Your summary of benefits

Empire BlueCross
An Anthem Company

Empire BlueCross

SUNY RF Graduate Student and Postdoctoral Employee Health Plan

Your Plan: Empire PPO Copay

Your Network: PPO/EPO

Out-of-Network Reimbursement rate: 150% of National Medicare

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	$100 person / Unlimited family
Overall Out-of-Pocket Limit	$5,080 person / $10,160 family	Unlimited
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 $10 copay per visit.*		
Primary Care (PCP) and Mental Health and Substance Abuse Care *virtual and office*	$10 copay per visit	20% coinsurance after deductible is met
Specialist Care *virtual and office*	$10 copay per visit	20% coinsurance after deductible is met
Other Practitioner Visits		
Routine Maternity Care (Prenatal and Postnatal)	No charge	20% 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.*	$10 copay per visit	20% coinsurance after deductible is met
Chiropractic Services	$10 copay per visit	20% coinsurance after deductible is met
Acupuncture	Not covered	Not covered
Other Services in an Office		
Allergy Testing	No charge	20% coinsurance after deductible is met
Prescription Drugs *Dispensed in the office*	No charge	20% coinsurance after deductible is met
Surgery	No charge	20% coinsurance after deductible is met
Preventive care / screenings / immunizations *Non-Network services only covered for for children up to age 18, not covered from age 18.*	No charge	20% coinsurance after deductible is met
Preventive Care for Chronic Conditions *per IRS guidelines*	No charge	20% coinsurance after deductible is met
Diagnostic Services		
Lab		
Office	No charge	20% coinsurance after deductible is met
Freestanding Lab/Reference Lab	No charge	20% coinsurance after deductible is met
Outpatient Hospital	$15 copay per visit	20% coinsurance after deductible is met
X-Ray		
Office	No charge	20% coinsurance after deductible is met
Outpatient Hospital	$15 copay per visit	20% coinsurance after deductible is met
Advanced Diagnostic Imaging *for example: MRI, PET and CAT scans*		
Office	No charge	20% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Outpatient Hospital	$15 copay per visit	20% coinsurance after deductible is met
Emergency and Urgent Care		
Urgent Care *includes doctor services. Additional charges may apply depending on the care provided.*	$10 copay per visit	20% coinsurance after deductible is met
Emergency Room Facility Services *Copay waived if admitted.*	$25 copay per visit	Covered as In-Network
Emergency Room Doctor and Other Services	No charge	Covered as In-Network
Ambulance	$15 copay per trip	Covered as In-Network
Outpatient Mental Health and Substance Abuse Care at a Facility		
Facility Fees	No charge	20% coinsurance after deductible is met
Doctor Services	No charge	20% coinsurance after deductible is met
Outpatient Surgery		
Facility Fees		
Hospital	$10 copay per visit	20% coinsurance after deductible is met
Ambulatory Surgical Center	$10 copay per visit	20% coinsurance after deductible is met
Doctor and Other Services		
Hospital	$10 copay per visit	20% coinsurance after deductible is met
Ambulatory Surgical Center	$10 copay per visit	20% coinsurance after deductible is met
Hospital (Including Maternity, Mental Health and Substance Abuse)		
Facility Fees *Non-Network Inpatient Admission applies $200 benefit deductible per plan year. Benefit deductible does not apply to any other calendar deductible.*	$200 copay per admission	20% coinsurance after deductible is met
Physician and other services *including surgeon fees*	No charge	20% coinsurance after deductible is met
Home Health Care	No charge	20% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Rehabilitation and Habilitation services *including physical, occupational and speech therapies.* *Non-Network Therapy Services applies $100 benefit deductible per plan year. Benefit deductible does not apply to any other calendar deductible.*		
Office	$10 copay per visit	20% coinsurance after deductible is met
Outpatient Hospital	$15 copay per visit	20% coinsurance after deductible is met
Pulmonary rehabilitation *office and outpatient hospital*	No charge	20% coinsurance after deductible is met
Cardiac rehabilitation *office and outpatient hospital*	$15 copay per visit	20% coinsurance after deductible is met
Dialysis/Hemodialysis *office and outpatient hospital*	No charge	20% coinsurance after deductible is met
Chemo/Radiation Therapy *office and outpatient hospital*	No charge	20% coinsurance after deductible is met
Skilled Nursing Care (facility) *Coverage is limited to 60 days per benefit period.*	$100 copay per admission	20% coinsurance after deductible is met
Inpatient Hospice *Coverage is limited to 210 days per benefit period.*	No charge	20% coinsurance after deductible is met
Durable Medical Equipment	No charge	20% coinsurance after deductible is met
Prosthetic Devices *Coverage for wigs is limited to 1 item after cancer treatment per benefit period.*	No charge	20% coinsurance after deductible is met

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.
- Covered Infertility services: lab and radiology tests, cryopreservation, fertility drugs, surgical treatments such as: Artificial Insemination, In-vitro fertilization (IVF), GIFT, ZIFT. Cost share will be applied based on service and setting. Lifetime Maximum: IVF limited to 3 cycles.

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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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 (844) 241-7085

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 (844) 241-7085 .

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՝ (844) 241-7085:

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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 (844) 241-7085.

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Language Access Services:

Navajo (Diné): Díí naaltsoos biká'ígíí łahgo bina'idiłkidgo ná bohónéedzą dóó bee ahóót'i' t'áá ni nizaad k'ehjí bee nił hodoonih t'áadoo bą́ą́h ílínígóó. Ata' halne'ígíí łą' bich'į' hadeesdzih ninízingo kojį' hodíilnih (844) 241-7085.

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