

Your summary of benefits



Anthem® Blue Cross and Blue Shield

Your School: **Oberlin College & Conservatory SHIP**

Your Plan: Student Advantage Health Insurance Plan

Your Network: Blue Access

Effective Date: 8/1/2024

Visits with Virtual Care-Only Providers available through our mobile app and website

Primary Care, and medical services for urgent/acute care	\$20 copay per visit deductible does not apply
Mental Health & Substance Use Disorder Services	\$20 copay per visit deductible does not apply
Specialist care	\$20 copay per visit 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 person	\$1,000 student person
Overall Out-of-Pocket Limit	\$9,000 person / \$17,100 family	\$9,000 person / \$17,100 family
<p>The family out-of-pocket limit is embedded, meaning each covered person is capped at his or her per single out-of-pocket limit; in addition, cost shares for all covered family members apply to the family out-of-pocket limit, yet no one member will pay more than the per single out-of-pocket limit.</p> <p>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.</p>		
Primary Care (PCP) <i>virtual and office</i>	\$20 copay per visit deductible does not apply	50% coinsurance after deductible is met
Mental Health and Substance Use Disorder Care <i>virtual and office</i>	\$20 copay per visit deductible does not apply	50% coinsurance after deductible is met
Specialist Care <i>virtual and office</i>	\$20 copay per visit deductible does not apply	50% 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>	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
Retail Health Clinic <i>for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.</i>	\$20 copay per visit deductible does not apply	50% coinsurance after deductible is met
Manipulation Therapy <i>Coverage is limited to 12 visits per benefit period.</i>	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Acupuncture	Not covered	Not covered
<u>Other Services in an Office</u>		
Allergy Testing	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Prescription Drugs - <i>Dispensed in the office</i>	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 deductible does not apply
Preventive care for Chronic Conditions <i>per IRS guidelines</i>	No charge	50% coinsurance deductible does not apply
<u>Diagnostic Services</u>		
Lab		
Office	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Lab/Reference Lab	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
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
Outpatient 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
Advanced Diagnostic Imaging Office Freestanding Radiology Center Outpatient Hospital	20% coinsurance after deductible is met 20% coinsurance after deductible is met 20% coinsurance after deductible is met	50% coinsurance after deductible is met 50% coinsurance after deductible is met 50% coinsurance after deductible is met
<u>Emergency and Urgent Care</u> Urgent Care Emergency Room Facility Services <i>Your copay will be waived if admitted.</i> Emergency Room Doctor and Other Services <u>Emergency Ambulance</u>	\$50 copay per visit and 20% coinsurance deductible does not apply \$200 copay per visit and then 20% coinsurance after deductible is met \$200 copay per visit and then 20% coinsurance after deductible is met 20% coinsurance after deductible is met	Covered as In-Network Covered as In-Network Covered as In-Network Covered as In-Network
<u>Outpatient Mental Health and Substance Use Disorder Care at a Facility</u> Facility Fees Doctor Services	20% coinsurance after deductible is met 20% coinsurance after deductible is met	50% coinsurance after deductible is met 50% coinsurance after deductible is met
<u>Outpatient Surgery</u> Facility Fees Hospital Ambulatory Surgical Center Doctor and Other Services	20% coinsurance after deductible is met 20% coinsurance after deductible is met	50% 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
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
<u>Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)</u>		
Facility Fees	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Human Organ and Tissue Transplants <i>Coverage includes acquisition and transplant procedures, collection and storage.</i>	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
<u>Recovery & Rehabilitation</u>		
Home Health Care	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Rehabilitation services <i>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.</i>		
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
Habilitation services <i>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.</i>		
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

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
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 <i>Coverage is limited to 36 visits per benefit period.</i>		
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
Skilled Nursing Care (facility) <i>Coverage for Inpatient Rehabilitation and Skilled Nursing services is limited to 60 days combined per benefit period.</i>	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-	Combined with Non-Network medical out-

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
	of-pocket limit	of-pocket limit
Prescription Drug Coverage Network: <i>Base Network</i> Drug List: <i>Select</i> <i>Drugs not included on the Select drug list will not be covered.</i>		
Day Supply Limits: Retail Pharmacy <i>31 day supply (cost shares noted below)</i> Retail 90 Pharmacy <i>90 day supply (cost shares noted below)</i> Specialty Pharmacy <i>31 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.</i>		
Tier 1 - Typically Generic <i>Each 90 day supply script filled at Retail 90 pharmacies is subject to 3 times the 31 day supply cost share(s) charged at In-Network Retail Pharmacies.</i>	\$10 copay per prescription (retail) and Not covered (home delivery)	\$10 copay per prescription (retail) and Not covered (home delivery)
Tier 2 – Typically Preferred Brand <i>Each 90 day supply script filled at Retail 90 pharmacies is subject to 3 times the 31 day supply cost share(s) charged at In-Network Retail Pharmacies.</i>	\$30 copay per prescription (retail) and Not covered (home delivery)	\$30 copay per prescription (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand <i>Each 90 day supply script filled at Retail 90 pharmacies is subject to 3 times the 31 day supply cost share(s) charged at In-Network Retail Pharmacies.</i>	\$60 copay per prescription (retail) and Not covered (home delivery)	\$60 copay 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
<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>		
<u>Children's Vision Essential Health Benefits (up to age 19)</u>		
Vision exam <i>Limited to 1 exam per benefit period.</i>	No charge	Reimbursed Up to \$30
Frames <i>Limited to 1 unit per benefit period.</i>	No charge	\$0 copayment up to plan's Maximum Allowed Amount
Lenses <i>Limited to 1 unit per benefit period.</i>	No charge	\$0 copayment up to plan's Maximum Allowed Amount

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Contact Lenses (Elective and Non-Elective) <i>Limited to 1 unit per benefit period.</i>	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 a Non-Network Provider
<i>This is a brief outline of your dental coverage. Only children's dental services count towards your out-of-pocket limit.</i>		
Children's Dental Essential Health Benefits Diagnostic and preventive <i>Limited to 2 visits per 12 months.</i>	No charge	No charge
Basic services	20% coinsurance deductible does not apply	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 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_PPOOH2447M002.

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>
OH/SH/Student Advantage Health Insurance Plan/Q9EW/08-01-2024

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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Farsi (فارسی): در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه ای به زبان مادریتان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره (844) 412-0752 تماس بگیرید.

French (Français): Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (844) 412-0752.

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.

Japanese (日本語): この文書についてなにかご不明な点があれば、あなたにはあなたの言語で無料で支援を受け情報を得る権利があります。通訳と話すには、(844) 412-0752 にお電話ください。

Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면(844) 412-0752로 문의하십시오.

Navajo (Diné): Díí naaltsoos biká'ígíí lahgo bína'ídiłkidgo ná bohónéedzá dóó bee ahóót'i' t'áá ni nizaad k'ehj bee níl hodoonih t'áadoo bááh ilínígóó. Ata' halne'ígíí la' bich'í' hadeesdzih nínízingo kojí' hodiilnih (844) 412-0752.

Language Access Services:

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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Spanish (Español): Si tiene preguntas acerca de este documento, tiene derecho a recibir ayuda e información en su idioma, sin costos. Para hablar con un intérprete, llame al (844) 412-0752.

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It's important we treat you fairly

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with 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 or by calling 1-800-368-1019 (TDD: 1-800-537-7697) or online at

<https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>. Complaint forms are available at

<http://www.hhs.gov/ocr/office/file/index.html>.