Your summary of benefits

Empire BlueCross BlueShield | STUDENT ADVANTAGE
An Anthem Company

Empire BlueCross BlueShield

Your Plan: Student Advantage Health Insurance Plan

Your School: MARIST 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	$100 student person	$200 student person
Overall Out-of-Pocket Limit	$7,900 person / $13,200 family	$0 person / $0 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 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 10% coinsurance after deductible is met*		
Primary Care (PCP) *virtual and office*	10% coinsurance after deductible is met	20% coinsurance after deductible is met
Mental Health and Substance Abuse Care *virtual and office*	10% coinsurance after deductible is met	20% coinsurance after deductible is met
Specialist Care *virtual and office*	10% coinsurance after deductible is met	20% 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%.*	No charge	20% coinsurance after deductible is met
Retail Health Clinic *for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.*	10% coinsurance after deductible is met	20% coinsurance after deductible is met
Manipulation Therapy	10% coinsurance after deductible is met	20% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Acupuncture	10% coinsurance after deductible is met	20% coinsurance after deductible is met
Other Services in an Office		
Allergy Testing	10% coinsurance after deductible is met	20% coinsurance after deductible is met
Prescription Drugs - *Dispensed in the office*	10% coinsurance after deductible is met	20% coinsurance after deductible is met
Surgery	10% coinsurance after deductible is met	20% coinsurance after deductible is met
Preventive care / screenings / immunizations	No charge	20% coinsurance after deductible is met
Preventive care for Chronic Conditions *per IRS guidelines*	No charge	20% coinsurance after deductible is met
Diagnostic Services **Lab**		
Office	10% coinsurance after deductible is met	20% coinsurance after deductible is met
Freestanding Lab/Reference Lab	10% coinsurance after deductible is met	20% coinsurance after deductible is met
Outpatient Hospital	10% coinsurance after deductible is met	20% coinsurance after deductible is met
X-Ray		
Office	10% coinsurance after deductible is met	20% coinsurance after deductible is met
Freestanding Radiology Center	10% coinsurance after deductible is met	20% coinsurance after deductible is met
Outpatient Hospital	10% coinsurance after deductible is met	20% coinsurance after deductible is met
Advanced Diagnostic Imaging		
Office	10% coinsurance after deductible is met	20% coinsurance after deductible is met
Freestanding Radiology Center	10% coinsurance after deductible is met	20% 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	10% coinsurance after deductible is met	20% coinsurance after deductible is met
Emergency and Urgent Care		
Urgent Care	10% coinsurance after deductible is met	20% coinsurance after deductible is met
Emergency Room Facility Services *Copay waived if admitted. Coinsurance waived if admitted. Cost share waived if admitted.*	$100 copay per visit and then 10% coinsurance after deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services	10% coinsurance after deductible is met	Covered as In-Network
Emergency Ambulance	10% coinsurance after deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Abuse Care at a Facility		
Facility Fees	10% coinsurance after deductible is met	20% coinsurance after deductible is met
Doctor Services	10% coinsurance after deductible is met	20% coinsurance after deductible is met
Outpatient Surgery		
Facility Fees		
Hospital	10% coinsurance after deductible is met	20% coinsurance after deductible is met
Ambulatory Surgical Center	10% coinsurance after deductible is met	20% coinsurance after deductible is met
Doctor and Other Services		
Hospital	10% coinsurance after deductible is met	20% coinsurance after deductible is met
Ambulatory Surgical Center	10% coinsurance after deductible is met	20% coinsurance after deductible is met
Hospital (Including Maternity, Mental / Behavioral Health, Substance Abuse)		
Facility Fees *Coverage for Inpatient Rehabilitation is limited to 60 days per benefit period. Limit is combined In-Network and Out-of-Network.*	10% coinsurance after deductible is met	20% coinsurance after deductible is met
Human Organ and Tissue Transplants	10% coinsurance after deductible is met	20% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Coverage includes acquisition and transplant procedures, collection and storage. **Doctor and other services**	10% coinsurance after deductible is met	20% coinsurance after deductible is met
Recovery & Rehabilitation **Home Health Care** *Coverage is limited to 40 visits per benefit period.*	10% coinsurance after deductible is met	20% 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	10% coinsurance after deductible is met	20% coinsurance after deductible is met
Outpatient Hospital	10% coinsurance after deductible is met	20% coinsurance after deductible is met
Habilitation services *Coverage for habilitative physical therapy, occupational therapy and speech therapy is limited to 60 visits combined per benefit period.*		
Office	10% coinsurance after deductible is met	20% coinsurance after deductible is met
Outpatient Hospital	10% coinsurance after deductible is met	20% coinsurance after deductible is met
Chemo/Radiation Therapy		
Office	10% coinsurance after deductible is met	20% coinsurance after deductible is met
Outpatient Hospital	10% coinsurance after deductible is met	20% coinsurance after deductible is met
Dialysis/Hemodialysis		
Office	10% coinsurance after deductible is met	20% coinsurance after deductible is met
Outpatient Hospital	10% coinsurance after deductible is met	20% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Cardiac rehabilitation		
Office	10% coinsurance after deductible is met	20% coinsurance after deductible is met
Outpatient Hospital	10% coinsurance after deductible is met	20% coinsurance after deductible is met
Skilled Nursing Care (facility) *Coverage is limited to 200 days per benefit period.*	10% coinsurance after deductible is met	20% coinsurance after deductible is met
Hospice *Coverage is limited to 210 days per benefit period.*	10% coinsurance after deductible is met	20% coinsurance after deductible is met
Durable Medical Equipment	10% coinsurance after deductible is met	20% coinsurance after deductible is met
Prosthetic Devices	10% coinsurance after deductible is met	20% 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*: 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.* **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 $45 copay per prescription (home delivery)	20% coinsurance (retail) and Not covered (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.*	$30 copay per prescription (retail) and $90 copay per prescription (home delivery)	20% coinsurance (retail) and Not covered (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.*	$30 copay per prescription (retail) and $90 copay per prescription (home delivery)	20% coinsurance (retail) and Not covered (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.*	Not Applicable	Not Applicable
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.
- 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=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.

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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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