Your summary of benefits

CEWW Health Insurance Consortium

Your Plan: Platinum I

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	$50 person / $125 family	$50 person / $125 family
Out-of-Pocket Limit	$450 person / $525 family	$450 person / $525 family
The family deductible and out-of-pocket maximum are embedded, meaning the cost shares of one family member will be applied to both per person deductible and per person 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 per person deductible or per person out-of-pocket maximum. The overall deductible and out-of-pocket limit are combined in-network and out-of-network, for both medical and retail pharmacy. Your copays, coinsurance, deductible, and prescription drugs count toward your out of pocket amount(s).		
Preventive Care / Screening / Immunization	No charge	100% of Allowed Amount
Preventive Care for Chronic Conditions *per IRS guidelines*	No charge	100% of Allowed Amount
Virtual Care (Telemedicine / Telehealth Visits) **Virtual Visits - Online visits with Doctors who also provide services in person**		
Primary Care (PCP)	20% coinsurance after deductible is met	20% coinsurance after deductible is met
Mental Health and Substance Abuse care	20% coinsurance after deductible is met	20% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Specialist	20% coinsurance after deductible is met	20% coinsurance after deductible is met
Medical Chats and Virtual (Video) Visits for Primary Care from our Online Provider K Health, through its affiliated Provider groups	Covered in Full	
Virtual Visits from Online Provider LiveHealth Online *via www.livehealthonline.com; our mobile app, website or Empire-enabled device*		
Primary Care (PCP) and Mental Health and Substance Abuse	20% coinsurance, not subject to deductible	
Specialist Care (Sleep Study)	Covered in Full	
Visits in an Office		
Primary Care (PCP)	20% coinsurance after deductible is met	20% coinsurance after deductible is met
Specialist Care	20% coinsurance after deductible is met	20% coinsurance after deductible is met
Other Practitioner Visits		
Routine Maternity Care (Prenatal and Postnatal) *In-Network preventive prenatal and postnatal services are covered at 100%.*	Covered in Full	100% of Allowed Amount
Retail Health Clinic	20% coinsurance after deductible is met	20% coinsurance after deductible is met
Chiropractic Services	20% coinsurance after deductible is met	20% coinsurance after deductible is met
Acupuncture	Covered in Full	100% of Allowed Amount
Other Services in an Office		
Allergy Testing	20% coinsurance after deductible is met	20% coinsurance after deductible is met
Chemo/Radiation Therapy	Covered in Full	100% of Allowed Amount

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Dialysis/Hemodialysis	Covered in Full	100% of Allowed Amount
Prescription Drugs *Dispensed in the office*	Covered in Full	100% of Allowed Amount
Surgery	Covered in Full	100% of Allowed Amount
Diagnostic Services **Lab**		
Office	Covered in Full	100% of Allowed Amount
Freestanding Lab/Reference Lab	Covered in Full	100% of Allowed Amount
Outpatient Hospital	Covered in Full	100% of Allowed Amount
X-Ray		
Office	Covered in Full	100% of Allowed Amount
Outpatient Hospital	Covered in Full	100% of Allowed Amount
Advanced Diagnostic Imaging *for example: MRI, PET and CAT scans*		
Office	Covered in Full	100% of Allowed Amount
Outpatient Hospital	Covered in Full	100% of Allowed Amount
Emergency and Urgent Care		
Urgent Care	Covered in Full	100% of Allowed Amount
Emergency Room Facility Services *Copay waived if admitted.*	Covered in Full	100% of Allowed Amount

