

Your summary of benefits

Empire BlueCross BlueShield

Your Plan: Student Advantage Health Insurance Plan

Your School: PACE UNIVERSITY - SHIP

Your Network: PPO/EPO

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	\$100 student person	\$200 student person
Overall Out-of-Pocket Limit	\$7,900 person / \$15,800 family	\$7,900 person / \$15,800 family
<p>The family out-of-pocket maximum is embedded, meaning the cost shares of one family member will be applied to the per person out-of-pocket maximum; in addition, amounts for all covered family members apply to the family out-of-pocket maximum. No one member will pay more than the per person out-of-pocket maximum.</p> <p>All medical and prescription drugs deductibles, copayments and coinsurance apply toward the out-of-pocket maximum.</p> <p>In-network and out-of-network out-of-pocket maximum amounts are separate and do not accumulate toward each other.</p>		
Doctor Visits (virtual and office) <i>You are encouraged to select a Primary Care Physician (PCP).</i>		
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 \$25 copay per visit medical deductible does not apply.		
Primary Care (PCP) <i>virtual and office</i>	\$25 copay per visit medical deductible does not apply	30% coinsurance after medical deductible is met
Mental Health and Substance Abuse Care <i>virtual and office</i>	\$25 copay per visit medical deductible does not apply	30% coinsurance after medical deductible is met
Specialist Care <i>virtual and office</i>	\$25 copay per visit medical deductible does not apply	30% coinsurance after medical deductible is met
Other Practitioner Visits		
Routine Maternity Care Prenatal <i>In-Network routine prenatal office visits and other preventive prenatal care and screening are covered at 100%.</i>	No charge	30% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Postnatal	\$20 copay per visit medical deductible does not apply	30% coinsurance after medical deductible is met
Retail Health Clinic <i>for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.</i>	\$25 copay per visit medical deductible does not apply	30% coinsurance after medical deductible is met
Manipulation Therapy	\$25 copay per visit medical deductible does not apply	30% coinsurance after medical deductible is met
Acupuncture	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
<u>Other Services in an Office</u>		
Allergy Testing	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Prescription Drugs - <i>Dispensed in the office</i>	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Surgery	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Preventive care / screenings / immunizations	No charge	30% coinsurance after medical deductible is met
Preventive care for Chronic Conditions <i>per IRS guidelines</i>	No charge	30% coinsurance after medical deductible is met
<u>Diagnostic Services</u>		
Lab		
Office	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Freestanding Lab/Reference Lab	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Outpatient Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
X-Ray		
Office	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Freestanding Radiology Center	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Advanced Diagnostic Imaging		
Office	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Freestanding Radiology Center	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
<u>Emergency and Urgent Care</u>		
Urgent Care	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Emergency Room Facility Services <i>Copay waived if admitted.</i>	\$250 copay per visit and then 0% coinsurance after medical deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services	0% coinsurance after medical deductible is met	Covered as In-Network

