




The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, <https://eoc.anthem.com/eocdps/SH08012021L00273M001>. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call (855) 333-5735 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$0/covered person for UTMC, UTP Providers . \$1,500/covered person for In- Network Providers . \$3,000/covered person for Out-of- Network Providers .	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay.
Are there services covered before you meet your deductible ?	Yes. Preventive care for In- Network Providers . Tier 1, Tier 2, Tier 3 for Prescription Drugs for In- Network and Out-of- Network Providers . Dental for In- Network and Out-of- Network Providers . Vision for In- Network Providers .	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan ?	\$7,900/student or \$15,800/family for UTMC, UTP Providers . \$7,900/student or \$15,800/family for In- Network Providers . \$7,900/student or \$15,800/family for Out-of- Network Providers .	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit ?	Premiums , balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .

Will you pay less if you use a <u>network provider</u>?	Yes, Blue Access Choice. See https://www.anthem.com/health-insurance/provider-directory/searchcriteria?planstate=OH&plantype=PPO&planname=Blue+Access+PPO or call (855) 333-5735 for a list of <u>network providers</u> .	You pay the least if you use a <u>provider</u> in <u>Preferred</u> . You pay more if you use a <u>provider</u> in <u>In-Network</u> . You will pay the most if you use an out-of- <u>network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an out-of- <u>network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u>?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		UTMC, UTP Provider (You will pay the least)	In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	30% <u>coinsurance</u>	\$10/visit then 40% <u>coinsurance</u>	\$15/visit then 50% <u>coinsurance</u>	Other <u>cost shares</u> may apply depending on services provided. <u>Copayment</u> waived for members under 19 years old.
	<u>Specialist</u> visit	30% <u>coinsurance</u>	\$20/visit then 40% <u>coinsurance</u>	\$30/visit then 50% <u>coinsurance</u>	-----none-----
	<u>Preventive care/screening/immunization</u>	No charge	No charge	50% <u>coinsurance</u>	Immunizations for children prior to their 6th birthday have No charge for In- <u>Network</u> and Out-of- <u>Network Providers</u> . You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	30% <u>coinsurance</u>	40% <u>coinsurance</u>	50% <u>coinsurance</u>	Costs may vary by site of service. Includes coverage for Breast Tomosynthesis.
	Imaging (CT/PET scans, MRIs)	30% <u>coinsurance</u>	40% <u>coinsurance</u>	50% <u>coinsurance</u>	Costs may vary by site of service.
If you need drugs to treat	Tier 1 - Typically Generic	\$5/prescription (retail)	\$10/prescription then 40% <u>coinsurance</u>	\$15/prescription then 50% <u>coinsurance</u>	*See Prescription Drug section

* For more information about limitations and exceptions, see plan or policy document at <https://eoc.anthem.com/eocdps/SH08012021L00273M001>.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		UTMC, UTP Provider (You will pay the least)	In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
your illness or condition More information about prescription drug coverage is available at http://www.anthem.com/pharmacyinformation/ National	Tier 2 - Typically Preferred / Brand	\$15/prescription (retail)	deductible does not apply (retail) \$20/prescription then 40% coinsurance deductible does not apply (retail)	deductible does not apply (retail) \$30/prescription then 50% coinsurance deductible does not apply (retail)	
	Tier 3 - Typically Non- Preferred / Specialty Drugs	\$30/prescription (retail)	\$30/prescription then 40% coinsurance deductible does not apply (retail)	\$60/prescription then 50% coinsurance deductible does not apply (retail)	
	Tier 4 - Typically Specialty (brand and generic)	\$75/prescription (retail)	Not covered	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	40% coinsurance	50% coinsurance	Costs may vary by site of service.
	Physician/surgeon fees	30% coinsurance	40% coinsurance	50% coinsurance	-----none-----
If you need immediate medical attention	Emergency room care	\$250/visit	\$250/visit	Covered as In- Network	Copay waived if admitted.
	Emergency medical transportation	30% coinsurance	30% coinsurance	Covered as In- Network	-----none-----
	Urgent care	30% coinsurance	\$30/visit then 40% coinsurance	\$45/visit then 50% coinsurance	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	40% coinsurance	50% coinsurance	-----none-----
	Physician/surgeon fees	30% coinsurance	40% coinsurance	50% coinsurance	-----none-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit 30% coinsurance Other Outpatient 30% coinsurance	Office Visit \$10/visit then 40% coinsurance Other Outpatient 40% coinsurance	Office Visit \$15/visit then 50% coinsurance Other Outpatient 50% coinsurance	Office Visit -----none----- Other Outpatient -----none-----
	Inpatient services	30% coinsurance	40% coinsurance	50% coinsurance	-----none-----
If you are pregnant	Office visits	30% coinsurance	40% coinsurance	50% coinsurance	In- Network preventive prenatal and postnatal services are covered at 100% Maternity care may
	Childbirth/delivery professional services	30% coinsurance	40% coinsurance	50% coinsurance	

