

Your summary of benefits



Anthem BlueCross BlueShield

Your Plan: Student Advantage Health Insurance Plan

Your School: Marist University - SHIP

Your Network: PPO/EPO

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	\$100 student person	\$200 student person
Overall Out-of-Pocket Limit	\$7,900 person /	\$0 person /
	\$13,200 family	\$0 family
<p>The family deductible and out-of-pocket maximum are embedded, meaning the cost shares of one family member will be applied to the per person deductible and per person out-of-pocket maximum; in addition, amounts for all covered family members apply to the family deductible and family out-of-pocket maximum. No one member will pay more than the per person deductible or per person out-of-pocket maximum.</p> <p>All medical and prescription drugs deductibles, copayments and coinsurance apply toward the out-of-pocket maximum. In-network and out-of-network out-of-pocket maximum amounts are separate and do not accumulate toward each other.</p>		
<p>Virtual Visits from online provider LiveHealth Online for urgent/acute medical and mental health and substance abuse care via www.livehealthonline.com are covered at 10% coinsurance after deductible is met</p>		
Primary Care (PCP) virtual and office	10% coinsurance after deductible is met	20% coinsurance after deductible is met
Mental Health and Substance Abuse Care virtual and office	10% coinsurance after deductible is met	20% coinsurance after deductible is met
Specialist Care virtual and office	10% coinsurance after deductible is met	20% coinsurance after deductible is met
<u>Other Practitioner Visits</u>		
Routine Maternity Care (Prenatal and Postnatal) <i>In-Network routine prenatal office visits and other preventive prenatal care and screening are covered at 100%.</i>	No charge	20% coinsurance after deductible is met
Retail Health Clinic for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.	10% coinsurance after deductible is met	20% coinsurance after deductible is met
Manipulation Therapy	10% coinsurance after deductible is met	20% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Acupuncture	10% coinsurance after deductible is met	20% coinsurance after deductible is met
<u>Other Services in an Office</u>		
Allergy Testing	10% coinsurance after deductible is met	20% coinsurance after deductible is met
Prescription Drugs - <i>Dispensed in the office</i>	10% coinsurance after deductible is met	20% coinsurance after deductible is met
Surgery	10% coinsurance after deductible is met	20% coinsurance after deductible is met
Preventive care / screenings / immunizations	No charge	20% coinsurance after deductible is met
Preventive care for Chronic Conditions per IRS guidelines	No charge	20% coinsurance after deductible is met
<u>Diagnostic Services</u>		
Lab		
Office	10% coinsurance after deductible is met	20% coinsurance after deductible is met
Freestanding Lab/Reference Lab	10% coinsurance after deductible is met	20% coinsurance after deductible is met
Outpatient Hospital	10% coinsurance after deductible is met	20% coinsurance after deductible is met
X-Ray		
Office	10% coinsurance after deductible is met	20% coinsurance after deductible is met
Freestanding Radiology Center	10% coinsurance after deductible is met	20% coinsurance after deductible is met
Outpatient Hospital	10% coinsurance after deductible is met	20% coinsurance after deductible is met
Advanced Diagnostic Imaging		
Office	10% coinsurance after deductible is met	20% coinsurance after deductible is met
Freestanding Radiology Center	10% coinsurance after deductible is met	20% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Outpatient Hospital	10% coinsurance after deductible is met	20% coinsurance after deductible is met
Emergency and Urgent Care <p>Urgent Care</p> <p>Emergency Room Facility Services <i>Copay waived if admitted. Coinsurance waived if admitted. Cost share waived if admitted.</i></p> <p>Emergency Room Doctor and Other Services</p> <p>Emergency Ambulance</p>	10% coinsurance after deductible is met \$100 copay per visit and then 10% coinsurance after deductible is met 10% coinsurance after deductible is met 10% coinsurance after deductible is met	20% coinsurance after deductible is met Covered as In-Network Covered as In-Network Covered as In-Network
Outpatient Mental Health and Substance Abuse Care at a Facility <p>Facility Fees</p> <p>Doctor Services</p>	10% coinsurance after deductible is met 10% coinsurance after deductible is met	20% coinsurance after deductible is met 20% coinsurance after deductible is met
Outpatient Surgery <p>Facility Fees</p> <p>Hospital</p> <p>Ambulatory Surgical Center</p> <p>Doctor and Other Services</p> <p>Hospital</p> <p>Ambulatory Surgical Center</p>	10% coinsurance after deductible is met 10% coinsurance after deductible is met 10% coinsurance after deductible is met 10% coinsurance after deductible is met	20% coinsurance after deductible is met 20% coinsurance after deductible is met 20% coinsurance after deductible is met 20% coinsurance after deductible is met
Hospital (Including Maternity, Mental / Behavioral Health, Substance Abuse) <p>Facility Fees <i>Coverage for Inpatient Rehabilitation is limited to 60 days per benefit period. Limit is combined In-Network and Out-of-Network.</i></p> <p>Human Organ and Tissue Transplants</p>	10% coinsurance after deductible is met 10% coinsurance after deductible is met	20% coinsurance after deductible is met 20% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p>Coverage includes acquisition and transplant procedures, collection and storage.</p> <p>Doctor and other services</p>	10% coinsurance after deductible is met	20% coinsurance after deductible is met
<p>Recovery & Rehabilitation</p> <p>Home Health Care Coverage is limited to 40 visits per benefit period.</p>	10% coinsurance after deductible is met	20% coinsurance after deductible is met
<p>Rehabilitation services Coverage for rehabilitative physical therapy, occupational therapy and speech therapy is limited to 60 visits combined per benefit period.</p>		
Office	10% coinsurance after deductible is met	20% coinsurance after deductible is met
Outpatient Hospital	10% coinsurance after deductible is met	20% coinsurance after deductible is met
<p>Habilitation services Coverage for habilitative physical therapy, occupational therapy and speech therapy is limited to 60 visits combined per benefit period.</p>		
Office	10% coinsurance after deductible is met	20% coinsurance after deductible is met
Outpatient Hospital	10% coinsurance after deductible is met	20% coinsurance after deductible is met
<p>Chemo/Radiation Therapy</p>		
Office	10% coinsurance after deductible is met	20% coinsurance after deductible is met
Outpatient Hospital	10% coinsurance after deductible is met	20% coinsurance after deductible is met
<p>Dialysis/Hemodialysis</p>		
Office	10% coinsurance after deductible is met	20% coinsurance after deductible is met
Outpatient Hospital	10% coinsurance after deductible is met	20% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Cardiac rehabilitation Office Outpatient Hospital	10% coinsurance after deductible is met 10% coinsurance after deductible is met	20% coinsurance after deductible is met 20% coinsurance after deductible is met
Skilled Nursing Care (facility) <i>Coverage is limited to 200 days per benefit period.</i>	10% coinsurance after deductible is met	20% coinsurance after deductible is met
Hospice <i>Coverage is limited to 210 days per benefit period.</i>	10% coinsurance after deductible is met	20% coinsurance after deductible is met
Durable Medical Equipment	10% coinsurance after deductible is met	20% coinsurance after deductible is met
Prosthetic Devices	10% coinsurance after deductible is met	20% coinsurance after deductible is met

