Your summary of benefits

Anthem® Blue Cross and Blue Shield

Your Plan: Student Advantage Health Insurance Plan

Your School: BOWDOIN COLLEGE - SHIP

Your Network: Blue Choice PPO

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	$100 person / $200 family	$250 person / $500 family
Overall Out-of-Pocket Limit	$5,000 person / $10,000 family	$15,000 person / $30,000 family
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. 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 separate and do not accumulate toward each other		
Doctor Visits (virtual and office) *You are encouraged to select a Primary Care Physician (PCP).*		
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 $20 copay per visit medical deductible does not apply.*		
Primary Care (PCP) *virtual and office*	$20 copay per visit medical deductible does not apply	30% coinsurance after medical deductible is met
Mental Health and Substance Abuse Care *virtual and office*	$20 copay per visit medical deductible does not apply	30% coinsurance after medical deductible is met
Specialist Care *virtual and office*	$20 copay per visit medical deductible does not apply	30% 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%.*	10% coinsurance after medical deductible is met	30% 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
Retail Health Clinic *for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.*	$20 copay per visit and then 10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Manipulation Therapy	$20 copay per visit and then 10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Acupuncture	Not covered	Not covered
Other Services in an Office		
Allergy Testing	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Prescription Drugs - *Dispensed in the office*	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Surgery	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Preventive care / screenings / immunizations	No charge	30% coinsurance after medical deductible is met
Preventive care for Chronic Conditions *per IRS guidelines*	No charge	30% coinsurance after medical deductible is met
Diagnostic Services **Lab**		
Office	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Preferred Reference Lab	No charge	30% coinsurance after medical deductible is met
Outpatient Hospital	10% coinsurance after medical deductible is met	30% 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
X-Ray		
Office	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Freestanding Radiology Center	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Outpatient Hospital	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Advanced Diagnostic Imaging		
Office	$50 copay per visit medical deductible does not apply	30% coinsurance after medical deductible is met
Freestanding Radiology Center	$50 copay per visit medical deductible does not apply	30% coinsurance after medical deductible is met
Outpatient Hospital	$50 copay per visit medical deductible does not apply	30% coinsurance after medical deductible is met
Emergency and Urgent Care		
Urgent Care	$50 copay per visit medical deductible does not apply	$50 copay per visit and then 30% coinsurance after medical deductible is met
Emergency Room Facility Services *Copay waived if admitted.*	$100 copay per visit medical deductible does not apply	Covered as In-Network
Emergency Room Doctor and Other Services	$100 copay per visit medical deductible does not apply	Covered as In-Network
Ambulance	$100 copay per trip medical deductible does not apply	Covered as In-Network

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Outpatient Mental Health and Substance Abuse Care at a Facility		
Facility Fees	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Doctor Services	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Outpatient Surgery		
Facility Fees		
Hospital	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Ambulatory Surgical Center	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Doctor and Other Services		
Hospital	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Ambulatory Surgical Center	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Hospital (Including Maternity, Mental / Behavioral Health, Substance Abuse)		
Facility Fees	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Human Organ and Tissue Transplants *Coverage includes acquisition and transplant procedures, collection and storage.*	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Doctor and other services	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Recovery & Rehabilitation		
Home Health Care	10% coinsurance after medical deductible is met	30% 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
Rehabilitation services *Benefit limit does not apply to Applied Behavioral Analysis. Benefit limit does not apply when performed as part of Early Intervention.*		
Office	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Outpatient Hospital	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Habilitation services *Benefit limit does not apply to Applied Behavioral Analysis. Benefit limit does not apply when performed as part of Early Intervention.*		
Office	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Outpatient Hospital	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Chemo/Radiation Therapy		
Office	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Outpatient Hospital	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Dialysis/Hemodialysis		
Office	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Outpatient Hospital	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Cardiac rehabilitation		

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Office	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Outpatient Hospital	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Skilled Nursing Care (facility)	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Inpatient Hospice	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Durable Medical Equipment	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Prosthetic Devices	10% coinsurance after medical deductible is met	30% 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 covered
Pharmacy Out of Pocket Limit	Combined with medical out-of-pocket limit	Not covered
Prescription Drug Coverage **Network*: Base Network*** **Drug List: *National***		
Day Supply Limits: **Retail Pharmacy** *30 day supply (cost shares noted below)* **Home Delivery Pharmacy** *90 day supply (maximum cost shares noted below) Maintenance medications are available through CarelonRx Mail (IngenioRx will become CarelonRx on January 1, 2023).* **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 (retail) and $20 copay per prescription (home delivery)	Not covered (retail and home delivery)
Tier 2 – Typically Preferred Brand	$45 copay per prescription (retail) and $50 copay per prescription (home delivery)	Not covered (retail and home delivery)
Tier 3 - Typically Non-Preferred Brand	$75 copay per prescription (retail) and $90 copay per prescription (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. 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.		
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 $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	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.
- For additional information on limitations and exclusions and other disclosure items that apply to this plan, go to https://le.anthem.com/pdf?x=ME_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.

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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

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(TTY/TDD: 711)

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Language Access Services:

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