

2022-2023



## Pace University - Domestic Student Health Insurance Plan

[student.empireblue.com/student/schools/pace](https://student.empireblue.com/student/schools/pace)

# Anthem Student Advantage

Keeping you at your personal best



### Important notice

This is a brief description of your student health plan underwritten by Empire Blue Cross and Blue Shield (Empire). If you would like more details about your coverage and costs, you can get the complete terms in the policy or plan document online at [empireblue.com](http://empireblue.com).

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**Welcome  
to Anthem  
Student  
Advantage**



As your new school year begins, it's important to understand your health care benefits and how they work. Your Anthem Student Advantage plan will help guide you through that process with information about who is eligible, what is covered, how much it costs, and the best ways to access care.

## What you need to know about Anthem Student Advantage



### Who is eligible?

You will be required to participate in this plan on a hard waiver basis if:

- › You are a full-time undergraduate student carrying 12 or more credits
- › You are a full-time graduate students carrying 9 or more credits
- › You are an enrolled full-time law student

The following student groups may participate on a voluntary basis:

- › Part-time graduate, undergraduate and law students registered for 6 or more credit hours



### Coverage is available for dependents too

If you're covered by Anthem Student Advantage through Pace University, you may enroll your lawful spouse, domestic partner or dependent children under the age of 26. Here is how it works:

- › Eligible students may also insure their Dependents.
- › Eligible Dependents are the student's spouse or Domestic Partner and dependent children under 26 years of age.
- › See the "Who is Covered" section of the Certificate of Coverage for the specific requirements needed to meet Domestic Partner eligibility.

# Coverage periods and rates



Coverage will become effective at 12:01 a.m., and will end at 11:59 p.m. on the dates shown below.

## Costs and dates of coverage

The rates listed below include a prorated annual \$2.00 fee for Togetherall behavioral health benefits provided by Togetherall.

Gross Rates	Annual 8-15-2022 to 8-14-2023	Fall 8-15-2022 to 12-31-2022	Spring 1-1-2023 to 8-14-2023	Summer 1 5-30-2023 to 8-14-2023	Summer 2 7-13-2023 to 8-14-2023
Student	\$3,473	\$1,323	\$2,150	\$733	\$314
Spouse	\$3,473	\$1,323	\$2,150	\$733	\$314
Child	\$3,473	\$1,323	\$2,150	\$733	\$314
2 or More Children	\$6,946	\$2,645	\$4,301	\$1,465	\$628







## Important dates for the coverage period



### Open enrollment

- › Fall: 8/15/2022 - 9/22/2022
- › Spring: 1/1/2023 - 2/7/2023
- › Summer I: 5/31/2023 - 6/14/2023
- › Summer II: 7/12/2023 - 7/28/2023



### Waiver deadlines

You can waive your Anthem Student Advantage if you have comparable coverage.

Fall: 9/22/2022

Spring: 2/7/2023

Summer I: 6/14/2023

Summer II: 7/28/2023



If you have questions about enrollment and waiver options, visit [www.mystudentmedical.com/](http://www.mystudentmedical.com/) or call 1-800-734-9326.



# Keep in touch with your benefits information



## Student Health Center

### New York Campus

1 Pace Plaza  
6th Floor East  
(\*\*Take elevators from the 4th Floor East and transfer to elevators for 6th Floor East\*\*)  
New York, NY 10038  
1-212-346-1600

### Pleasantville Campus

Paton House – Ground Floor  
861 Bedford Road  
Pleasantville, NY 10570  
1-914-773-3760

Hours of Operation:  
9 a.m. to 5 p.m.  
Closed between Christmas  
and New Year's



## Claims and coverage

1-844-412-0752  
Anthem Blue Cross Life and Health Insurance Company  
P.O. Box 1407  
Church Street Station  
New York, NY 10008



## Benefits, eligibility and enrollment

The Allen J. Flood Companies, Inc.  
500 Mamaroneck Ave., Suite 402  
Harrison, NY 10528  
1-800-734-9326  
[www.mystudentmedical.com/](http://www.mystudentmedical.com/)



## General information

The Allen J. Flood Companies, Inc.  
500 Mamaroneck Ave., Suite 402  
Harrison, NY 10528  
1-800-734-9326

# Easy access to care

Access the care you need, when you need it,  
and in the way that works best for you.



