GeoBlue® Student Member Guide

Cornell University | 2023-2024

GeoBlue
International Health Insurance for Higher Education

GeoBlue

Your Guide to GeoBlue®

Welcome to GeoBlue, a program designed to keep you safe and healthy throughout your journey. Your GeoBlue® health insurance plan provides you access to global medical expertise with responsive, multi-channel service. Download our app or register online to learn about the extra care you receive when you travel with GeoBlue.

Getting Started

Important plan information and health tools

Getting Care

How to get care when you are in the U.S.

Accessing Self-Service Tools

Convenient online and mobile tools

Submitting a Claim

File a claim for reimbursement

Reviewing Plan Benefits

What is covered by your plan?

Getting Started

Important plan information and health tools

Download the GeoBlue app to register

Download our app from the Apple or Google Play app stores to put your plan in the palm of your hand:

- Display an electronic ID card
- Locate Blue Cross and Blue Shield providers and hospitals within the U.S.
- Arrange direct payment to your provider
- Access global health and safety tools including translations, drug equivalents, news and safety information
- Submit and track claims

You can also register online at **www.geobluestudents.com**.

Visit the GeoBlue Member Hub

Visit the Member Hub on **www.geobluestudents.com** to view important plan information and to access convenient self-service tools. Login with the username and password you created when you registered through the app. If you have not previously registered through the app, you can register directly online.

Get your GeoBlue ID card

It is important to have your GeoBlue ID card to access healthcare services; you will need to present your ID card whenever you receive medical care. This card can be accessed from multiple sources:

- Your ID card(s) will be mailed to you
- You can show, fax or email your ID card through the app
- Your ID card is available in the Member Hub on **www.geobluestudents.com**
- Customer Service can provide replacement ID cards

When you receive your ID card, please check the information for accuracy. Call Customer Service if you find an error.

Need help with registration?

Contact us for assistance:

Inside the U.S. call **1.844.268.2686**
Outside the U.S. call **+1.610.263.2847**
customerservice@geo-blue.com

Getting Care

Get care when you are in the U.S.

Student health center

Student health centers are a convenient healthcare option for basic health services. Consult your school's resources for more specific information about the care available to you, location(s) and hours. If you choose to receive care from your student health center, coinsurance, copayments and/or deductibles may be waived.

Finding a provider

If you need care outside of what is available from your institution, you also have access to the Blue Cross and Blue Shield network within the U.S., Puerto Rico, and U.S. Virgin Islands. To find a doctor or facility, visit the "Provider Finder" section in the Member Hub on **www.geobluestudents.com** or in the app.

Contact us for assistance:

- Toll free within the U.S. call 1.844.268.2686
- Outside the U.S. call +1.610.263.2847
- **customerservice@geo-blue.com**

Scheduling an appointment with a Blue Cross and Blue Shield provider

Call the provider to confirm they are in network and schedule your appointment. At the time of service, you will need to show the provider your GeoBlue ID card and tell them you are covered by Blue Cross and Blue Shield.

Using an out-of-network provider

This typically results in a higher coinsurance and may result in additional costs to you. If you receive care from an out-of-network provider, you may need to pay out of pocket and submit a claim for reimbursement. Click "How to File a Claim" in the Member Hub on **www.geobluestudents.com** to download the appropriate claim form. Submit claims electronically using the GeoBlue app or the "File an eClaim" link on the Member Hub.

Prescription benefits

Present your ID card at any participating pharmacy and you will be charged in accordance with your plan benefits.*

Paying for care - Glossary of terms

In the U.S., your health plan typically pays your medical bills for you with the following exceptions:

- ***Copay or Copayment:*** The specific dollar amount you will pay at the time of service.
- ***Coinsurance:*** The percentage of the cost you are responsible for.
- ***Deductible:*** An amount you are responsible to pay for eligible expenses before the plan begins to pay.
- ***Out-of-Network Provider:*** Medical provider who is not contracted with Blue Cross and Blue Shield companies. This typically results in a higher coinsurance and may result in additional costs to you.

See your Certificate of Coverage for details.

In the event of a medical emergency

If you have an emergency, dial 911 or go to the closest Emergency Room immediately. If you're not sure whether your situation is an emergency, dial 911 and let the call-taker determine if you need emergency help. Once you are safe, call the Medical Assistance phone number for 24/7 care located on the back of your ID card. We will then take the appropriate action to assist and monitor your medical care until the situation is resolved.

