Your summary of benefits

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 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

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
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

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
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

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
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

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 *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
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_PPOL00273MD01.

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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Curious to know what all this says? We would be too. Here's the English version:
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(TTY/TDD: 711)

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