Your summary of benefits

Anthem® Blue Cross and Blue Shield

Your Plan: Student Advantage Health Insurance Plan

Your School: HAMPTON UNIVERSITY - SHIP

Your Network: KeyCare

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	$0 student person	$0 student person
Overall Out-of-Pocket Limit	$3,000 person / $6,000 family	$3,000 person / $6,000 family
The family out-of-pocket maximum is embedded, meaning the cost shares of one family member will be applied to the per person out-of-pocket maximum; in addition, amounts for all covered family members apply to the family out-of-pocket maximum. No one member will pay more than the 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 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.*		
Primary Care (PCP) *virtual and office*	$25 copay per visit	$25 copay per visit and 30% coinsurance
Mental Health and Substance Abuse Care *virtual and office*	No charge	30% coinsurance
Specialist Care *virtual and office*	$25 copay per visit	$25 copay per visit and 30% coinsurance
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%.*	$25 copay per visit	30% coinsurance
Retail Health Clinic *for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.*	$25 copay per visit	30% coinsurance
Manipulation Therapy *Coverage is limited to 30 visits per benefit period.*	$25 copay per visit	$25 copay per visit and 30% coinsurance
Acupuncture	$25 copay per visit	$25 copay per visit and 30% coinsurance

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Other Services in an Office		
Allergy Testing	20% coinsurance	30% coinsurance
Prescription Drugs - *Dispensed in the office*	20% coinsurance	30% coinsurance
Surgery	20% coinsurance	30% coinsurance
Preventive care / screenings / immunizations	No charge	30% coinsurance
Preventive care for Chronic Conditions *per IRS guidelines*	No charge	30% coinsurance
Diagnostic Services		
Lab		
Office	20% coinsurance	30% coinsurance
Preferred Reference Lab	20% coinsurance	30% coinsurance
Outpatient Hospital	20% coinsurance	30% coinsurance
X-Ray		
Office	20% coinsurance	30% coinsurance
Freestanding Radiology Center	20% coinsurance	30% coinsurance
Outpatient Hospital	20% coinsurance	30% coinsurance
Advanced Diagnostic Imaging		
Office	20% coinsurance	30% coinsurance
Freestanding Radiology Center	20% coinsurance	30% coinsurance
Outpatient Hospital	20% coinsurance	30% coinsurance
Emergency and Urgent Care		
Urgent Care	$25 copay per visit	$25 copay per visit and 30% coinsurance

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Emergency Room Facility Services	$150 copay per visit and 20% coinsurance	Covered as In-Network
Emergency Room Doctor and Other Services	20% coinsurance	Covered as In-Network
Emergency Ambulance	20% coinsurance	Covered as In-Network
Outpatient Mental Health and Substance Abuse Care at a Facility		
Facility Fees	20% coinsurance	30% coinsurance
Doctor Services	20% coinsurance	30% coinsurance
Outpatient Surgery		
Facility Fees		
Hospital	20% coinsurance	30% coinsurance
Ambulatory Surgical Center	20% coinsurance	30% coinsurance
Doctor and Other Services		
Hospital	20% coinsurance	30% coinsurance
Ambulatory Surgical Center	20% coinsurance	30% coinsurance
Hospital (Including Maternity, Mental / Behavioral Health, Substance Abuse)		
Facility Fees *Coverage for Inpatient Rehabilitation and Skilled Nursing services is limited to 120 visits combined per benefit period.*	20% coinsurance	30% coinsurance
Human Organ and Tissue Transplants *Coverage includes acquisition and transplant procedures, collection and storage.*	20% coinsurance	30% coinsurance
Doctor and other services	20% coinsurance	30% coinsurance
Recovery & Rehabilitation		
Home Health Care *Coverage is limited to 100 visits per benefit period.*	20% coinsurance	30% coinsurance

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Rehabilitation services *Coverage for speech therapy is limited to 30 visits per benefit period. Coverage for rehabilitative physical therapy and occupational therapy combined is limited to 30 visits per benefit period. Benefit limit does not apply to Applied Behavioral Analysis. Benefit limit does not apply when performed as part of Early Intervention.*		
Office	$25 copay per visit	$25 copay per visit and 30% coinsurance
Outpatient Hospital	$25 copay per visit	$25 copay per visit and 30% coinsurance
Habilitation services *Coverage for speech therapy is limited to 30 visits per benefit period. Coverage for habilitative physical therapy and occupational therapy combined is limited to 30 visits per benefit period. Benefit limit does not apply to Applied Behavioral Analysis.*		
Office	$25 copay per visit	30% coinsurance
Outpatient Hospital	$25 copay per visit	30% coinsurance
Chemo/Radiation Therapy		
Office	20% coinsurance	30% coinsurance
Outpatient Hospital	20% coinsurance	30% coinsurance
Dialysis/Hemodialysis		
Office	20% coinsurance	30% coinsurance
Outpatient Hospital	20% coinsurance	30% coinsurance
Cardiac rehabilitation		
Office	$25 copay per visit	$25 copay per visit and 30% coinsurance
Outpatient Hospital	$25 copay per visit	$25 copay per visit and 30% coinsurance
Skilled Nursing Care (facility) *Coverage for Inpatient Rehabilitation and Skilled Nursing services is limited to 120 visits combined per benefit period.*	20% coinsurance	30% coinsurance

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Hospice	20% coinsurance	30% coinsurance
Durable Medical Equipment	20% coinsurance	30% coinsurance
Prosthetic Devices	20% coinsurance	30% coinsurance

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.*	$5 copay per prescription (retail) and Not covered (home delivery)	30% coinsurance up to $100 per prescription (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.*	$15 copay per prescription (retail) and Not covered (home delivery)	30% coinsurance up to $200 per prescription (retail) and Not covered (home delivery)
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.*	$40 copay per prescription (retail) and Not covered (home delivery)	30% coinsurance up to $250 per prescription (retail) and Not covered (home delivery)
Tier 4 - Typically Specialty (brand and generic)	$40 copay per prescription (retail) and Not covered (home delivery)	30% coinsurance up to $400 per prescription (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.*	No charge	No charge
Basic services	50% coinsurance	50% 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=VA_SH_PPOL03453MU02.

This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This policy has exclusions and limitations to benefits and terms under which the policy may be continued in force or discontinued. For costs and complete details of the coverage, contact your insurance agent or contact us. If there is a difference between this summary and the contract of coverage, the contract of coverage will prevail.

This benefit summary is not to be distributed without also providing access to the applicable Anthem enrollment brochure.

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 (844) 412-0752 .

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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Language Access Services:

Navajo (Diné): Díí naaltsoos biká'ígíí łahgo bina'idiłkidgo ná bohónéedzą dóó bee ahóót'i' t'áá ni nizaad k'ehjí bee nił hodoonih t'áadoo bą́ą́h ílínígóó. Ata' halne'ígíí łą' bich'į' hadeesdzih ninízingo kojį' hodíilnih (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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