**Certain limitations and exclusions apply to your coverage under this plan and may affect your coverage. Your Certificate of Insurance is on file with your school and in the Member Hub on www.geobluestudents.com.*

Accessing Self-Service Tools

Convenient online and mobile tools

Find a doctor or facility

Review detailed profiles of contracted doctors to find the best match and then locate the office.

Translate medications

Find country-specific equivalents for prescription and over-the-counter medications.

Translate medical terms and phrases

Translate hundreds of key medical phrases and terms into the most widely spoken languages with audio clips and transliterations.

Understand health and security risks

Receive daily alerts detailing the latest security and health issues in your destination. View country or city profiles on crime, terrorism or natural disasters.

Telehealth

Members have anytime access to remotely delivered care through **Global TeleMD™**, a new smartphone app—at no additional cost— which provides confidential access to international doctors by telephone or video call.

Features include:

- Global network of doctors
- Medical guidance and consultations (for non-medical emergencies)
- Same-day virtual appointments, available 24/7
- Multiple language options
- Consultation notes sent directly to your phone
- Prescriptions and referral letters (subject to local regulation)

Global Assistance Program

Global Wellness Assist is an international assistance program (commonly referred to as an employee assistance program or EAP) for students, faculty and staff traveling globally on behalf of a college or university,providing access to free, confidential assistance any time, any day.Professionals are ready to assist with any issue.

Features include:

- Available 24/7/365
- Up to 6 sessions of counseling per issue, per year (telephonic and in person)
- Information, resources and counseling on any work, life, personal or family issue
- Available worldwide by phone, email or web
- No additional cost to use
- Available in several languages

Visit **www.geobluestudents.com** or **download the GeoBlue app** to access self-service tools for navigating risks and finding the best care options.

Services are provided by WorkPlace Options, an independent company that is not affiliated with GeoBlue and does not provide Blue Cross or Blue Shield products or services. WorkPlace Options is solely responsible for referring participants for counseling, coaching and work-life services by providers who are appropriately licensed by local authorities. The evaluation and efficacy of any service delivered by a provider lies solely with the employee, spouse, dependent or other authorized party who inquires on behalf of the participant. GeoBlue shall have no responsibility or liability whatsoever for any aspect of the provider counseling or the counselor/participant relationship.

Telemedicine services are provided by Teladoc Health, directly to you. GeoBlue assumes no liability and accepts no responsibility for information provided by Teladoc Health and the performance of their services. Support and information provided through this service does not confirm that any related treatment or additional support is covered under your health plan. To discuss the coverage under your health plan, please contact us. This service is not intended to be used for emergency or urgent treatment medical questions.

Submitting a Claim

File a claim for reimbursement

eClaims

You can quickly and conveniently submit claims electronically, through the app or through the Member Hub on **www.geobluestudents.com**. Scanned paper documents are delivered directly to our Claims Department and your eClaims are saved in the Claims section of the Member Hub.

Choose "Claims" in the GeoBlue app or visit the "File an eClaim" section of the Member Hub on **www.geobluestudents.com**.

Email and fax

If you prefer to submit a claim via email or fax, a printable claim form and detailed instructions are available in the Member Hub on **www.geobluestudents.com**.

Visit the "How to File a Claim" section of the Member Hub on **www.geobluestudents.com** and click "How do you file a claim with GeoBlue?" to download the appropriate claim form.

Email: claims@geo-blue.com

Fax: +1.610.482.9623

Postal mail

If you prefer to submit a claim via postal mail, a printable claim form and detailed instructions are available in the Member Hub on **www.geobluestudents.com**.

Visit the "How to File a Claim" section of the Member Hub on **www.geobluestudents.com** and click "How do you file a claim with GeoBlue?" to download the appropriate claim form.

Claims Incurred Inside the U.S., Puerto Rico and the U.S. Virgin Islands:

GeoBlue, P.O. Box 21974, Eagan, MN 55121

Checking the status of your claim

To check your claim status, choose "Claims" in the GeoBlue app or visit the "View My Claims" section of the Member Hub on **www.geobluestudents.com**.

