

Your summary of benefits



Anthem® Blue Cross and Blue Shield

Your Plan: Student Advantage Health Insurance Plan

Your School: Union College SHIP

Your Network: Blue Access 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	\$4,000 person
Overall Out-of-Pocket Limit	\$5,000 person	\$30,000 person
All medical and prescription drugs deductibles, copayments and coinsurance apply toward the out-of-pocket maximum. Student Health Center benefits: No charge for covered medical expenses; deductible does not apply.		
Primary Care (PCP) <i>virtual and office</i>	\$25 copay per visit	30% coinsurance after deductible is met
Mental Health and Substance Use Disorder Care <i>virtual and office</i>	\$25 copay per visit	30% coinsurance after deductible is met
Specialist Care <i>virtual and office</i>	\$25 copay per visit	30% coinsurance after deductible is met
<u>Other Practitioner Visits</u>		
Routine Maternity Care (Prenatal and Postnatal) <i>In-Network routine prenatal office visits and other preventive prenatal care and screening are covered at 100%.</i>	No charge	30% coinsurance after deductible is met
Retail Health Clinic for routine care and treatment of common illnesses; <i>usually found in major pharmacies or retail stores.</i>	\$25 copay per visit	30% coinsurance after deductible is met
Manipulation Therapy	\$25 copay per visit	30% coinsurance after deductible is met
Acupuncture	Not covered	Not covered

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
<p><u>Other Services in an Office</u></p> <p>Allergy Testing</p> <p>Prescription Drugs - <i>Dispensed in the office</i></p> <p>Surgery</p>	<p>\$25 copay per visit[†]</p> <p>No charge</p> <p>No charge</p>	<p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p>
<p>Preventive care / screenings / immunizations</p>	<p>No charge</p>	<p>30% coinsurance after deductible is met</p>
<p>Preventive care for Chronic Conditions <i>per IRS guidelines</i></p>	<p>No charge</p>	<p>30% coinsurance after deductible is met</p>
<p><u>Diagnostic Services</u></p> <p>Lab</p> <p>Office</p> <p>Freestanding Lab/Reference Lab</p> <p>Outpatient Hospital</p>	<p>No charge</p> <p>No charge</p> <p>No charge</p>	<p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p>
<p>X-Ray</p> <p>Office</p> <p>Freestanding Radiology Center</p> <p>Outpatient Hospital</p>	<p>No charge</p> <p>No charge</p> <p>No charge</p>	<p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p>
<p>Advanced Diagnostic Imaging</p> <p>Office</p> <p>Freestanding Radiology Center</p> <p>Outpatient Hospital</p>	<p>No charge</p> <p>No charge</p> <p>No charge</p>	<p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
<p><u>Emergency and Urgent Care</u></p> <p>Urgent Care</p> <p>Emergency Room Facility Services <i>Your copay will be waived if admitted.</i></p> <p>Emergency Room Doctor and Other Services</p> <p><u>Emergency Ambulance</u></p>	<p>\$25 copay per visit</p> <p>\$100 copay per visit</p> <p>No charge</p> <p>\$100 copay per trip</p>	<p>\$25 copay per visit deductible does not apply</p> <p>Covered as In-Network</p> <p>Covered as In-Network</p> <p>Covered as In-Network</p>
<p><u>Outpatient Mental Health and Substance Use Disorder Care at a Facility</u></p> <p>Facility Fees</p> <p>Doctor Services</p>	<p>No charge</p> <p>No charge</p>	<p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p>
<p><u>Outpatient Surgery</u></p> <p>Facility Fees</p> <p>Hospital</p> <p>Ambulatory Surgical Center</p> <p>Doctor and Other Services</p> <p>Hospital</p> <p>Ambulatory Surgical Center</p>	<p>No charge</p> <p>No charge</p> <p>No charge</p> <p>No charge</p> <p>No charge</p>	<p>30% coinsurance after deductible is met</p>
<p><u>Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)</u></p> <p>Facility Fees <i>Coverage for Inpatient Rehabilitation is limited to 60 days per benefit period.</i></p> <p>Human Organ and Tissue Transplants <i>Coverage includes acquisition and transplant procedures, collection and storage.</i></p> <p>Doctor and other services</p>	<p>No charge</p> <p>No charge</p> <p>No charge</p>	<p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
<p><u>Recovery & Rehabilitation</u></p> <p>Home Health Care <i>Coverage is limited to 60 visits per benefit period.</i></p>	\$25 copay per visit	30% coinsurance after deductible is met
<p>Rehabilitation services <i>Coverage for rehabilitative physical therapy, occupational therapy and speech therapy is limited to 60 visits combined per benefit period.</i></p> <p>Office</p> <p>Outpatient Hospital</p> <p>Habilitation services <i>Coverage for habilitative physical therapy, occupational therapy and speech therapy is limited to 60 visits combined per benefit period.</i></p> <p>Office</p> <p>Outpatient Hospital</p>	<p>\$25 copay per visit</p> <p>\$25 copay per visit</p> <p>\$25 copay per visit</p> <p>\$25 copay per visit</p>	<p>30% coinsurance after deductible is met</p>
<p>Chemo/Radiation Therapy</p> <p>Office</p> <p>Outpatient Hospital</p>	<p>\$25 copay per visit</p> <p>\$25 copay per visit</p>	<p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p>
<p>Dialysis/Hemodialysis</p> <p>Office</p> <p>Outpatient Hospital</p>	<p>\$25 copay per visit</p> <p>\$25 copay per visit</p>	<p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p>
<p>Cardiac rehabilitation</p> <p>Office</p> <p>Outpatient Hospital</p>	<p>\$25 copay per visit</p> <p>\$25 copay per visit</p>	<p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p>
<p>Skilled Nursing Care (facility) <i>Coverage is limited to 200 days per benefit period.</i></p>	No charge	30% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Hospice – Inpatient <i>Coverage is limited to 200 days per benefit period.</i>	No charge	30% coinsurance after deductible is met
Hospice – Outpatient <i>Coverage is limited to 200 days per benefit period.</i>	\$25 copay per visit	30% coinsurance after deductible is met
Durable Medical Equipment	No charge	30% coinsurance after deductible is met
Prosthetic Devices	No charge	30% coinsurance after deductible is met

