Your summary of benefits

Empire BlueCross BlueShield STUDENT ADVANTAGE
An Anthem Company

Empire BlueCross BlueShield

Your School: AMERICAN MUSICAL AND DRAMATIC ACADEMY - SHIP

Your Network: PPO

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	$350 student	$700 student
Out-of-Pocket Limit	$8,500 student	$8,500 student
All medical and prescription drugs deductibles, copayments and coinsurance apply toward the out-of-pocket maximum. In-network and out-of-network deductibles and out-of-pocket maximum amounts are combined and do accumulate toward each other.		
Preventive Care / Screening / Immunization	No charge	40% coinsurance after medical deductible is met
Virtual Care (Telemedicine / Telehealth Visits) **Virtual Visits with Doctors who also provide services in person**		
Primary Care (PCP)	$10 copay per visit and then 20% coinsurance after medical deductible is met	$10 copay per visit and then 40% coinsurance after medical deductible is met
Mental Health and Substance Abuse Care	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Specialist Care	$20 copay per visit and then 20% coinsurance after medical deductible is met	$20 copay per visit and then 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
Virtual Visits from Online Provider LiveHealth Online *via www.livehealthonline.com; our mobile app, website or Empire-enabled device*		
Primary Care (PCP)	$10 copay per visit and then 20% coinsurance after medical deductible is met	$10 copay per visit and then 40% coinsurance after medical deductible is met
Mental Health and Substance Abuse Care	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Specialist Care	$20 copay per visit and then 20% coinsurance after medical deductible is met	$20 copay per visit and then 40% coinsurance after medical deductible is met
Visits in an Office		
Primary Care (PCP)	$35 copay per visit and then 20% coinsurance after medical deductible is met	$45 copay per visit and then 40% coinsurance after medical deductible is met
Specialist Care	$20 copay per visit and then 20% coinsurance after medical deductible is met	$20 copay per visit and then 40% coinsurance after medical deductible is met
Other Practitioner Visits		
Routine Maternity Care (Prenatal and Postnatal) *In-Network routine prenatal office visits and other preventive prenatal care and screening are covered at 100%.*	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Retail Health Clinic	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Manipulation Therapy	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
Other Services in an Office		
Allergy Testing	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Chemo/Radiation Therapy	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Dialysis/Hemodialysis	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Prescription Drugs - *Dispensed in the office*	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
Diagnostic Services **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
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

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
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
Emergency and Urgent Care		
Urgent Care	$35 copay per visit and then 20% coinsurance after medical deductible is met	$35 copay per visit and then 40% coinsurance after medical deductible is met
Emergency Room Facility Services	20% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met
Emergency Room Doctor and Other Services	20% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met
Ambulance	20% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met
Outpatient Mental/Behavioral Health and Substance Abuse		
Doctor Office Visit	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Facility Visit		
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

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Outpatient Surgery		
Facility Fees		
Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Freestanding 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
Freestanding Surgical Center	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Hospital (Including Maternity, Mental / Behavioral Health, Substance Abuse)		
Facility Fees *Coverage for Inpatient Rehabilitation is limited to 30 days per benefit period.*	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Human Organ and Tissue Transplants *Coverage includes acquisition and transplant procedures, collection and storage.*	20% coinsurance after medical deductible is met	Not Covered
Doctor and other services	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Recovery & Rehabilitation		
Home Health Care *Coverage is limited to 40 visits per benefit period.*	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Rehabilitation services *Coverage for rehabilitative and habilitative physical therapy, occupational therapy and speech therapy is limited to 60 visits combined per benefit period.*		
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
Habilitation services *Coverage for rehabilitative and habilitative physical therapy, occupational therapy and speech therapy is limited to 60 visits combined per benefit period.*		
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
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) *Coverage is limited to 200 days per benefit period.*	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	Combined with medical out-of-pocket limit
Prescription Drug Coverage *Cost shares for drugs included on the Traditional Open drug list appear below. Your plan uses the Base Network. You may receive up to a 90 day supply of medication at Retail 90 pharmacies.*		
Home Delivery Pharmacy		
Tier 1 - Typically Generic *Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).*	$20 copay per prescription (retail) and $60 copay per prescription (home delivery)	30% coinsurance, (retail and home delivery)
Tier 2 – Typically Preferred Brand *Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).*	$50 copay per prescription (retail) and $150 copay per prescription (home delivery)	30% coinsurance, (retail and home delivery)
Tier 3 - Typically Non-Preferred Brand/Specialty Drugs *Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).*	$75 copay per prescription (retail) and $225 copay per prescription (home delivery)	30% coinsurance, (retail and home delivery)

Pediatric Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
This is a brief outline of your vision coverage. Only children's vision services count towards your out of pocket limit.		
Children's Vision Essential Health Benefits (up to age 19) **Vision exam** *Limited to 1 exam per benefit period.*	No charge	Reimbursed Up to $30
Frames *Limited to 1 unit per benefit period.*	No charge	Reimbursed Up to $45
Lenses *Limited to 1 unit per benefit period combined with OON Coverage. OON Reimbursement: Single Reimbursed Up to $25, Bifocal Reimbursed Up to $45, Trifocal Reimbursed Up to $55.*	No charge	Receives Reimbursement
Elective Contact Lenses *Limited to 1 unit per benefit period.*	No charge	Reimbursed Up to $60
Non-Elective Contact Lenses *Limited to 1 unit per benefit period.*	No charge	Reimbursed Up to $210

Pediatric Dental Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
This is a brief outline of your dental coverage. Only children's dental services count towards your out of pocket limit.		
Children's Dental Essential Health Benefits **Diagnostic and preventive** *Limited to 2 visits per 12 months.*	No charge	No charge
Basic services	No charge	No charge
Major services	50% coinsurance	50% coinsurance
Endodontic, Periodontics, Oral Surgery	50% coinsurance	50% coinsurance
Medically Necessary Orthodontia services	50% coinsurance	50% coinsurance
Cosmetic Orthodontia services	Not covered	Not covered
Deductible	Not Applicable	Not Applicable
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.

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.

Exclusions

Medical

In this section you will find a review of items that are not covered by your Plan. Excluded items will not be covered even if the service, supply, or equipment is Medically Necessary. This section is only meant to be an aid to point out certain items that may be misunderstood as Covered Services. This section is not meant to be a complete list of all the items that are excluded by your Plan. We will have the right to make the final decision about whether services or supplies are Medically Necessary and if they will be covered by your Plan.

1. Acts of War, Disasters, or Nuclear Accidents
2. Administrative Charges
3. Alternative / Complementary Medicine
4. Charges Over the Maximum Allowed Amount
5. Cosmetic Services
6. Court Ordered Testing
7. Custodial Care
8. Experimental or Investigational Services
9. Eyeglasses and Contact Lenses
10. Health Club Memberships and Fitness Services
11. Non-Medically Necessary Services
12. Nutritional or Dietary Supplements
13. Personal Care and Convenience items
14. Private Duty Nursing
15. Stand-By Charges
16. Travel Costs
17. Vision Services
18. Weight Loss Programs

Pharmacy

In addition to the above Exclusions, certain items are not covered under the Prescription Drug Retail or Home Delivery (Mail Order) Pharmacy benefit:

1. Clinically-Equivalent Alternatives
2. Compound Drugs
3. Drugs Prescribed by Providers Lacking Qualifications/ Registrations/Certifications
4. Drugs That Do Not Need a Prescription
5. Lost or Stolen Drugs
6. Non-approved Drugs
7. Nutritional or Dietary Supplements
8. Off label use
9. Over-the-Counter Items
10. Weight Loss Drugs