New York Student Health Plan
2023 SCHEDULE OF BENEFITS
Platinum Level / Actuarial Value: 93.98%

COST-SHARING	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
See the Cost-Sharing and Allowed Amount section of this Certificate for a description of how We calculate the Allowed Amount. Any charges of a Non-Participating Provider that are in excess of the Allowed Amount do not apply towards the Deductible or Out-of-Pocket Limit. You must pay the amount of the Non-Participating Providers charge that exceeds Our Allowed Amount.			
Deductible **Out-of-Pocket Limit**	$100 $2,500	$1,000 $5,000	
OFFICE VISITS			
Primary Care Office Visits (or Home Visits)	$20 Copayment and then 0% Coinsurance not subject to Deductible	20% Coinsurance after Deductible	See benefit for description
Specialist Office Visits (or Home Visits)	$20 Copayment and then 0% Coinsurance not subject to Deductible	20% Coinsurance after Deductible	See benefit for description
PREVENTIVE CARE – See benefit for description			
• **Well Child Visits and Immunizations***	Covered in full	20% Coinsurance after Deductible	
• **Adult Annual Physical Examinations***	Covered in full	20% Coinsurance after Deductible	
• **Adult Immunizations***	Covered in full	20% Coinsurance after Deductible	
• **Routine Gynecological Services/Well Woman Exams***	Covered in full	20% Coinsurance after Deductible	
• **Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer**	Covered in full	20% Coinsurance after Deductible	
• **Sterilization Procedures for Women***	Covered in full	20% Coinsurance after Deductible	
• **Screening for Colon Cancer**	Covered in full	20% Coinsurance after Deductible	
• **Vasectomy**	0% Coinsurance after Deductible	20% Coinsurance after Deductible	
• **Bone Density Testing***	Covered in full	20% Coinsurance after Deductible	
• **Screening for Prostate Cancer**	Covered in full	20% Coinsurance after Deductible	
• All other preventive services required by USPSTF and HRSA.	Covered in full	20% Coinsurance after Deductible	
* When preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA.	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visits; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing.	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visits; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing.	

COST-SHARING	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
EMERGENCY CARE			
Pre-Hospital Emergency Medical Services (Ambulance Services)	0% Coinsurance after Deductible	20% Coinsurance after Deductible	See benefit for description
Non-Emergency Ambulance Services	0% Coinsurance after Deductible	20% Coinsurance after Deductible	See benefit for description
Emergency Department	$100 Copayment and then 0% Coinsurance after Deductible Health care forensic examinations performed under Public Health Law §2805-I are not subject to Cost-Sharing	$100 Copayment and then 0% Coinsurance after Deductible Health care forensic examinations performed under Public Health Law §2805-I are not subject to Cost-Sharing	See benefit for description
Urgent Care Center	$20 Copayment and then 0% Coinsurance not subject to Deductible	20% Coinsurance after Deductible	See benefit for description
PROFESSIONAL SERVICES and OUTPATIENT CARE			
Acupuncture	$20 Copayment and then 0% Coinsurance not subject to Deductible	20% Coinsurance after Deductible	See benefit for description
Advanced Imaging Services • Performed in a Specialist Office • Performed in a Freestanding Radiology Facility • Performed as Outpatient Hospital Services	$20 Copayment and then 0% Coinsurance not subject to Deductible 0% Coinsurance after Deductible 0% Coinsurance after Deductible	20% Coinsurance after Deductible	See benefit for description
Allergy Testing and Treatment	$20 Copayment and then 0% Coinsurance not subject to Deductible	20% Coinsurance after Deductible	See benefit for description
Ambulatory Surgical Center Facility Fee	0% Coinsurance after Deductible	20% Coinsurance after Deductible	See benefit for description
Anesthesia Services (all settings)	0% Coinsurance after Deductible	20% Coinsurance after Deductible	See benefit for description
Cardiac and Pulmonary Rehabilitation • Performed in a Specialist Office • Performed as Outpatient Hospital Services • Performed as Inpatient Hospital Services	$20 Copayment and then 0% Coinsurance not subject to Deductible 0% Coinsurance after Deductible Included as part of inpatient Hospital service Cost-Sharing	20% Coinsurance after Deductible 20% Coinsurance after Deductible Included as part of inpatient Hospital service Cost-Sharing	See benefit for description
Chemotherapy and Immunotherapy • Performed in a PCP Office • Performed in a Specialist Office • Performed as Outpatient Hospital Services	$20 Copayment and then 0% Coinsurance not subject to Deductible $20 Copayment and then 0% Coinsurance not subject to Deductible 0% Coinsurance after Deductible	20% Coinsurance after Deductible	See benefit for description

