Empire BlueCross  
Research Foundation For SUNY - 376958: Ded PPO  
Coverage Period: 01/01/2017 – 12/31/2017  
Coverage for: Individual/Family | Plan Type: PPO

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [https://eoc.empireblue.com/eocdps/aso](https://eoc.empireblue.com/eocdps/aso) or the RF Benefits website ([www.rf.suny.org/benefits](http://www.rf.suny.org/benefits)) or by calling 1-800-563-0317.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why this Matters:</th>
</tr>
</thead>
</table>
| **What is the overall deductible?** | For in-network providers $500 individual / $1,250 family  
For out-of-network providers $1,500/ individual $3,750/ family | You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**. |
| **Are there other deductibles for specific services?** | No. | You don’t have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers. |
| **Is there an out-of-pocket limit on my expenses?** | Yes. For in network providers $1,500 individual / $3,750 family.  
For out-of-network providers $5,500 individual / $13,750 family.  
These both include the deductible above. | The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. |
| **What is not included in the out-of-pocket limit?** | Premiums, balance-billed charges, and health care this plan doesn’t cover. | Even though you pay these expenses, they don’t count toward the **out-of-pocket limit**. |
| **Is there an overall annual limit on what the plan pays?** | No. | The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits. |
| **Does this plan use a network of providers?** | Yes. For a list of in-network providers, see [www.empireblue.com](http://www.empireblue.com) or call 1-800-563-0317. | If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers. |

Questions: Call 1-800-563-0317 or visit us at [www.empireblue.com](http://www.empireblue.com)

If you aren’t clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [www.empireblue.com](http://www.empireblue.com) or call 1-800-563-0317 to request a copy.
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**Do I need a referral to see a specialist?**
- No.
  - You can see the **specialist** you choose without permission from this plan.

**Are there services this plan doesn’t cover?**
- Yes.
  - Some of the services this plan doesn’t cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

#### Copayments
- Fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.

#### Coinsurance
- **Coinsurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan’s **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven’t met your **deductible**.

- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)

- This plan may encourage you to use **in-network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

### Common Medical Event

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>Your Cost If You Use an In-Network Provider</th>
<th>Your Cost If You Use an Out-of-Network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you visit a health care provider's office or clinic</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary care visit to treat an injury or illness</td>
<td>$30/visit</td>
<td>40% coinsurance</td>
<td>Hospital Clinics are not covered.</td>
</tr>
<tr>
<td>Specialist visit</td>
<td>$30/visit</td>
<td>40% coinsurance</td>
<td>The office visit copayment applies to office visits, examinations and evaluations. All other covered services rendered during visit are subject to coinsurance.</td>
</tr>
<tr>
<td>Other practitioner office visit</td>
<td>$30/visit</td>
<td>40% coinsurance</td>
<td></td>
</tr>
<tr>
<td>Preventive care/screening/immunization</td>
<td>No Charge</td>
<td>40% coinsurance</td>
<td></td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic test (x-ray, blood work)</td>
<td>10% coinsurance</td>
<td>40% coinsurance</td>
<td>none</td>
</tr>
<tr>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>10% coinsurance</td>
<td>40% coinsurance</td>
<td>none</td>
</tr>
</tbody>
</table>

#### Questions:
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</thead>
<tbody>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic drugs</td>
<td>$10/prescription for retail &amp; home delivery</td>
<td>Amount over Plan Allowance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>$25/prescription for retail, $50 for home delivery</td>
<td>Amount over Plan Allowance</td>
<td>Supply limits: 30-day for retail, 90-day for home delivery</td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>$45/prescription for retail, $90 for home delivery</td>
<td>Amount over Plan Allowance</td>
<td>Special rules apply to Specialty Medications; see the section on Specialty Medications</td>
</tr>
<tr>
<td></td>
<td>Specialty drugs</td>
<td>Call: Express Scripts 1-800-251-7690</td>
<td>Amount over Plan Allowance</td>
<td></td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>10% coinsurance</td>
<td>40% coinsurance</td>
<td>Precertification is required.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>10% coinsurance</td>
<td>40% coinsurance</td>
<td></td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room services</td>
<td>$50/admit</td>
<td>$50/admit</td>
<td>Waived if admitted within 24 hours.</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>10% coinsurance</td>
<td>10% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$30/visit</td>
<td>40% coinsurance</td>
<td></td>
</tr>
</tbody>
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<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>10% coinsurance</td>
<td>40% coinsurance</td>
<td>In-network - up to $250 maximum</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fee</td>
<td>10% coinsurance</td>
<td>40% coinsurance</td>
<td>Behavioral Health treatment will be subject to pre-service review.</td>
</tr>
<tr>
<td>If you have mental health, behavioral health, or substance abuse needs</td>
<td>Mental/Behavioral health outpatient services</td>
<td>$30 Copay/Visit for Office visits, 10% Coinsurance for visits in a facility</td>
<td>40% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mental/Behavioral health inpatient services</td>
<td>10% coinsurance</td>
<td>40% coinsurance</td>
<td>In-network - up to $250 maximum</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder outpatient services</td>
<td>$30 Copay/Visit for Office visits, 10% Coinsurance for visits in a facility</td>
<td>40% coinsurance</td>
<td>Subject to pre-service review.</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder inpatient services</td>
<td>10% coinsurance</td>
<td>40% coinsurance</td>
<td>none</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Prenatal and postnatal care</td>
<td>$30/visit</td>
<td>40% coinsurance</td>
<td>none</td>
</tr>
<tr>
<td></td>
<td>Delivery and all inpatient services</td>
<td>10% coinsurance</td>
<td>40% coinsurance</td>
<td>none</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>10% coinsurance</td>
<td>40% coinsurance</td>
<td>Up to 200 visits per calendar year. Not subject to deductible</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>10% coinsurance</td>
<td>40% coinsurance</td>
<td>Therapy Limits: Physical – 60 inpatient/90 outpatient visits, Occupational/Speech – 60 visits combined per calendar year.</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>10% coinsurance</td>
<td>40% coinsurance</td>
<td>All rehabilitation and habilitation visits count toward your rehabilitation visit limit.</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>No Charge</td>
<td>Not Covered</td>
<td>Up to 120 days per calendar year.</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>No Charge</td>
<td>Not Covered</td>
<td>none</td>
</tr>
<tr>
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<td>----------------------</td>
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<td>---------------------------------------------</td>
<td>-----------------------------------------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td>Hospice service</td>
<td>No Charge</td>
<td>Not Covered</td>
<td>Up to 210 days per lifetime.</td>
<td></td>
</tr>
<tr>
<td>Eye exam</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Glasses</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dental check-up</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Excluded Services & Other Covered Services:**

