

Your summary of benefits



STUDENT ADVANTAGE

An Anthem Company

Empire BlueCross BlueShield

Your Plan: Anthem Student Advantage SHPSHC Blue Access Plan

Your School: LIM College - 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	\$350 person	\$700 person
Out-of-Pocket Limit	\$8,700 person / \$17,400 family	\$8,700 person / \$17,400 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.</p> <p>In-network and out-of-network deductibles and out-of-pocket maximum amounts are separate and do not accumulate toward each other</p>		
Preventive Care / Screening / Immunization	No charge	30% coinsurance after deductible is met
Virtual Care (Telemedicine / Telehealth Visits)		
Virtual Visits with Doctors who also provide services in person		
Primary Care (PCP)	\$25 copay per visit after deductible is met	\$25 copay per visit after deductible is met
Mental Health and Substance Abuse Care	\$25 copay per visit after deductible is met	\$25 copay per visit after deductible is met
Specialist Care	\$25 copay per visit after deductible is met	\$25 copay per visit after deductible is met
Virtual Visits from Online Provider LiveHealth Online via www.livehealthonline.com ; our mobile app, website or Empire-enabled device		

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Primary Care (PCP) and Mental Health and Substance Abuse Care	\$25 copay per visit after deductible is met	\$25 copay per visit after deductible is met
Specialist Care	\$25 copay per visit after deductible is met	\$25 copay per visit after deductible is met
<p><u>Visits in an Office</u></p> <p>Primary Care (PCP)</p> <p>Specialist Care</p>	<p>\$25 copay per visit after deductible is met</p> <p>\$25 copay per visit after deductible is met</p>	<p>\$25 copay per visit after deductible is met</p> <p>\$25 copay per visit after deductible is met</p>
<p><u>Other Practitioner Visits</u></p> <p>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></p> <p>Retail Health Clinic</p> <p>Manipulation Therapy</p> <p>Acupuncture</p>	<p>20% coinsurance after deductible is met</p> <p>\$25 copay per visit after deductible is met</p> <p>\$25 copay per visit after deductible is met</p> <p>\$25 copay per visit after deductible is met</p>	<p>40% coinsurance after deductible is met</p> <p>\$25 copay per visit after deductible is met</p> <p>\$25 copay per visit after deductible is met</p> <p>\$25 copay per visit after deductible is met</p>
<p><u>Other Services in an Office</u></p> <p>Allergy Testing</p> <p>Chemo/Radiation Therapy</p> <p>Dialysis/Hemodialysis</p> <p>Prescription Drugs - <i>Dispensed in the office</i></p> <p>Surgery</p>	<p>\$25 copay per visit and 20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>\$25 copay per visit and 20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>\$25 copay per visit and 30% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><u>Diagnostic Services</u> Lab</p> <p>Office</p> <p>Freestanding Lab/Reference Lab</p> <p>Outpatient Hospital</p>	<p>\$25 copay per visit after deductible is met</p> <p>\$25 copay per visit after deductible is met</p> <p>\$25 copay per visit after deductible is met</p>	<p>\$25 copay per visit after deductible is met</p> <p>\$25 copay per visit after deductible is met</p> <p>\$25 copay per visit after deductible is met</p>
<p>X-Ray</p> <p>Office</p> <p>Freestanding Radiology Center</p> <p>Outpatient Hospital</p>	<p>\$25 copay per visit after deductible is met</p> <p>\$25 copay per visit after deductible is met</p> <p>\$25 copay per visit after deductible is met</p>	<p>\$25 copay per visit after deductible is met</p> <p>\$25 copay per visit after deductible is met</p> <p>\$25 copay per visit after deductible is met</p>
<p>Advanced Diagnostic Imaging</p> <p>Office</p> <p>Freestanding Radiology Center</p> <p>Outpatient Hospital</p>	<p>\$25 copay per visit after deductible is met</p> <p>\$50 copay per visit and 20% coinsurance after deductible is met</p> <p>\$50 copay per visit and 20% coinsurance after deductible is met</p>	<p>\$25 copay per visit after deductible is met</p> <p>\$50 copay per visit and 30% coinsurance after deductible is met</p> <p>\$50 copay per visit and 30% coinsurance after deductible is met</p>
<p><u>Emergency and Urgent Care</u></p> <p>Urgent Care</p> <p>Emergency Room Facility Services <i>Copay waived if admitted.</i></p> <p>Emergency Room Doctor and Other Services</p> <p><u>Ambulance</u></p>	<p>\$25 copay per visit after deductible is met</p> <p>\$175 copay per visit after deductible is met</p> <p>\$175 copay per visit after deductible is met</p> <p>0% coinsurance after deductible is met</p>	<p>\$25 copay per visit after deductible is met</p> <p>Covered as In-Network</p> <p>Covered as In-Network</p> <p>Covered as In-Network</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><u>Outpatient Mental/Behavioral Health and Substance Abuse</u></p> <p>Doctor Office Visit</p> <p>Facility Visit <i>Coinsurance limited to the copay amount reflected for Primary Care Office visit.</i></p> <p>Facility Fees</p> <p>Doctor Services</p>	<p>\$25 copay per visit after deductible is met</p> <p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p>	<p>\$25 copay per visit after deductible is met</p> <p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p>
<p><u>Outpatient Surgery</u></p> <p>Facility Fees</p> <p>Hospital</p> <p>Freestanding Surgical Center</p> <p>Doctor and Other Services</p> <p>Hospital</p> <p>Freestanding Surgical Center</p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p>
<p><u>Hospital (Including Maternity, Mental / Behavioral Health, Substance Abuse)</u></p> <p>Facility Fees <i>Coverage for Inpatient Rehabilitation is limited to 60 days per benefit period.</i></p> <p>Human Organ and Tissue Transplants <i>Coverage includes acquisition and transplant procedures, collection and storage.</i></p> <p>Doctor and other services</p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p>
<p><u>Recovery & Rehabilitation</u></p> <p>Home Health Care <i>Coverage is limited to 40 visits per benefit period.</i></p>	<p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p>Rehabilitation services Coverage for rehabilitative physical therapy, occupational therapy and speech therapy is limited to 60 visits combined per benefit period.</p> <p>Office</p> <p>Outpatient Hospital</p> <p>Habilitation services Coverage for habilitative physical therapy, occupational therapy and speech therapy is limited to 60 visits combined per benefit period.</p> <p>Office</p> <p>Outpatient Hospital</p>	<p>\$25 copay per visit and 20% coinsurance after deductible is met</p> <p>\$25 copay per visit and 20% coinsurance after deductible is met</p> <p>\$25 copay per visit and 20% coinsurance after deductible is met</p> <p>\$25 copay per visit and 20% coinsurance after deductible is met</p> <p>\$25 copay per visit and 20% coinsurance after deductible is met</p>	<p>\$25 copay per visit and 30% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p> <p>\$25 copay per visit and 30% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p>
<p>Cardiac rehabilitation</p> <p>Office</p> <p>Outpatient Hospital</p>	<p>\$25 copay per visit and 20% coinsurance after deductible is met</p> <p>\$25 copay per visit and 20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p>
<p>Skilled Nursing Care (facility)</p>	<p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p>
<p>Inpatient Hospice</p>	<p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p>
<p>Durable Medical Equipment</p>	<p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p>
<p>Prosthetic Devices Coverage for wigs is limited to 1 item after cancer treatment per lifetime.</p>	<p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p>

