Your summary of benefits

Anthem

Anthem® Blue Cross

Your Plan: Anthem Student Health Insurance Plan

Your School: Albany College of Pharmacy and Health Sciences SHIP

Your Network: Blue Access PPO with Blue Card

Student Health Center Benefits:
No Charge for Covered Medical Expenses
Deductible and Coinsurance Waived

Visits with Virtual Care-Only Providers	Cost through our mobile app and website
Primary Care, and medical services for urgent/acute care	No charge
Mental Health & Substance Use Disorder Services	No charge
Specialist care	No charge

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Overall Deductible	$250 person	$1,000 person
Out-of-Pocket Limit	$5,000 person	$6,000 person
All medical and prescription drug deductibles, copayments and coinsurance apply to the out-of-pocket limit. In-Network and Non-Network out-of-pocket limit amounts are separate and do not accumulate toward each other.		
Doctor Visits (virtual and office) *You are encouraged to select a Primary Care Physician (PCP).*		
Primary Care (PCP) *virtual and office*	$30 copay per visit deductible does not apply	40% coinsurance after deductible is met
Mental Health and Substance Use Disorder Services *virtual and office*	No charge	40% coinsurance after deductible is met
Specialist Care *virtual and office*	$30 copay per visit deductible does not apply	40% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Other Practitioner Visits		
Routine Maternity Care (Prenatal and Postnatal)	No charge	40% coinsurance after deductible is met
Retail Health Clinic *for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.*	$30 copay per visit deductible does not apply	40% coinsurance after deductible is met
Chiropractic Services	$30 copay per visit deductible does not apply	40% coinsurance after deductible is met
Acupuncture	Not covered	Not covered
Other Services in an Office		
Allergy Testing	$30 copay per visit deductible does not apply	40% coinsurance after deductible is met
Prescription Drugs - *Dispensed in the office*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Surgery	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Preventive care / screenings / immunizations	No charge	40% coinsurance after deductible is met
Diagnostic Services		
Lab:		
Office	No charge	40% coinsurance after deductible is met
Freestanding Lab/Reference Lab	No charge	40% coinsurance after deductible is met
Outpatient Hospital	No charge	40% coinsurance after deductible is met
X-Ray:		
Office	No charge	40% coinsurance after deductible is met
Outpatient Hospital	No charge	40% coinsurance after deductible is met

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 and CAT scans*		
Office	No charge	40% coinsurance after deductible is met
Outpatient Hospital	No charge	40% coinsurance after deductible is met
Emergency and Urgent Care		
Urgent Care *includes doctor services. Additional charges may apply depending on the care provided.*	$30 copay per visit deductible does not apply	$30 copay per visit deductible does not apply
Emergency Room Facility Services *Your copay will be waived if admitted.*	$200 copay per visit deductible does not apply	Covered as In-Network
Emergency Room Doctor and Other Services	$200 copay per visit deductible does not apply	Covered as In-Network
Ambulance	$200 copay per trip deductible does not apply	Covered as In-Network
Outpatient Mental/Behavioral Health and Substance Use Disorder Services at a Facility		
Facility Fees	No charge	40% coinsurance after deductible is met
Doctor Services	No charge	40% coinsurance after deductible is met
Outpatient Surgery		
Facility Fees:		
Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Ambulatory Surgical Center	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Physician and Other Services *including surgeon fees*		
Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Ambulatory Surgical Center	20% coinsurance after deductible is met	40% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)		
Facility Fees *Coverage for Inpatient Rehabilitation is limited to 60 days per benefit period.*	20% coinsurance after deductible is met	40% coinsurance after deductible is me
Physician and other services *including surgeon fees*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Home Health Care *Coverage is limited to 60 visits per benefit period.*	$30 copay per visit deductible does not apply	40% coinsurance after deductible is met
Rehabilitation and Habilitation services *including physical, occupational and speech therapies.* *Coverage for physical, occupational, and speech therapies is limited to 60 visits combined per benefit period.*		
Office	$30 copay per visit deductible does not apply	40% coinsurance after deductible is met
Outpatient Hospital	$30 copay per visit deductible does not apply	40% coinsurance after deductible is met
Pulmonary Rehabilitation *office and outpatient hospital*	$30 copay per visit deductible does not apply	40% coinsurance after deductible is met
Cardiac rehabilitation *Coverage is limited to 36 visits per benefit period.*	$30 copay per visit deductible does not apply	40% coinsurance after deductible is me
Dialysis/Hemodialysis *office and outpatient hospital*	$30 copay per visit deductible does not apply	40% coinsurance after deductible is met
Chemo/Radiation Therapy *office and outpatient hospital*	$30 copay per visit deductible does not apply	40% coinsurance after deductible is met
Skilled Nursing Care (facility) *Limited to 200 days per benefit period*	20% coinsurance after deductible is met	40% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Hospice *Limited to 210 days per benefit period.*		
Inpatient Hospice	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospice	$30 copay per visit deductible does not apply	40% coinsurance after deductible is met
Durable Medical Equipment	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Prosthetic Devices *Coverage for wigs is limited to 1 item after cancer treatment per benefit period.*	20% coinsurance after deductible is met	40% 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	Combined with medical
Pharmacy Out of Pocket Limit	Combined with medical	Combined with medical
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. You will need to call us on the number on your ID card to sign up when you first use the service.* **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	$10 copay per prescription, deductible does not apply (retail) and $25 copay per prescription, deductible does not apply (home delivery)	Not covered (retail and home delivery)
Tier 2 – Typically Preferred Brand	$50 copay per prescription, deductible does not apply (retail) and $125 copay per prescription, deductible does not apply (home delivery)	Not covered (retail and home delivery)
Tier 3 - Typically Non-Preferred Brand/Specialty Drugs	$100 copay per prescription, deductible does not apply (retail) and $250 copay per prescription, deductible does not apply (home delivery)	Not covered (retail and home delivery)

Covered 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) **Child Vision Deductible** **Vision exam** *Limited to 1 exam per benefit period.*	 $0 person No charge	 $0 person 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 $40*, 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

Covered 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	20% coinsurance deductible does not apply	20% coinsurance deductible does not apply
Major services	50% coinsurance deductible does not apply	50% coinsurance deductible does not apply
Medically Necessary Orthodontia services	50% coinsurance deductible does not apply	50% coinsurance deductible does not apply
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.
- All medical and prescription drug deductibles, copayments and coinsurance apply toward the out-of-pocket maximum.
- 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.
- ‡ Your cost share may be reduced when services are provided in a PCP's office.
- 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 (844) 412-0752

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 (844) 412-0752 .

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՝ (844) 412-0752:

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Farsi (فارسي) : 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 (844) 412-0752 تماس بگیرید.

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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 (844) 412-0752.

Italian (Italiano): In caso di eventuali domande sul presente documento, ha il diritto di ricevere assistenza e informazioni nella sua lingua senza alcun costo aggiuntivo. Per parlare con un interprete, chiami il numero (844) 412-0752.

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Navajo (Diné): Díí naaltsoos biká'ígíí łahgo bína'ídíłkidgo ná bohónéedzą dóó bee ahóót'i' t'áá ni nizaad k'ehjí bee nił

Language Access Services:

hodoonih t'áadoo bą́ą́h ílínígóó. Ata' halne'ígíí ła' bich'į' hadeesdzih nínízingo koji' hodíilnih (844) 412-0752.

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: (844) 412-0752.

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