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Pharmacy Deductible	Not applicable	Not applicable
Pharmacy Out of Pocket Limit	Combined with medical out-of-pocket limit	Combined with medical out-of-pocket limit
Prescription Drug Coverage Network: Base Network Drug List: Traditional Open		
Day Supply Limits: Retail Pharmacy 30 day supply (cost shares noted below) Retail 90 Pharmacy 90 day supply (cost shares noted below) Home Delivery Pharmacy 90 day supply (maximum cost shares noted below) Maintenance medications are available through CarelonRx Mail. Specialty Pharmacy 30 day supply (cost shares noted below for retail and home delivery apply). We may require certain drugs with special handling, provider coordination or patient education be filled by our designated specialty pharmacy.		
Tier 1 - Typically Generic Each 90 day supply script filled at Retail 90 pharmacies is subject to 3 times the 30 day supply cost share(s) charged at In-Network Retail Pharmacies.	\$15 copay per prescription (retail) and \$45 copay per prescription (home delivery)	20% coinsurance (retail) and Not covered (home delivery)
Tier 2 – Typically Preferred Brand Each 90 day supply script filled at Retail 90 pharmacies is subject to 3 times the 30 day supply cost share(s) charged at In-Network Retail Pharmacies.	\$30 copay per prescription (retail) and \$90 copay per prescription (home delivery)	20% coinsurance (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand/Specialty Drugs Each 90 day supply script filled at Retail 90 pharmacies is subject to 3 times the 30 day supply cost share(s) charged at In-Network Retail Pharmacies.	\$30 copay per prescription (retail) and \$90 copay per prescription (home delivery)	20% coinsurance (retail) and Not covered (home delivery)

