Empire BlueCross BlueShield
An Anthem Company

ALT PPO / HA PPO / EPO Select 20 Benefit Comparison
Effective 7/1/2021

	ALT PPO		Healthy Advantage PPO		EPO Select 20
Benefit	**In-Network**	**Out-of Network**	**In-Network**	**Out-of Network**	**In Network**
Deductible	N/A	$300/$750	$0	$500/$1,250	$0
Coinsurance	N/A	30%	10%	30%	0%
Coinsurance Stop Loss	N/A	$2,500/$4,166 ($750/$1,250 out-of-pocket)	$2,500/$6,250 ($250/$625 out-of-pocket)	$3,000/$7,500 ($900/$2,250 out-of-pocket)	N/A
Out-of-Pocket Maximum	$5,080 individual/ $12,700 family	$1,050 individual / $2,000 family	$5,080 individual/ $12,700 family	$1,400 Individual / $3,500 Family	$5,080 individual/ $12,700 family
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Dependent Children (covered to the end of the month)	Dependents to age 26	Dependents to age 26	Dependents to age 26	Dependents to age 26	Dependents to age 26
Preventive Care					
Adult Preventive Care	$0	Deductible and Coinsurance	$0	Deductible and Coinsurance	$0
Annual Physical Exam	$0	Covered in-network only	$0	Covered in-network only	$0
Well-Child Care (Up to age 19; including necessary immunizations)	$0	Deductible and Coinsurance	$0	Deductible and Coinsurance	$0
Well-Woman Care	$0	Deductible and Coinsurance	$0	Deductible and Coinsurance	$0
Home/Office/Outpatient Care					
Home/Office Visits	$15 copay	Deductible and Coinsurance	$30 copay *	Deductible and Coinsurance	$20 copay
Emergency Room/Facility (initial visit per occurrence)	$35 copay (Waived if admitted within 24 hours)	$35 copay (Waived if admitted within 24 hours)	$50 copay (Waived if admitted within 24 hours)	$50 copay (Waived if admitted within 24 hours)	$50 copay (Waived if admitted within 24 hours)
Maternity Care	$0	Deductible and Coinsurance	$30 copay first visit, Coinsurance all other visits/services	Deductible and Coinsurance	$0
Allergy Testing & Treatment	$15 copay (Waived for treatment)	Deductible and Coinsurance	Office visit $30 copay Testing: Coinsurance Treatment: $0	Deductible and Coinsurance	$20 copay (waived for treatment)
Home Healthcare	$0 (Up to 365 visits per calendar year)	Coinsurance (no deductible)	Coinsurance (Up to 365 visits per calendar year)	Coinsurance (no deductible)	$0 (Up to 200 visits per calendar year)
Home Infusion Therapy	$0	Covered in-network only	Coinsurance	Covered in-network only	$0
Hospice Care (Up to 210 days per lifetime)	$0	Covered in-network only	Coinsurance	Covered in-network only	$0
Surgery, Presurgical Testing, Anesthesia	$0	Deductible and Coinsurance	$30 copay applies to visit services (examinations and evaluations); other services performed will be subject to In-Network Coinsurance.	Deductible and Coinsurance	$0
Chemotherapy, Radiation Therapy	$0	Deductible and Coinsurance		Deductible and Coinsurance	$0
Laboratory Tests, X-rays	$0	Deductible and Coinsurance		Deductible and Coinsurance	$0

	ALT PPO		Healthy Advantage PPO		EPO Select 20
Benefit	**In-Network**	**Out-of Network**	**In-Network**	**Out-of Network**	**In Network**
MRI/MRA, CAT Scan, PET & Nuclear Cardiology	$0	Deductible and Coinsurance	$30 copay applies to visit services (examinations and evaluations); other services performed will be subject to In-Network Coinsurance. (Unlimited vists per year for PT)	Deductible and Coinsurance	$0
Chiropractic Care	$15 copay	Deductible and Coinsurance		Deductible and Coinsurance	$20 copay
Physical Therapy	$0 copay for outpatient facility $15 copay for home or office **(Unlimited vists per year for PT)**	Covered in-network only		Covered in-network only	$20 copay (30 visits outpatient, 90 days inpatient max per year)
Other Short-Term Rehabilitative Therapies - Speech/Language, Occupational (Up to 30 visits per calendar year combined in home, office or outpatient facility)	$0 copay for outpatient facility $15 copay for home or office	Covered in-network only		Covered in-network only	$20 copay
Vision Therapy	$0 copay for outpatient facility $15 copay for home or office	Covered in-network only		Covered in-network only	$20 copay
Cardiac Rehabilitation (Unlimited visits per calendar year)	$15 copay	Deductible and Coinsurance		Deductible and Coinsurance	$20 copay
Second Surgical Opinion	$15 copay	Deductible and Coinsurance		Deductible and Coinsurance	$20 copay
Kidney Dialysis	$0	Deductible and Coinsurance		Deductible and Coinsurance	$0
Inpatient Care					
Inpatient Hospital (As many days as is medically necessary; semiprivate room and board)	$0	Deductible and Coinsurance	Coinsurance	Deductible and Coinsurance	$0
Surgery, Surgical Assistant, Anesthesia	$0	Deductible and Coinsurance	Coinsurance	Deductible and Coinsurance	$0
Physical Therapy, Physical Medicine, or Rehabilitation	$0 **(Unlimited Inpatient vists per year for PT)**	Deductible and Coinsurance	Coinsurance **(Unlimited Inpateint vists per year for PT)**	Deductible and Coinsurance	$0 (maximum 90 days inpatient per year)
Skilled Nursing Facility (Up to 365 days per calendar year)	$0 (Up to 365 days per calendar year)	Covered in-network only	Coinsurance (Up to 365 days per calendar year)	Coinsurance	$0 (Up to 60 days per calendar year)
Mental Health					
Outpatient Visits in Office	$15 copay	Deductible and Coinsurance	$30 copay applies to visit services (examinations and evaluations); other services performed will be subject to In-Network Coinsurance	Deductible and Coinsurance	$20 copay
Outpatient Visits in Facility	$0	Deductible and Coinsurance	Coinsurance	Deductible and Coinsurance	$0
Inpatient Care (As many days as is medically necessary; semiprivate room and board)	$0	Deductible and Coinsurance	Coinsurance	Deductible and Coinsurance	$0
Alcohol/Substance Abuse					
Outpatient Visits in Office	$15 copay	Deductible and Coinsurance	$30 copay applies to visit services (examinations and evaluations); other services performed will be subject to In-Network Coinsurance	Deductible and Coinsurance	$20 copay
Outpatient Visits in Facility	$0	Deductible and Coinsurance	Coinsurance	Deductible and Coinsurance	$0
Inpatient Detoxification (As many days as is medically necessary; semiprivate room and board)	$0	Deductible and Coinsurance	Coinsurance	Deductible and Coinsurance	$0
Inpatient Rehabilitation	$0	Deductible and Coinsurance	Coinsurance	Deductible and Coinsurance	$0

