Your summary of benefits

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
Out-of-Pocket Limit	$6,350 person / $12,700 family	Not covered
The family deductible and out-of-pocket maximum are non-embedded meaning the cost shares of all family members apply to one shared family deductible and one shared family out-of-pocket maximum. The individual deductible and individual out-of-pocket maximum only apply to individuals enrolled under single coverage.		
Preventive Care / Screening / Immunization	No charge	Not covered
Doctor Home and Office Services **Primary Care Visit**	$20 copay per visit after deductible is met	Not covered
Specialist Care Visit - *Includes On-line Visit*	$20 copay per visit after deductible is met	Not covered
Prenatal and Post-natal Care	$0 copay per pregnancy after deductible is met	Not covered
Other Practitioner Visits: Medical Chats - *within our mobile app*	$0 copay after deductible is met	Not Applicable
Retail Health Clinic	$20 copay per visit after deductible is met	Not covered
Preferred On-line Visit *Includes Primary Care, Mental/Behavioral Health and Substance Abuse* *Live Health Online is the preferred telehealth solution.* *(www.livehealthonline.com).*	$0 copay per visit, deductible does not apply	Not Applicable

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Other Provider On-line Visit *Includes Primary Care, Mental/Behavioral Health and Substance Abuse*	$20 copay per visit after deductible is met	Not covered
Chiropractic Services	$20 copay per visit after deductible is met	Not covered
Acupuncture	$20 copay per visit after deductible is met	Not covered
Other Services in an Office:		
Allergy Testing	$20 copay per visit after deductible is met‡	Not covered
Chemo/Radiation Therapy	$20 copay per visit after deductible is met‡	Not covered
Dialysis/Hemodialysis	$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
Diagnostic Services **Lab:**		
Office	**PCP** $20 copay per visit after deductible is met **Specialist** $20 copay per visit after deductible is met	Not Applicable
Freestanding Lab/Reference Lab	0% coinsurance after deductible is met	Not Applicable
Outpatient Hospital	0% coinsurance after deductible is met	Not covered
X-Ray:		
Office	**PCP** $20 copay per visit after deductible is met **Specialist** $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
Outpatient Hospital	0% coinsurance after deductible is met	Not covered
Advanced Diagnostic Imaging:		
Office	$0 copay per visit after deductible is met	Not covered
Outpatient Hospital	0% coinsurance after deductible is met	Not covered
Emergency and Urgent Care		
Urgent Care	$25 copay per visit after deductible is met	Covered as In-Network
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 copay per trip after deductible is met	Covered as In-Network
Outpatient Mental/Behavioral Health and Substance Abuse		
Doctor Office Visit	$20 copay per visit after deductible is met	Not covered
Facility Visit:		
Facility Fees	0% coinsurance after deductible is met	Not covered
Doctor Services	0% coinsurance after deductible is met	Not covered
Outpatient Surgery		
Facility Fees:		
Hospital	$0 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
Freestanding Surgical Center	$0 copay per visit after deductible is met	Not covered
Doctor and Other Services:		
Hospital	$20 copay per visit after deductible is met	Not covered
Freestanding Surgical Center	$20 copay per visit after deductible is met	Not covered
Hospital (Including Maternity, Mental / Behavioral Health, Substance Abuse):		
Facility Fees *Coverage for Inpatient Rehabilitation is limited to 30 days per year.*	$0 copay 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 200 visits per year.*	$20 copay per visit after deductible is met	Not covered
Rehabilitation services:		
Office *Coverage for rehabilitative and habilitative physical therapy, occupational therapy, and rehabilitative and habilitative speech therapy combined is limited to 60 visits per year.*	$20 copay per visit after deductible is met	Not covered
Outpatient Hospital *Coverage for rehabilitative and habilitative physical therapy, occupational therapy, and rehabilitative and habilitative speech therapy combined is limited to 60 visits per year.*	$20 copay per visit 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

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Skilled Nursing Care (facility) *Coverage is limited to 120 days per year.*	$0 copay per admission after deductible is met	Not covered
Hospice	0% coinsurance after deductible is met	Not covered
Durable Medical Equipment	50% coinsurance after deductible is met	Not covered
Prosthetic Devices	20% coinsurance 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	Not covered
Prescription Drug Coverage *National with R90* *National Drug List* *This product has a 90-day Retail Pharmacy Network available. No coverage for non-formulary drugs.*		
Preventive Drugs *Preventive Rx Plus: Deductible is waived for certain drugs for diabetes, asthma, heart health, high blood pressure, high cholesterol, stroke, and osteoporosis. This plan has Preventive RX coverage that allows the cost share without application to Deductible for designated Preventive drugs.*		
Tier 1 -Preventive Drugs- Typically Generic	$10 copay per prescription, deductible does not apply (retail) and $20 copay per prescription, deductible does not apply (home delivery)	Not covered (retail and home delivery)
Tier 2 - Preventive Drugs-Typically Preferred Brand	$25 copay per prescription, deductible does not apply (retail) and $50 copay per	Not covered (retail and home delivery)

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
	prescription, deductible does not apply (home delivery)	
Tier 1 - Typically Generic *30 day supply (retail pharmacy). 90 day supply (home delivery).*	$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 *30 day supply (retail pharmacy). 90 day supply (home delivery). If you select a brand name drug when a generic drug is available, additional cost sharing amounts may apply.*	$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 *30 day supply (retail pharmacy). 90 day supply (home delivery). 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) and $80 copay per prescription after deductible is met (home delivery)	Not covered

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.
- ‡ Your cost share may be reduced when services are provided in a PCP's office.

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.

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) 241-7085

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)

Arabic (العربية): إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على 241-7085 (844) .

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) 241-7085:

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) 241-7085。

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 241-7085 (844) 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) 241-7085.

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) 241-7085.

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) 241-7085.

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) 241-7085 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) 241-7085로 문의하십시오.

Language Access Services:

Navajo (Diné): Díí naaltsoos biká'ígíí łahgo bína'ídíłkidgo ná bohónéedzą́ dóó bee ahóót'i' t'áá ni nizaad k'ehjį bee nił hodoonih t'áadoo bą́ą́h ílínígóó. Ata' halne'ígíí ła' bich'į' hadeesdzih nínízingo kojį' hodíílnih (844) 241-7085.

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) 241-7085.

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, (844) 241-7085 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) 241-7085.

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) 241-7085.

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) 241-7085.

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) 241-7085.

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.