Your summary of benefits

Anthem

Anthem® Blue Cross and Blue Shield

Your Plan: Student Advantage Health Insurance Plan

Your School: Colby College

Your Network: Blue Choice PPO

Visits with Virtual Care-Only Providers	Cost 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 an Out-of-Network Provider
Overall Deductible	$0 person	$0 person
Overall Out-of-Pocket Limit	$2,350 person	$5,000 person
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 deductibles and out-of-pocket maximum amounts are separate and do not accumulate toward each other Student Health Center benefits: No charge for covered medical expenses; deductible does not apply.		
Primary Care (PCP) *virtual and office*	20% coinsurance	40% coinsurance
Mental Health and Substance Use Disorder Care *virtual and office*	20% coinsurance	40% coinsurance
Specialist Care *virtual and office*	20% coinsurance	40% 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%.*	20% coinsurance	40% coinsurance
Retail Health Clinic *for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.*	20% coinsurance	40% coinsurance
Manipulation Therapy *Coverage is limited to 40 visits per benefit period.*	20% coinsurance	40% coinsurance
Acupuncture *Coverage is limited to 30 visits per benefit period.*	20% coinsurance	40% coinsurance

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Other Services in an Office		
Allergy Testing	20% coinsurance	40% coinsurance
Prescription Drugs - *Dispensed in the office*	20% coinsurance	40% coinsurance
Surgery	20% coinsurance	40% coinsurance
Preventive care / screenings / immunizations	No charge	40% coinsurance
Preventive care for Chronic Conditions *per IRS guidelines*	No charge	40% coinsurance
Diagnostic Services		
Lab		
Office	20% coinsurance	40% coinsurance
Preferred Reference Lab	20% coinsurance	40% coinsurance
Outpatient Hospital	20% coinsurance	40% coinsurance
X-Ray		
Office	20% coinsurance	40% coinsurance
Freestanding Radiology Center	20% coinsurance	40% coinsurance
Outpatient Hospital	20% coinsurance	40% coinsurance
Advanced Diagnostic Imaging		
Office	20% coinsurance	40% coinsurance
Freestanding Radiology Center	20% coinsurance	40% coinsurance
Outpatient Hospital	20% coinsurance	40% coinsurance
Emergency and Urgent Care		
Urgent Care	20% coinsurance	40% coinsurance
Emergency Room Facility Services *Your copay will be waived if admitted.*	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 Use Disorder Care at a Facility	20% coinsurance	
Facility Fees	20% coinsurance	40% coinsurance
Doctor Services	20% coinsurance	40% coinsurance
Outpatient Surgery		
Facility Fees		

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Hospital	20% coinsurance	40% coinsurance
Ambulatory Surgical Center	20% coinsurance	40% coinsurance
Doctor and Other Services		
Hospital	20% coinsurance	40% coinsurance
Ambulatory Surgical Center	20% coinsurance	40% coinsurance
Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)		
Facility Fees *Coverage for Inpatient Rehabilitation and Skilled Nursing services is limited to 150 days combined per benefit period.*	20% coinsurance	40% coinsurance
Human Organ and Tissue Transplants *Coverage includes acquisition and transplant procedures, collection and storage.*	20% coinsurance	40% coinsurance
Doctor and other services	20% coinsurance	40% coinsurance
Recovery & Rehabilitation		
Home Health Care	20% coinsurance	40% coinsurance
Rehabilitation services *Coverage for rehabilitative physical therapy, occupational therapy and speech therapy is limited to 30 visits per therapy per benefit period. Combined with Habilitation services.*		
Office	20% coinsurance	40% coinsurance
Outpatient Hospital	20% coinsurance	40% coinsurance
Habilitation services *Coverage for habilitative physical therapy, occupational therapy and speech therapy is limited to 30 visits per therapy per benefit period. Combined with Rehabilitation services.*		
Office	20% coinsurance	40% coinsurance
Outpatient Hospital	20% coinsurance	40% coinsurance
Chemo/Radiation Therapy		
Office	20% coinsurance	40% coinsurance
Outpatient Hospital	20% coinsurance	40% coinsurance
Dialysis/Hemodialysis		
Office	20% coinsurance	40% coinsurance

