Your summary of benefits

Anthem® Blue Cross and Blue Shield

Your School: University of Toledo SHIP

Your Plan: Student Advantage Health Insurance Plan

Your Network: Blue Access

Effective Date: 8/11/2025

Visits with Virtual Care-Only Providers	Cost through our mobile app and website
Primary Care, and medical services for urgent/acute care	$10 copay per visit and then 30% coinsurance after deductible is met
Mental Health & Substance Use Disorder Services	$10 copay per visit and then 30% coinsurance after deductible is met
Specialist care	$20 copay per visit and then 30% 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 an Out-of-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 (excluding Out-of-Network Human Organ and Tissue Transplant (HOTT) Services). 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.			
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 Use Disorder 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

Covered Medical Benefits	Cost if you use a In-Network Provider	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
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
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

Covered Medical Benefits	Cost if you use a In-Network Provider	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
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 *Your copay will be 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 Use Disorder 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

Covered Medical Benefits	Cost if you use a In-Network Provider	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)			
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

Covered Medical Benefits	Cost if you use a In-Network Provider	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
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 an Out-of-Network Provider
Pharmacy Deductible	Not applicable	Not applicable	Not applicable
Pharmacy Out-of-Pocket Limit	Combined with In-Network medical out-of-pocket limit	Combined with In-Network medical out-of-pocket limit	Combined with Out-of-Network medical out-of-pocket limit
Prescription Drug Coverage **Network*: Base Network*** **Drug List: *Traditional Open***			
Day Supply Limits: **Retail 90 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 *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 and In-Network Retail Pharmacies.*	$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 *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 and In-Network Retail Pharmacies.*	$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)

Covered Prescription Drug Benefits	Cost if you use Preferred Network Provider	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Tier 3 - Typically Non-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 and In-Network *Retail Pharmacies.*	$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 an Out-of-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 an Out-of-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

Covered Dental Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
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 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.
- 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 an Out-of-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_PPOL00273.

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.

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 fòma nan dokiman sa a.

Arabic
لك الحق في الحصول على هذه المعلومات والحصول على المساعدة بلغتك مجانًا. فقط اتصل برقم خدمات الأعضاء الموجود على بطاقة هويتك. هل تعاني من ضعف البصر؟ يمكنك أيضًا 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: Պարզապես զանգահարեք ձեր ID քարտի վրա գտնվող Անդամների սպասարկման համարին: Տեսողության խանգարում ունեցո՞ղ 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