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 deductible
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 You will need to call us on the number on your ID card to sign up when you first use the service.		
Tier 1 - Typically Generic <i>Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).</i>	\$20 copay per prescription, deductible does not apply (retail) and \$60 copay per prescription, deductible does not apply (home delivery)	40% coinsurance after deductible is met (retail and home delivery)
Tier 2 – Typically Preferred Brand <i>Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).</i>	\$45 copay per prescription, deductible does not apply (retail) and \$135 copay per prescription, deductible does not apply (home delivery)	40% coinsurance after deductible is met (retail and home delivery)
Tier 3 - Typically Non-Preferred Brand/Specialty Drugs <i>Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery). Per 30 day (specialty pharmacy).</i>	\$100 copay per prescription, deductible does not apply (retail) and \$300 copay per prescription, deductible does not apply (home delivery)	40% coinsurance after deductible is met (retail and home delivery)

Covered Vision 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 vision coverage. Only children's vision services count towards your out of pocket limit.</i>		
<u>Children's Vision Essential Health Benefits (up to age 19)</u>		
Vision exam <i>Limited to 1 exam per benefit period.</i>	No charge	Reimbursed Up to \$30
Frames	No charge	Reimbursed Up to \$45

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<i>Limited to 1 unit per benefit period.</i>		
Lenses <i>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.</i>	No charge	Receives Reimbursement
Elective Contact Lenses <i>Limited to 1 unit per benefit period.</i>	No charge	Reimbursed Up to \$60
Non-Elective Contact Lenses <i>Limited to 1 unit per benefit period.</i>	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 (up to age 19) Diagnostic and preventive <i>Limited to 2 visits per 12 months.</i>	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
Deductible	Combined with medical deductible	Combined with medical deductible
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.

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

Exclusions

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

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 .

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 .

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): Dii naaltsoos biká'ígíí lahgo bina'ídiikidgo ná bohónéedzá dóó bee ahóót'i' t'áá ni nizaad k'ehj̄ bee nił hodoonih t'áadoo bááh ilínígóó. Ata' halne'ígíí la' bich'í' hadeesdzih ninízingo koj̄' hodiílnih .

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: .

Punjabi (ਪੰਜਾਬੀ): ਜੇ ਤੁਹਾਡੇ ਇਸ ਦਸਤਾਵੇਜ਼ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹੁੰਦੇ ਹਨ ਤਾਂ ਤੁਹਾਡੇ ਕੋਲ ਮੁਫਤ ਵਿੱਚ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੁੰਦਾ ਹੈ। ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, ਤੇ ਕਾਲ ਕਰੋ।

Russian (Русский): если у вас есть какие-либо вопросы в отношении данного документа, вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы связаться с устным переводчиком, позвоните по тел. .

Spanish (Español): Si tiene preguntas acerca de este documento, tiene derecho a recibir ayuda e información en su idioma, sin costos. Para hablar con un intérprete, llame al .

Tagalog (Tagalog): Kung mayroon kang anumang katanungan tungkol sa dokumentong ito, may karapatan kang humingi ng tulong at impormasyon sa iyong wika nang walang bayad. Makipag-usap sa isang tagapagpaliwanag, tawagan ang .

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>.