* For more information about limitations and exceptions, see [plan](#) or policy document at <https://eoc.anthem.com/eocdps/SH08012021L00273M001>.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		UTMC, UTP Provider (You will pay the least)	In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
	Childbirth/delivery facility services	30% coinsurance	40% coinsurance	50% coinsurance	include tests and services described elsewhere in the SBC (i.e. ultrasound).
If you need help recovering or have other special health needs	Home health care	30% coinsurance	40% coinsurance	50% coinsurance	100 visits/benefit period for In-Network Providers and Out-of-Network Providers combined with private duty nursing.
	Rehabilitation services	30% coinsurance	40% coinsurance	50% coinsurance	*See Therapy Services section
	Habilitation services	30% coinsurance	40% coinsurance	50% coinsurance	
	Skilled nursing care	30% coinsurance	40% coinsurance	50% coinsurance	90 days limit/benefit period for In-Network Providers and Out-of-Network Providers combined.
	Durable medical equipment	30% coinsurance	40% coinsurance	50% coinsurance	*See Durable Medical Equipment Section
	Hospice services	30% coinsurance	40% coinsurance	50% coinsurance	-----none-----
If your child needs dental or eye care	Children's eye exam	Not covered	No charge	Reimbursed Up to \$30	*See Vision Services section
	Children's glasses	Not covered	No charge	Reimbursed Up to \$45	
	Children's dental check-up	Not covered	No charge	No charge	*See Dental Services section

Excluded Services & Other Covered Services:

Services Your [Plan](#) Generally Does NOT Cover (Check your policy or [plan](#) document for more information and a list of any other [excluded services](#).)

- | | | |
|--|---|---|
| <ul style="list-style-type: none"> • Acupuncture • Dental care (adult) • Glasses for a child • Routine foot care unless you have been diagnosed with diabetes. | <ul style="list-style-type: none"> • Bariatric surgery • Dental Check-up • Infertility treatment • Weight loss programs | <ul style="list-style-type: none"> • Cosmetic surgery • Eye exams for a child • Long-term care |
|--|---|---|

* For more information about limitations and exceptions, see [plan](#) or policy document at <https://eoc.anthem.com/eocdps/SH08012021L00273M001>.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- Chiropractic care
- Hearing aids 1 unit every 36 months.
- Most coverage provided outside the United States. See www.bcbsglobalcore.com
- Private-duty nursing 100 visits/benefit period combined with [home health care](#).
- Routine eye care (adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Ohio Department of Insurance, 50 W. Town Street, Third Floor - Suite 300, Columbus, Ohio 43215, (800) 686-1526, (614) 644-2673. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, 1-877-267-2323 x61565, www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact:

ATTN: [Grievances](#) and [Appeals](#), P.O. Box 105568, Atlanta GA 30348-5568

Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, 1-877-267-2323 x61565, www.cciio.cms.gov

Ohio Department of Insurance, 50 W. Town Street, Third Floor - Suite 300, Columbus, Ohio 43215, (800) 686-1526, (614) 644-2673

Does this plan provide Minimum Essential Coverage? Yes

[Minimum Essential Coverage](#) generally includes [plans](#), health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

————— *To see examples of how this plan might cover costs for a sample medical situation, see the next section.* —————

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- The [plan's](#) overall [deductible](#) \$0
- [Specialist coinsurance](#) 30%
- Hospital (facility) [coinsurance](#) 30%
- Other [coinsurance](#) 30%

This EXAMPLE event includes services like:

- [Specialist](#) office visits (*prenatal care*)
- Childbirth/Delivery Professional Services
- Childbirth/Delivery Facility Services
- [Diagnostic tests](#) (*ultrasounds and blood work*)
- [Specialist](#) visit (*anesthesia*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$10
Coinsurance	\$3,800
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$3,870

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$0
- [Specialist coinsurance](#) 30%
- Hospital (facility) [coinsurance](#) 30%
- Other [coinsurance](#) 30%

This EXAMPLE event includes services like:

- [Primary care physician](#) office visits (*including disease education*)
- [Diagnostic tests](#) (*blood work*)
- [Prescription drugs](#)
- [Durable medical equipment](#) (*glucose meter*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$600
Coinsurance	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$920

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$0
- [Specialist coinsurance](#) 30%
- Hospital (facility) [coinsurance](#) 30%
- Other [coinsurance](#) 30%

This EXAMPLE event includes services like:

- [Emergency room care](#) (*including medical supplies*)
- [Diagnostic test](#) (*x-ray*)
- [Durable medical equipment](#) (*crutches*)
- [Rehabilitation services](#) (*physical therapy*)

Total Example Cost	\$2,800
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$300
Coinsurance	\$600
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$900

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

Language Access Services:

(TTY/TDD: 711)

Albanian (Shqip): Nëse keni pyetje në lidhje me këtë dokument, keni të drejtë të merrni falas ndihmë dhe informacion në gjuhën tuaj. Për të kontaktuar me një përkthyes, telefononi (855) 333-5735