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Outpatient Hospital	20% coinsurance	40% coinsurance
Cardiac rehabilitation *Coverage is limited to 36 visits per episode.*		
Office	20% coinsurance	40% coinsurance
Outpatient Hospital	20% coinsurance	40% coinsurance
Skilled Nursing Care (facility) *Coverage for Inpatient Rehabilitation and Skilled Nursing services is limited to 150 days combined per benefit period.*	20% coinsurance	40% coinsurance
Hospice	20% coinsurance	40% coinsurance
Durable Medical Equipment	20% coinsurance	40% coinsurance
Prosthetic Devices	20% coinsurance	40% coinsurance

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Pharmacy Deductible	Not applicable	Not applicable
Pharmacy Out-of-Pocket Limit	Combined with In-Network medical out-of-pocket limit	Combined with Out-of-Network medical out-of-pocket limit
Prescription Drug Coverage **Network*: Base Network*** **Drug List: *Traditional Open***		
Day Supply Limits: **No cost sharing applies to ACA Preventive Care medications filled at a participating network pharmacy.** **Retail Pharmacy** *30 day supply (cost shares noted below)* **Retail 90 Pharmacy** *90 day supply (cost shares noted below)* **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.*	$10 copay per prescription (retail) and Not covered (home delivery)	40% coinsurance per prescription (retail) and Not covered (home delivery)
More than a 30 day supply but less than a 61 day supply filled at a Retail pharmacy	$20 copay per prescription (retail) and Not covered (home delivery)	40% coinsurance per prescription (retail) and Not covered (home delivery)
More than a 60 day supply filled at a Retail pharmacy	$30 copay per prescription (retail) and Not covered (home delivery)	40% coinsurance 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.*	$30 copay per prescription (retail) and Not covered (home delivery)	40% coinsurance per prescription (retail) and Not covered (home delivery)
More than a 30 day supply but less than a 61 day supply filled at a Retail pharmacy	$60 copay per prescription (retail) and Not covered (home delivery)	40% coinsurance per prescription (retail) and Not covered (home delivery)
More than a 60 day supply filled at a Retail pharmacy	$90 copay per prescription (retail) and Not covered (home delivery)	40% coinsurance per prescription (retail) and Not covered (home delivery)

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
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.*	$50 copay per prescription (retail) and Not covered (home delivery)	40% coinsurance per prescription (retail) and Not covered (home delivery)
More than a 30 day supply but less than a 61 day supply filled at a Retail pharmacy	$100 copay per prescription (retail) and Not covered (home delivery)	40% coinsurance per prescription (retail) and Not covered (home delivery)
More than a 60 day supply filled at a Retail pharmacy	$150 copay per prescription (retail) and Not covered (home delivery)	40% coinsurance per prescription (retail) and Not covered (home delivery)

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-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	$0 copayment up to plan's Maximum Allowed Amount
Frames *Limited to 1 unit per benefit period.*	No charge	$0 copayment up to plan's Maximum Allowed Amount
Lenses *Limited to 1 unit per benefit period.*	No charge	$0 copayment up to plan's Maximum Allowed Amount
Contact Lenses (Elective and Non-Elective) *Limited to 1 unit per benefit period.*	No charge	$0 copayment up to plan's Maximum Allowed Amount

Covered Dental Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
This is a brief outline of your dental coverage. Only children's dental services count towards your out-of-pocket limit. You must use a Dental Complete provider.		
Children's Dental Essential Health Benefits **Diagnostic and preventive** *Limited to 2 visits per 12 months.*	No charge	No charge
Basic services	No charge	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 Out-of-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 an Out-of-Network provider, the member is responsible for any balance due after the plan payment.
- ‡ You will pay the PCP's office visit copay when services are provided in their office.
- 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.
- For additional information on limitations and exclusions and other disclosure items that apply to this plan, go to https://le.anthem.com/pdf?x=ME_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.

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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Navajo (Diné): Díí naaltsoos biká'ígíí łahgo bína'ídiłkidgo ná bohónéedzą dóó bee ahóót'i' t'áá ni nizaad k'ehjí bee nił hodoonih t'áadoo bą́ąh ílínígóó. Ata' halne'ígíí ła' bich'į' hadeesdzih nínízingo kojį' hodíílnih (844) 412-0752.

Language Access Services:

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