2020-2021

Pace University - Domestic

Student Health Insurance Plan

empireblue.com/studentadvantage

Anthem Student Advantage

Keeping you at your personal best

A00293NYMENEBS 12/20

Empire BlueCross BlueShield | STUDENT ADVANTAGE

An Anthem Company

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.

Table of contents

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 can help keep you at your personal best. This book will guide you through your plan benefits, with information about who is eligible, what is covered, how to access the right type of care when you need it, and more.

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

Gross Rates	Annual 8-15-20 to 8-14-21	Fall 8-15-20 to 12-31-20	Spring 1-1-21 to 8-14-21	Summer 1 5-20-21 to 8-14-21	Summer 2 7-15-21 to 8-14-21
Student	$3,107.00	$1,183.00	$1,924.00	$741.00	$264.00
Spouse	$3,107.00	$1,183.00	$1,924.00	$741.00	$264.00
Child	$3,107.00	$1,183.00	$1,924.00	$741.00	$264.00
2 or More Children	$6,214.00	$2,366.00	$3,848.00	$1,482.00	$528.00

The rates listed above do not include a prorated annual $10.08 fee for Geo Blue Medical Evacuation and Repatriation Benefits provided by 4 Ever Life International Limited.

Important dates for the coverage period

Open enrollment

- Fall: 8/15/20 - 9/25/20
- Spring: 1/1/21 - 2/10/21
- Summer I: 5/20/21 - 6/10/21
- Summer II: 7/15/21 - 7/28/21

Waiver deadlines

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

Fall: 9/25/20
Spring: 2/10/21
Summer I: 6/10/21
Summer II: 7/28/21

If you have **questions about enrollment and waiver options,** visit www.mystudentmedical.com/ or call 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
(212) 346-1600

Pleasantville Campus
Paton House – Ground Floor
861 Bedford Road
Pleasantville, NY 10570
(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 60007
Los Angeles, CA 90060-0007

Benefits, eligibility and enrollment

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

General information

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

Easy access to care

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

Sydney Health app

With the Sydney Health[1] 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℠ or Google Play™ 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.[2] Go to your Sydney Health app or **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

Use **this link** to find the right doctor or facility close to where you are.

Anthem Student Advantage Pace University website

Use **this link** to see your health plan information, including providers, benefits, claims, covered drugs and more.

1 Sydney Health is a service mark of CareMarket, Inc.
2 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
Overall Deductible *See notes section to understand how your deductible works. Your plan may also have a separate Prescription Drug Deductible. See Prescription Drug Coverage section.*	$100 student / None family	$200 student / None family
Out-of-Pocket Limit *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.*	$7,900 student/ $15,800 family	
Preventive care/screening/immunization *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.*	Covered in full	30% coinsurance after deductible
Doctor Home and Office Services		
Primary Care Office Visit to treat an injury or illness	$25 copay per visit 0% coinsurance not subject to deductible	30% coinsurance after deductible
Specialist Care Office Visit	$25 copay per visit 0% coinsurance not subject to deductible	30% coinsurance after deductible
Prenatal Care	Covered in full	30% coinsurance after deductible
Post-natal Care	$20 copay per visit, 0% coinsurance, deductible does not apply	30% coinsurance after deductible
Abortion		
Medically Necessary Abortions	Covered in full after deductible	35% coinsurance after deductible
Elective Abortions *One (1) procedure per Plan Year*	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
Other Practitioner Visits:		
On-line Visit *Live Health Online is the preferred telehealth solutions (www.livehealthonline.com)*	$25 copay per visit 0% coinsurance after deductible	30% coinsurance
Manipulation Therapy *Coverage is limited to 20 visits per benefit period. Limit is combined In-Network and Out-of-Network across all outpatient settings.*	$25 copay per visit 0% coinsurance not subject to deductible	30% coinsurance after deductible
Acupuncture	20% coinsurance after deductible	40% coinsurance after deductible
Other Services in an Office:		
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 *For the drugs itself dispensed in the office through infusion/ injection.*	20% coinsurance after deductible	40% coinsurance after deductible
Infertility *Covered according to services provided (diagnostic radiology service, surgery, lab, or diagnostic procedures)*	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
Diagnostic Services		
Lab:		
Office *Office Cost Share applies only when Freestanding/ Reference Labs are not used.*	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
X-Ray:		
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
Advanced Diagnostic Imaging (for example, MRI/PET/CAT scans):		
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
Emergency and Urgent Care		
Urgent Care (Office Setting)	20% coinsurance after deductible	40% coinsurance after deductible
Emergency Room Doctor and Other Services	$250 copay per visit 0% coinsurance after deductible	Covered as In- Network
Ambulance (Air and Ground)	20% coinsurance after deductible	Covered as In- Network
Outpatient Mental Health and Substance Use Disorder *Outpatient Mental Health and Substance Abuse Care (including Partial Hospitalization and Intensive Outpatient Program Services)*		
Doctor Office Visit and Online Visit	$25 copay 0% coinsurance not subject to deductible	30% coinsurance after deductible
Facility visit:		
Facility Fees *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.*	20% coinsurance not subject to deductible	40% coinsurance after deductible
Doctor Services	20% coinsurance not subject to deductible	40% coinsurance after deductible
Outpatient Surgery		
Facility Fees:		
Hospital	20% coinsurance after deductible	40% coinsurance after deductible
Freestanding Surgical Center	20% coinsurance after deductible	40% coinsurance after deductible
Hospital Stay (all Inpatient stays including Maternity, Mental and Substance Use Disorder):		
Facility fees (for example, room & board) *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.*	20% coinsurance after deductible	40% coinsurance after deductible

