DEHIC
ALT PPO / EPO Select 20 Benefit Comparison
Effective 7/1/2025

	ALT PPO		EPO Select 20
Benefit	**In-Network**	**Out-of Network**	**In Network**
	N/A	$300/$750	$0
Coinsurance	N/A	30%	0%
Coinsurance Stop Loss	N/A	$2,500/$4,166 ($750/$1,250 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
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dependent Children (covered to the end of the month)	Dependents to age 26	Dependents to age 26	Dependents to age 26
Preventive Care			
Adult Preventive Care	$0	Deductible and Coinsurance	$0
Annual Physical Exam	$0	Covered in-network only	$0
Well-Child Care (Up to age 19; including necessary immunizations)	$0	Deductible and Coinsurance	$0
Well-Woman Care	$0	Deductible and Coinsurance	$0
Home/Office/Outpatient Care			
Home/Office Visits***	$15 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)
Maternity Care	$0	Deductible and Coinsurance	$0
Allergy Testing & Treatment	$15 copay (Waived for treatment)	Deductible and Coinsurance	$20 copay (waived for treatment)
Home Healthcare	$0 (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	$0
Hospice Care (Up to 210 days per lifetime)	$0	Covered in-network only	$0
Surgery, Presurgical Testing, Anesthesia	$0	Deductible and Coinsurance	$0
Chemotherapy, Radiation Therapy	$0	Deductible and Coinsurance	$0
Laboratory Tests, X-rays	$0	Deductible and Coinsurance	$0
MRI/MRA, CAT Scan, PET & Nuclear Cardiology	$0	Deductible and Coinsurance	$0
Chiropractic Care	$15 copay	Deductible and Coinsurance	$20 copay
Physical Therapy	$0 copay for outpatient facility $15 copay for home or office (Unlimited visits per calendar year combined in home, office or outpatient facility)	Covered in-network only	$20 copay (30 visits per calendar 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	$20 copay
Vision Therapy	$0 copay for outpatient facility $15 copay for home or office	Covered in-network only	$20 copay
Cardiac Rehabilitation (Unlimited visits per calendar year)	$15 copay	Deductible and Coinsurance	$20 copay
Second Surgical Opinion	$15 copay	Deductible and Coinsurance	$20 copay
Kidney Dialysis	$0	Deductible and Coinsurance	$0
Inpatient Care			
Inpatient Hospital (As many days as is medically necessary; semiprivate room and board)	$0	Deductible and Coinsurance	$0
Surgery, Surgical Assistant, Anesthesia	$0	Deductible and Coinsurance	$0
Physical Therapy, Physical Medicine, or Rehabilitation	$0 (Unlimited inpatient days per calendar year)	Deductible and Coinsurance	$0 (90 days per calenday year)
Skilled Nursing Facility	$0 (Up to 365 visits per calendar year)	Covered in-network only	$0 (60 days per calendar year)
Mental Health			
Outpatient Visits in Office	$15 copay	Deductible and Coinsurance	$20 copay
Outpatient Visits in Facility	$0	Deductible and Coinsurance	$0
Inpatient Care (As many days as is medically necessary; semiprivate room and board)	$0 (Up to 365 days per calendar year)	Deductible and Coinsurance	$0

******Office visits include in-office care as well as Medical Chats and Virtual Visits for Primary Care*** (From our Online Provider K Health, its affiliated Provider groups, via our mobile app, website or Empire-enabled device)** : **$0 copayment - Covered in-network only**

**Empire-enabled device refers to laptops/tablets/other devices where our app can be downloaded

	ALT PPO		EPO Select 20
Benefit	**In-Network**	**Out-of Network**	**In Network**
Alcohol/Substance Abuse			
Outpatient Visits in Office	$15 copay	Deductible and Coinsurance	$20 copay
Outpatient Visits in Facility	$0	Deductible and Coinsurance	$0
Inpatient Detoxification (As many days as is medically necessary; semiprivate room and board)	$0	Deductible and Coinsurance	$0
Inpatient Rehabilitation	$0	Deductible and Coinsurance	$0
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)	$0
Durable Medical Equipment	$0	Covered in-network only	$0
Prosthetics & Orthotics	$0	Covered in-network only	$0
Ambulance (Land/Air ambulance)	$0	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	$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
Qualified Mail Order Service Options (Maintenance Medications)	If you are taking a Maintenance Medication, you must select one of the qualified mail order service options through our Pharmacy Benefits Manager, CVS, or a DEHIC designated participating retail pharmacy. 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 need to select one of the qualified mail order service options to fill your prescription through the mail order supplier, CVS, or a designated participating pharmacy for maintenance drugs in order to realize 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 *OON benefits available. See BVV benefit summary.

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.