## Sydney Health app

With the Sydney Health<sup>1</sup> app through Anthem Student Advantage, you have instant access to:

- › Your member ID card.
- › The Find a Doctor tool.
- › More information about your plan benefits.
- › Health tips that are tailored to you.
- › LiveHealth Online and 24/7 NurseLine.
- › Student support specialists (through click-to-chat or by phone).

### Access the Sydney Health app

Go to the App Store<sup>SM</sup> or Google Play<sup>TM</sup> and search for the Sydney Health app to download it today.



## LiveHealth Online

From your mobile device or computer with a webcam, you can use LiveHealth Online to visit with a board-certified doctor, psychiatrist or licensed therapist through live video.<sup>2</sup> Go to your Sydney Health app or [www.livehealthonline.com](http://www.livehealthonline.com).

You can also download the free LiveHealth Online app to sign up.



## 24/7 NurseLine

Call **1-844-545-1429** to speak to a registered nurse who can help you with health issues like fever, allergy relief, cold and flu symptoms and where to go for care. Nurses can also help you enroll in health management programs if you have specific health conditions, and remind you about scheduling important screenings and exams, and more.



## Provider finder

Visit [www.empireblue.com/find-care/](http://www.empireblue.com/find-care/) to find the right doctor or facility close to where you are.



## Anthem Student Advantage Pace University website

Visit [www.student.empireblue.com/student/schools/pace](http://www.student.empireblue.com/student/schools/pace) to see your health plan information, including providers, benefits, claims, covered drugs and more.

<sup>1</sup> Sydney Health is a service mark of CareMarket, Inc.

<sup>2</sup> Appointments subject to availability of a therapist. Psychologists or therapists using LiveHealth Online cannot prescribe medications. Online counseling is not appropriate for all kinds of problems. If you are in crisis or have suicidal thoughts, it's important that you seek help immediately. Please call 1-800-784-2433 (National Suicide Prevention Lifeline) or 911 and ask for help. If your issue is an emergency, call 911 or go to your nearest emergency room. LiveHealth Online does not offer emergency services.

LiveHealth Online is the trade name of Health Management Corporation, a separate company, providing telehealth services on behalf of Anthem Blue Cross and Blue Shield.





# Your summary of benefits

Empire Blue Cross  
and Blue Shield

Student health insurance plan:  
Pace University

Your network:  
BlueChoice  
Open Access POS



*Student Health Center Benefits: No charge for covered medical expenses, the deductible is waived, and 100% of Usual and Reasonable Charge for Covered RX Expenses.*

*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.*

## Medical

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
<b>Overall Deductible</b>		
<i>When the Deductible applies, you must pay it before benefits begin. See the sections below to find out when the Deductible applies. Copayments and Coinsurance are separate from and do not apply to the Deductible.</i>	\$100 student / None family	\$200 student / None family
<b>Out-of-Pocket Limit</b>		
<i>When you meet your out-of-pocket limit, you will no longer have to pay cost- shares during the remainder of your benefit period. See notes section for additional information regarding your out of pocket maximum.</i>	\$7,900 student/ \$15,800 family	
<b>Preventive care/screening/immunization</b>		
<i>In-network preventive care is not subject to deductible, if your plan has a deductible. Out-of-Network preventive care services for children prior to their 6th birthday have no deductible.</i>	Covered in full	30% coinsurance after deductible
<b>Doctor Home and Office Services</b>		
<b>Primary Care Office Visit to treat an injury or illness</b>	\$25 copay per visit 0% coinsurance not subject to deductible	30% coinsurance after deductible
<b>Specialist Care Office Visit</b>	\$25 copay per visit 0% coinsurance not subject to deductible	30% coinsurance after deductible
<b>Prenatal Care</b>	Covered in full	30% coinsurance after deductible
<b>Post-natal Care</b>	\$20 copay per visit, 0% coinsurance, deductible does not apply	30% coinsurance after deductible
<b>Abortion</b>		
<b>Medically Necessary Abortions</b>	Covered in full after deductible	35% coinsurance after deductible
<b>Elective Abortions</b> <i>One (1) procedure per Plan Year</i>	20% coinsurance after deductible	40% coinsurance after deductible

