Anthem® Blue Cross and Blue Shield

Your Plan: Student Advantage Health Insurance Plan

Your School: UNIVERSITY OF TOLEDO - SHIP

Your Network: Blue Access

| **Covered Medical Benefits** | **Cost if you use a In-Network Provider** | **Cost if you use an In-Network Provider** | **Cost if you use a Non-Network Provider** |
| --- | --- | --- | --- |
| **Overall Deductible** | $0 student person | $1,500 student person | $3,000 student person |
| **Overall Out-of-Pocket Limit** | $5,000 person / $10,000 family | $5,000 person / $10,000 family | $5,000 person / $10,000 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 (Tier 1 and Tier 2) and out-of-network out-of-pocket maximum amounts are separate and do not accumulate toward each other. In-network (Tier 2) and out-of-network deductibles are separate and do not accumulate toward each other.  The Out-of-Pocket Maximums for In-Network (Tier 1) and In-Network (Tier 2) cross apply as well. | | | |
| **Virtual Visits from online provider LiveHealth Online** *for urgent/acute medical and mental health and substance abuse care via* [*www.livehealthonline.com*](http://www.livehealthonline.com) *are covered at $10 copay per visit and then 30% coinsurance after deductible is met.* | | | |
| **Primary Care (PCP)** *virtual and office* | 20% coinsurance | $10 copay per visit and then 30% coinsurance after deductible is met | $15 copay per visit and then 40% coinsurance after deductible is met |
| **Mental Health and Substance Abuse Care** *virtual and office* | 20% coinsurance | $10 copay per visit and then 30% coinsurance after deductible is met | 40% coinsurance after deductible is met |
| **Specialist Care** *virtual and office* | 20% coinsurance | $20 copay per visit and then 30% coinsurance after deductible is met | $30 copay per visit and then 40% coinsurance after deductible is met |
| **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 | 30% coinsurance after deductible is met | 40% coinsurance after deductible is met |
| Retail Health Clinic *for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.* | 20% coinsurance | $20 copay per visit and then 30% coinsurance after deductible is met | $30 copay per visit and then 40% coinsurance after deductible is met |
| Manipulation Therapy | 20% coinsurance | 30% coinsurance after deductible is met | 40% coinsurance after deductible is met |
| Acupuncture | Not covered | Not covered | Not covered |
| **Other Services in an Office** |  |  |  |
| Allergy Testing | 20% coinsurance | 30% coinsurance after deductible is met | 40% coinsurance after deductible is met |
| Prescription Drugs - *Dispensed in the office* | 20% coinsurance | 30% coinsurance after deductible is met | 40% coinsurance after deductible is met |
| Surgery | 20% coinsurance | 30% coinsurance after deductible is met | 40% coinsurance after deductible is met |
| **Preventive care / screenings / immunizations** | No charge | No charge | 40% coinsurance after deductible is met |
| **Preventive care for Chronic Conditions** *per IRS guidelines* | No charge | No charge | 40% coinsurance after deductible is met |
| **Diagnostic Services**  **Lab** |  |  |  |
| Office | 20% coinsurance | 30% coinsurance after deductible is met | 40% coinsurance after deductible is met |
| Freestanding Lab/Reference Lab | 20% coinsurance | 30% coinsurance after deductible is met | 40% coinsurance after deductible is met |
| Outpatient Hospital | 20% coinsurance | 30% coinsurance after deductible is met | 40% coinsurance after deductible is met |
| **X-Ray** |  |  |  |
| Office | 20% coinsurance | 30% coinsurance after deductible is met | 40% coinsurance after deductible is met |
| Freestanding Radiology Center | 20% coinsurance | 30% coinsurance after deductible is met | 40% coinsurance after deductible is met |
| Outpatient Hospital | 20% coinsurance | 30% coinsurance after deductible is met | 40% coinsurance after deductible is met |
| **Advanced Diagnostic Imaging** |  |  |  |
| Office | 20% coinsurance | 30% coinsurance after deductible is met | 40% coinsurance after deductible is met |
| Freestanding Radiology Center | 20% coinsurance | 30% coinsurance after deductible is met | 40% coinsurance after deductible is met |
| Outpatient Hospital | 20% coinsurance | 30% coinsurance after deductible is met | 40% coinsurance after deductible is met |
| **Emergency and Urgent Care** |  |  |  |
| **Urgent Care** | 20% coinsurance | $30 copay per visit and then 30% coinsurance after deductible is met | $45 copay per visit and then 40% coinsurance after deductible is met |
| **Emergency Room Facility Services**  *Copay waived if admitted.* | $250 copay per visit | $250 copay per visit deductible does not apply | Covered as In-Network |
| **Emergency Room Doctor and Other Services** | No charge | No charge | Covered as In-Network |
| **Emergency Ambulance** | 20% coinsurance | 20% coinsurance after deductible is met | Covered as In-Network |
| **Outpatient Mental Health and Substance Abuse Care at a Facility** |  |  |  |
| Facility Fees | 20% coinsurance | 30% coinsurance after deductible is met | 40% coinsurance after deductible is met |
| Doctor Services | 20% coinsurance | 30% coinsurance after deductible is met | 40% coinsurance after deductible is met |
| **Outpatient Surgery** |  |  |  |
| **Facility Fees** |  |  |  |
| Hospital | 20% coinsurance | 30% coinsurance after deductible is met | 40% coinsurance after deductible is met |
| Ambulatory Surgical Center | 20% coinsurance | 30% coinsurance after deductible is met | 40% coinsurance after deductible is met |
| **Doctor and Other Services** |  |  |  |
| Hospital | 20% coinsurance | 30% coinsurance after deductible is met | 40% coinsurance after deductible is met |
| Ambulatory Surgical Center | 20% coinsurance | 30% coinsurance after deductible is met | 40% coinsurance after deductible is met |
| **Hospital (Including Maternity, Mental / Behavioral Health, Substance Abuse)** |  |  |  |
| **Facility Fees** | 20% coinsurance | 30% coinsurance after deductible is met | 40% coinsurance after deductible is met |
| **Human Organ and Tissue Transplants**  *Coverage includes acquisition and transplant procedures, collection and storage.* | 20% coinsurance | 30% coinsurance after deductible is met | 40% coinsurance after deductible is met |
| **Doctor and other services** | 20% coinsurance | 30% coinsurance after deductible is met | 40% coinsurance after deductible is met |
| **Recovery & Rehabilitation** |  |  |  |
| **Home Health Care**  *Coverage is limited to 100 visits per benefit period.* | 20% coinsurance | 30% coinsurance after deductible is met | 40% coinsurance after deductible is met |
| **Rehabilitation services** |  |  |  |
| Office | 20% coinsurance | 30% coinsurance after deductible is met | 40% coinsurance after deductible is met |
| Outpatient Hospital | 20% coinsurance | 30% coinsurance after deductible is met | 40% coinsurance after deductible is met |
| **Habilitation services** |  |  |  |
| Office | 20% coinsurance | 30% coinsurance after deductible is met | 40% coinsurance after deductible is met |
| Outpatient Hospital | 20% coinsurance | 30% coinsurance after deductible is met | 40% coinsurance after deductible is met |
| **Chemo/Radiation Therapy** |  |  |  |
| Office | 20% coinsurance | 30% coinsurance after deductible is met | 40% coinsurance after deductible is met |
| Outpatient Hospital | 20% coinsurance | 30% coinsurance after deductible is met | 40% coinsurance after deductible is met |
| **Dialysis/Hemodialysis** |  |  |  |
| Office | 20% coinsurance | 30% coinsurance after deductible is met | 40% coinsurance after deductible is met |
| Outpatient Hospital | 20% coinsurance | 30% coinsurance after deductible is met | 40% coinsurance after deductible is met |
| **Cardiac rehabilitation**  *Coverage is limited to 36 visits per benefit period.* |  |  |  |
| Office | 20% coinsurance | 30% coinsurance after deductible is met | 40% coinsurance after deductible is met |
| Outpatient Hospital | 20% coinsurance | 30% coinsurance after deductible is met | 40% coinsurance after deductible is met |

