

# Your summary of benefits



Anthem® Blue Cross and Blue Shield

Your Plan: XAVIER UNIVERISTY: Anthem Non-Link Blue Connection

Your Network: Blue Connection

Effective Date 1/1/2022

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<b>Overall Deductible</b>	\$750 person / \$1,500 family	Not covered
<b>Out-of-Pocket Limit</b>	\$2,000 person / \$4,000 family	Not covered
<p>The family deductible and out-of-pocket maximum are embedded, meaning the cost shares of one family member will be applied to both per person deductible and per person out-of-pocket maximum; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket maximum. No one member will pay more than the per person deductible or per person out-of-pocket maximum.</p> <p>All medical and prescription drug deductibles, copayments and coinsurance apply toward the out-of-pocket maximum (excluding Non-Network Human Organ and Tissue Transplant (HOTT) Services).</p>		
<b>Preventive Care / Screening / Immunization</b>	No charge	Not covered
<b>Preventive Care for Chronic Conditions</b> <i>per IRS guidelines</i>	No charge	Not covered
<b><u>Virtual Care (Telemedicine / Telehealth Visits)</u></b>		
<b>Virtual Visits - Online visits with Doctors who also provide services in person</b>		
Primary Care (PCP)	\$20 copay per visit medical deductible does not apply	Not covered
Mental Health and Substance Abuse care	\$20 copay per visit medical deductible does not apply	Not covered
Specialist	\$40 copay per visit medical deductible does not apply	Not covered

