Your summary of benefits

Empire BlueCross

Fulmont Health Trust

Your Plan: Empire EPO

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	$0 person / $0 family	Not covered
Out-of-Pocket Limit	$6,350 person / $12,700 family	Not covered
The family deductible and out-of-pocket maximum are embedded meaning the cost shares of one family member will be applied to both the individual deductible and individual out-of-pocket maximum; in addition, 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.		
Preventive Care / Screening / Immunization	No charge	Not covered
Doctor Home and Office Services **Primary Care Visit**	 $20 copay per visit	 Not covered
Specialist Care Visit - *Includes On-line Visit*	$20 copay per visit	Not covered
Prenatal and Post-natal Care	No charge after initial $20 copay	Not covered
Other Practitioner Visits: Medical Chats - *within our mobile app* Retail Health Clinic 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 $20 copay per visit $0 copay per visit	 Not Applicable Not covered 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	Not covered
Chiropractic Services	$20 copay per visit	Not covered
Acupuncture	No charge	Not covered
Other Services in an Office:		
Allergy Testing	No charge	Not covered
Chemo/Radiation Therapy	No charge	Not covered
Dialysis/Hemodialysis	No charge	Not covered
Prescription Drugs - *Dispensed in the office*	No charge	Not covered
Diagnostic Services **Lab:**		
Office	No charge	Not Applicable
Freestanding Lab/Reference Lab	No charge	Not Applicable
Outpatient Hospital	No charge	Not covered
X-Ray:		
Office	No charge	Not covered
Outpatient Hospital	No charge	Not covered
Advanced Diagnostic Imaging:		
Office	$0 copay per service	Not covered

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Outpatient Hospital	$0 copay per service	Not covered
<u>**Emergency and Urgent Care**</u>		
Urgent Care	$25 copay per visit	Covered as In-Network
Emergency Room Facility Services *Copay waived if admitted.*	$200 copay per visit	Covered as In-Network
Emergency Room Doctor and Other Services	No charge	Covered as In-Network
<u>**Ambulance**</u>	$0 copay per trip	Covered as In-Network
<u>**Outpatient Mental/Behavioral Health and Substance Abuse**</u>		
Doctor Office Visit	No charge	Not covered
Facility Visit:		
Facility Fees	No charge	Not covered
Doctor Services	No charge	Not covered
<u>**Outpatient Surgery**</u>		
Facility Fees:		
Hospital	$0 copay per visit	Not covered
Freestanding Surgical Center	$0 copay per visit	Not covered
Doctor and Other Services:		
Hospital	No charge	Not covered
Freestanding Surgical Center	No charge	Not covered

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Hospital (Including Maternity, Mental / Behavioral Health, Substance Abuse): **Facility Fees** *Coverage for Inpatient Rehabilitation is limited to 120 days per year.* **Doctor and other services**	$0 copay per admission No charge	Not covered Not covered
Recovery & Rehabilitation **Home Health Care** *Unlimited visits per year*	No charge	Not covered
Rehabilitation services: Office Coverage for rehabilitative and habilitative physical therapy, occupational therapy, and rehabilitative and habilitative speech therapy combined is limited to 120 visits per year. Outpatient Hospital *Coverage for rehabilitative and habilitative physical therapy, occupational therapy, and rehabilitative and habilitative speech therapy combined is limited to 120 visits per year.*	$20 copay per visit $20 copay per visit	Not covered Not covered
Cardiac rehabilitation Office Outpatient Hospital	$20 copay per visit $20 copay per visit	Not covered Not covered
Skilled Nursing Care (facility) *Unlimited days per year.*	$0 copay per admission	Not covered
Hospice	No charge	Not covered
Durable Medical Equipment	No charge	Not covered
Prosthetic Devices	20% coinsurance	Not covered

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Pharmacy Deductible	Not applicable	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. A 90 day supply is available at most retail pharmacies.*		
Tier 1 - Typically Generic *30 day supply (retail pharmacy). 90 day supply (home delivery).*	$10 copay per prescription, deductible does not apply (retail) and $20 copay per prescription, deductible does not apply (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, deductible does not apply (retail) and $50 copay per prescription, deductible does not apply (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, deductible does not apply (retail) and $80 copay per prescription, deductible does not apply (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.

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 7085-241 (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:

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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.

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Language Access Services:

Navajo (Diné): Díí naaltsoos biká'ígíí łahgo bína'ídílkidgo ná bohónéedzą́ dóó bee ahóót'i' t'áá ni nizaad k'ehjį bee nił hodoonih t'áadoo bą́ąh 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.

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