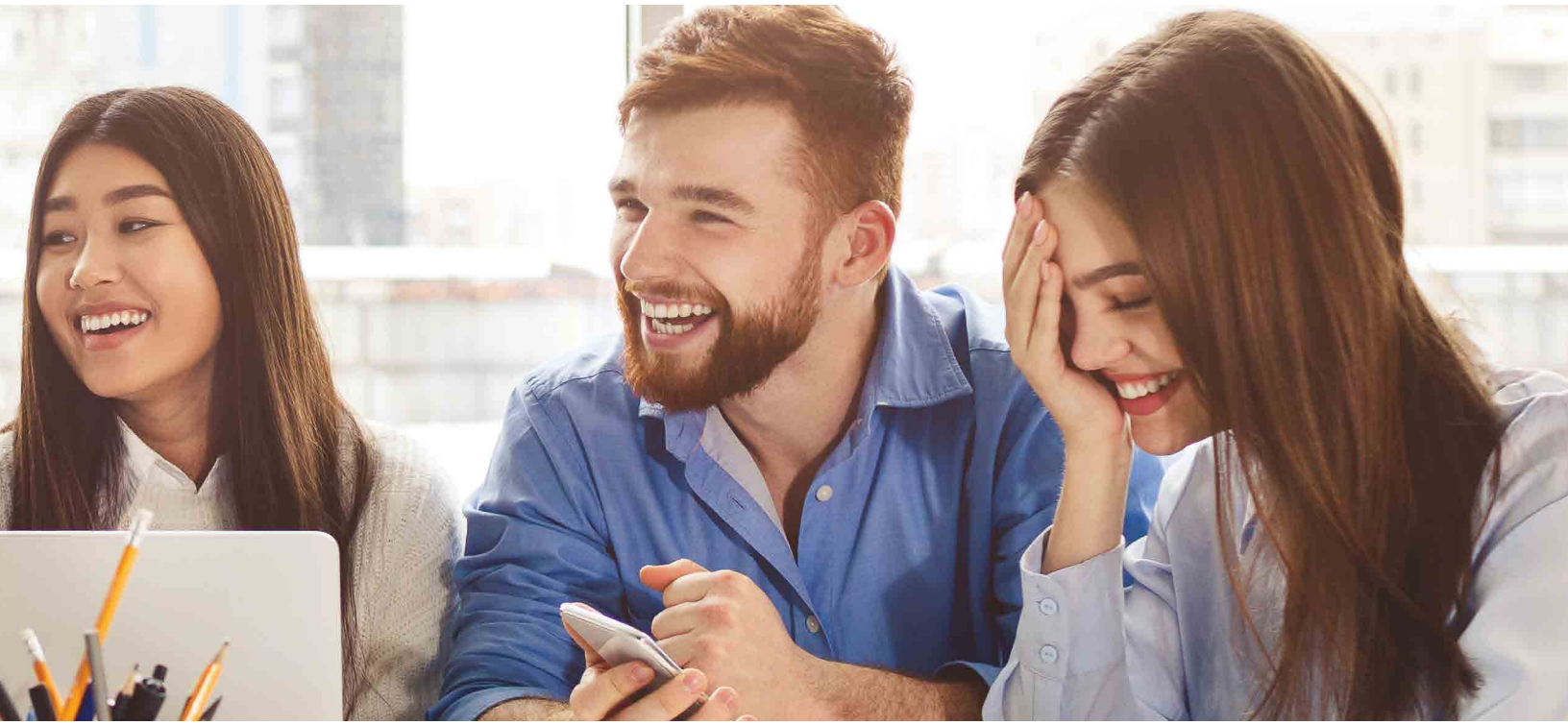
Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Doctor and other services	20% coinsurance after deductible	40% coinsurance after deductible
Preadmission Testing	20% coinsurance after deductible	40% coinsurance after deductible
Recovery & Rehabilitation		
Home Care Visits *Coverage for In-Network Providers and Out-of-Network Providers combined is limited to 40 visits per benefit period.*	20% coinsurance after deductible	40% coinsurance after deductible
Rehabilitation services (for example, physical/speech/ occupational therapy):		
Office *Coverage for physical therapy and occupational therapy. Preauthorization required. 365 days per plan year.*	20% coinsurance after deductible	40% coinsurance after deductible
Outpatient Hospital *Coverage for physical therapy and occupational therapy. Preauthorization required. 365 days per plan year.*	20% coinsurance after deductible	40% coinsurance after deductible
Habilitation services (for example, physical/speech/ occupational therapy):		
Office *Coverage for physical therapy and occupational therapy. Preauthorization required. 365 days per plan year.*	20% coinsurance after deductible	40% coinsurance after deductible
Outpatient Hospital *Coverage for physical therapy and occupational therapy. Preauthorization required. 365 days per plan year.*	20% coinsurance after deductible	40% coinsurance after deductible
Cardiac rehabilitation		
Office	20% coinsurance after deductible	40% coinsurance after deductible
Outpatient Hospital	20% coinsurance after deductible	40% coinsurance after deductible
Skilled Nursing Care (in a facility) *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.*	20% coinsurance after deductible	40% coinsurance after deductible
Hospice *Coverage for Inpatient and Outpatient Unlimited visits – 5 visits for family bereavement counseling.*	20% coinsurance after deductible	40% coinsurance after deductible
Durable Medical Equipment *Coverage for hearing aids services; single purchase once every 3 years. Cochlear/BAHA Implants; One per ear per time covered.*	20% coinsurance after deductible	40% coinsurance after deductible
Prosthetic Devices *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.*	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
Prescription Drug Coverage *Traditional Open Drug List* *This product has a 90-day Retail Pharmacy Network available.* *A 90 day supply is available at most retail pharmacies.*		
Tier 1 - Typically Lower Cost Generic *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
Tier 2 – Typically Preferred Brand *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
Tier 3 - Typically Non-Preferred Brand *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