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 covered
Pharmacy Out-of-Pocket Limit	Combined with In-Network medical out-of-pocket limit	Not covered
Prescription Drug Coverage Network: <i>Base Network</i> Drug List: <i>Traditional Open</i>		
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 our home delivery 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.	\$10 copay per prescription (retail) and \$25 copay per prescription (home delivery)	Not covered (retail and 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.	\$45 copay per prescription (retail) and \$112.50 copay per prescription (home delivery)	Not covered (retail and 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.	\$75 copay per prescription (retail) and \$187.50 copay per prescription (home delivery)	Not covered (retail and home delivery)

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
<p><i>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.</i></p>		
<p><u>Children's Vision Essential Health Benefits (up to age 19)</u></p>		
<p>Vision exam <i>Limited to 1 exam per benefit period.</i></p>	No charge	Reimbursed Up to \$30
<p>Frames <i>Limited to 1 unit per benefit period.</i></p>	No charge	Reimbursed Up to \$45
<p>Lenses <i>Limited to 1 unit per benefit period combined with Out-of-Network Coverage. Out-of-Network Reimbursement: Single Reimbursed Up to \$25, Bifocal Reimbursed Up to \$40, Trifocal Reimbursed Up to \$55.</i></p>	No charge	Receives Reimbursement
<p>Elective Contact Lenses <i>Limited to 1 unit per benefit period.</i></p>	No charge	Reimbursed Up to \$60
<p>Non-Elective Contact Lenses <i>Limited to 1 unit per benefit period.</i></p>	No charge	Reimbursed Up to \$210

Covered Dental Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
<p><i>This is a brief outline of your dental coverage. Only children's dental services count towards your out-of-pocket limit.</i></p>		
<p>Children's Dental Essential Health Benefits</p>		
<p>Diagnostic and preventive <i>Limited to 2 visits per 12 months.</i></p>	No charge	No charge
<p>Basic services</p>	20% coinsurance	20% coinsurance
<p>Major services</p>	50% coinsurance	50% coinsurance
<p>Medically Necessary Orthodontia services</p>	50% coinsurance	50% coinsurance
<p>Cosmetic Orthodontia services</p>	Not covered	Not covered
<p>Adult Dental</p>	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=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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Questions: (844) 412-0752 or visit us at <https://student.anthem.com>
NY/SH/Anthem Student Advantage SHPSHC Blue Access 3-Tier Plan//08-01-2025

We're here for you – in many languages

The law requires us to include a message in all of these different languages. Curious what they say? Here's the English version: "You have the right to get help in your language for free. Just call the Member Services number on your ID card." Visually impaired? You can also ask for other formats of this document

Spanish

Usted tiene derecho a obtener asistencia en su idioma sin cargo. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación ¿Tiene alguna deficiencia visual? También puede solicitar este documento en otros formatos.

