Your summary of benefits

Anthem

Anthem® BlueCross BlueShield

Your Contract Code:

Your Plan: Research Foundation The City University Of NY: POS

Your Network: POS

Out-of-Network Reimbursement rate: 330% of National Medicare

Visits with Virtual Care-Only Providers	Cost through our mobile app and website
Primary Care, and medical services for urgent/acute care	**K Health:** No charge **LiveHealth Online:** $20 copay per visit
Mental Health & Substance Use Disorder Services	$20 copay per visit
Specialist care	$25 copay per visit

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	$0 person / $0 family	$500 person / $1,250 family
Overall Out-of-Pocket Limit	$5,080 person / $12,700 family	$2,000 person / $5,000 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. All medical and prescription drug deductibles, copayments and coinsurance apply to the out-of-pocket limit. 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).*		
Primary Care (PCP) and Mental Health and Substance Use Disorder Services *virtual and office*	$20 copay per visit	30% coinsurance after deductible is met
Specialist Care *virtual and office*	$25 copay per visit	30% coinsurance after deductible is met
Other Practitioner Visits		
Routine Maternity Care (Prenatal and Postnatal)	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
Retail Health Clinic *for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.*	$20 copay per visit	30% coinsurance after deductible is met
Chiropractic Services	$20 copay per visit	30% coinsurance after deductible is met
Acupuncture	$20 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
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

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Emergency and Urgent Care		
Urgent Care *includes doctor services. Additional charges may apply depending on the care provided.*	$25 copay per visit	$25 copay per visit deductible does not apply
Emergency Room Facility Services *Your copay will be waived if admitted within 24 hours.*	$75 copay per occurrence	Covered as In-Network
Emergency Room Doctor and Other Services	No charge	Covered as In-Network
Ambulance	No charge	30% coinsurance after deductible is met
Outpatient Mental Health and Substance Use Disorder Services 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
Physician and other services *including surgeon fees*		
Hospital	No charge	30% coinsurance after deductible is met
Ambulatory Surgical Center	No charge	30% coinsurance after deductible is met
Hospital (Including Maternity, Mental Health and Substance Use Disorder Services) *If readmitted within 90 days for the same or related condition, no additional facility copay is required. If transferred between facilities, only one copay will apply.*		
Facility Fees	$250 copay per admission up to $625 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

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
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	$20 copay per visit	30% coinsurance after deductible is met
Outpatient Hospital	$25 copay per visit	30% coinsurance after deductible is met
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.*	$25 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 30 days per benefit period.*	$250 copay per admission up to $625 maximum per benefit period	30% coinsurance after deductible is met
Inpatient Hospice *Coverage is limited to 210 days per lifetime.*	No charge	30% coinsurance after deductible is met
Durable Medical Equipment	No charge	30% coinsurance after deductible is met
Prosthetic Devices *Coverage for wigs is limited to 1 item after cancer treatment per benefit period.*	No charge	30% coinsurance after deductible is met
Hearing Aids *Coverage is limited to 1 item per ear every 2 years.*	No charge	30% coinsurance after deductible is met

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Pharmacy Deductible	Not applicable	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. 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 (retail) and $10 copay per prescription (home delivery)	Not covered
Tier 2 – Typically Preferred Brand	$25 copay per prescription (retail) and $50 copay per prescription (home delivery)	Not covered
Tier 3 - Typically Non-Preferred Brand/Specialty Drugs	$50 copay per prescription (retail) and $100 copay per prescription (home delivery)	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.
- The limits for physical, occupational, and speech therapy, if any apply to this plan, will not apply if you get care as part of the Mental Health and Substance Use Disorder benefit.

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.

Questions: Visit us at www.anthem.com

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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 (800) 342-9816

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)

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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՝ (800) 342-9816:

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