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Chiropractic Services	$20 Copayment and then 0% Coinsurance not subject to Deductible	20% Coinsurance after Deductible	See benefit for description
Clinical Trials	Use Cost-Sharing for appropriate service	Use Cost-Sharing for appropriate service	See benefit for description
Diagnostic Testing • Performed in a PCP Office • Performed in a Specialist Office • Performed in an Outpatient Facility	 $20 Copayment and then 0% Coinsurance not subject to Deductible $20 Copayment and then 0% Coinsurance not subject to Deductible 0% Coinsurance after Deductible	 20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible	See benefit for description
Dialysis • Performed in a PCP Office • Performed in a Specialist Office • Performed in a Freestanding Center • Performed in an Outpatient Facility	 $20 Copayment and then 0% Coinsurance not subject to Deductible $20 Copayment and then 0% Coinsurance not subject to Deductible 0% Coinsurance after Deductible 0% Coinsurance after Deductible	20% Coinsurance after Deductible	See benefit for description
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) • Performed in a PCP Office • Performed in a Specialist Office • Performed in an Outpatient Facility	 $20 Copayment and then 0% Coinsurance not subject to Deductible $20 Copayment and then 0% Coinsurance not subject to Deductible 0% Coinsurance after Deductible	 20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible	60 visits per condition, per Plan Year combined therapies
Home Health Care	0% Coinsurance after Deductible	20% Coinsurance after Deductible	40 visits per Plan Year
Infertility Services	0% Coinsurance after Deductible	20% Coinsurance after Deductible	See benefit for description
Infusion Therapy • Performed in a PCP Office • Performed in a Specialist Office • Performed in an Outpatient Facility • Home Infusion Therapy	 $20 Copayment and then 0% Coinsurance not subject to Deductible $20 Copayment and then 0% Coinsurance not subject to Deductible 0% Coinsurance after Deductible 0% Coinsurance after Deductible	20% Coinsurance after Deductible	See benefit for description
Inpatient Medical Visits	0% Coinsurance after Deductible	20% Coinsurance after Deductible	See benefit for description

COST-SHARING	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Interruption of Pregnancy			
• Medically Necessary Abortions	Covered in full	20% Coinsurance after Deductible	Unlimited
• Elective Abortions	0% Coinsurance after Deductible	20% Coinsurance after Deductible	One (1) procedure per Plan Year
Laboratory Procedures (All Settings)	0% Coinsurance after Deductible	20% Coinsurance after Deductible	See benefit for description
Maternity and Newborn Care			See benefit for description
• Prenatal Care			
– Prenatal Care provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA	Covered in full	20% Coinsurance after Deductible	
– When Prenatal Care is not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visits; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing.	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visits; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing.	
• Inpatient Hospital Services and Birthing Center	0% Coinsurance after Deductible	20% Coinsurance after Deductible	
• Physician and Midwife Services for Delivery	0% Coinsurance after Deductible	20% Coinsurance after Deductible	One (1) home care visit is covered at no Cost-Sharing if mother is discharged from Hospital early
• Breastfeeding Support, Counseling and Supplies, Including Breast Pumps	Covered in full	20% Coinsurance after Deductible	Covered for duration of breast feeding
• Postnatal Care	Covered in full	20% Coinsurance after Deductible	
Outpatient Hospital Surgery Facility Charge	0% Coinsurance after Deductible	20% Coinsurance after Deductible	See benefit for description
Preadmission Testing	0% Coinsurance after Deductible	20% Coinsurance after Deductible	See benefit for description
Prescription Drugs Administered in Office or Outpatient Facilities		20% Coinsurance after Deductible	See benefit for description
• Performed in an Office	0% Coinsurance after Deductible		
• Performed in Outpatient Facility	0% Coinsurance after Deductible		