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
<b>Other Practitioner Visits:</b>		
On-line Visit <i>Live Health Online is the preferred telehealth solutions (<a href="http://www.livehealthonline.com">www.livehealthonline.com</a>)</i>	\$25 copay per visit 0% coinsurance after deductible	30% coinsurance
Manipulation Therapy <i>Coverage is limited to 20 visits per benefit period. Limit is combined In-Network and Out-of-Network across all outpatient settings.</i>	\$25 copay per visit 0% coinsurance not subject to deductible	30% coinsurance after deductible
Acupuncture	20% coinsurance after deductible	40% coinsurance after deductible
<b>Other Services in an Office:</b>		
Allergy Testing	20% coinsurance after deductible	40% coinsurance after deductible
Chemo/Radiation Therapy	20% coinsurance after deductible	40% coinsurance after deductible
Hemodialysis	20% coinsurance after deductible	40% coinsurance after deductible
Prescription Drugs <i>For the drugs itself dispensed in the office through infusion/injection.</i>	20% coinsurance after deductible	40% coinsurance after deductible
Infertility <i>Covered according to services provided (diagnostic radiology service, surgery, lab, or diagnostic procedures)</i>	20% coinsurance after deductible	40% coinsurance after deductible
Autism		
ABA treatment for Autism Spectrum Disorder	\$20 copay per visit 0% coinsurance, not subject to deductible	30% coinsurance after deductible
Assistive Communication Devices for Autism Spectrum Disorder	\$25 copay per visit 0% coinsurance after deductible	30% coinsurance after deductible
<b>Diagnostic Services</b>		
<b>Lab:</b>		
Office <i>Office Cost Share applies only when Freestanding/Reference Labs are not used.</i>	20% coinsurance after deductible	40% coinsurance after deductible
Freestanding Lab/Reference Lab	20% coinsurance after deductible	40% coinsurance after deductible
Outpatient Hospital	20% coinsurance after deductible	40% coinsurance after deductible
<b>X-Ray:</b>		
Office	20% coinsurance after deductible	40% coinsurance after deductible
Freestanding Radiology Center	20% coinsurance after deductible	40% coinsurance after deductible
Outpatient Hospital	20% coinsurance after deductible	40% coinsurance after deductible

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
<b>Advanced Diagnostic Imaging (for example, MRI/PET/CAT scans):</b>		
Office	20% coinsurance after deductible	40% coinsurance after deductible
Freestanding Radiology Center	20% coinsurance after deductible	40% coinsurance after deductible
Outpatient Hospital	20% coinsurance after deductible	40% coinsurance after deductible
<b>Emergency and Urgent Care</b>		
<b>Urgent Care (Office Setting)</b>	20% coinsurance after deductible	40% coinsurance after deductible
<b>Emergency Room Doctor and Other Services</b>	\$250 copay per visit 0% coinsurance after deductible	Covered as In- Network
<b>Ambulance (Air and Ground)</b>	20% coinsurance after deductible	Covered as In- Network
<b>Outpatient Mental Health and Substance Use Disorder</b> <i>Outpatient Mental Health and Substance Abuse Care (including Partial Hospitalization and Intensive Outpatient Program Services)</i>		
<b>Doctor Office Visit and Online Visit</b>	\$25 copay 0% coinsurance not subject to deductible	30% coinsurance after deductible
<b>Facility visit:</b>		
Facility Fees <i>Outpatient Substance Use Services (including Partial Hospitalization, Intensive Outpatient Program Services, and Medication Assisted Treatment) Up to 20 visits per Plan Year may be used for family counseling.</i>	20% coinsurance not subject to deductible	40% coinsurance after deductible
Doctor Services	20% coinsurance not subject to deductible	40% coinsurance after deductible
<b>Outpatient Surgery</b>		
<b>Facility Fees:</b>		
Hospital	20% coinsurance after deductible	40% coinsurance after deductible
Freestanding Surgical Center	20% coinsurance after deductible	40% coinsurance after deductible
<b>Hospital Stay (all Inpatient stays including Maternity, Mental and Substance Use Disorder):</b>		
<b>Facility fees (for example, room &amp; board)</b> <i>Coverage for Inpatient rehabilitation and skilled nursing services combined In-Network Providers and Out-of-Network Providers combined is limited to 365 days per benefit year. Inpatient Mental Health Care including Residential Treatment (for a continuous confinement when in a Hospital) Preauthorization Required. However, Preauthorization is Not Required for emergency admissions. Inpatient Substance Use Services including Residential Treatment (for a continuous confinement when in a Hospital) Preauthorization Required. However, Preauthorization is Not Required for Emergency Admissions or for Participating OASAS certified Facilities.</i>	20% coinsurance after deductible	40% coinsurance after deductible



Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
<b>Doctor and other services</b>	20% coinsurance after deductible	40% coinsurance after deductible
<b>Preadmission Testing</b>	20% coinsurance after deductible	40% coinsurance after deductible
<b>Recovery &amp; Rehabilitation</b>		
<b>Home Care Visits</b> <i>Coverage for In-Network Providers and Out-of-Network Providers combined is limited to 40 visits per benefit period.</i>	20% coinsurance after deductible	40% coinsurance after deductible
<b>Rehabilitation services (for example, physical/speech/occupational therapy):</b>		
Office <i>Coverage for physical therapy and occupational therapy. Preauthorization required. 365 days per plan year.</i>	20% coinsurance after deductible	40% coinsurance after deductible
Outpatient Hospital <i>Coverage for physical therapy and occupational therapy. Preauthorization required. 365 days per plan year.</i>	20% coinsurance after deductible	40% coinsurance after deductible
<b>Habilitation services (for example, physical/speech/occupational therapy):</b>		
Office <i>Coverage for physical therapy and occupational therapy. Preauthorization required. 365 days per plan year.</i>	20% coinsurance after deductible	40% coinsurance after deductible
Outpatient Hospital <i>Coverage for physical therapy and occupational therapy. Preauthorization required. 365 days per plan year.</i>	20% coinsurance after deductible	40% coinsurance after deductible
<b>Cardiac rehabilitation</b>		
Office	20% coinsurance after deductible	40% coinsurance after deductible
Outpatient Hospital	20% coinsurance after deductible	40% coinsurance after deductible
<b>Skilled Nursing Care (in a facility)</b>		
<i>Coverage for Inpatient rehabilitation and skilled nursing services combined In- Network Providers and Out-of-Network Providers combined is limited to 365 days per benefit period.</i>	20% coinsurance after deductible	40% coinsurance after deductible
<b>Hospice</b>		
<i>Coverage for Inpatient and Outpatient Unlimited visits – 5 visits for family bereavement counseling.</i>	20% coinsurance after deductible	40% coinsurance after deductible
<b>Durable Medical Equipment</b>		
<i>Coverage for hearing aids services; single purchase once every 3 years. Cochlear/BAHA Implants; One per ear per time covered.</i>	20% coinsurance after deductible	40% coinsurance after deductible
<b>Prosthetic Devices</b>		
<i>Coverage for wigs needed after cancer treatment In-Network Providers and Out-of-Network Providers combined is limited to 1 items per benefit period. Internal - One prosthetic device, per limb per lifetime. External - unlimited.</i>	20% coinsurance after deductible	40% coinsurance after deductible



## Pharmacy

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Pharmacy Deductible	Not applicable	Not applicable
Pharmacy Out of Pocket	Combined with medical out of pocket maximum	Combined with medical out of pocket maximum
<b>Prescription Drug Coverage</b> <i>Traditional Open Drug List</i> This product has a 90-day Retail Pharmacy Network available. A 90 day supply is available at most retail pharmacies.		
<b>Tier 1 - Typically Lower Cost Generic</b> Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). Covers up to 90 day supply (retail maintenance pharmacy).	\$20 copay per Prescription deductible does not apply. Home delivery copay is 2 times the retail copayment per prescription Deductible does not apply.	Not covered
<b>Tier 2 - Typically Preferred Brand</b> Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). Covers up to 90 day supply (retail maintenance pharmacy).	\$40 copay per Prescription deductible does not apply. Home delivery copay is 2 times the retail copayment per prescription Deductible does not apply.	Not covered
<b>Tier 3 - Typically Non-Preferred Brand</b> Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). Covers up to 90 day supply (retail maintenance pharmacy).	\$60 copay per Prescription deductible does not apply. Home delivery copay is 2 times the retail copayment per prescription Deductible does not apply.	Not covered

