

# Your summary of benefits



An Anthem Company

Empire BlueCross

Fulmont Health Trust

Your Plan: Empire PPO-Low (RX: \$10/\$20/\$40)

Your Network: PPO/EPO

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<b>Overall Deductible</b>	\$0 person / \$0 family	\$750 person / \$1,500 family
<b>Out-of-Pocket Limit</b>	\$6,350 person / \$12,700 family	\$2,500 person / \$5,000 family
<p>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.</p>		
<b>Preventive Care / Screening / Immunization</b>	No charge	30% coinsurance after deductible is met
<b><u>Doctor Home and Office Services</u></b>		
<b>Primary Care Visit</b>	\$20 copay per visit	30% coinsurance after deductible is met
<b>Specialist Care Visit - Includes On-line Visit</b>	\$20 copay per visit	30% coinsurance after deductible is met
<b>Prenatal and Post-natal Care</b>	No charge after initial \$20 copay	30% coinsurance after deductible is met
<b><u>Other Practitioner Visits:</u></b>		
Medical Chats - <i>within our mobile app</i>	\$0 copay per visit	Not Applicable
Retail Health Clinic	\$20 copay per visit	30% coinsurance after deductible is met
Preferred On-line Visit <i>Includes Primary Care, Mental/Behavioral Health and Substance Abuse Live Health Online is the preferred telehealth solution. (<a href="http://www.livehealthonline.com">www.livehealthonline.com</a>).</i>	\$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 <i>Includes Primary Care, Mental/Behavioral Health and Substance Abuse</i>	\$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
<b><u>Other Services in an Office:</u></b> Allergy Testing Chemo/Radiation Therapy Dialysis/Hemodialysis Prescription Drugs - <i>Dispensed in the office</i>	No charge	30% coinsurance after deductible is met
<b><u>Diagnostic Services</u></b> <b>Lab:</b> Office Freestanding Lab/Reference Lab Outpatient Hospital	No charge	30% coinsurance after deductible is met
<b>X-Ray:</b> Office Outpatient Hospital	No charge	30% coinsurance after deductible is met
<b>Advanced Diagnostic Imaging:</b> 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
<b><u>Emergency and Urgent Care</u></b> <b>Urgent Care</b>	\$25 copay per visit	Covered as In-Network
<b>Emergency Room Facility Services</b> <i>Copay waived if admitted.</i>  <b>Emergency Room Doctor and Other Services</b>	\$200 copay per visit  No charge	Covered as In-Network  Covered as In-Network
<b><u>Ambulance</u></b>	\$0 copay per trip	Covered as In-Network
<b><u>Outpatient Mental/Behavioral Health and Substance Abuse</u></b> <b>Doctor Office Visit</b>  <b>Facility Visit:</b> Facility Fees  Doctor Services	No charge  No charge  No charge	30% coinsurance after deductible is met  30% coinsurance after deductible is met  30% coinsurance after deductible is met
<b><u>Outpatient Surgery</u></b> <b>Facility Fees:</b> Hospital  Freestanding Surgical Center  <b>Doctor and Other Services:</b> Hospital  Freestanding Surgical Center	\$0 copay per visit  \$0 copay per visit  No charge  No charge	30% coinsurance after deductible is met  30% coinsurance after deductible is met  30% coinsurance after deductible is met  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
<p><b><u>Hospital (Including Maternity, Mental / Behavioral Health, Substance Abuse):</u></b></p> <p><b>Facility Fees</b> <i>Coverage for Inpatient Rehabilitation is limited to 120 days per year.</i></p> <p><b>Doctor and other services</b></p>	<p>\$0 copay per admission</p> <p>No charge</p>	<p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p>
<p><b><u>Recovery &amp; Rehabilitation</u></b></p> <p><b>Home Health Care</b> <i>Unlimited visits per year.</i></p>	<p>No charge</p>	<p>30% coinsurance after deductible is met</p>
<p><b>Rehabilitation services:</b></p> <p>Office <i>Coverage for rehabilitative and habilitative physical therapy, occupational therapy, and rehabilitative and habilitative speech therapy combined is limited to 120 visits per year.</i></p> <p>Outpatient Hospital <i>Coverage for rehabilitative and habilitative physical therapy, occupational therapy, and rehabilitative and habilitative speech therapy combined is limited to 120 visits per year.</i></p>	<p>\$20 copay per visit</p> <p>\$20 copay per visit</p>	<p>Not covered</p> <p>Not covered</p>
<p><b>Cardiac rehabilitation</b></p> <p>Office</p> <p>Outpatient Hospital</p>	<p>\$20 copay per visit</p> <p>\$20 copay per visit</p>	<p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p>
<p><b>Skilled Nursing Care (facility)</b> <i>Unlimited days per year.</i></p>	<p>\$0 copay per admission</p>	<p>30% coinsurance after deductible is met</p>
<p><b>Hospice</b></p>	<p>No charge</p>	<p>30% coinsurance after deductible is met</p>
<p><b>Durable Medical Equipment</b></p>	<p>No charge</p>	<p>30% coinsurance after deductible is met</p>
<p><b>Prosthetic Devices</b></p>	<p>20% coinsurance</p>	<p>20% coinsurance after deductible is met</p>

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<b>Pharmacy Deductible</b>	Not applicable	Not covered
<b>Pharmacy Out of Pocket</b>	Combined with medical	Not covered
<b>Prescription Drug Coverage</b>  <i>National with R90 National Drug List</i>  <i>This product has a 90-day Retail Pharmacy Network available. A 90 day supply is available at most retail pharmacies.</i>		
<b>Tier 1 - Typically Generic</b>  <i>30 day supply (retail pharmacy). 90 day supply (home delivery).</i>	\$10 copay per prescription, deductible does not apply (retail) and \$20 copay per prescription, deductible does not apply (home delivery)	Not covered
<b>Tier 2 – Typically Preferred Brand</b>  <i>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.</i>	\$25 copay per prescription, deductible does not apply (retail) and \$50 copay per prescription, deductible does not apply (home delivery)	Not covered
<b>Tier 3 - Typically Non-Preferred Brand/Specialty Drugs</b>  <i>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.</i>	\$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.*

## 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)

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## Language Access Services:

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**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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