

Your summary of benefits



Anthem® Blue Cross and Blue Shield

Your Plan: Student Health Insurance Plan

Your School: PACE UNIVERSITY - SHIP

Your Network: PPO/EPO

Visits with Virtual Care-Only Providers available through our mobile app and website	
Primary Care, and medical services for urgent/acute care	\$20 copay per visit
Mental Health & Substance Use Disorder Services	\$20 copay per visit
Specialist care	\$20 copay per visit

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	\$70 person	\$70 person
Overall Out-of-Pocket Limit	\$6,350 person / \$12,700 family	\$6,350 person / \$12,700 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. In-network and out-of-network out-of-pocket maximum amounts are separate and do not accumulate toward each other.</p>		
Primary Care (PCP) <i>virtual and office</i>	\$20 copay per visit deductible does not apply	30% coinsurance after deductible is met
Mental Health and Substance Use Disorder Care <i>virtual and office</i>	\$20 copay per visit deductible does not apply	30% coinsurance after deductible is met
Specialist Care <i>virtual and office</i>	\$20 copay per visit deductible does not apply	30% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><u>Other Practitioner Visits</u></p> <p>Routine Maternity Care Prenatal <i>In-Network routine prenatal office visits and other preventive prenatal care and screening are covered at 100%.</i> Postnatal Retail Health Clinic for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores. Manipulation Therapy Acupuncture</p>	<p>No charge</p> <p>\$20 copay per visit deductible does not apply</p> <p>\$20 copay per visit deductible does not apply</p> <p>\$20 copay per visit deductible does not apply</p> <p>15% coinsurance after deductible is met</p>	<p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p> <p>35% coinsurance after deductible is met</p>
<p><u>Other Services in an Office</u></p> <p>Allergy Testing</p> <p>Prescription Drugs - <i>Dispensed in the office</i></p> <p>Surgery</p>	<p>15% coinsurance after deductible is met</p> <p>15% coinsurance after deductible is met</p> <p>15% coinsurance after deductible is met</p>	<p>35% coinsurance after deductible is met</p> <p>35% coinsurance after deductible is met</p> <p>35% coinsurance after deductible is met</p>
<p>Preventive care / screenings / immunizations</p>	<p>No charge</p>	<p>30% coinsurance after deductible is met</p>
<p>Preventive care for Chronic Conditions per IRS guidelines</p>	<p>No charge</p>	<p>30% coinsurance after deductible is met</p>
<p><u>Diagnostic Services</u></p> <p>Lab Office Freestanding Lab/Reference Lab Outpatient Hospital</p>	<p>15% coinsurance after deductible is met</p> <p>15% coinsurance after deductible is met</p> <p>15% coinsurance after deductible is met</p>	<p>35% coinsurance after deductible is met</p> <p>35% coinsurance after deductible is met</p> <p>35% coinsurance after deductible is met</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
X-Ray Office Freestanding Radiology Center Outpatient Hospital	15% coinsurance after deductible is met 15% coinsurance after deductible is met 15% coinsurance after deductible is met	35% coinsurance after deductible is met 35% coinsurance after deductible is met 35% coinsurance after deductible is met
Advanced Diagnostic Imaging Office Freestanding Radiology Center Outpatient Hospital	15% coinsurance after deductible is met 15% coinsurance after deductible is met 15% coinsurance after deductible is met	35% coinsurance after deductible is met 35% coinsurance after deductible is met 35% coinsurance after deductible is met
<u>Emergency and Urgent Care</u> Urgent Care Emergency Room Facility Services <i>Copay waived if admitted.</i> Emergency Room Doctor and Other Services <u>Ambulance</u>	15% coinsurance after deductible is met 0% coinsurance after deductible is met 0% coinsurance after deductible is met 15% coinsurance after deductible is met	35% coinsurance after deductible is met Covered as In-Network Covered as In-Network Covered as In-Network
<u>Outpatient Mental Health and Substance Abuse Care at a Facility</u> Facility Fees Doctor Services	15% coinsurance after deductible is met 15% coinsurance deductible does not apply	35% coinsurance after deductible is met 35% coinsurance after deductible is met
<u>Outpatient Surgery</u> Facility Fees Hospital Ambulatory Surgical Center	15% coinsurance after deductible is met 15% coinsurance after deductible is met	35% coinsurance after deductible is met 35% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p>Doctor and Other Services</p> <p>Hospital</p> <p>Ambulatory Surgical Center</p>	<p>15% coinsurance after deductible is met</p> <p>15% coinsurance after deductible is met</p>	<p>35% coinsurance after deductible is met</p> <p>35% coinsurance after deductible is met</p>