**Pediatric Vision** *Limited to covered persons under the age of 19.*

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
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This is a brief outline of your vision coverage. Not all cost shares for covered services are shown below. Benefits include coverage for student’s choice of eyeglass lenses or contact lenses, but not both. For a full list, including benefits, exclusions and limitations, see the combined Evidence of Coverage/Disclosure form/Certificate. If there is a difference between this summary and either Evidence of Coverage/Disclosure form/Certificate, the Evidence of Coverage/Disclosure form/Certificate will prevail.

**Children’s Vision Essential Health Benefits**  
*Limited to covered persons under the age of 19.*

Child Vision Deductible	Not Applicable	Not Applicable
<b>Vision exam</b> <i>Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 exam per benefit period</i>	No charge	\$0 copay plus all charges in excess of the maximum allowed amount
<b>Frames</b> <i>Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 unit per benefit period.</i>	No charge	\$0 copay plus all charges in excess of the maximum allowed amount
<b>Lenses</b> <i>Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 unit per benefit period.</i>		
Single Vision	No Charge	\$0 copay plus all charges in excess of the maximum allowed amount
Bifocal lenses	No Charge	\$0 copay plus all charges in excess of the maximum allowed amount
Trifocal lenses	No Charge	\$0 copay plus all charges in excess of the maximum allowed amount
Standard Progressive	No Charge	\$0 copay plus all charges in excess of the maximum allowed amount
<b>Elective contact lenses</b> <i>Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 unit per benefit period.</i>	No charge	\$0 copay plus all charges in excess of the maximum allowed amount
<b>Non-Elective Contact Lenses</b> <i>Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 unit per benefit period.</i>	No charge	\$0 copay plus all charges in excess of the maximum allowed amount







**Pediatric Dental** *Limited to covered persons under the age of 19.*

Covered Dental Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
<p>This is a brief outline of your dental coverage. Not all cost shares for covered services are shown below. For a full list, including benefits, exclusions and limitations, see the combined Evidence of Coverage/Disclosure form/Certificate. If there is a difference between this summary and either Evidence of Coverage/Disclosure form/Certificate, the Evidence of Coverage/Disclosure form/Certificate will prevail. Only children's dental services count towards your out of pocket limit.</p>		
<p><b>Children's Dental Essential Health Benefits</b> <i>Limited to covered persons under the age of 19.</i></p>		
<p><b>Diagnostic and preventive</b> <i>Includes cleanings, exams, x-rays, sealants, fluoride</i></p>	No charge	No charge
<p><b>Basic services</b> <i>Includes filing and simple extractions</i></p>	No charge	No charge
<p><b>Major services/Prosthodontic</b></p>	50% coinsurance after deductible is met	50% coinsurance after deductible is met
<p><b>Endodontic, Periodontics, Oral Surgery</b></p>	50% coinsurance after deductible is met	50% coinsurance after deductible is met
<p><b>Medically Necessary Orthodontia</b></p>	50%	50%
<p><b>Deductible</b></p>	Not applicable	Not applicable
<p><b>Adult Dental</b></p>	Not covered	Not covered

# Benefits that go with you



You can count on medical coverage anywhere worldwide with GeoBlue.<sup>1</sup> Easily access international doctors by phone or video and use our 24/7 help center for emergency health questions. Anthem Student Advantage and GeoBlue provides the right support and services when you need them the most.



Visit <https://www.geobluestudents.com> to learn more.

## GeoBlue benefits for the 2022-2023 school year

*Use of benefits must be coordinated and approved by GeoBlue.*

### International telemedicine services<sup>2</sup>

Global TeleMD™ Confidential access to international doctors by telephone or video call.

### Coverage outside the U.S., excluding student's home country.

Medical Expenses Coverage is based on medical plan benefits. You should refer to your existing health plan for full details of what's included and what is not.

