

Your summary of benefits



An Anthem Company

CEWW Health Insurance Consortium

Your Plan: Platinum II

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	\$250 person / \$750 family	\$250 person / \$750 family
Out-of-Pocket Limit	\$750 person / \$2,250 family	\$750 person / \$2,250 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 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.</p> <p>The overall deductible and out-of-pocket limit are combined in-network and out-of-network, for medical only. Your copays, coinsurance, and deductible count toward your out of pocket amount(s).</p>		
Preventive Care / Screening / Immunization	No charge	100% of Allowed Amount
Preventive Care for Chronic Conditions <i>per IRS guidelines</i>	No charge	100% of Allowed Amount
<u>Virtual Care (Telemedicine / Telehealth Visits)</u>		
Virtual Visits - Online visits with Doctors who also provide services in person		
Primary Care (PCP)	10% coinsurance after deductible is met	10% coinsurance after deductible is met
Mental Health and Substance Abuse care	10% coinsurance after deductible is met	10% coinsurance after deductible is met

Services provided by Empire 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.empireblue.com

NY/LG/CEWW Health Insurance Consortium/07-01-2023

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Specialist	10% coinsurance after deductible is met	10% 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 Specialist Care (Sleep Study)	Covered in Full (In-Network) / 20% coinsurance after deductible is met (Non-Network) Covered in Full	
<u>Visits in an Office</u> Primary Care (PCP) Specialist Care	10% coinsurance after deductible is met 10% coinsurance after deductible is met	10% coinsurance after deductible is met 10% coinsurance after deductible is met
<u>Other Practitioner Visits</u> Routine Maternity Care (Prenatal and Postnatal) <i>In-Network preventive prenatal and postnatal services are covered at 100%.</i> Retail Health Clinic Chiropractic Services Acupuncture	Covered in Full 10% coinsurance after deductible is met 20% coinsurance after deductible is met Covered in Full	100% of Allowed Amount 10% coinsurance after deductible is met 20% coinsurance after deductible is met 100% of Allowed Amount
<u>Other Services in an Office</u> Allergy Testing Chemo/Radiation Therapy	20% coinsurance after deductible is met Covered in Full	20% coinsurance after deductible is met 100% of Allowed Amount

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p>Dialysis/Hemodialysis</p> <p>Prescription Drugs <i>Dispensed in the office</i></p> <p>Surgery</p>	<p>Covered in Full</p> <p>Covered in Full</p> <p>Covered in Full</p>	<p>100% of Allowed Amount</p> <p>100% of Allowed Amount</p> <p>100% of Allowed Amount</p>
<p><u>Diagnostic Services</u></p> <p>Lab</p> <p>Office</p> <p>Freestanding Lab/Reference Lab</p> <p>Outpatient Hospital</p>	<p>Covered in Full</p> <p>Covered in Full</p> <p>\$30 copay</p>	<p>100% of Allowed Amount</p> <p>100% of Allowed Amount</p> <p>100% of Allowed Amount</p>
<p>X-Ray</p> <p>Office</p> <p>Outpatient Hospital</p>	<p>Covered in Full</p> <p>\$30 copay</p>	<p>100% of Allowed Amount</p> <p>100% of Allowed Amount</p>
<p>Advanced Diagnostic Imaging <i>for example: MRI, PET and CAT scans</i></p> <p>Office</p> <p>Outpatient Hospital</p>	<p>Covered in Full</p> <p>\$30 copay</p>	<p>100% of Allowed Amount</p> <p>100% of Allowed Amount</p>
<p><u>Emergency and Urgent Care</u></p> <p>Urgent Care</p> <p>Emergency Room Facility Services <i>Copay waived if admitted.</i></p>	<p>Covered in Full</p> <p>\$100 copay</p>	<p>100% of Allowed Amount</p> <p>Covered as In-Network</p>

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 Ambulance	Covered in Full Covered in Full	100% of Allowed Amount 100% of Allowed Amount
<u>Outpatient Mental Health and Substance Abuse</u> Doctor Office Visit <i>Family counseling related to Substance Abuse is limited to 20 visits per year.</i> Facility Visit Facility Fees Doctor Services	Covered in Full Covered in Full Covered in Full	100% of Allowed Amount 100% of Allowed Amount 100% of Allowed Amount
<u>Outpatient Surgery</u> Facility Fees Hospital Freestanding Surgical Center Doctor and Other Services Hospital Freestanding Surgical Center	Covered in Full Covered in Full Covered in Full Covered in Full	100% of Allowed Amount 100% of Allowed Amount 100% of Allowed Amount 100% of Allowed Amount
<u>Hospital (Including Maternity, Mental Health and Substance Abuse)</u> Facility Fees <i>Coverage for Inpatient Rehabilitation is unlimited days per year.</i> Doctor and other services	Covered in Full Covered in Full	100% of Allowed Amount 100% of Allowed Amount
<u>Recovery & Rehabilitation</u> Home Health Care <i>Visits 1 - 40</i> <i>Visits 41 - 325</i>	Covered in Full 20% coinsurance after deductible is met	100% of Allowed Amount 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
<p>Rehabilitation services <i>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.</i></p> <p>Office</p> <p>Outpatient Hospital</p>	<p>Covered in Full</p> <p>Covered in Full</p>	<p>100% of Allowed Amount</p> <p>100% of Allowed Amount</p>
<p>Cardiac rehabilitation</p> <p>Office</p> <p>Outpatient Hospital</p>	<p>Covered in Full</p> <p>Covered in Full</p>	<p>100% of Allowed Amount</p> <p>100% of Allowed Amount</p>
<p>Skilled Nursing Care (facility) <i>Coverage is limited to 200 days per year.</i></p>	<p>Covered in Full</p>	<p>100% of Allowed Amount</p>
<p>Inpatient Hospice</p>	<p>Covered in Full</p>	<p>100% of Allowed Amount</p>
<p>Durable Medical Equipment</p>	<p>Covered in Full</p>	<p>20% coinsurance after deductible is met</p>
<p>Prosthetic Devices</p>	<p>Covered in Full</p>	<p>20% coinsurance after deductible is met</p>
Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
<p>Pharmacy Deductible</p>	<p>Not applicable</p>	<p>Not covered</p>
<p>Pharmacy Out-of-Pocket Limit <i>The pharmacy out-of-pocket limit is separate from medical.</i></p>	<p>\$500 person / \$1,500 family</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
<p>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.</p>		
<p>Tier 1 - Typically Generic Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program).</p>	<p>\$5 copay per 30 day prescription (retail), \$10 copay per maintenance prescription (home delivery)</p>	<p>Not covered</p>
<p>Tier 2 – Typically Preferred Brand Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program).</p>	<p>\$15 copay per 30 day prescription (retail), \$30 copay per maintenance prescription (home delivery)</p>	<p>Not covered</p>
<p>Tier 3 - Typically Non-Preferred Brand/Specialty Drugs Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program).</p>	<p>\$30 copay per 30 day prescription (retail), \$60 copay per maintenance prescription (home delivery)</p>	<p>Not covered</p>

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 Mail-Order 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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Get help in your language

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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

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(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:

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It's important we treat you fairly

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