<p><u>Hospital (Including Maternity, Mental / Behavioral Health, Substance Abuse)</u></p> <p>Facility Fees <i>Coverage for Inpatient Rehabilitation is limited to 365 days per benefit period.</i></p> <p>Human Organ and Tissue Transplants <i>Coverage includes acquisition and transplant procedures, collection and storage.</i></p> <p>Doctor and other services</p>	<p>15% coinsurance after deductible is met</p> <p>15% coinsurance after deductible is met</p> <p>15% coinsurance after deductible is met</p>	<p>35% coinsurance after deductible is met</p> <p>35% coinsurance after deductible is met</p> <p>35% coinsurance after deductible is met</p>
<p><u>Recovery & Rehabilitation</u></p> <p>Home Health Care <i>Coverage is limited to 40 visits per benefit period.</i></p>	<p>15% coinsurance after deductible is met</p>	<p>35% coinsurance after deductible is met</p>
<p>Rehabilitation services <i>Coverage for rehabilitative physical therapy, occupational therapy and speech therapy is limited to 365 visits combined per benefit period.</i></p> <p>Office</p> <p>Outpatient Hospital</p> <p>Habilitation services <i>Coverage for habilitative physical therapy, occupational therapy and speech therapy is limited to 365 visits combined per benefit period.</i></p> <p>Office</p> <p>Outpatient Hospital</p>	<p>15% coinsurance after deductible is met</p> <p>15% coinsurance after deductible is met</p> <p>15% coinsurance after deductible is met</p> <p>15% coinsurance after deductible is met</p>	<p>35% coinsurance after deductible is met</p> <p>35% coinsurance after deductible is met</p> <p>35% coinsurance after deductible is met</p> <p>35% coinsurance after deductible is met</p>
<p>Chemo/Radiation Therapy</p> <p>Office</p> <p>Outpatient Hospital</p>	<p>15% coinsurance after deductible is met</p> <p>15% coinsurance after deductible is met</p>	<p>35% coinsurance after deductible is met</p> <p>35% coinsurance after deductible is met</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Dialysis/Hemodialysis Office Outpatient Hospital	15% coinsurance after deductible is met 15% coinsurance after deductible is met	35% coinsurance after deductible is met 35% coinsurance after deductible is met
Cardiac rehabilitation Office Outpatient Hospital	15% coinsurance after deductible is met 15% coinsurance after deductible is met	35% coinsurance after deductible is met 35% coinsurance after deductible is met
Skilled Nursing Care (facility) <i>Coverage is limited to 365 days per benefit period.</i>	15% coinsurance after deductible is met	35% coinsurance after deductible is met
Inpatient Hospice	15% coinsurance after deductible is met	35% coinsurance after deductible is met
Durable Medical Equipment	15% coinsurance after deductible is met	35% coinsurance after deductible is met
Prosthetic Devices	15% coinsurance after deductible is met	35% coinsurance after 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 Each 90 day supply script filled at Retail 90 pharmacies is subject to 3 times the 30 day supply cost share(s) charged at In-Network Retail Pharmacies.	\$15 copay per prescription (retail) and \$30 copay per prescription (home delivery)	Not covered (retail and home delivery)
Tier 2 – Typically Preferred Brand Each 90 day supply script filled at Retail 90 pharmacies is subject to 3 times the 30 day supply cost share(s) charged at In-Network Retail Pharmacies.	\$30 copay per prescription (retail) and \$60 copay per prescription (home delivery)	Not covered (retail and home delivery)
Tier 3 - Typically Non-Preferred Brand/Specialty Drugs Each 90 day supply script filled at Retail 90 pharmacies is subject to 3 times the 30 day supply cost share(s) charged at In-Network Retail Pharmacies.	\$50 copay per prescription (retail) and \$100 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
<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>		
Children's Vision Essential Health Benefits (up to age 19)		
Vision exam <i>Limited to 1 exam per benefit period.</i>	No charge	Reimbursed Up to \$30
Frames <i>Limited to 1 unit per benefit period.</i>	No charge	Reimbursed Up to \$45
Lenses <i>Limited to 1 unit per benefit period combined with OON Coverage. OON Reimbursement: Single Reimbursed Up to \$25, Bifocal Reimbursed Up to \$40, Trifocal Reimbursed Up to \$55.</i>	No charge	Receives Reimbursement
Elective Contact Lenses <i>Limited to 1 unit per benefit period.</i>	No charge	Reimbursed Up to \$60
Non-Elective Contact Lenses <i>Limited to 1 unit per benefit period.</i>	No charge	Reimbursed Up to \$210

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 deductible does not apply
Medically Necessary Orthodontia services	50% coinsurance	50% coinsurance 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)

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) 412-0752.

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) 412-0752:

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Language Access Services:

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Polish (polski): W przypadku jakichkolwiek pytań związanych z niniejszym dokumentem masz prawo do bezpłatnego uzyskania pomocy oraz informacji w swoim języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer: (844) 412-0752.

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