### Coverage worldwide except within 100 miles of primary residence for U.S. students. Coverage worldwide, excluding home country for international students.

Emergency medical evacuation	Unlimited
Repatriation of remains	Unlimited
Emergency family travel arrangements	Maximum benefit up to \$5,000 per coverage year
Political emergency and natural disaster evacuation (Available only when traveling outside the United States) <sup>4</sup>	Covered 100% up to \$100,000 per person. Subject to a combined \$5,000,000 limit per any one covered event for all people covered under the plan.
Accidental death and dismemberment	Maximum benefit up to \$10,000 per coverage year



<sup>1</sup> GeoBlue is the trade name of Worldwide Insurance Services, LLC (Worldwide Services Insurance Agency, LLC in California and New York), an independent licensee of the Blue Cross and Blue Shield Association. GeoBlue is the administrator of coverage provided under insurance policies issued by 4 Ever Life International Limited, Bermuda, an independent licensee of the Blue Cross Blue Shield Association. Coverage is not available in all states. Some restrictions apply.

<sup>2</sup> Telemedicine services are provided by Teladoc Health, directly to members. GeoBlue assumes no liability and accepts no responsibility for information provided by Teladoc Health and the performance of the services by Teladoc Health. Support and information provided through this service does not confirm that any related treatment or additional support is covered under a member's health plan.

<sup>3</sup> These medical expenses are limited and are subject to limitations and exclusions. See full certificate of insurance for a full description of services and coverage of what is and isn't covered.

<sup>4</sup> The Political, Military and Natural Disaster Evacuation Services (PEND) are provided through Crisis24, an independent third party, non-affiliated service provider. Crisis24 does not supply Blue Cross or Blue Shield products or other benefits, and is therefore solely responsible for PEND and other collateral services it provides. GeoBlue makes no warranty, express or implied, and accepts no responsibility resulting from the provision or use of Crisis24 PEND or other Crisis24 services.



**Designed with you in mind**

Offering you healthy support and easy-to-use benefits to help you stay focused on your education and your future.



# Exclusions

Exclusions and Limitations apply and are outlined in the Certificate of Coverage Exclusions and Limitations: No coverage is available under this Certificate for the following:

**A. Aviation.**

We do not Cover services arising out of aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline.

**B. Convalescent and Custodial Care.**

We do not Cover services related to rest cures, custodial care or transportation. "Custodial care" means help in transferring, eating, dressing, bathing, toileting and other such related activities. Custodial care does not include Covered Services determined to be Medically Necessary.

**C. Conversion Therapy.**

We do not Cover conversion therapy. Conversion therapy is any practice by a mental health professional that seeks to change the sexual orientation or gender identity of a member under 18 years of age, including efforts to change behaviors, gender expressions, or to eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same sex. Conversion therapy does not include counseling or therapy for any individual who is seeking to undergo a gender transition or who is in the process of undergoing a gender transition, that provides acceptance, support and understanding of an individual or the facilitation of an individual's coping, social support, and identity exploration and development, including sexual orientation-neutral interventions to prevent or address unlawful conduct or unsafe sexual practices, provided that the counseling or therapy does not seek to change sexual orientation or gender identity.

**D. Cosmetic Services.**

We do not Cover cosmetic services, Prescription Drugs, or surgery, unless otherwise specified, except that cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered Child which has resulted in a functional defect. We also Cover services in connection with reconstructive surgery following a mastectomy, as provided elsewhere in this Certificate. Cosmetic surgery does not include surgery determined to be Medically Necessary. If a claim for a procedure listed in 11 NYCRR 56 (e.g. certain plastic surgery and dermatology procedures) is submitted retrospectively and without medical information, any denial will not be subject to the Utilization Review process in the Utilization Review and External appeal sections of this Certificate unless medical information is submitted.

**E. Coverage Outside of the United States, Canada or Mexico.**

We do not Cover care or treatment provided outside of the United States, its possessions, Canada or Mexico except for Emergency Services, Pre-Hospital Emergency Medical Services and ambulance services to treat Your Emergency Condition.

