Your summary of benefits

Anthem® Blue Cross and Blue Shield

Your Plan: Student Advantage Health Insurance Plan

Your School: Siena College - SHIP

Your Network: Blue Access

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

Visits with Virtual Care-Only Providers available 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 a Non-Network Provider
Overall Deductible	$500 student	$4,000 student
Overall Out-of-Pocket Limit	$5,000 student	$6,000 student
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.		
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 Care *virtual and office*	No charge	40% coinsurance after deductible is met
Specialist Care *virtual and office*	$50 copay per visit deductible does not apply	40% coinsurance after 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%.*	Benefits are based on the setting in which Covered Services are received	40% coinsurance after 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.*	$30 copay per visit deductible does not apply	40% coinsurance after deductible is met
Manipulation Therapy	$50 copay per visit deductible does not apply	40% coinsurance after deductible is met
Acupuncture *Coverage is limited to 10 visits per benefit period.*	$30 copay per visit deductible does not apply	40% coinsurance after deductible is met
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*	$50 copay per visit deductible does not apply	40% coinsurance after deductible is met
Surgery	30% coinsurance after deductible is met	40% coinsurance after deductible is met
Preventive care / screenings / immunizations	No charge	40% coinsurance after deductible is met
Preventive care for Chronic Conditions *per IRS guidelines*	No charge	40% coinsurance after deductible is met
Diagnostic Services		
Lab		
Office	$30 copay per service deductible does not apply	40% coinsurance after deductible is met
Freestanding Lab/Reference Lab	No charge	40% coinsurance after deductible is met
Outpatient Hospital	$30 copay per service 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 a Non-Network Provider
X-Ray		
Office	$30 copay per service deductible does not apply	40% coinsurance after deductible is met
Freestanding Radiology Center	$30 copay per service deductible does not apply	40% coinsurance after deductible is met
Outpatient Hospital	$30 copay per service deductible does not apply	40% coinsurance after deductible is met
Advanced Diagnostic Imaging		
Office	$30 copay per service deductible does not apply	40% coinsurance after deductible is met
Freestanding Radiology Center	$30 copay per service deductible does not apply	40% coinsurance after deductible is met
Outpatient Hospital	$30 copay per service deductible does not apply	40% coinsurance after deductible is met
Emergency and Urgent Care		
Urgent Care	$50 copay per visit deductible does not apply	$50 copay per visit deductible does not apply
Emergency Room Facility Services	30% coinsurance after deductible is met	Same as In-Network Tier 2
Emergency Room Doctor and Other Services	30% coinsurance after deductible is met	Same as In-Network Tier 2
Emergency Ambulance	30% coinsurance after deductible is met	Same as In-Network Tier 2
Outpatient Mental Health and Substance Use Disorder Care at a Facility		
Facility Fees	No charge	40% coinsurance after deductible is met
Doctor Services	No charge	40% 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 Surgery		
Facility Fees		
Hospital	30% coinsurance after deductible is met	40% coinsurance after deductible is met
Ambulatory Surgical Center	30% coinsurance after deductible is met	40% coinsurance after deductible is met
Doctor and Other Services		
Hospital	30% coinsurance after deductible is met	40% coinsurance after deductible is met
Ambulatory Surgical Center	30% coinsurance after deductible is met	40% coinsurance after deductible is met
Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)		
Facility Fees *Coverage for Inpatient Rehabilitation is limited to 60 days per benefit period.*	30% coinsurance after deductible is met	40% coinsurance after deductible is met
Human Organ and Tissue Transplants *Coverage includes acquisition and transplant procedures, collection and storage.*	30% coinsurance after deductible is met	40% coinsurance after deductible is met
Doctor and other services	30% coinsurance after deductible is met	40% coinsurance after deductible is met
Recovery & Rehabilitation		
Home Health Care	No charge	40% coinsurance after deductible is met
Rehabilitation services *Coverage for rehabilitative physical therapy, occupational therapy and speech therapy 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

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Habilitation services *Coverage for habilitative physical therapy, occupational therapy and speech therapy 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
Chemo/Radiation Therapy		
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
Dialysis/Hemodialysis		
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
Cardiac rehabilitation		
Office	No charge	40% coinsurance after deductible is met
Outpatient Hospital	No charge	40% coinsurance after deductible is met
Skilled Nursing Care (facility) *Coverage is limited to 200 days per benefit period.*	30% coinsurance after deductible is met	40% coinsurance after deductible is met
Hospice	30% coinsurance after deductible is met	40% coinsurance after deductible is met
Durable Medical Equipment	30% coinsurance after deductible is met	40% coinsurance after deductible is met
Prosthetic Devices	30% 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	Not covered
Pharmacy Out-of-Pocket Limit	Combined with In-Network medical out-of-pocket limit	Not covered
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 Pharmacy. 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 *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 $30 copay per prescription (home delivery)	Not covered (retail and 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.*	$25 copay per prescription (retail) and $50 copay per prescription (home delivery)	Not covered (retail and 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.*	$50 copay per prescription (retail) and $100 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 $0*, Bifocal* Reimbursed Up to $0*, Trifocal* Reimbursed Up to $0.	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.
- 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.
- The limits for physical, occupational, and speech therapy, if any apply to this plan, will not apply if you get care as part of the Mental Health and Substance Use Disorder benefit.
- The representations of benefits in this document are subject to Department of Financial Services (DFS) approval and are subject to change.
- 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_PPOL11030.

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 412-0752 (844) .

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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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.

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

Language Access Services:

hodoonih t'áadoo bą́ą́h ílínígóó. Ata' halne'ígíí łą' bich'į' hadeesdzih nínízingo koj̨į' hodíílnih (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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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.