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Emergency Room Doctor and Other Services	Covered in Full	100% of Allowed Amount
Ambulance	Covered in Full	100% of Allowed Amount
<u>Outpatient Mental Health and Substance Abuse</u>		
Doctor Office Visit *Family counseling related to Substance Abuse is limited to 20 visits per year.*	Covered in Full	100% of Allowed Amount
Facility Visit		
Facility Fees	Covered in Full	100% of Allowed Amount
Doctor Services	Covered in Full	100% of Allowed Amount
<u>Outpatient Surgery</u>		
Facility Fees		
Hospital	Covered in Full	100% of Allowed Amount
Freestanding Surgical Center	Covered in Full	100% of Allowed Amount
Doctor and Other Services		
Hospital	Covered in Full	100% of Allowed Amount
Freestanding Surgical Center	Covered in Full	100% of Allowed Amount
<u>Hospital (Including Maternity, Mental Health and Substance Abuse)</u>		
Facility Fees *Coverage for Inpatient Rehabilitation is unlimited days per year.*	Covered in Full	100% of Allowed Amount
Doctor and other services	Covered in Full	100% of Allowed Amount
<u>Recovery & Rehabilitation</u>		
Home Health Care		
Visits 1 - 40	Covered in Full	100% of Allowed Amount
Visits 41 - 325	20% coinsurance after deductible is met	20% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Rehabilitation services *Coverage for rehabilitative and habilitative physical therapy, occupational therapy, and speech therapy is unlimited visits per year. Visit limits are combined across both outpatient and other professional office visits.*		
Office	Covered in Full	100% of Allowed Amount
Outpatient Hospital	Covered in Full	100% of Allowed Amount
Cardiac rehabilitation		
Office	Covered in Full	100% of Allowed Amount
Outpatient Hospital	Covered in Full	100% of Allowed Amount
Skilled Nursing Care (facility) *Coverage is limited to 200 days per year.*	Covered in Full	100% of Allowed Amount
Inpatient Hospice	Covered in Full	100% of Allowed Amount
Durable Medical Equipment	Covered in Full	20% coinsurance after deductible is met
Prosthetic Devices	Covered in Full	20% coinsurance after deductible is met

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Pharmacy Deductible *Retail pharmacy is combined with medical deductible.* *Home Delivery is not subject to deductible.*	\$50 person / \$125 family	Not covered
Pharmacy Out-of-Pocket Limit *Retail pharmacy is combined with medical out of pocket.* *A separate Home Delivery out of pocket is noted to the right.*	\$500 person / \$1,500 family	Not covered

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Prescription Drug Coverage *Cost shares for drugs included on the National drug list appear below. Your plan uses the Base Network. You may receive up to a 90 day supply of medication at most retail pharmacies.*		
Tier 1 - Typically Generic *Covers up to a 90 day supply.*	20% coinsurance per prescription (retail), $8 copay per maintenance prescription (home delivery)	Not covered
Tier 2 – Typically Preferred Brand *Covers up to a 90 day supply.*	20% coinsurance per prescription (retail), $8 copay per maintenance prescription (home delivery)	Not covered
Tier 3 - Typically Non-Preferred Brand/Specialty Drugs *Covers up to a 90 day supply.*	20% coinsurance per prescription (retail), $8 copay per maintenance prescription (home delivery)	Not covered

Notes:

- The prescription drug plan listed on this Summary meets the Centers for Medicare and Medicaid Services (CMS) standard for Creditable Coverage under the Medicare Modernization Act of 2003.
- Preauthorization - You may have to pay for all or a portion of any test, equipment, service or procedure that is not preauthorized. To find out which services require Preauthorization and to be sure that Preauthorization has been given, you may contact us.
- If You seek coverage for services that require Preauthorization or notification, You or Your Provider must call Us or Our vendor at the number indicated on Your ID card.
- Preventive care benefits not subject to copay, deductible and coinsurance; when provided In-Network include: mammography screenings, cervical cancer screenings, colorectal cancer screenings, prostate cancer screenings, hypercholesterolemia screenings, diabetes screenings for pregnant women, bone density testing, annual physical examinations and annual obstetric and gynecological examinations. May also include other services as required under State and Federal Law. May be subject to age and frequency limits.
- To receive a 90-day supply of prescription drugs through Empire's Home Delivery Program, the prescription must be written specifically for a 90-day supply.

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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(TTY/TDD: 711)

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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.

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