Your Summary of Benefits

SUNY RF: Deductible PPO • Effective Date: 01/01/2027

Overall Deductible & Out-of-Pocket Maximums

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Overall Deductible (Individual)	$500	$1,500
Overall Deductible (Family)	$1,250	$3,750
Overall Out-of-Pocket Limit (Individual)	$1,500	$5,500
Overall Out-of-Pocket Limit (Family)	$3,750	$13,750

Office Visits (Virtual and Office)

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Primary Care (PCP) and Mental Health & Substance Use Disorder Services virtual and office	$30 copay per visit (deductible does not apply)	40% coinsurance after deductible is met
Specialist Care virtual and office	$30 copay per visit (deductible does not apply)	40% coinsurance after deductible is met

Preventive and Well Care Services

Covered Medical Benefits	Participating Provider	Non-Participating Provider
Well Child Visits and Immunizations	No charge	40% coinsurance after deductible
Adult Annual Physical Examinations	No charge	40% coinsurance after deductible
Adult Immunizations	No charge	40% coinsurance after deductible
Routine Gynecological Services / Well Woman Exams	No charge	40% coinsurance after deductible
Mammograms, Screening & Breast Cancer Imaging	No charge	40% coinsurance after deductible
Bone Density, Prostate & Colon Cancer Screenings	No charge	40% coinsurance after deductible

Diagnostic Testing

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Laboratory Services	10% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Radiology and Imaging Services	10% coinsurance after deductible is met	40% coinsurance after deductible is met
Advanced Diagnostic Imaging (MRI, PET, CAT)	10% coinsurance after deductible is met	40% coinsurance after deductible is met

Emergency and Urgent Care

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Urgent Care (includes doctor services)	$30 copay per visit	$30 copay, deductible does not apply
Emergency Room Facility Services	$50 copay per visit	Covered as In-Network
Ambulance	10% coinsurance after deductible is met	Covered as In-Network

Maternity Services

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Maternity (Prenatal and Postnatal Care)	10% coinsurance after deductible is met	40% coinsurance after deductible is met
Maternity – Inpatient Hospital Services	10% coinsurance after deductible is met	40% coinsurance after deductible is met

Hospital Services

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Hospital Inpatient Stay	10% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Surgery	10% coinsurance after deductible is met	40% coinsurance after deductible is met

Condition Support Services

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Home Health Care (limit 200 visits/period)	10% coinsurance after deductible is met	40% coinsurance after deductible is met
Skilled Nursing Care (120 days per year)	10% coinsurance after deductible is met	Not covered
Hospice	10% coinsurance after deductible is met	Not covered
Chemotherapy/Radiation Therapy	10% coinsurance after deductible is met	40% coinsurance after deductible
Durable Medical Equipment & Prosthetic Devices	10% coinsurance after deductible is met	Not covered
Hearing Aids (2 hearing aids every 36 months)	No Charge	No Charge

Outpatient Rehabilitative Services

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Physical, Occupational and Speech Therapy (90 visits per year for Physical Therapy, 60 visits per year combined for Occupational Therapy and Speech Therapy)	10% coinsurance after deductible is met	40% coinsurance after deductible is met

Behavioral Health & Substance Use Disorder Services

Covered Medical Benefits	Participating Provider	Non-Participating Provider
Inpatient Mental Health & Substance Use Care	10% coinsurance after deductible is met	40% coinsurance after deductible
Outpatient Mental Health / Substance Use Office Visits	$30 copay per visit (Office / Telehealth)	40% coinsurance after deductible

Covered Prescription Drug Benefits

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Out-of-Network Pharmacy
Tier 1 - Typically Generic	$10 copay per prescription (retail and home delivery)	Not covered
Tier 2 - Typically Preferred Brand	$25 copay (retail) / $50 copay (home delivery)	Not covered
Tier 3 - Typically Non-Preferred Brand	$45 copay (retail) / $90 copay (home delivery)	Not covered

Notes:

• This summary of benefits is a brief outline of coverage designed to help you with the selection process. Official plan documents and Summary Plan Descriptions (SPDs) govern all benefit programs. If there is any discrepancy between this FAQ and the plan documents, the plan documents will govern.