Amharic (አማርኛ):- ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በነጻ የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር (855) 333-5735 ይደውሉ።

Arabic (العربية): إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (855) 333-5735

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՝ (855) 333-5735:

Bassa (Bàsɔ̀ Wùdù): M̄ dyi dyi-diè-djè b̄é b̄édjé b̄á céè-djè nià ke dyí ní, ɔ̀ m̄ò ni dyí-b̄èdjèin-djè b̄é m̄ ké gbo-kpá-kpá kè b̄ǎ kpǎ djé m̄ bídí-wùdùùn b̄ó pídyi. B̄é m̄ ké wuɖu-ziiin-nyò djò gbo wùdù ke, djá (855) 333-5735.

Bengali (বাংলা): যদি এই নথিপত্রের বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য পাওয়ার ও তথ্য পাওয়ার অধিকার আপনার আছে। একজন দোভাষীর সাথে কথা বলার জন্য (855) 333-5735 -তে কল করুন।

Burmese (မြန်မာ): ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အချက်အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖုန်း (855) 333-5735 သို့ ခေါ်ဆိုပါ။

Chinese (中文): 如果您对本文件有任何疑问，您有权使用您的语言免费获得协助和资讯。如需与译员通话，请致电 (855) 333-5735。

Dinka (Dinka): Na nɔŋ thiëc nē ke de yā thorē, ke yin nɔŋ loŋ bē yi kuony ku wēr alēu bē gɛɛr yic yin ne thoŋ du ke cin wēu tāäuē ke piny. Te kōr yin ba jam wēnē ran ye thok geryic, ke yin cəl (855) 333-5735.

Dutch (Nederlands): Bij vragen over dit document hebt u recht op hulp en informatie in uw taal zonder bijkomende kosten. Als u een tolk wilt spreken, belt u (855) 333-5735.

Farsi (فارسی): در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه‌ای به زبان مادری‌تان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره (855) 333-5735 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 (855) 333-5735.

Language Access Services:

German (Deutsch): Wenn Sie Fragen zu diesem Dokument haben, haben Sie Anspruch auf kostenfreie Hilfe und Information in Ihrer Sprache. Um mit einem Dolmetscher zu sprechen, bitte wählen Sie (855) 333-5735.

Greek (Ελληνικά): Αν έχετε τυχόν απορίες σχετικά με το παρόν έγγραφο, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας δωρεάν. Για να μιλήσετε με κάποιον διερμηνέα, τηλεφωνήστε στο (855) 333-5735.

Gujarati (ગુજરાતી): જો આ દસ્તાવેજ અંગે આપને કોઈપણ પ્રશ્નો હોય તો, કોઈપણ ખર્ચ વગર આપની ભાષામાં મદદ અને માહિતી મેળવવાનો તમને અધિકાર છે. દુભાષિયા સાથે વાત કરવા માટે, કોલ કરો (855) 333-5735.

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 (855) 333-5735.

Hindi (हिंदी): अगर आपके पास इस दस्तावेज़ के बारे में कोई प्रश्न हैं, तो आपको निःशुल्क अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है।
दुभाषिये से बात करने के लिए, कॉल करें (855) 333-5735 ।

Hmong (White Hmong): Yog tias koj muaj lus nug dab tsi ntsig txog daim ntawv no, koj muaj cai tau txais kev pab thiab lus qhia hais ua koj hom lus yam tsim xam tus nqi. Txhawm rau tham nrog tus neeg txhais lus, hu xov tooj rau (855) 333-5735.

Igbo (Igbo): Ọ bụr ụ na ị nwere ajuju ọ bụla gbasara akwụkwọ a, ị nwere ikike inweta enyemaka na ozi n'asụsụ gị na akwụghị ugwo ọ bụla. Ka gị na ọkọwa okwu kwuo okwu, kpọọ (855) 333-5735.

Ilokano (Ilokano): Nu addaan ka iti aniaman a saludsod panggep iti daytoy a dokumento, adda karbengam a makaala ti tulong ken impormasyon babaen ti lenguahem nga awan ti bayad na. Tapno makatungtong ti maysa nga tagipatarus, awagan ti (855) 333-5735.

Indonesian (Bahasa Indonesia): Jika Anda memiliki pertanyaan mengenai dokumen ini, Anda memiliki hak untuk mendapatkan bantuan dan informasi dalam bahasa Anda tanpa biaya. Untuk berbicara dengan interpreter kami, hubungi (855) 333-5735.

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 (855) 333-5735

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、(855) 333-5735 にお電話ください。

Language Access Services:

Khmer (ខ្មែរ): បើអ្នកមានសំណួរផ្សេងទៀតអំពីឯកសារនេះ អ្នកមានសិទ្ធិទទួលជំនួយនិងព័ត៌មានជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។
ដើម្បីជ្រកជាមួយអ្នកបកប្រែ សូមហៅ (855) 333-5735 ។

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