Your summary of benefits

Anthem® Blue Cross and Blue Shield

Your Plan: Student Advantage Health Insurance Plan

Your School: Mount Saint Joseph University - SHIP

Your Network: Blue Access

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

Visits with Virtual Care-Only Providers available through our mobile app and website	
Primary Care, and medical services for urgent/acute care	$35 copay per visit and 20% coinsurance deductible does not apply
Mental Health & Substance Use Disorder Services	$35 copay per visit and 20% coinsurance deductible does not apply
Specialist care	$35 copay per visit and 20% coinsurance deductible does not apply

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	$500 student	$500 student
Overall Out-of-Pocket Limit	$7,150 student	$7,150 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 combined and accumulate toward each other.		
Primary Care (PCP) *virtual and office*	$35 copay per visit and 20% coinsurance deductible does not apply	$35 copay per visit and 50% coinsurance deductible does not apply
Mental Health and Substance Use Disorder Care *virtual and office*	$35 copay per visit and 20% coinsurance deductible does not apply	$35 copay per visit and 50% coinsurance deductible does not apply
Specialist Care *virtual and office*	$35 copay per visit and 20% coinsurance deductible does not apply	$35 copay per visit and 50% coinsurance deductible does not apply

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
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	50% coinsurance after deductible is met
Retail Health Clinic *for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.*	$35 copay per visit and 20% coinsurance deductible does not apply	$35 copay per visit and 50% coinsurance deductible does not apply
Manipulation Therapy *Coverage is limited to 12 visits per benefit period.*	$35 copay per visit deductible does not apply	$35 copay per visit deductible does not apply
Other Services in an Office		
Allergy Testing	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Prescription Drugs - *Dispensed in the office*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Surgery	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Preventive care / screenings / immunizations	No charge	50% coinsurance after deductible is met
Preventive care for Chronic Conditions *per IRS guidelines*	No charge	50% coinsurance after deductible is met
Diagnostic Services **Lab**		
Office	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Lab/Reference Lab	No charge	50% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
X-Ray		
Office	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Radiology Center	20% coinsurance after deductible is met	50% 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	50% coinsurance after deductible is met
Advanced Diagnostic Imaging		
Office	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Radiology Center	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Emergency and Urgent Care		
Urgent Care	$35 copay per visit and 20% coinsurance deductible does not apply	$35 copay per visit and 50% coinsurance deductible does not apply
Emergency Room Facility Services *Your copay will be waived if admitted.*	$250 copay per visit and 20% coinsurance deductible does not apply	Covered as In-Network
Emergency Room Doctor and Other Services	$250 copay per visit and 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 Use Disorder Care at a Facility		
Facility Fees	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Doctor Services	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Surgery		
Facility Fees		
Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Ambulatory Surgical Center	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Doctor and Other Services		
Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Ambulatory Surgical Center	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)		
Facility Fees	20% coinsurance after deductible is met	50% 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	50% coinsurance after deductible is met
Doctor and other services	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Recovery & Rehabilitation		
Home Health Care *Coverage is limited to 100 visits per benefit period.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Rehabilitation services *Coverage for Physical Therapy is limited to 20 visits per benefit period. Coverage for Occupational Therapy is limited to 20 visits per benefit period. Coverage for speech therapy is limited to 20 visits per benefit period.*		
Office	$35 copay per visit and 20% coinsurance deductible does not apply	$35 copay per visit and 50% coinsurance deductible does not apply
Outpatient Hospital	$35 copay per visit and 20% coinsurance deductible does not apply	$35 copay per visit and 50% coinsurance deductible does not apply

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Habilitation services *Coverage for rehabilitative and habilitative Physical Therapy is limited to 20 visits combined per benefit period. Coverage for rehabilitative and habilitative Occupational Therapy is limited to 20 visits combined per benefit period. Coverage for rehabilitative and habilitative speech therapy is limited to 20 visits combined per benefit period.*		
Office	$35 copay per visit and 20% coinsurance deductible does not apply	$35 copay per visit and 50% coinsurance deductible does not apply
Outpatient Hospital	$35 copay per visit and 20% coinsurance deductible does not apply	$35 copay per visit and 50% coinsurance deductible does not apply
Chemo/Radiation Therapy		
Office	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Dialysis/Hemodialysis		
Office	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Cardiac rehabilitation *Coverage is limited to 36 visits per benefit period.*		
Office	$35 copay per visit and 20% coinsurance deductible does not apply	$35 copay per visit and 50% coinsurance deductible does not apply
Outpatient Hospital	$35 copay per visit and 20% coinsurance deductible does not apply	$35 copay per visit and 50% coinsurance deductible does not apply

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Skilled Nursing Care (facility) *Coverage is limited to 90 days per benefit period.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Hospice	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Durable Medical Equipment	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Prosthetic Devices	20% coinsurance after deductible is met	50% 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 In-Network medical out-of-pocket limit	Combined with Non-Network 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 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.*	$20 copay per prescription (retail) and $50 copay per prescription (home delivery)	50% 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.*	$50 copay per prescription (retail) and $125 copay per prescription (home delivery)	50% coinsurance (retail) and Not covered (home delivery)

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-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.*	$75 copay per prescription (retail) and $187.50 copay per prescription (home delivery)	50% 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.*	No charge	No charge

Covered Dental Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Basic services	20% coinsurance	20% coinsurance deductible does not apply
Major services	50% coinsurance	50% coinsurance deductible does not apply
Medically Necessary Orthodontia services	50% coinsurance	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.
- 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.
- The representations of benefits in this document are subject to Ohio Department of Insurance (ODI) 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=OH_SH_PPOL08412.

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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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 0752-412 (844) .

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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.

Italian (Italiano): In caso di eventuali domande sul presente documento, ha il diritto di ricevere assistenza e informazioni nella sua lingua senza alcun costo aggiuntivo. Per parlare con un interprete, chiami il numero (844) 412-0752.

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

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It's important we treat you fairly

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