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<u>Ambulance</u>	20% coinsurance after medical deductible is met	Covered as In-Network
<u>Outpatient Mental Health and Substance Abuse Care at a Facility</u>		
Facility Fees	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Doctor Services	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
<u>Outpatient Surgery</u>		
Facility Fees		
Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Ambulatory Surgical Center	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Doctor and Other Services		
Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Ambulatory Surgical Center	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
<u>Hospital (Including Maternity, Mental / Behavioral Health, Substance Abuse)</u>		
Facility Fees <i>Coverage for Inpatient Rehabilitation is limited to 365 days per benefit period.</i>	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Human Organ and Tissue Transplants <i>Coverage includes acquisition and transplant procedures, collection and storage.</i>	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Doctor and other services	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<u>Recovery & Rehabilitation</u> Home Health Care <i>Coverage is limited to 40 visits per benefit period.</i>	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Rehabilitation services <i>Coverage for rehabilitative physical therapy, occupational therapy and speech therapy is limited to 365 visits combined per benefit period.</i> Office Outpatient Hospital Habilitation services <i>Coverage for habilitative physical therapy, occupational therapy and speech therapy is limited to 365 visits combined per benefit period.</i> Office Outpatient Hospital	20% coinsurance after medical deductible is met 20% coinsurance after medical deductible is met 20% coinsurance after medical deductible is met 20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met 40% coinsurance after medical deductible is met 40% coinsurance after medical deductible is met 40% coinsurance after medical deductible is met
Chemo/Radiation Therapy Office Outpatient Hospital	20% coinsurance after medical deductible is met 20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met 40% coinsurance after medical deductible is met
Dialysis/Hemodialysis Office	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Outpatient Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Cardiac rehabilitation		
Office	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Skilled Nursing Care (facility) <i>Coverage is limited to 365 days per benefit period.</i>	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Inpatient Hospice	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Durable Medical Equipment	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Prosthetic Devices	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Pharmacy Deductible	Not applicable	Not applicable
Pharmacy Out of Pocket Limit	Combined with medical out-of-pocket limit	Not covered
Prescription Drug Coverage Network: <i>Base Network</i> Drug List: <i>Traditional Open</i>		
Day Supply Limits: Retail Pharmacy 30 day supply (cost shares noted below) Retail 90 Pharmacy 90 day supply (cost shares noted below) 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). 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	\$20 copay per prescription (retail) and \$40 copay per prescription (home delivery)	Not covered (retail and home delivery)
Tier 2 – Typically Preferred Brand	\$40 copay per prescription (retail) and \$80 copay per prescription (home delivery)	Not covered (retail and home delivery)
Tier 3 - Typically Non-Preferred Brand/Specialty Drugs	\$60 copay per prescription (retail) and \$120 copay per prescription (home delivery)	Not covered (retail and home delivery)

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><i>This is a brief outline of your vision coverage. To receive the In-Network benefit, you must use a Blue View Vision Provider. Only children's vision services count towards your out of pocket limit.</i></p>		
<u>Children's Vision Essential Health Benefits (up to age 19)</u>		
Vision exam <i>Limited to 1 exam per benefit period.</i>	No charge	\$0 copayment up to plan's Maximum Allowed Amount
Frames <i>Limited to 1 unit per benefit period.</i>	No charge	\$0 copayment up to plan's Maximum Allowed Amount
Lenses <i>Limited to 1 unit per benefit period.</i>	No charge	\$0 copayment up to plan's Maximum Allowed Amount
Contact Lenses (Elective and Non-Elective) <i>Limited to 1 unit per benefit period.</i>	No charge	\$0 copayment up to plan's Maximum Allowed Amount

Covered Dental 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 dental coverage. Only children's dental services count towards your out of pocket limit.</i>		
Children's Dental Essential Health Benefits Diagnostic and preventive <i>Limited to 2 visits per 12 months.</i>	No charge	No charge
Basic services	No charge	No charge
Major services	50% coinsurance	50% coinsurance dental deductible does not apply
Medically Necessary Orthodontia services	50% coinsurance	50% coinsurance dental deductible does not apply
Cosmetic Orthodontia services	Not covered	Not covered
Adult Dental	Not covered	Not covered

Notes:

- Members are encouraged to always obtain prior approval when using non-network providers. Precertification will help the member know if the services are considered not medically necessary.
- No charge means no deductible/copayment/coinsurance up to the maximum allowable amount. 0% means no coinsurance up to the maximum allowable amount. However, when choosing a Non-network provider, the member is responsible for any balance due after the plan payment.
- When using a non-network pharmacy, members are responsible for the stated copay & costs in excess of the prescription drug maximum allowed amount. Members will pay upfront and submit a claim form.
- For additional information on limitations and exclusions and other disclosure items that apply to this plan, go to https://le.anthem.com/pdf?x=NY_SH_PPO.

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.

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) 412-0752

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)

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Language Access Services:

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