Your summary of benefits

Empire BlueCross BlueShield

An Anthem Company

Empire BlueCross BlueShield

Your Contract Code: KP09

Your Plan: Research Foundation The City University Of Ny: PPO with vision

Your Network: PPO

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible *Your plan applies a separate Pharmacy Deductible to prescription drugs obtained at a pharmacy. See the Covered Prescription Drug Benefits section.*	$0 person / $0 family	$750 person / $1,875 family
Overall Out-of-Pocket Limit	$5,080 person / $12,700 family	$3,000 person / $7,500 family
The family deductible and out-of-pocket limit are embedded, meaning the cost shares of one family member will be applied to the per person deductible and per person out-of-pocket limit; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket limit. No one member will pay more than the per person deductible or per person out-of-pocket limit. Your copays, coinsurance and deductible count toward your out of pocket limit(s). In-Network and Non-Network out-of-pocket limit amounts are separate and do not accumulate toward each other.		
Doctor Visits (virtual and office) *You are encouraged to select a Primary Care Physician (PCP).*		
Medical Chats and Virtual Visits for Primary Care *from our Online Provider K Health, through its affiliated Provider groups are covered at No charge.*		
Virtual Visits from online provider LiveHealth Online *for urgent/acute medical and mental health and substance abuse care via www.livehealthonline.com are covered at $30 copay per visit.*		
Primary Care (PCP) and Mental Health and Substance Abuse Care *virtual and office*	$30 copay per visit	30% coinsurance after deductible is met
Specialist Care *virtual and office*	$40 copay per visit	30% coinsurance after deductible is met
Other Practitioner Visits		

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Routine Maternity Care (Prenatal and Postnatal)	No charge	30% coinsurance after deductible is met
Retail Health Clinic *for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.*	$30 copay per visit	30% coinsurance after deductible is met
Chiropractic Services	$30 copay per visit	30% coinsurance after deductible is met
Acupuncture	$30 copay per visit	30% coinsurance after deductible is met
Other Services in an Office		
Allergy Testing	No charge	30% coinsurance after deductible is met
Prescription Drugs *Dispensed in the office*	No charge	30% coinsurance after deductible is met
Surgery	No charge	30% coinsurance after deductible is met
Preventive care / screenings / immunizations	No charge	30% coinsurance after deductible is met
Preventive Care for Chronic Conditions *per IRS guidelines*	No charge	30% coinsurance after deductible is met
Diagnostic Services		
Lab		
Office	No charge	30% coinsurance after deductible is met
Freestanding Lab/Reference Lab	No charge	30% coinsurance after deductible is met
Outpatient Hospital	No charge	30% coinsurance after deductible is met
X-Ray		
Office	No charge	30% coinsurance after deductible is met
Outpatient Hospital	No charge	30% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Advanced Diagnostic Imaging *for example: MRI, PET and CAT scans*		
Office	No charge	30% coinsurance after deductible is met
Outpatient Hospital	No charge	30% coinsurance after deductible is met
Emergency and Urgent Care		
Urgent Care *includes doctor services. Additional charges may apply depending on the care provided.*	$30 copay per visit	Covered as In-Network
Emergency Room Facility Services *Copay waived if admitted within 24 hours.*	$75 copay per occurrence for the first 1 visit	Covered as In-Network
Emergency Room Doctor and Other Services	No charge	Covered as In-Network
Ambulance	No charge	Covered as In-Network
Outpatient Mental Health and Substance Abuse Care at a Facility		
Facility Fees	No charge	30% coinsurance after deductible is met
Doctor Services	No charge	30% coinsurance after deductible is met
Outpatient Surgery		
Facility Fees		
Hospital	No charge	30% coinsurance after deductible is met
Ambulatory Surgical Center	No charge	30% coinsurance after deductible is met
Doctor and Other Services		
Hospital	No charge	30% coinsurance after deductible is met
Ambulatory Surgical Center	No charge	30% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Hospital (Including Maternity, Mental Health and Substance Abuse)		
Facility Fees	$300 copay per admission up to $750 maximum per benefit period	30% coinsurance after deductible is met
Physician and other services *including surgeon fees*	No charge	30% coinsurance after deductible is met
Home Health Care *Coverage is limited to 200 visits per benefit period.*	No charge	30% coinsurance after deductible is met
Rehabilitation and Habilitation services *including physical, occupational and speech therapies.* *Coverage for physical and occupational therapies is limited to 30 visits combined per benefit period. Coverage for speech therapy is limited to 30 visits per benefit period.*		
Office	$30 copay per visit	Not covered
Outpatient Hospital	$40 copay per visit	Not covered
Pulmonary rehabilitation *office and outpatient hospital*	No charge	30% coinsurance after deductible is met
Cardiac rehabilitation *office and outpatient hospital* *Coverage is limited to 36 visits per benefit period.*	$40 copay per visit	30% coinsurance after deductible is met
Dialysis/Hemodialysis *office and outpatient hospital*	No charge	30% coinsurance after deductible is met
Chemo/Radiation Therapy *office and outpatient hospital*	No charge	30% coinsurance after deductible is met
Skilled Nursing Care (facility) *Coverage is limited to 60 days per benefit period.*	No charge	Not covered
Inpatient Hospice *Coverage is limited to 210 days per lifetime.*	No charge	Not covered
Durable Medical Equipment	No charge	Not covered
Prosthetic Devices *Coverage for wigs is limited to 1 item after cancer treatment per benefit period.*	No charge	Not covered
Hearing Aids	No charge	Not covered

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Coverage is limited to 1 item per ear every 2 years.		

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Pharmacy Deductible	$50 Person (does not apply to Tier 1 drugs)	Not covered
Pharmacy Out-of-Pocket Limit	Combined with In-Network medical out-of-pocket limit	Not covered
Prescription Drug Coverage **Network:** ***Base Network*** **Drug List:** ***National***		
Day Supply Limits: **Retail Pharmacy** *30 day supply (cost shares noted below)* **Retail 90 Pharmacy** *90 day supply (3 times the 30 day supply cost share(s) charged at In-Network Retail Pharmacies noted below applies).* **Home Delivery Pharmacy** *90 day supply (maximum cost shares noted below) Maintenance medications are available through CarelonRx Mail (IngenioRx will become CarelonRx on January 1, 2023). You will need to call us on the number on your ID card to sign up when you first use the service.* **Specialty Pharmacy** *30 day supply (cost shares noted below for retail and home delivery apply). We may require certain drugs with special handling, provider coordination or patient education be filled by our designated specialty pharmacy.*		
Tier 1 - Typically Generic	$5 copay per prescription, Pharmacy deductible does not apply (retail) and $5 copay per prescription (home delivery)	Not covered
Tier 2 – Typically Preferred Brand	$25 copay per prescription, Pharmacy deductible applies (retail) and $25 copay per prescription (home delivery)	Not covered
Tier 3 - Typically Non-Preferred Brand/Specialty Drugs	$50 copay per prescription, Pharmacy deductible applies (retail) and $50 copay per prescription (home delivery)	Not covered

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
This is a brief outline of your vision coverage. Only children's vision services count towards your out of pocket limit.		
Child Vision exam	$5 copay per exam	Not covered
Adult Vision exam *Limited to 1 exam every 24 months.*	$5 copay per exam	Not covered

Notes:

- If you have an office visit with your Primary Care Physician or Specialist at an Outpatient Facility (e.g., Hospital or Ambulatory Surgical Facility), benefits for Covered Services will be paid under "Outpatient Facility Services".
- Costs may vary by the site of service. Other cost shares may apply depending on services provided. Check your Certificate of Coverage for details.

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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