Your summary of benefits

Anthem

Greene County

Your Plan: EPO Deductible Plan

Your Network: PPO/EPO

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 Certificate of Insurance or Evidence of Coverage (EOC). If there is a difference between this summary and the Certificate of Insurance or Evidence of Coverage (EOC), the Certificate of Insurance or Evidence of Coverage (EOC), will prevail.

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible *See notes section to understand how your deductible works. Your plan may also have a separate Prescription Drug Deductible. See Prescription Drug Coverage section.*	$400 person / $800 family	Not Covered
Out-of-Pocket Limit *When you meet your out-of-pocket limit, you will no longer have to pay cost-shares during the remainder of your benefit period. See notes section for additional information regarding your out of pocket maximum.*	Medical: $1,000 person /$2,000 family RX: $5,350 person / $10,700 family	Not Covered
Preventive care/screening/immunization *In-network preventive care is not subject to deductible, if your plan has a deductible.*	No charge	Not covered
Doctor Home and Office Services		
Primary care visit to treat an injury or illness ***Pediatric visits for children up to age 19 covered in full***	$20 copay per visit deductible does not apply	Not covered
Specialist care visit	$20 copay per visit deductible does not apply	Not covered
Prenatal and Post-natal Care	20% coinsurance after deductible is met	Not covered
Other practitioner visits: Retail health clinic	$20 copay per visit deductible does not apply	Not covered

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On-line Visit *Live Health Online (www.livehealthonline.com)*	$0 copay per visit deductible does not apply	N/A
Chiropractor services	$20 copay per visit deductible does not apply	Not covered
Acupuncture	$20 copay per visit deductible does not apply	Not covered
Other services in an office:		
Allergy testing performed by a Primary Care Physician	No Charge	Not covered
Allergy testing performed by a Specialist	No Charge	Not covered
Chemo/radiation therapy performed by a Primary Care Physician	20% coinsurance after deductible is met	Not covered
Chemo/radiation therapy performed by a Specialist	20% coinsurance after deductible is met	Not covered
Hemodialysis performed by a Primary Care Physician *Coverage for Non-Network Providers is limited to 10 visits per benefit period.*	20% coinsurance after deductible is met	20% coinsurance after deductible is met
Hemodialysis performed by a Specialist *Coverage for Non-Network Providers is limited to 10 visits per benefit period.*	20% coinsurance after deductible is met	20% coinsurance after deductible is met
Prescription drugs administered in an office by a Primary Care Physician *For the drugs itself dispensed in the office through infusion/injection*	20% coinsurance after deductible is met	Not covered
Prescription drugs administered in an office by a Specialist *For the drugs itself dispensed in the office through infusion/injection*	20% coinsurance after deductible is met	Not covered
Diagnostic Services		
Lab:		
Office performed by a Primary Care Physician	$20 copay per visit deductible does not apply	Not covered

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Office performed by a Specialist	$20 copay per visit deductible does not apply	Not covered
Freestanding Lab	20% coinsurance after deductible is met	Not covered
Outpatient Hospital	20% coinsurance after deductible is met	Not covered
X-ray:		
Office performed by a Primary Care Physician	20% coinsurance after deductible is met	Not covered
Office performed by a Specialist	20% coinsurance after deductible is met	Not covered
Freestanding Radiology Center	20% coinsurance after deductible is met	Not covered
Outpatient Hospital	20% coinsurance after deductible is met	Not covered
Advanced diagnostic imaging (for example, MRI/PET/CAT scans):		
Office	20% coinsurance after deductible is met	Not covered
Freestanding Radiology Center	20% coinsurance after deductible is met	Not covered
Outpatient Hospital	20% coinsurance after deductible is met	Not covered
Emergency and Urgent Care		
Emergency room facility services *Cost share except deductible waived if admitted.*	$35 copay per visit deductible does not apply	$35 copay per visit deductible does not apply

