Your summary of benefits

Empire BlueCross
An Anthem Company

Empire BlueCross

Fulmont Health Trust

Your Plan: Empire PPO-High (RX: $5/$15/$30)

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	$750 person / $1,500 family
Out-of-Pocket Limit	$6,350 person / $12,700 family	$2,500 person / $5,000 family
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	30% coinsurance after deductible is met
Doctor Home and Office Services **Primary Care Visit**	$20 copay per visit	30% coinsurance after deductible is met
Specialist Care Visit - *Includes On-line Visit*	$20 copay per visit	30% coinsurance after deductible is met
Prenatal and Post-natal Care	No charge after initial $20 copay	30% coinsurance after deductible is met
Other Practitioner Visits:		
Medical Chats - *within our mobile app*	$0 copay per visit	Not Applicable
Retail Health Clinic	$20 copay per visit	30% coinsurance after deductible is met
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	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	30% coinsurance after deductible is met
Chiropractic Services	$20 copay per visit	30% coinsurance after deductible is met
Acupuncture	No charge	Not covered
Other Services in an Office:		
Allergy Testing	No charge	30% coinsurance after deductible is met
Chemo/Radiation Therapy	No charge	30% coinsurance after deductible is met
Dialysis/Hemodialysis	No charge	30% coinsurance after deductible is met
Prescription Drugs - *Dispensed in the office*	No charge	30% coinsurance after deductible is met
Diagnostic Services **Lab:**		
Office	No charge	30% coinsurance after deductible is met
Freestanding Lab/Reference Lab	No charge	30% coinsurance after deductible is met
Outpatient Hospital	No charge	30% coinsurance after deductible is met
X-Ray:		
Office	No charge	30% coinsurance after deductible is met
Outpatient Hospital	No charge	30% coinsurance after deductible is met
Advanced Diagnostic Imaging:		
Office	$0 copay per service	30% coinsurance after deductible is met

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	30% coinsurance after deductible is met
Emergency and Urgent Care **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
Ambulance	$0 copay per trip	Covered as In-Network
Outpatient Mental/Behavioral Health and Substance Abuse **Doctor Office Visit**	No charge	30% coinsurance after deductible is met
Facility Visit:		
Facility Fees	No charge	30% coinsurance after deductible is met
Doctor Services	No charge	30% coinsurance after deductible is met
Outpatient Surgery **Facility Fees:**		
Hospital	$0 copay per visit	30% coinsurance after deductible is met
Freestanding Surgical Center	$0 copay per visit	30% coinsurance after deductible is met
Doctor and Other Services:		
Hospital	No charge	30% coinsurance after deductible is met
Freestanding Surgical Center	No charge	30% coinsurance after deductible is met

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.*	$0 copay per admission	30% coinsurance after deductible is met
Doctor and other services	No charge	30% coinsurance after deductible is met
Recovery & Rehabilitation		
Home Health Care *Unlimited visits per year.*	No charge	30% coinsurance after deductible is met
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.*	$20 copay per visit	Not covered
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	Not covered
Cardiac rehabilitation		
Office	$20 copay per visit	30% coinsurance after deductible is met
Outpatient Hospital	$20 copay per visit	30% coinsurance after deductible is met
Skilled Nursing Care (facility) *Unlimited days per year.*	$0 copay per admission	30% coinsurance after deductible is met
Hospice	No charge	30% coinsurance after deductible is met
Durable Medical Equipment	No charge	30% coinsurance after deductible is met
Prosthetic Devices	20% coinsurance	20% coinsurance after deductible is met

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).*	$5 copay per prescription, deductible does not apply (retail) and $10 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.*	$15 copay per prescription, deductible does not apply (retail) and $30 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.*	$30 copay per prescription, deductible does not apply (retail) and $60 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 (844) 241-7085 .

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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Language Access Services:

Navajo (Diné): Díí naaltsoos bíká'ígíí łahgo bína'idiłkidgo ná bohónéedzą́ dóó bee ahóót'i' t'áá ni nizaad k'ehjí bee nił hodoonih t'áadoo bą́ą́h ílínígóó. Ata' halne'ígíí ła' bich'į' hadeesdzih nínízingo koji' hodíilnih (844) 241-7085.

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