Your summary of benefits

Anthem® Blue Cross and Blue Shield

Your Plan: Student Advantage Health Insurance Plan

Your School: MOREHOUSE SCHOOL OF MEDICINE - SHIP

Your Network: Blue Open Access POS

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	$300 person / $600 family	$3,000 person/ $9,000 family
Overall Out-of-Pocket Limit	$4,500 person / $9,000 family	$13,500 person / $27,000 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 (excluding Non-Network Human Organ and Tissue Transplant (HOTT) Services). In-network and out-of-network deductibles and out-of-pocket maximum amounts are separate and do not accumulate toward each other		
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 No charge for the first 12 visits and then $15 copay per visit medical deductible does not apply*		
Primary Care (PCP) *virtual and office*	No charge	40% coinsurance after deductible is met
Mental Health and Substance Abuse 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%.*	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 a Non-Network Provider
Retail Health Clinic *for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.*	No charge	40% coinsurance after deductible is met
Manipulation Therapy *Coverage is limited to 20 visits per benefit period.*	$25 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	No charge or $50 copay if preformed in a specialist office. 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	30% coinsurance after deductible is met
Preventive care for Chronic Conditions *per IRS guidelines*	No charge	30% coinsurance after deductible is met
Diagnostic Services **Lab**		
Office *All services performed in the office are included in the office copay.*	No charge or $50 copay if preformed in a specialist office. deductible does not apply	40% coinsurance after deductible is met
Freestanding Lab/Reference Lab	No charge	40% coinsurance after deductible is met
Outpatient Hospital	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 a Non-Network Provider
X-Ray		
Office *All services performed in the office are included in the office copay.*	No charge or $50 copay if preformed in a specialist office. deductible does not apply	40% coinsurance after deductible is met
Freestanding Radiology Center	20% coinsurance deductible does not apply	40% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Advanced Diagnostic Imaging		
Office	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Freestanding Radiology Center	20% coinsurance deductible does not apply	40% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Emergency and Urgent Care		
Urgent Care	$60 copay per visit deductible does not apply	40% coinsurance after deductible is met
Emergency Room Facility Services *Copay waived if admitted. Non-emergency use of Emergency Room Services is Not Covered.*	$150 copay per visit and 20% coinsurance deductible does not apply	Covered as In-Network
Emergency Room Doctor and Other Services	20% coinsurance deductible does not apply	Covered as In-Network
Emergency Ambulance	20% coinsurance after deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Abuse Care at a Facility		
Facility Fees	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 a Non-Network Provider
Doctor Services	20% coinsurance after deductible is met	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	$150 copay per visit and 20% coinsurance deductible does not apply	40% coinsurance after deductible is met
Doctor and Other Services		
Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Ambulatory Surgical Center	20% coinsurance deductible does not apply	40% coinsurance after deductible is met
Hospital (Including Maternity, Mental / Behavioral Health, Substance Abuse)		
Facility Fees *Coverage for Inpatient Rehabilitation and Skilled Nursing services is limited to 60 days combined per year.*	20% 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.*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Doctor and other services	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Recovery & Rehabilitation		
Home Health Care *Coverage is limited to 120 visits per benefit period.*	$25 copay per visit deductible does not apply	40% coinsurance after deductible is met
Rehabilitation services *Coverage for speech therapy is limited to 20 visits per benefit period. Coverage for rehabilitative physical therapy and occupational therapy combined is limited to 20 visits per year.*		
Office	$25 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
Outpatient Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Habilitation services *Coverage for speech therapy is limited to 20 visits per year. Coverage for habilitative physical therapy and occupational therapy combined is limited to 20 visits per year.*		
Office	$25 copay per visit deductible does not apply	40% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Chemo/Radiation Therapy *State Mandate: Cost share cannot exceed $200 per filled prescription for any orally administered chemotherapy drug.*		
Office	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Dialysis/Hemodialysis		
Office	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Cardiac rehabilitation		
Office	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Skilled Nursing Care (facility) *Coverage for Inpatient Rehabilitation and Skilled Nursing services is limited to 60 days combined per year.*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Hospice	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
Durable Medical Equipment	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Prosthetic Devices	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	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*:*** **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 or an In-Network Pharmacy that carries your specialty drug.*		
Tier 1 - Typically Generic *Each 90 day supply script filled at Retail 90 pharmacies is subject to one 30 day supply cost share(s) charged at In-Network Retail Pharmacies.*	$15 copay per prescription (retail and home delivery)	$15 copay per prescription (retail only)
Tier 2 – Typically Preferred Brand *Each 90 day supply script filled at Retail 90 pharmacies is subject to 2 times the 30 day supply cost share(s) charged at In-Network Retail Pharmacies.*	$35 copay per prescription (retail) and $70 copay per prescription (home delivery)	$35 copay per prescription (retail only)
Tier 3 - Typically Non-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.*	$60 copay per prescription (retail) and $180 copay per prescription (home delivery)	$60 copay per prescription (retail only)
Tier 4 - Typically Specialty (brand and generic)	20% coinsurance up to $300 per prescription (retail and home delivery)	20% coinsurance up to $300 per prescription (retail only)

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 (up to age 19) **Diagnostic and preventive** *Limited to 2 visits per Benefit Period.*	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	See adult benefit summary	See adult benefit summary

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=GA_SH_POSGA6104M004.

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 Certificate of Coverage. If there is a difference between this summary and the Certificate of Coverage the Certificate of Coverage 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)

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Language Access Services:

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