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Emergency room doctor and other services	No charge	No charge
Ambulance (air and ground)	20% coinsurance after deductible is met	20% coinsurance after deductible is met
Urgent Care (office setting)	$20 copay per visit deductible does not apply	Not covered
Outpatient Mental/Behavioral Health and Substance Abuse		
Doctor office visit	No Charge	Not covered
Facility visit:		
Facility fees	No Charge	Not covered
Doctor Services	No Charge	Not covered
Outpatient Surgery		
Facility fees:		
Hospital	20% coinsurance after deductible is met	Not covered
Freestanding Surgical Center	20% coinsurance after deductible is met	Not covered
Doctor and other services		
Surgery performed by a Primary Care Physician	20% coinsurance after deductible is met	Not covered
Surgery performed by a Specialist	20% coinsurance after deductible is met	Not covered

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Hospital Stay (all inpatient stays including maternity, mental / behavioral health, and substance abuse)		
Facility fees (for example, room & board) *Coverage for Inpatient physical medicine and rehabilitation including day rehabilitation programs In-Network Providers is limited to 60 days per benefit period.*	20% coinsurance after deductible is met	Not covered
Doctor and other services	20% coinsurance after deductible is met	Not covered
Recovery & Rehabilitation		
Home health care *Coverage for In-Network Providers is limited to 200 visits per benefit period.*	No Charge	Not covered
Rehabilitation services (for example, physical/speech/occupational therapy):		
Office *Coverage for physical therapy and occupational therapy and Speech Therapy is limited to 90 combined visits per benefit period.*	20% coinsurance after deductible is met	Not covered
Outpatient hospital *Coverage for physical therapy and occupational therapy and Speech Therapy is limited to 90 combined visits per benefit period.*	20% coinsurance after deductible is met	Not covered
Habilitation services (for example, physical/speech/occupational therapy):		
Office *Habilitation and Rehabilitation visits count towards your Rehabilitation limit.*	20% coinsurance after deductible is met	Not covered
Outpatient hospital *Habilitation and Rehabilitation visits count towards your Rehabilitation limit.*	20% coinsurance after deductible is met	Not covered
Cardiac rehabilitation Office	20% coinsurance after deductible is met	Not covered
Outpatient hospital	20% coinsurance after deductible is met	Not covered

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Skilled nursing care (in a facility) *Coverage for In-Network Providers is limited to 120 days per benefit period.*	20% coinsurance after deductible is met	Not covered
Hospice	No charge	Not covered
Durable Medical Equipment	20% coinsurance after deductible is met	Not covered
Prosthetic Devices	20% coinsurance	Not covered

Your summary of benefits

Covered Prescription Drug Benefits Network: Base Network Drug List: National Direct Plus	**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	$5,350 person / $10,700 family	Not Covered
Prescription Drug Coverage ***Mandatory mail order applies after 2 retail fills of maintenance medication*		
Tier 1 - Typically Generic *Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program).*	$10 copay per prescription (retail only) and $20 copay per prescription (home delivery only)	Not covered
Tier 2 - Typically Preferred / Brand *Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). If you select a brand name drug when a generic drug is available, additional cost sharing amounts may apply.*	$30 copay per prescription (retail only) and $60 copay per prescription (home delivery only)	Not covered
Tier 3 - Typically Non-Preferred / Specialty Drugs *Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). If you select a brand name drug when a generic drug is available, additional cost sharing amounts may apply.*	$45 copay per prescription (retail only) and $90 copay per prescription (home delivery only)	Not covered
Tier 4 - Typically Specialty Drugs	Not Applicable	Not Applicable

Notes:

- 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.
- 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.
- Our Preauthorization is required before You receive certain Covered Services. You are responsible for requesting Preauthorization for the following services: All inpatient admissions, including maternity admissions and admissions for illness or injury to newborns; Inpatient Mental Health Care, Substance Abuse Care and Alcohol Detoxification; Skilled Nursing Facility; Outpatient/Ambulatory Surgical Treatments (certain procedures); Chiropractic Care (after the 5th visit); Physical, Occupational, and Speech Therapy; Diagnostics; Outpatient Treatments; Air Ambulance; High tech radiology services: MRI, MRA, PET, CAT, Nuclear Technology services; Durable Medical Equipment; Prosthetics and Orthotics; Assistive Communication Devices.
- 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.

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) 241-7087.

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) 241-7087.

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) 241-7087:

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Language Access Services:

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) 241-7087.

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