**F. Dental Services.**

We do not Cover dental services except for: care or treatment due to accidental injury to sound natural teeth within 12 months of the accident;

dental care or treatment necessary due to congenital disease or anomaly; or dental care or treatment specifically stated in the Outpatient and Professional Services and Pediatric Dental Care sections of this Certificate.

**G. Experimental or Investigational Treatment.**

We do not Cover any health care service, procedure, treatment, device or Prescription Drug that is experimental or investigational. However, We will Cover experimental or investigational treatments, including treatment for Your rare disease or patient costs for Your participation in a clinical trial as described in the Outpatient and Professional Services section of this Certificate, when Our denial of services is overturned by an External Appeal Agent certified by the State. However, for clinical trials, We will not Cover the costs of any investigational drugs or devices, non-health services required for You to receive the treatment, the costs of managing the research, or costs that would not be Covered under this Certificate for non-investigational treatments. See the Utilization Review and External Appeal sections of this Certificate for a further explanation of Your Appeal rights.

**H. Felony Participation.**

We do not Cover any illness, treatment or medical condition due to Your participation in a felony, riot or insurrection. This exclusion does not apply to Coverage for services involving injuries suffered by a victim of an act of domestic violence or for services as a result of Your medical condition (including both physical and mental health conditions).

**I. Foot Care.**

We do not cover routine foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet. However, we will Cover foot care when You have a specific medical condition or disease resulting in circulatory deficits or areas of decreased sensation in Your legs or feet.

**J. Government Facility.**

We do not Cover care or treatment provided in a Hospital that is owned or operated by any federal, state or other governmental entity, except as otherwise required by law unless You are taken to the Hospital because it is close to the place where You were injured or became ill and Emergency Services are provided to treat Your Emergency Condition.

**K. Medically Necessary.**

In general, We will not Cover any health care service, procedure, treatment, test, device or Prescription Drug that We determine is not Medically Necessary. If an External Appeal Agent certified by the State overturns Our denial, however, We will Cover the service, procedure, treatment, test, device or Prescription Drug for which coverage has been denied, to the extent that such service, procedure, treatment, test, device or Prescription Drug is otherwise Covered under the terms of this Certificate.

**L. Medicare or Other Governmental Program.**

We do not Cover services if benefits are provided for such services under the federal Medicare program or other governmental program (except Medicaid).

**M. Military Service.**

We do not Cover an illness, treatment or medical condition due to service in the Armed Forces or auxiliary units.

**N. No-Fault Automobile Insurance.**

We do not Cover any benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable. This exclusion applies even if You do not make a proper or timely claim for the benefits available to You under a mandatory no-fault policy.

**O. Services Not Listed.**

We do not Cover services that are not listed in this Certificate as being Covered.

**P. Services Provided by a Family Member.**

We do not Cover services performed by a member of the covered person's immediate family. "Immediate family" shall mean a child, spouse, mother, father, sister or brother of You or Your Spouse.

**Q. Service Separately Billed by Hospital Employees.**

We do not Cover services rendered and separately billed by employees of Hospitals, laboratories or other institutions.

**R. Services With No Charge.**

We do not Cover services for which no charge is normally made.

**S. Vision Services.**

We do not Cover the examination or fitting of eyeglasses or contact lenses, except as specifically stated in the Pediatric Vision Care section of this Certificate.

**T. War.**

We do not Cover an illness, treatment or medical condition due to war, declared or undeclared.

**U. Workers' Compensation.**

We do not Cover services if benefits for such services are provided under any state or federal Workers' Compensation, employers' liability or occupational disease law.

# Access help in your language

If you have any questions about this document, you have the right to help and information in your language at no cost. To talk to an interpreter, call **1-855-330-1098**.