**Services Your Plan Does NOT Cover** *(This isn’t a complete list. Check your policy or plan document for other excluded services.)*

- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Private-duty nursing
- Weight loss programs

**Other Covered Services** *(This isn’t a complete list. Check your policy or plan document for other covered services and your costs for these services.)*

- Chiropractic care (Limits apply)
- Coverage provided outside the United States. See [www.BCBS.com/bluecardworldwide](http://www.BCBS.com/bluecardworldwide)
- Hearing aids (Limits apply)
Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-563-0317. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact:

Grievance and Appeals address
P.O. Box 1407
Church Street Station,
New York, NY 10008

Department of Labor’s Employee Benefits Security Administration
1-866-444-EBSA (3272)
www.dol.gov/ebsa/healthreform

Additionally, a consumer assistance program can help you file your appeal. Contact:

Community Service Society of New York, Community Health Advocates
105 East 22nd Street, 8th floor
New York, NY 10010
(888) 614-5400
http://www.communityhealthadvocates.org/
Does this Coverage Provide Minimum Essential Coverage?
The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” This plan or policy does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?
The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.
Language Access Services:

(TTY/TDD: 711)

Albanian (Shqip): Nëse keni pyetje në lindje me këtë dokument, keni të drejtë të merrni falas ndihmë dhe informacion në gjuhën tuaj. Për të kontaktuar me një përkrthes, telefononi (855)333-5734

Amharic (አማርኛ): ከእና ቤት በእስከታወች ከተጠቀም ከምርዓት ያልተወረጆች ከምርሳው ለማፋዳት ያለባቸው ከሚስማት እና ከእና በእስከታወች ከተጠቀም ከምርሳው ከምርሳው ከማፋዳት ከእና በእስከታወች ያልተወረጆች (855)333-5734

Armenian (հայերեն): Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար օգնության և տեղեկատվության համար. Կազմեք հանրային թարգմանչության համար (855)333-5734


Bengali (বাংলা): যদি এই ভাষায় প্রশ্ন থাকেন, তবে আপনার বিবেকানন্দ যোগাযোগ কেন্দ্র হতে প্রশ্ন করতে পারবেন। একজন ভাষাসহকারীর সাথে কথা বলার জন্য কল করুন (855)333-5734

Burmese (ဗီစီ): စာမျက်နှာထဲမှ မြန်မာဘာသာဖြင့် မျက်နှာအပေါ် ပြည်ဆောင်းချက်များရှိသည်အခြေဖြင့် နိုင်သည်။ (855)333-5734 သို့ ဆက်စပ်

Chinese (中文)：如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電 (855)333-5734。

Dinka (Dinka): Na nong thëëre ke de ya thore, ke yin nong løj bë yi kuony ku wek ake bë geër yic yin ne thon du ke cin wëu tääü ke piny. Te kër yin ba jam wënë ca te thok geryic, ke yin col (855)333-5734.

Dutch (Nederlands): Bij vragen over dit document hebt u recht op hulp en informatie in uw taal zonder bijkomende kosten. Als u een tolk wilt spreken, belt u (855)333-5734.

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French (Français): Si vous avez des questions sur ce document, vous avez la possibilité d’accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (855)333-5734.