COST-SHARING	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Diagnostic Radiology Services			
• Performed in an Office	$20 Copayment and then 0% Coinsurance not subject to Deductible	20% Coinsurance after Deductible	See benefit for description
• Performed in a Freestanding Radiology Facility	0% Coinsurance after Deductible		
• Performed in Outpatient Facility	0% Coinsurance after Deductible		
Therapeutic Radiology Services			
• Performed in an Office	$20 Copayment and then 0% Coinsurance not subject to Deductible	20% Coinsurance after Deductible	See benefit for description
• Performed in a Freestanding Radiology Facility	0% Coinsurance after Deductible		
• Performed in Outpatient Hospital Facility	0% Coinsurance after Deductible		
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)			
• Performed in a PCP Office	$20 Copayment and then 0% Coinsurance not subject to Deductible	20% Coinsurance after Deductible	60 visits per condition, per Plan Year combined therapies
• Performed in a Specialist Office	$20 Copayment and then 0% Coinsurance not subject to Deductible	20% Coinsurance after Deductible	
• Performed in an Outpatient Facility	0% Coinsurance after Deductible	20% Coinsurance after Deductible	
Retail Health Clinic Care	$20 Copayment and then 0% Coinsurance not subject to Deductible	20% Coinsurance after Deductible	
Second Opinions on the Diagnosis of Cancer, Surgery and Other	$20 Copayment and then 0% Coinsurance not subject to Deductible	20% Coinsurance after Deductible Second opinions on diagnosis of cancer are Covered at participating Cost-Sharing for non-participating Specialist	See benefit for description
Surgical Services (including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; and Transplants)	0% Coinsurance after Deductible	20% Coinsurance after Deductible	See benefit for description

ADDITIONAL SERVICES, EQUIPMENT and DEVICES

COST-SHARING	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Diabetic Equipment, Supplies and Self-Management Education			
• Diabetic Equipment, Supplies and Insulin (Up to a 90-day supply)	0% Coinsurance after Deductible Cost -sharing for an insulin drug shall not exceed $100 per 30-day supply.	20% Coinsurance after Deductible	See benefit for description
• Diabetic Education	0% Coinsurance after Deductible	20% Coinsurance after Deductible	
Durable Medical Equipment and Braces	0% Coinsurance after Deductible	20% Coinsurance after Deductible	See benefit for description
External Hearing Aids	0% Coinsurance after Deductible	20% Coinsurance after Deductible	Single purchase once every three (3) years
Cochlear Implants	0% Coinsurance after Deductible	20% Coinsurance after Deductible	One (1) per year per time Covered
Hospice Care			
• Inpatient	0% Coinsurance after Deductible	20% Coinsurance after Deductible	210 days per Plan Year
• Outpatient	0% Coinsurance after Deductible	20% Coinsurance after Deductible	Five (5) visits for family bereavement counseling
Medical Supplies	0% Coinsurance after Deductible	20% Coinsurance after Deductible	See benefit for description
Prosthetic Devices			
• External	0% Coinsurance after Deductible	20% Coinsurance after Deductible	One (1) prosthetic device, per limb, per lifetime with coverage for repairs and replacements
• Internal	0% Coinsurance after Deductible	20% Coinsurance after Deductible	Unlimited; See benefit for description
INPATIENT SERVICES and FACILITIES			
Autologous Blood Banking	0% Coinsurance after Deductible	20% Coinsurance after Deductible	See benefit for description
Inpatient Hospital for a Continuous Confinement (including an Inpatient Stay for Mastectomy Care, Cardiac and Pulmonary Rehabilitation, and End of Life Care)	0% Coinsurance after Deductible	20% Coinsurance after Deductible	See benefit for description
Observation Stay	0% Coinsurance after Deductible	20% Coinsurance after Deductible	See benefit for description
Skilled Nursing Facility (including Cardiac and Pulmonary Rehabilitation)	0% Coinsurance after Deductible	20% Coinsurance after Deductible	200 days per Plan Year
Inpatient Habilitation Services (Physical Speech and Occupational Therapy)	0% Coinsurance after Deductible	20% Coinsurance after Deductible	
Inpatient Rehabilitation Services (Physical, Speech and Occupational Therapy)	0% Coinsurance after Deductible	20% Coinsurance after Deductible	

COST-SHARING	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES (*All mental health and substance use benefits will be paid at the same level of coinsurance as any other illness/injury)*			
Inpatient Mental Health Care for a continuous confinement when in a Hospital (including Residential Treatment)	0% Coinsurance after Deductible	20% Coinsurance after Deductible	See benefit for description
Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services)	0% Coinsurance after Deductible	20% Coinsurance after Deductible	See benefit for description
ABA Treatment for Autism Spectrum Disorder	$20 Copayment and then 0% Coinsurance not subject to Deductible	20% Coinsurance after Deductible	See benefit for description
Assistive Communication Devices for Autism Spectrum Disorder	0% Coinsurance after Deductible	20% Coinsurance after Deductible	See benefit for description
Inpatient Substance Use Services for a continuous confinement when in a Hospital (including Residential Treatment)	0% Coinsurance after Deductible	20% Coinsurance after Deductible	See benefit for description
Outpatient Substance Use Services (including Partial Hospitalization, Intensive Outpatient Program Services, and Medication Assisted Treatment)	0% Coinsurance after Deductible	20% Coinsurance after Deductible	Unlimited; Up to 20 visits per Plan Year may be used for family counseling
Opioid Treatment Programs	Covered in full	20% Coinsurance after Deductible	