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
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 (up to age 19)		
Child Vision Deductible	$0 person	Not Applicable
Vision exam *Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 exam per benefit period*	No charge	Reimbursed Up to $30
Frames *Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 unit per benefit period.*	No charge	Reimbursed Up to $45
Lenses *Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 unit per benefit period.*	No charge	$25 Reimbursement for Single, $45 Reimbursement for Bifocal, $55 Reimbursement for Trifocal Vision Lens and $40 Reimbursement for Standard Progressive
Elective contact lenses *Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 unit per benefit period.*	No charge	Reimbursed Up to $60
Non-Elective Contact Lenses *Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 unit per benefit period.*	No charge	Reimbursed Up to $210



Pediatric Dental

Covered Dental Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
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.		
Children's Dental Essential Health Benefits (up to age 19)		
Diagnostic and preventive *Includes cleanings, exams, x-rays, sealants, fluoride*	No charge	No charge
Basic services *Includes filing and simple extractions*	No charge	No charge
Major services/Prosthodontic	50% coinsurance after deductible is met	50% coinsurance after deductible is met
Endodontic, Periodontics, Oral Surgery	50% coinsurance after deductible is met	50% coinsurance after deductible is met
Medically Necessary Orthodontia	50%	50%
Deductible	Not applicable	Not applicable
Adult Dental	Not covered	Not covered

Benefits that go with you

You are covered for emergency health situations when travelling abroad. With our 24/7 help center and international network of doctor advisors, you have the right support and services when you need them through GeoBlue®.

In a medical emergency:

1. Go immediately to the nearest doctor or hospital.
2. Call us at **1-833-511-4763**. The GeoBlue Global Health & Safety Team will contact the doctor treating you and closely monitor your situation to decide whether a medical evacuation is needed. When you call, have this information ready:

- Your name
- Details of the emergency
- The name and contact information of the doctor and/or the hospital treating you
- The ID number on the front of your member ID card
- The name of your health coverage program: **Anthem Student Advantage**
- Your specific location, using GPS if it is available

What is covered?