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| **Skilled Nursing Care (facility)**  *Coverage is limited to 100 days per benefit period.* | 20% coinsurance | 30% coinsurance after deductible is met | 40% coinsurance after deductible is met |
| **Hospice** | 20% coinsurance | 30% coinsurance after deductible is met | 40% coinsurance after deductible is met |
| **Durable Medical Equipment** | 20% coinsurance | 30% coinsurance after deductible is met | 40% coinsurance after deductible is met |
| **Prosthetic Devices** | 20% coinsurance | 30% coinsurance after deductible is met | 40% coinsurance after deductible is met |

| **Covered Prescription Drug Benefits** | **Cost if you use Preferred Network Provider** | **Cost if you use an In-Network Provider** | **Cost if you use a Non-Network Provider** |
| --- | --- | --- | --- |
| **Pharmacy Deductible** | Not applicable | Not applicable | Not applicable |
| **Pharmacy Out of Pocket Limit** | Combined with medical 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***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** *Per 90 day supply (retail pharmacy).* | $5 copay per prescription (retail) and Not covered (home delivery) | $10 copay per prescription and 40% coinsurance (retail) and Not covered (home delivery) | $15 copay per prescription and 50% coinsurance (retail) and Not covered (home delivery) |
| **Tier 2 – Typically Preferred Brand** *Per 90 day supply (retail pharmacy).* | $15 copay per prescription (retail) and Not covered (home delivery) | $20 copay per prescription and 40% coinsurance (retail) and Not covered (home delivery) | $30 copay per prescription and 50% coinsurance (retail) and Not covered (home delivery) |
| **Tier 3 - Typically Non-Preferred Brand** *Per 90 day supply (retail pharmacy).* | $30 copay per prescription (retail) and Not covered (home delivery) | $30 copay per prescription and 40% coinsurance (retail) and Not covered (home delivery | $60 copay per prescription and 50% coinsurance (retail) and Not covered (home delivery |
| **Tier 4 - Typically Specialty (brand and generic)** | $75 copay per prescription (retail) and Not covered (home delivery) | *Not covered* (retail and home delivery) | Not covered (retail and 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**  L*imited 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** | 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.
* 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=OH_SH_PPO>L00273MD01.

*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.*

# 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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**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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| image18 | (844) 412-0752 | image19 |

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| image21 | image22 | (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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**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>](https://ocrportal.hhs.gov/ocr/portal/lobby.jsf). Complaint forms are available at [<http://www.hhs.gov/ocr/office/file/index.html>](http://www.hhs.gov/ocr/office/file/index.html).