

# Your summary of benefits



Anthem BlueCross

Fulmont Health Trust

Your Plan: Anthem 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
<b>Overall Deductible</b>	\$1,600 person / \$3,200 family	Not covered
<b>Overall Out-of-Pocket Limit</b>	\$6,350 person / \$12,700 family	Not covered
<p>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.</p> <p>Your copays, coinsurance and deductible count toward your out of pocket limit(s).</p>		
<p><b>Doctor Visits (virtual and office)</b> <i>You are encouraged to select a Primary Care Physician (PCP).</i></p>		
<p><b>Medical Chats and Virtual Visits for Primary Care</b> <i>from our Online Provider K Health, through its affiliated Provider groups are covered at 0% coinsurance after deductible is met.</i></p>		
<p><b>Virtual Visits from online provider LiveHealth Online</b> <i>for urgent/acute medical and mental health and substance abuse care via <a href="http://www.livehealthonline.com">www.livehealthonline.com</a> are covered at No charge; and \$20 copay per visit after deductible is met for covered Specialist Care.</i></p>		
<p><b>Primary Care (PCP) and Mental Health and Substance Abuse Care</b> <i>virtual and office</i></p>	\$20 copay per visit after deductible is met	Not covered
<p><b>Specialist Care</b> <i>virtual and office</i></p>	\$20 copay per visit after deductible is met	Not covered
<p><b><u>Other Practitioner Visits</u></b></p>		
<p><b>Routine Maternity Care</b> (Prenatal and Postnatal)</p>	0% coinsurance after deductible is met	Not covered
<p><b>Retail Health Clinic</b> <i>for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.</i></p>	\$20 copay per visit after deductible is met	Not covered

Services provided by Anthem HealthChoice Assurance, Inc., licensee of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans.

Questions: Visit us at [www.Anthemblue.com](http://www.Anthemblue.com)

NY/LG/Fulmont Health Trust: Anthem EPO with HSA/513E/07-01-2024

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<b>Chiropractic Services</b>	\$20 copay per visit after deductible is met	Not covered
<b>Acupuncture</b>	\$20 copay per visit after deductible is met	Not covered
<u><b>Other Services in an Office</b></u> <b>Allergy Testing</b>  <b>Prescription Drugs</b> <i>Dispensed in the office</i>  <b>Surgery</b>	\$20 copay per visit after deductible is met  \$20 copay per visit after deductible is met  \$20 copay per surgery after deductible is met	Not covered  Not covered  Not covered
<b>Preventive care / screenings / immunizations</b>	No charge	Not covered
<b>Preventive Care for Chronic Conditions</b> <i>per IRS guidelines</i>	No charge	Not covered
<u><b>Diagnostic Services</b></u> <b>Lab</b> Office  Freestanding Lab/Reference Lab  Outpatient Hospital	\$20 copay per visit after deductible is met  0% coinsurance after deductible is met  0% coinsurance after deductible is met	Not covered  Not covered  Not covered
<b>X-Ray</b> Office  Outpatient Hospital	\$20 copay per visit after deductible is met  0% coinsurance after deductible is met	Not covered  Not covered
<b>Advanced Diagnostic Imaging</b> <i>for example: MRI, PET and CAT scans</i>  Office  Outpatient Hospital	0% coinsurance after deductible is met  0% coinsurance after deductible is met	Not covered  Not covered
<u><b>Emergency and Urgent Care</b></u> <b>Urgent Care</b> <i>includes doctor services. Additional charges may apply depending on the care provided.</i>	\$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
<b>Emergency Room Facility Services</b> <i>Copay waived if admitted.</i>	\$200 copay per visit after deductible is met	Covered as In-Network
<b>Emergency Room Doctor and Other Services</b>	0% coinsurance after deductible is met	Covered as In-Network
<b>Ambulance</b>	0% coinsurance after deductible is met	Covered as In-Network
<u><b>Outpatient Mental Health and Substance Abuse Care at a Facility</b></u> Facility Fees  Doctor Services	0% coinsurance after deductible is met  0% coinsurance after deductible is met	Not covered  Not covered
<u><b>Outpatient Surgery</b></u> <b>Facility Fees</b> Hospital  Ambulatory Surgical Center  <b>Doctor and Other Services</b> Hospital  Ambulatory Surgical Center	0% coinsurance after deductible is met  0% coinsurance after deductible is met  \$20 copay per visit after deductible is met  \$20 copay per visit after deductible is met	Not covered  Not covered  Not covered  Not covered
<u><b>Hospital (Including Maternity, Mental Health and Substance Abuse)</b></u>  <b>Facility Fees</b> <i>Coverage for Inpatient Rehabilitation is limited to 30 days per per year.</i>  <b>Physician and other services including surgeon fees</b>	\$0 copay per admission after deductible is met  0% coinsurance after deductible is met	Not covered  Not covered
<b>Home Health Care</b> <i>Coverage is limited to 200 visits per per year.</i>	\$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
<p><b>Rehabilitation and Habilitation services</b> <i>including physical, occupational and speech therapies.</i>  <i>Coverage for physical, occupational and speech therapies is limited to 60 visits combined per year.</i></p> <p>Office</p> <p>Outpatient Hospital</p>	<p>\$20 copay per visit after deductible is met</p> <p>\$20 copay per visit after deductible is met</p>	<p>Not covered</p> <p>Not covered</p>
<p><b>Pulmonary rehabilitation</b></p> <p>Office</p> <p>Outpatient Hospital</p>	<p>\$20 copay per visit after deductible is met</p> <p>0% coinsurance after deductible is met</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 after deductible is met</p> <p>0% coinsurance after deductible is met</p>	<p>Not covered</p> <p>Not covered</p>
<p><b>Dialysis/Hemodialysis</b> <i>office and outpatient hospital</i></p>	<p>\$20 copay per visit after deductible is met</p>	<p>Not covered</p>
<p><b>Chemo/Radiation Therapy</b> <i>office and outpatient hospital</i></p>	<p>\$20 copay per visit after deductible is met</p>	<p>Not covered</p>
<p><b>Skilled Nursing Care (facility)</b>  <i>Coverage is limited to 120 days per per year.</i></p>	<p>\$0 copay per admission after deductible is met</p>	<p>Not covered</p>
<p><b>Inpatient Hospice</b></p>	<p>0% coinsurance after deductible is met</p>	<p>Not covered</p>
<p><b>Durable Medical Equipment</b></p>	<p>50% coinsurance after deductible is met</p>	<p>Not covered</p>
<p><b>Prosthetic Devices</b>  <i>Coverage for wigs is limited to 1 item after cancer treatment per benefit period.</i></p>	<p>20% coinsurance after deductible is met</p>	<p>Not covered</p>

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
<b>Prescription Drug Coverage</b> <b>Network: <i>Base Network</i></b> <b>Drug List: <i>National</i></b> <i>If you select a brand name drug when a generic drug is available, additional cost sharing amounts may apply.</i>		
<b>Day Supply Limits:</b> <b>Retail Pharmacy</b> <i>30 day supply (cost shares noted below)</i> <b>Retail 90 Pharmacy</b> <i>90 day supply (3 times the 30 day supply cost share(s) charged at In-Network Retail Pharmacies noted below applies).</i> <b>Home Delivery Pharmacy</b> <i>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.</i> <b>Specialty Pharmacy</b> <i>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.</i>		
<b>Preventive Drugs</b> <i>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.</i>		
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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## 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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