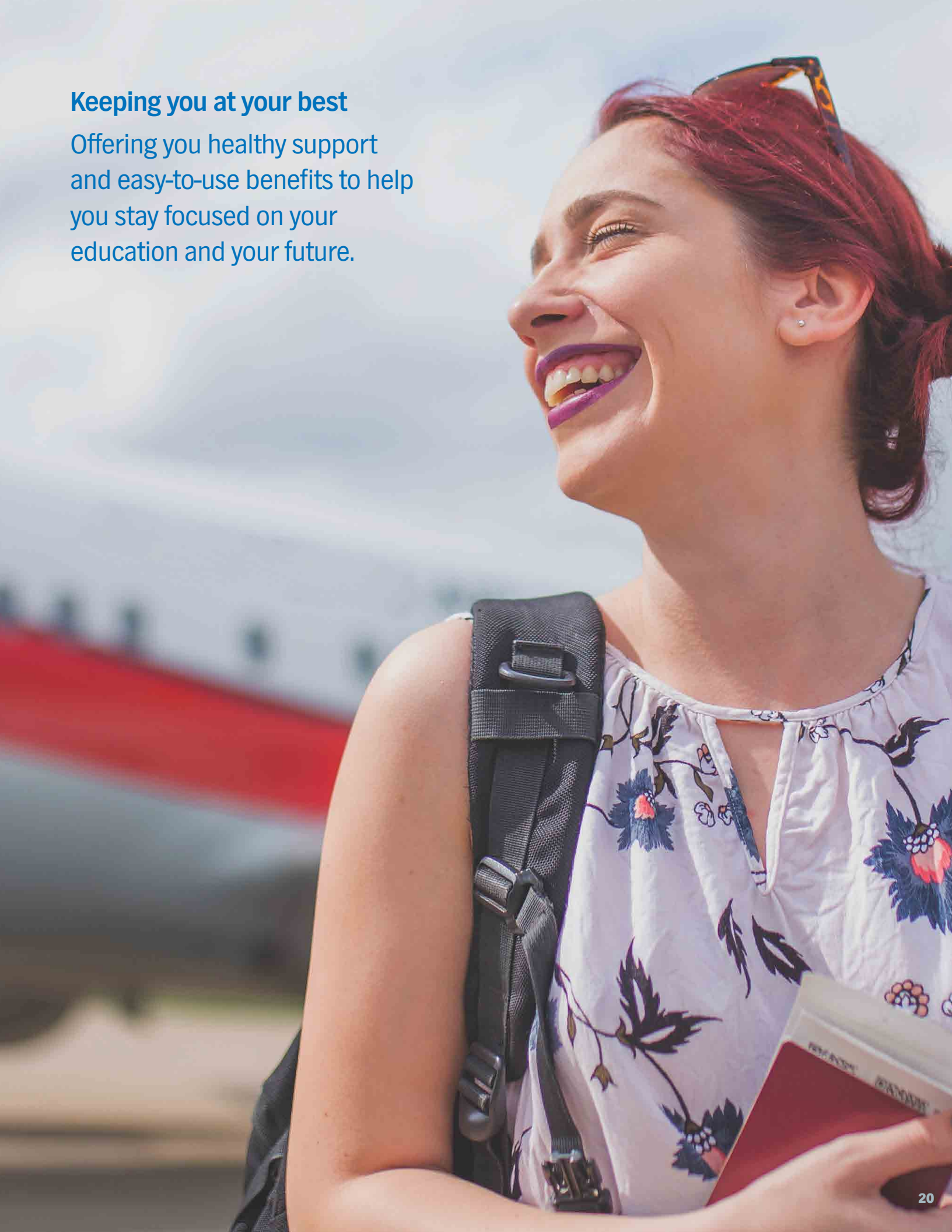
Emergency medical evacuation	Unlimited
Repatriation of remains	Unlimited
Emergency family travel arrangements	Maximum benefit up to $5,000 per coverage year
Political emergency and natural disaster evacuation *(Available only when traveling outside the U.S.)*	Covered 100% up to $100,000 per person. Subject 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

Use of benefits must be coordinated and approved by GeoBlue.

GeoBlue

Keeping you at your best

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

يحق لك الحصول على هذه المعلومات والمساعدة بلغتك مجانًا. اتصل بمقدم خدمات الأعضاء الموجود على بطاقة هويتك الخاصة بك للمساعدة.(TTY/TDD: 711)

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

شما این حق را دارید که این اطلاعات و کمکهای مربوطه به رایگان به زبان خودتان دریافت کنید. برای کمک دریافت به زبان خود با شماره مرکز تماس اعضاء که روی کارت شناسایی شما درج شده است، تماس بگیرید. (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'i' t'áá ni nizaad k'ehjí níká a'doowoł t'áá jíík'e. Naaltsoos bee atah nílínígíí bee néého' dólzingo nanitinígíí béésh bee hane' í bikáá' áaji' hodíílnih. (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 ਮੁਫ਼ਤ ਵਿੱਚ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਮਦਦ ਲਈ ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਉੱਤੇ ਮੈਂਬਰ ਸਰਵਿਸਿਜ਼ 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 empireblue.com/studentadvantage.

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