Your summary of benefits

Anthem

Anthem® Blue Cross

Your Contract Code: 79CV

Your Plan: RESEARCH FOUNDATION OF SUNY: Traditional PPO

Your Network: PPO

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

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Overall Deductible	$0 person / $0 family	$1,000 person / $2,500 family
Overall Out-of-Pocket Limit	$4,224 person / $10,560 family	$4,000 person / $10,000 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 deductibles, copayments and coinsurance apply to the out-of-pocket limit. In-Network and Out-of-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	20% coinsurance after deductible is met
Specialist Care *virtual and office*	$20 copay per visit	20% coinsurance after deductible is met
Other Practitioner Visits		
Maternity Doctor services (prenatal/postnatal care and delivery)	No charge	20% coinsurance after deductible is met
Retail Health Clinic *for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.*	$20 copay per visit	20% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Chiropractic Services	$20 copay per visit	20% coinsurance after deductible is met
Acupuncture	$20 copay per visit	Not covered
Other Services in an Office		
Allergy Testing	$20 copay per visit	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	No charge	20% coinsurance after deductible is met
Diagnostic Services		
Lab		
Office	$20 copay per visit	20% coinsurance after deductible is met
Freestanding Lab/Reference Lab	No charge	20% coinsurance after deductible is met
Outpatient Hospital	$20 copay per visit	20% coinsurance after deductible is met
X-Ray		
Office	$20 copay per visit	20% coinsurance after deductible is met
Outpatient Hospital	$20 copay per visit	20% coinsurance after deductible is met
Advanced Diagnostic Imaging *for example: MRI, PET and CAT scans*		
Office	$20 copay per visit	20% coinsurance after deductible is met
Outpatient Hospital	$20 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.*	$50 copay per visit	$50 copay per visit deductible does not apply

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Emergency Room Facility Services *Your copay will be waived if admitted within 24 hours.*	$50 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 Use Disorder Services 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	$150 copay per visit	20% coinsurance after deductible is met
Ambulatory Surgical Center	$150 copay per visit	20% coinsurance after deductible is met
Physician and other services *including surgeon fees*		
Hospital	$20 copay per visit	20% coinsurance after deductible is met
Ambulatory Surgical Center	$20 copay per visit	20% 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 *Coverage for Inpatient Rehabilitation is limited to 60 days per benefit period.*	$100 copay up to $250 maximum 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 *Coverage is limited to 200 visits per benefit period.*	No charge	20% coinsurance deductible does not apply

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Rehabilitation and Habilitation services *including physical, occupational and speech therapies.* *Coverage for physical therapy is limited to 90 visits per benefit period.* *Coverage for occupational and speech therapies is limited to 60 visits combined per benefit period.*		
Office	$20 copay per visit	Not covered
Outpatient Hospital	No charge	Not covered
Pulmonary rehabilitation		
Office	$20 copay per visit	20% coinsurance after deductible is met
Outpatient Hospital	No charge	20% coinsurance after deductible is met
Cardiac rehabilitation		
Office	$20 copay per visit	20% coinsurance after deductible is met
Outpatient Hospital	No charge	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 120 days per benefit period.*	No charge	Not covered
Inpatient Hospice	No charge	Not covered
Durable Medical Equipment	No charge	Not covered
Prosthetic Devices	No charge	Not covered
Hearing Aids *Coverage is limited 1 item per impaired ear once every 3 years, for adults and children.*	No charge	Difference between the allowed amount and the total charge.

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use an Out-of-Network Pharmacy
Pharmacy Deductible	Not applicable	Not covered
Pharmacy Out-of-Pocket Limit	Not applicable	Not covered
Prescription Drug Coverage **Network:** **Drug List:**		
Day Supply Limits:		
Tier 1 - Typically Generic	$10 copay per prescription (retail and 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	$45 copay per prescription (retail) and $90 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.
- Screening and diagnostic imaging for the detection of breast cancer, including diagnostic mammograms, 3D mammography, breast ultrasounds and MRIs are covered in full as required by state mandate.
- 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.
- 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.

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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(TTY/TDD: 711)

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