German (Deutsch): Wenn Sie Fragen zu diesem Dokument haben, haben Sie Anspruch auf kostenfreie Hilfe und Information in Ihrer Sprache. Um mit einem Dolmetscher zu sprechen, bitte wählen Sie (855)333-5734.

Greek (Ελληνικά): Αν έχετε τυχόν απορίες σχετικά με το παρόν έγγραφο, έχετε τη δυνατότητα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας δωρεάν. Για να μιλήσετε με κάποιον διερμηνέα, τηλεφωνήστε στο (855)333-5734.

Gujarati (ગુજરાતી): ત્યારે એ દસ્તાવેજ અંગે આપને ઓફિશિયલ પ્રશ્નો લાવવું તો, ઓફિશિયલ અવસર અંગે આપની ભાષામાં મદદ અને માહત્ત્વરૂપી માહિતી તમને અધિકાર છે. દુભાષયા સાથે વાત કરવા માટે, કોલ કરો (855)333-5734.

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 (855)333-5734.

Hindi (हिंदी): अगर आपके पास इस दस्तावेज के बारे में कोई प्रश्न है, तो आपको नि:शुल्क अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। दुभाषियों से बात करने के लिए, कॉल करें (855)333-5734.

Hmong (White Hmong): Yog tias koj muaj lus nug dab tsi ntsig txog daim ntawv no, koj muaj cai tau txais kev pab thiab lus qhia hais ua koj hom lus yam tsim xam tus nqi. Txhawm rau tham nrog tus neeg txhais lus, hu xov tooj rau (855)333-5734.

Igbo (Igbo): Ọ bụrụ na ụ nwere ajuụ ọ bụla gbasara akwụkwọ a, ụ nwere ikike ďweta enyemaka na ozi n’asụsụ gị na akwụghị ụgwọ ọ bụla. Ka gị na ọkọwa okwu kwu okwu, kpọọ (855)333-5734.

Ilokano (Ilokano): Nu addaan ka iti aniaman a saludsod panggip iti daytoy a dokumento, adda karbengam a makaala ti tulong ken impormasyon babaen ti lenguahem nga awan ti bayad na. Tapno makatungtong ti maysa nga tagipatarus, awagan ti (855)333-5734.

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Indonesian (Bahasa Indonesia): Jika Anda memiliki pertanyaan mengenai dokumen ini, Anda memiliki hak untuk mendapatkan bantuan dan informasi dalam bahasa Anda tanpa biaya. Untuk berbicara dengan interpreter kami, hubungi (855)333-5734.

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 (855)333-5734.

Japanese (日本語): この文書についてなにか不明な点があれば、あなたにはあなたの言語で無料で支援を受け情報を得る権利があります。通訳と話すには、(855)333-5734 にお電話ください。

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**Empire BlueCross**  
Research Foundation For SUNY - 376958: Ded PPO  
Summary of Benefits and Coverage: What this Plan Covers & What it Costs  
Coverage Period: 01/01/2017 – 12/31/2017  
Coverage for: Individual/Family | Plan Type: PPO

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About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don’t use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

<table>
<thead>
<tr>
<th>Having a baby (normal delivery)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Amount owed to providers:</strong> $7,540</td>
</tr>
<tr>
<td><strong>Plan pays:</strong> $6,470</td>
</tr>
<tr>
<td><strong>Patient pays:</strong> $1,070</td>
</tr>
</tbody>
</table>

**Sample care costs:**
- Hospital charges (mother) $2,700
- Routine obstetric care $2,100
- Hospital charges (baby) $900
- Anesthesia $900
- Laboratory tests $500
- Prescriptions $200
- Radiology $200
- Vaccines, other preventive $40

**Total** $7,540

**Patient pays:**
- Deductibles $500
- Copays $20
- Coinsurance $400
- Limits or exclusions $150

**Total** $1,070

<table>
<thead>
<tr>
<th>Managing type 2 diabetes (routine maintenance of a well-controlled condition)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Amount owed to providers:</strong> $5,400</td>
</tr>
<tr>
<td><strong>Plan pays:</strong> $4,040</td>
</tr>
<tr>
<td><strong>Patient pays:</strong> $1,360</td>
</tr>
</tbody>
</table>

**Sample care costs:**
- Prescriptions $2,900
- Medical Equipment and Supplies $1,300
- Office Visits and Procedures $700
- Education $300
- Laboratory tests $100
- Vaccines, other preventive $100

**Total** $5,400

**Patient pays:**
- Deductibles $500
- Copays $680
- Coinsurance $100
- Limits or exclusions $80

**Total** $1,360
Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don’t include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren’t specific to a particular geographic area or health plan.
- The patient’s condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn’t covered or payment is limited.

Does the Coverage Example predict my own care needs?

- **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor’s advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- **No.** Coverage Examples are not cost estimators. You can’t use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

- **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you’ll find the same Coverage Examples. When you compare plans, check the “Patient Pays” box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- **Yes.** An important cost is the premium you pay. Generally, the lower your premium, the more you’ll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.