**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

يـاء دوجوملا عاضعلا تامدخ مقر لصتا . تاجم كفتخب تدعاسملاو تامولعلا ذه يـاء لوصحلا انا قحج  
(TTY/TDD: 711) تدعاسملا كئب تماصاخلا فجرعتلا تقاطب

## Armenian

Դուք իրավունք ունեք Ձեր լեզվով անվճար ստանալ այս  
տեղեկատվությունը և ցանկացած օգնություն: Օգնություն ստանալու  
համար զանգահարեք Անդամների սպասարկման կենտրոն՝ Ձեր ID  
քարտի վրա նշված համարով: (TTY/TDD: 711)

## Chinese

您有權使用您的語言免費獲得該資訊和協助。請撥打您的 ID 卡上的成員服務號碼尋求協助。(TTY/TDD: 711)

## Farsi

تروص به ار ابعكمك و شاعلاطا نيا بهك ديراد ار قح نيا امش  
به كمك تفايرد ي ارب . مدينك تفايرد ناتدوخ نايز به ناكيار  
چرد نات ي ياسانش تراک ي ور بهك عاضعا تامدخ زكرم هرامش  
ديريگب سلامت ،تمسا . ه دش (TTY/TDD: 711)

## French

Vous avez le droit d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour cela, veuillez appeler le numéro des Services destinés aux membres qui figure sur votre carte d'identification. (TTY/TDD: 711)

## Haitian

Ou gen dwa pou resevwa enfòmasyon sa a ak asistans nan lang ou pou gratis. Rele nimewo Manm Sèvis la ki sou kat idantifikasyon ou a pou jwenn èd. (TTY/TDD: 711)

## Italian

Ha il diritto di ricevere queste informazioni ed eventuale assistenza nella sua lingua senza alcun costo aggiuntivo. Per assistenza, chiami il numero dedicato ai Servizi per i membri riportato sul suo libretto. (TTY/TDD: 711)

## Japanese

この情報と支援を希望する言語で無料で受けることができます。支援を受けるには、IDカードに記載されているメンバーサービス番号に電話してください。(TTY/TDD: 711)

## Korean

귀하에게는 무료로 이 정보를 얻고 귀하의 언어로 도움을 받을 권리가 있습니다. 도움을 얻으려면 귀하의 ID 카드에 있는 회원 서비스 번호로 전화하십시오. (TTY/TDD: 711)

## Navajo

Bee ná ahóót'í t'áá ni nizaad k'éhjí níká a'doowof t'áá jíík'e.  
Naaltsoos bee atah níńínígíí bee néého' dólzingo nanitínígíí béésh  
bee hane' í bikáá' áajj'í hod'ílnih. (TTY/TDD: 711)

## Polish

Masz prawo do bezpłatnego otrzymania niniejszych informacji oraz uzyskania pomocy w swoim języku. W tym celu skontaktuj się z Działem Obsługi Klienta pod numerem telefonu podanym na karcie identyfikacyjnej. (TTY/TDD: 711)

## Punjabi

ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਇਹ ਜਾਣਕਾਰੀ ਅਤੇ ਮਦਦ ਮੁਫਤ ਵਿੱਚ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ।  
ਮਦਦ ਲਈ ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਉੱਤੇ ਮੈਂਬਰ ਸੇਵਾ ਸਿੱਧੀ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ। (TTY/TDD: 711)

## Russian

Вы имеете право получить данную информацию и помощь на вашем языке бесплатно. Для получения помощи звоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. (TTY/TDD: 711)

## Spanish

Tiene el derecho de obtener esta información y ayuda en su idioma en forma gratuita. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación para obtener ayuda. (TTY/TDD: 711)

## Tagalog

May karapatan kayong makuha ang impormasyon at tulong na ito sa ginagamit ninyong wika nang walang bayad. Tumawag sa numero ng Member Services na nasa inyong ID card para sa tulong. (TTY/TDD: 711)

## Vietnamese

Quý vị có quyền nhận miễn phí thông tin này và sự trợ giúp bằng ngôn ngữ của quý vị. Hãy gọi cho số Dịch Vụ Thành Viên trên thẻ ID của quý vị để được giúp đỡ. (TTY/TDD: 711)

## It is important we treat you fairly

That is why we follow federal civil rights laws in our health programs and activities. We do not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language is not English, we offer free language assistance services through interpreters and other written languages. If you are interested in these services, call the Customer Service number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. You can also file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.



If you have  
questions, call  
1-844-412-0752  
or visit us at  
[student.empireblue.com/  
student/schools/pace.](https://student.empireblue.com/student/schools/pace)

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