived for drugs included on the PreventiveRX Plus drug list, a designated list of drugs to treat health conditions, such as: diabetes, asthma, depression, heart health, high blood pressure, high cholesterol, and osteoporosis.*		
Tier 1 - Typically Generic	$10 copay per prescription after deductible is met (retail) and $20 copay per prescription after deductible is met (home delivery)	Not covered
Tier 2 – Typically Preferred Brand	$25 copay per prescription after deductible is met (retail) and $50 copay per prescription after deductible is met (home delivery)	Not covered
Tier 3 - Typically Non-Preferred Brand/Specialty Drugs	$40 copay per prescription after deductible is met (retail) and $80 copay per prescription after	Not covered

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
	deductible is met (home delivery)	

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".
- Costs may vary by the site of service. Other cost shares may apply depending on services provided. Check your Certificate of Coverage for details.
- Covered Infertility services: lab and radiology tests, cryopreservation, fertility drugs, surgical treatments such as: Artificial Insemination, In-vitro fertilization (IVF), GIFT, ZIFT. Cost share will be applied based on service and setting. Lifetime Maximum: IVF limited to 3 cycles.

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.

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