Chinese

您有權免費獲得使用您的語言提供的協助。只需撥打印於您的 ID 卡上的會員服務部電話號碼即可。視力障礙？您也可以索取本文件的其他格式。

Vietnamese

Quý vị có quyền nhận trợ giúp bằng ngôn ngữ của mình, miễn phí. Quý vị chỉ cần gọi đến số điện thoại của Ban Dịch vụ Thành viên trên thẻ ID của quý vị. Quý vị bị khiếm thị? Quý vị cũng có thể yêu cầu các định dạng khác của tài liệu này.

Korean

귀하는 귀하의 언어로 된 도움을 무료로 받을 권리가 있습니다. 귀하의 ID 카드에 있는 가입자 서비스 번호로 전화하십시오. 시각 장애인이신가요? 다른 형식으로 된 이 문서를 요청하실 수 있습니다.

Tagalog

May karapatan kang makakuha ng tulong na nasa iyong wika nang libre. Tawagan lang ang numero ng Member Services na nasa iyong ID card. May kapansanan sa paningin? Maaari ka ring humingi ng iba pang mga format ng dokumentong ito.

Russian

У вас есть право на бесплатное получение помощи на вашем родном языке. Просто позвоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. У вас проблемы со зрением? Вы также можете запросить этот документ в других форматах.

French Creole

Ou gen dwa jwenn èd nan lang ou gratis. Jis rele nimewo Sèvis Manm ki sou Kat ID ou a gratis Gen pwoblèm vizyèl? Ou ka mande tou pou lòt fòm nan dokiman sa a.

Arabic

لك الحق في الحصول على هذه المعلومات والحصول على المساعدة بلغتك مجاناً. فقط اتصل برقم خدمات الأعضاء الموجود على بطاقة هويتك. هل تعاني من ضعف البصر؟ يمكنك أيضاً طلب تنسيقات أخرى لهذه الوثيقة.

French

Vous avez le droit d'obtenir de l'aide dans votre langue gratuitement. Appelez simplement le numéro du Services membres figurant sur votre carte d'identité. Vous êtes une personne malvoyante ? Vous pouvez également demander à accéder à ce document dans d'autres formats.

Persian

شما حق دارید به زبان خود به صورت رایگان کمک بگیرید. فقط با شماره خدمات اعضا مندرج در کارت عضویت خود تماس بگیرید. آیا دچار اختلال بینایی هستید؟ همچنین می‌توانید فرمت‌های دیگر این سند را درخواست کنید.

Armenian

Դուք իրավունք ունեք անվճար օգնություն ստանալու ձեր լեզվով: Դարձապես զանգահարեք ձեր ID քարտի վրա գտնվող Անդամների սպասարկման համարին: Տեսողության խանգարում ունեցող եք: Կարող եք նաև խնդրել այս փաստաթղթի այլ ձևաչափեր:

Japanese

あなたにはあなたの言語で無料で支援を受ける権利があります。IDカードに記載されている会員サービス番号にお電話ください。視覚障害をお持ちですか？他の形式でこの文書を要求することもできます。

Italian

Hai il diritto di ricevere assistenza gratuita nella tua lingua. Basta chiamare il numero del Servizio Membri presente sulla tua tessera identificativa. Hai problemi di vista? È possibile richiedere anche altri formati di questo documento.

German

Sie haben das Recht, kostenlose Hilfe in Ihrer Sprache zu erhalten. Rufen Sie einfach die Nummer des Mitgliederservices auf Ihrer ID-Karte an. Sehbehindert? Sie können dieses Dokument auch in anderen Formaten anfordern.

Polish

Masz prawo do bezpłatnej pomocy w swoim języku. Wystarczy zadzwonić pod numer Biura Obsługi Klienta podany na karcie identyfikacyjnej. Masz wadę wzroku? Możesz również poprosić o inne formaty tego dokumentu.

Pennsylvania Dutch

Du hoscht's Recht fer Hilf griege in dei Schprooch fer nix. Duh yuscht die Member Services Number uffrufe uff dei ID Card. Hoscht Druwwel fer sehne? Du kannscht des do Schreiwes in en differnter Weg griege so as du's besser sehne kannscht.

TTY/TTD:711

It's important we treat you fairly

We follow federal civil rights laws in our health programs and activities. Members can get reasonable modifications as well as free auxiliary aids and services if you have a disability. We don't discriminate, on the basis of race, color, national origin, sex, age or disability. For people whose primary language isn't English (or have limited proficiency), we offer free language assistance services like interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711) or visit our website. If you think we failed in any areas or to learn more about grievance procedures, you can mail a complaint to: Compliance Coordinator, P.O. Box 27401, Richmond, VA 23279, or directly to the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201. You can also call 1-800-368-1019 (TDD: 1-800-537-7697) or visit <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>