	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
PRESCRIPTION DRUGS *Certain Prescription Drugs are not subject to Cost-Sharing when provided in accordance with the comprehensive guidelines supported by HRSA or if the item or service has an "A" or "B" rating from the USPSTF and obtained at a participating pharmacy. A member's out-of-pocket costs for prescription insulin drugs shall not exceed $100 per 30-day supply, regardless of the amount or type of insulin that is needed to fill such member's prescription.			
Retail Pharmacy			
Tier 1- Generic	$10 Copayment per 30-day supply, not subject to Deductible	$10 Copayment per 30-day supply, not subject to Deductible	See benefit for description
Tier 2 – Preferred Brand	$25 Copayment per 30-day supply, not subject to Deductible	$25 Copayment per 30-day supply, not subject to Deductible	
Tier 3 – Non-Preferred Brand	20% Coinsurance, not subject to Deductible	20% Coinsurance, not subject to Deductible	
Up to a 90-day supply for Maintenance Drugs are available at retail level – copays apply for each 30-day supply			
Mail Order Pharmacy Up to a 90-day supply			
Tier 1- Generic	$30 Copayment per 90-day supply, not subject to Deductible	$30 Copayment per 90-day supply, not subject to Deductible	See benefit for description
Tier 2 – Preferred Brand	$75 Copayment per 90-day supply, not subject to Deductible	$75 Copayment per 90-day supply, not subject to Deductible	
Tier 3 – Non-Preferred Brand	20% Coinsurance, not subject to Deductible	20% Coinsurance, not subject to Deductible	
Enteral Formulas			See benefit for description
Tier 1- Generic	$10 Copayment per 30-day supply, not subject to Deductible	$10 Copayment per 30-day supply, not subject to Deductible	
Tier 2 – Preferred Brand	$25 Copayment per 30-day supply, not subject to Deductible	$25 Copayment per 30-day supply, not subject to Deductible	
Tier 3 – Non-Preferred Brand	20% Coinsurance, not subject to Deductible	20% Coinsurance, not subject to Deductible	
WELLNESS BENEFITS			
Gym Reimbursement	Up to $200 per six (6) month period	Up to $200 per six (6) month period	
PEDIATRIC DENTAL and VISION CARE			
Pediatric Dental Care	Benefits are the same for Participating or Non-Participating Provider		
• Preventive Dental Care	20% Coinsurance not subject to Deductible	20% Coinsurance not subject to Deductible	One (1) dental exam and cleaning per six (6)-month period
• Routine Dental Care	20% Coinsurance not subject to Deductible	20% Coinsurance not subject to Deductible	Full mouth x-rays or panoramic x-rays at 36-month intervals and bitewing x-rays at six (6) month intervals
• Major Dental Care (Oral Surgery, Endodontics, Periodontics and Prosthodontics)	50% Coinsurance not subject to Deductible	50% Coinsurance not subject to Deductible	
• Orthodontics	50% Coinsurance not subject to Deductible	50% Coinsurance not subject to Deductible	

	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Pediatric Vision Care Benefits are the same for Participating or Non-Participating Providers • Exams • Lenses and Frames • Contact Lenses	 0% Coinsurance, No Deductible 0% Coinsurance, No Deductible 0% Coinsurance, No Deductible	 0% Coinsurance, No Deductible 0% Coinsurance, No Deductible 0% Coinsurance, No Deductible	One (1) exam per Plan Year; One (1) prescribed lenses and frames per Plan Year or One-year supply of Contact lenses per Plan Year
OTHER ADDITIONAL BENEFITS			
Emergency Medical Transportation	Maximum Benefit up to $250,000		See benefit for description
Repatriation of Mortal Remains	Maximum Benefit up to $50,000		
Emergency Family Travel Arrangements	Maximum Benefit up to $2,500		
Accidental Death & Dismemberment Benefit	Maximum Benefit: Principal Sum up to $10,000 per insured Member		See benefit for description

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 an 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 section 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. Services 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.

For questions about your medical plan:

Toll free within the U.S. call 1.844.268.2686
Outside the U.S. call +1.610.263.2847
customerservice@geo-blue.com

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