

Your summary of benefits

Empire BlueCross BlueShield

Your Contract Code: KP0A

Your Plan: Research Foundation The City University Of Ny: POS With Vision

Your Network: POS

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	\$1,500 person / \$3,750 family
<p>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.</p> <p>Your copays, coinsurance and deductible count toward your out of pocket limit(s).</p> <p>The In-Network and Non-Network out-of-pocket limit amounts are separate and do not accumulate toward each other.</p>		
<p>Doctor Visits (virtual and office) <i>You are encouraged to select a Primary Care Physician (PCP).</i></p>		
<p>Medical Chats and Virtual Visits for Primary Care <i>from our Online Provider K Health, through its affiliated Provider groups are covered at No charge.</i></p>		
<p>Virtual Visits from online provider LiveHealth Online <i>for urgent/acute medical and mental health and substance abuse care via www.livehealthonline.com are covered at \$20 copay per visit.</i></p>		
Primary Care (PCP) and Mental Health and Substance Abuse Care <i>virtual and office</i>	\$20 copay per visit	30% coinsurance after deductible is met
Specialist Care <i>virtual and office</i>	\$25 copay per visit	30% coinsurance after deductible is met
<p>Other Practitioner Visits</p>		
Routine Maternity Care (Prenatal and Postnatal)	No charge	30% coinsurance after deductible is met
Retail Health Clinic <i>for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.</i>	\$20 copay per visit	30% coinsurance after deductible is met

Services provided by Empire HealthChoice Assurance, Inc., licensee of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans.

Questions: Visit us at www.empireblue.com

NY/LG/Research Foundation The City University Of Ny: POS With Vision/KP0A/01-01-2023

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Chiropractic Services	\$20 copay per visit	30% coinsurance after deductible is met
Acupuncture	\$20 copay per visit	30% coinsurance after deductible is met
<u>Other Services in an Office</u>		
Allergy Testing	No charge	30% coinsurance after deductible is met
Prescription Drugs <i>Dispensed in the office</i>	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 <i>per IRS guidelines</i>	No charge	30% coinsurance after deductible is met
<u>Diagnostic Services</u>		
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 <i>for example: MRI, PET and CAT scans</i>		
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
<p><u>Emergency and Urgent Care</u></p> <p>Urgent Care <i>includes doctor services. Additional charges may apply depending on the care provided.</i></p> <p>Emergency Room Facility Services <i>Copay waived if admitted within 24 hours</i></p> <p>Emergency Room Doctor and Other Services</p> <p>Ambulance</p>	<p>\$25 copay per visit</p> <p>\$75 copay per occurrence for the first 1 visit</p> <p>No charge</p> <p>No charge</p>	<p>Covered as In-Network</p> <p>Covered as In-Network</p> <p>Covered as In-Network</p> <p>30% coinsurance after deductible is met</p>
<p><u>Outpatient Mental Health and Substance Abuse Care at a Facility</u></p> <p>Facility Fees</p> <p>Doctor Services</p>	<p>No charge</p> <p>No charge</p>	<p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p>
<p><u>Outpatient Surgery</u></p> <p>Facility Fees</p> <p>Hospital</p> <p>Ambulatory Surgical Center</p> <p>Doctor and Other Services</p> <p>Hospital</p> <p>Ambulatory Surgical Center</p>	<p>No charge</p> <p>No charge</p> <p>No charge</p> <p>No charge</p>	<p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p>
<p><u>Hospital (Including Maternity, Mental Health and Substance Abuse)</u></p> <p>Facility Fees</p> <p>Physician and other services <i>including surgeon fees</i></p>	<p>\$250 copay per admission up to \$625 maximum per benefit period</p> <p>No charge</p>	<p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p>
<p>Home Health Care <i>Coverage is limited to 200 visits per benefit period.</i></p>	<p>No charge</p>	<p>30% coinsurance after deductible is met</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p>Rehabilitation and Habilitation services <i>including physical, occupational and speech therapies.</i> <i>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.</i></p> <p>Office</p> <p>Outpatient Hospital</p>	<p>\$20 copay per visit</p> <p>\$25 copay per visit</p>	<p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p>
<p>Pulmonary rehabilitation <i>office and outpatient hospital</i></p>	<p>No charge</p>	<p>30% coinsurance after deductible is met</p>
<p>Cardiac rehabilitation <i>office and outpatient hospital</i> <i>Coverage is limited to 36 visits per benefit period.</i></p>	<p>\$25 copay per visit</p>	<p>30% coinsurance after deductible is met</p>
<p>Dialysis/Hemodialysis <i>office and outpatient hospital</i></p>	<p>No charge</p>	<p>30% coinsurance after deductible is met</p>
<p>Chemo/Radiation Therapy <i>office and outpatient hospital</i></p>	<p>No charge</p>	<p>30% coinsurance after deductible is met</p>
<p>Skilled Nursing Care (facility) <i>Coverage is limited to 30 days per benefit period.</i></p>	<p>\$250 copay per admission up to \$625 maximum per benefit period</p>	<p>30% coinsurance after deductible is met</p>
<p>Inpatient Hospice <i>Coverage is limited to 210 days per lifetime.</i></p>	<p>No charge</p>	<p>30% coinsurance after deductible is met</p>
<p>Durable Medical Equipment</p>	<p>No charge</p>	<p>30% coinsurance after deductible is met</p>
<p>Prosthetic Devices <i>Coverage for wigs is limited to 1 item after cancer treatment per benefit period.</i></p>	<p>No charge</p>	<p>30% coinsurance after deductible is met</p>
<p>Hearing Aids <i>Coverage is limited to 1 item per ear every 2 years.</i></p>	<p>No charge</p>	<p>30% coinsurance after deductible is met</p>
Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
<p>Pharmacy Deductible</p>	<p>Not applicable</p>	<p>Not covered</p>

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Pharmacy Out-of-Pocket Limit	Combined with In-Network medical out-of-pocket limit	Not covered
Prescription Drug Coverage Network: <i>Base Network</i> Drug List: <i>National</i>		
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 (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
Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<i>This is a brief outline of your vision coverage. Only children's vision services count towards your out of pocket limit.</i>		
Child Vision exam	\$5 copay per exam	Not covered
Adult Vision exam <i>Limited to 1 exam every 24 months.</i>	\$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 Certificate of Insurance or Evidence of Coverage (EOC), the Certificate of Insurance or Evidence of Coverage (EOC), will prevail.

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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)

Arabic (العربية): إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (800) 342-9816.

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Haitian Creole (Kreyòl Ayisyen): Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (800) 342-9816.

Italian (Italiano): In caso di eventuali domande sul presente documento, ha il diritto di ricevere assistenza e informazioni nella sua lingua senza alcun costo aggiuntivo. Per parlare con un interprete, chiami il numero (800) 342-9816.

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Language Access Services:

Navajo (Diné): Dii naaltsoos biká'ígíí lahgo bina'ídiikidgo ná bohónéedzǎ dóó bee ahóót'i' t'áá ni nizaad k'ehǫ́ bee nił hodoonih t'áadoo bǫ́ǫ́h ilínígóó. Ata' halne'ígíí la' bich'í' hadeesdzih ninízingo kojí' hodíílnih (800) 342-9816.

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