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Other					
Medical Supplies	$0 when obtained through Empire's medical supplies vendor	Difference between the allowed amount and the total charge (deductible and coinsurance do not apply)	Coinsurance	Difference between the allowed amount and the total charge	$0
Durable Medical Equipment	$0	Covered in-network only	Coinsurance	Covered in-network only	$0
Prosthetics & Orthotics	$0	Covered in-network only	Coinsurance	Covered in-network only	$0
Ambulance (Land/Air ambulance)	$0	In-network benefits apply	Coinsurance	In-network benefits apply	$0
Prescription Drugs					
Retail Program – One copay required for up to a 30-day supply	$0 Deductible per person per calendar year Retail: $5 copay for generic $5 copay plus ancillary charge for multisource brand $20 copay for single source brand Includes Contraceptives (Retail & Mail-Order)	Covered in-network only	$50 Deductible per person per calendar year Deductible does not apply to Tier 1 Generic drugs Tier 1/Tier 2/Tier3 $10/$20/$40 Includes Contraceptives (Retail & Mail-Order)	Covered in-network only	$0 Deductible Tier 1/Tier 2/Tier3 $10/$20/$40 Includes Contraceptives (Retail & Mail-Order)
Mail-Order Program – Only two copays required for a 90-day supply	$0 Deductible The Mail-Order Program has the same copayments as the Retail Program listed above	Covered in-network only	$0 Deductible The Mail-Order Program has the same copayments as the Retail Program listed above	Covered in-network only	$0 Deductible The Mail-Order Program has the same copayments as the Retail Program listed above
Mandatory Mail Order - Maintenance Medications	If you are taking a Maintenance Medication, you are required to use the mail order service through our Pharmacy Benefits Manager. For new Maintenance Medication prescriptions, you may get the first 30 day supply and up to one additional 30 day refill of the Maintenance Medication at your local Retail Pharmacy. After that, you will have to fill your prescription through the mail order supplier, CVS, or a designated participating pharmacy for maintenance drugs in order to get the In-Network level of benefits.				
Routine Vision Care	***Vision benefits - once every 24 months frequency*** $5 copay for 1 exam $10 eyeglass lense copay $115 allowance then 20% off remaining balance for frames $75 allowance then 15 % off remaining balance for conventional contacts	$30 allowance for out-of-network exam $64 allowance for pair of frames $25-$35 allowance for lenses	***Vision benefits - once every 12 months frequency*** $5 copay for 1 exam $10 eyeglass lense copay $115 allowance then 20% off remaining balance for frames $75 allowance then 15 % off remaining balance for conventional contacts	$30 allowance for out-of-network exam $64 allowance for pair of frames $25-$35 allowance for lenses	***Vision benefits - once every 12 months frequency*** $5 copay for 1 exam $10 eyeglass lense copay $115 allowance then 20% off remaining balance for frames $75 allowance then 15 % off remaining balance for conventional contacts *OON benefits available. See BVV benefit summary

*office visits are covered at $30 copay. All other services are subject to coinsurance. The $30 office visit copay is for examinations/evaluations/consultations. Other services done during the visit would have the co-insurance applied (ie MRI)

NOTE: Please refer to your SPD (Summary Plan Description) for detailed information regarding your coverage as well as services that require pre-certification. This is a benefit comparison only and is subject to terms, conditions, limitations and exclusions set forth in your Certificate of Coverage, Schedule of Benefits, and any additional Riders or Contracts your group has purchased.