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><i>This is a brief outline of your vision coverage. To receive the In-Network benefit, you must use a Blue View Vision Provider. Only children's vision services count towards your out of pocket limit.</i></p>		
<p><u>Children's Vision Essential Health Benefits (up to age 19)</u></p> <p>Vision exam Limited to 1 exam per benefit period.</p>	No charge	Reimbursed Up to \$30
<p>Frames Limited to 1 unit per benefit period.</p>	No charge	Reimbursed Up to \$45
<p>Lenses Limited to 1 unit per benefit period combined with OON Coverage. OON Reimbursement: Single Reimbursed Up to \$25, Bifocal Reimbursed Up to \$40, Trifocal Reimbursed Up to \$55.</p>	No charge	Receives Reimbursement
<p>Elective Contact Lenses Limited to 1 unit per benefit period.</p>	No charge	Reimbursed Up to \$60
<p>Non-Elective Contact Lenses Limited to 1 unit per benefit period.</p>	No charge	Reimbursed Up to \$210

Covered Dental Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<i>This is a brief outline of your dental coverage. Only children's dental services count towards your out of pocket limit.</i>		
Children's Dental Essential Health Benefits Diagnostic and preventive <i>Limited to 2 visits per 12 months.</i>	Not Applicable	Not Applicable
Basic services	20% coinsurance	20% coinsurance
Major services	50% coinsurance	50% coinsurance
Medically Necessary Orthodontia services	50% coinsurance	50% coinsurance
Cosmetic Orthodontia services	Not covered	Not covered
Adult Dental	Not covered	Not covered

Notes:

- Members are encouraged to always obtain prior approval when using non-network providers. Precertification will help the member know if the services are considered not medically necessary.
- No charge means no deductible/copayment/coinsurance up to the maximum allowable amount. 0% means no coinsurance up to the maximum allowable amount. However, when choosing a Non-network provider, the member is responsible for any balance due after the plan payment.
- When using a non-network pharmacy, members are responsible for the stated copay & costs in excess of the prescription drug maximum allowed amount. Members will pay upfront and submit a claim form.
- For additional information on limitations and exclusions and other disclosure items that apply to this plan, go to https://le.anthem.com/pdf?x=NY_SH_PPO.

This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This summary does not reflect each and every benefit, exclusion and limitation which may apply to the coverage. For more details, important limitations and exclusions, please review the formal Evidence of Coverage (EOC). If there is a difference between this summary and the Evidence of Coverage (EOC), the Evidence of Coverage (EOC), will prevail.

Language Access Services:

Get help in your language

Curious to know what all this says? We would be too. Here's the English version:

If you have any questions about this document, you have the right to get help and information in your language at no cost. To talk to an interpreter, call

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

(TTY/TDD: 711)

Arabic (العربية): إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على .

Armenian (հայերեն): Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով :

Chinese(中文) : 如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電。

Farsi (فارسی) : در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه ای به زبان مادریتان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره تماس بگیرید.

French (Français) : Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le .

Haitian Creole (Kreyòl Ayisyen): Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele .

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Japanese (日本語): この文書についてなにかご不明な点があれば、あなたにはあなたの言語で無料で支援を受け情報を得る権利があります。 通訳と話すには、 にお電話ください。

Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면 문의하십시오.

Language Access Services:

Navajo (Diné): Díí naaltsoos biká'ígíí ɬahgo bína'ídílkidgo ná bohónéedzá dóó bee ahóót'i' t'áá ni nizaad k'ehjí bee níl hodoonih t'áadoo bájáh ilníigóó. Ata' halne'ígíí ɬa' bich'í' hadeesdzih nínízingo kojí' hodíilnih.

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

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Vietnamese (Tiếng Việt): Nếu quý vị có bất kỳ thắc mắc nào về tài liệu này, quý vị có quyền nhận sự trợ giúp và thông tin bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Để trao đổi với một thông dịch viên, hãy gọi .

It's important we treat you fairly

That's why we follow federal civil rights laws in our health programs and activities. We don't 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 isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services 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. Or you can 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>.