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><b>Virtual Visits from Online Provider LiveHealth Online</b> via <a href="http://www.livehealthonline.com">www.livehealthonline.com</a>; our mobile app, website or Anthem-enabled device</p> <p>Primary Care (PCP) and Mental Health and Substance Abuse</p> <p>Specialist Care</p>	<p>\$10 copay per visit medical deductible does not apply</p> <p>\$20 copay per visit medical deductible does not apply</p>	<p>Not covered</p> <p>Not covered</p>
<p><b><u>Visits in an Office</u></b></p> <p>Primary Care (PCP)</p> <p>Specialist Care</p>	<p>\$20 copay per visit medical deductible does not apply</p> <p>\$40 copay per visit medical deductible does not apply</p>	<p>Not covered</p> <p>Not covered</p>
<p><b><u>Other Practitioner Visits</u></b></p> <p>Routine Maternity Care (Prenatal and Postnatal)</p> <p>Retail Health Clinic</p> <p>Manipulation Therapy <i>Coverage is limited to 12 visits per benefit period.</i></p> <p>Acupuncture</p>	<p>20% coinsurance after medical deductible is met</p> <p>\$20 copay per visit medical deductible does not apply</p> <p>\$40 copay per visit medical deductible does not apply</p> <p>\$40 copay per visit medical deductible does not apply</p>	<p>Not covered</p> <p>Not covered</p> <p>Not covered</p> <p>Not covered</p>
<p><b><u>Other Services in an Office</u></b></p> <p>Allergy Testing</p> <p>Chemo/Radiation Therapy</p>	<p>20% coinsurance after medical deductible is met</p> <p>\$40 copay per visit medical deductible does not apply<sup>†</sup></p>	<p>Not covered</p> <p>Not covered</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><b>Dialysis/Hemodialysis</b></p> <p><b>Prescription Drugs</b> <i>Dispensed in the office</i></p> <p><b>Surgery</b></p>	<p>No charge</p> <p>20% coinsurance after medical deductible is met</p> <p>\$40 copay per visit medical deductible does not apply<sup>‡</sup></p>	<p>Not covered</p> <p>Not covered</p> <p>Not covered</p>
<p><b><u>Diagnostic Services</u></b></p> <p><b>Lab</b></p> <p>Office</p> <p>Freestanding Lab/Reference Lab</p> <p>Outpatient Hospital</p>	<p>No charge</p> <p>No charge</p> <p>20% coinsurance after medical deductible is met</p>	<p>Not covered</p> <p>Not covered</p> <p>Not covered</p>
<p><b>X-Ray</b></p> <p>Office</p> <p>Freestanding Radiology Center</p> <p>Outpatient Hospital</p>	<p>No charge</p> <p>20% coinsurance after medical deductible is met</p> <p>20% coinsurance after medical deductible is met</p>	<p>Not covered</p> <p>Not covered</p> <p>Not covered</p>
<p><b>Advanced Diagnostic Imaging</b> <i>for example: MRI, PET and CAT scans</i></p> <p>Office</p> <p>Freestanding Radiology Center</p> <p>Outpatient Hospital</p>	<p>20% coinsurance after medical deductible is met</p> <p>20% coinsurance after medical deductible is met</p> <p>20% coinsurance after medical deductible is met</p>	<p>Not covered</p> <p>Not covered</p> <p>Not covered</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><b><u>Emergency and Urgent Care</u></b></p> <p><b>Urgent Care</b></p> <p><b>Emergency Room Facility Services</b> <i>Copay waived if admitted.</i></p> <p><b>Emergency Room Doctor and Other Services</b></p> <p><b>Ambulance</b></p>	<p>\$35 copay per visit medical deductible does not apply</p> <p>\$150 copay per visit medical deductible does not apply</p> <p>No charge</p> <p>20% coinsurance after medical deductible is met</p>	<p>Covered as In-Network</p> <p>Covered as In-Network</p> <p>Covered as In-Network</p> <p>Covered as In-Network</p>
<p><b><u>Outpatient Mental Health and Substance Abuse</u></b></p> <p><b>Doctor Office Visit</b></p> <p><b>Facility Visit</b></p> <p>Facility Fees</p> <p>Doctor Services</p>	<p>\$20 copay per visit medical deductible does not apply</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>Not covered</p> <p>Not covered</p> <p>Not covered</p>
<p><b><u>Outpatient Surgery</u></b></p> <p><b>Facility Fees</b></p> <p>Hospital</p> <p>Freestanding Surgical Center</p> <p><b>Doctor and Other Services</b></p> <p>Hospital</p>	<p>20% coinsurance after medical deductible is met</p> <p>20% coinsurance after medical deductible is met</p> <p>20% coinsurance after medical deductible is met</p>	<p>Not covered</p> <p>Not covered</p> <p>Not covered</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Freestanding Surgical Center	20% coinsurance after medical deductible is met	Not covered
<p><b><u>Hospital (Including Maternity, Mental Health and Substance Abuse)</u></b></p> <p><b>Facility Fees</b></p> <p><b>Human Organ and Tissue Transplants</b> <i>Kidney and Cornea are treated the same as any other illness and subject to the medical benefits.</i></p> <p><b>Doctor and other services</b></p>	<p>20% coinsurance after medical deductible is met</p> <p>No Charge</p> <p>20% coinsurance after medical deductible is met</p>	<p>Not covered</p> <p>Not covered</p> <p>Not covered</p>
<p><b><u>Recovery &amp; Rehabilitation</u></b></p> <p><b>Home Health Care</b> <i>Coverage is limited to 90 visits per benefit period. Limits are combined for all home health services.</i></p>	20% coinsurance after medical deductible is met	Not covered
<p><b>Rehabilitation services</b> <i>Coverage for Occupational Therapy is limited to 60 visits per benefit period, Physical Therapy is limited to 60 visits per benefit period and Speech Therapy is limited to 60 visits per benefit period. Limit is combined for rehabilitative and habilitative services. Benefits for Autism Spectrum Disorders for members up to age 14 includes an additional 20 visits for speech and language therapies, 20 visits for occupational therapy, and a limit of 20 hours per week for Clinical Therapeutic Intervention services.</i></p> <p>Office</p> <p>Outpatient Hospital</p>	<p>\$40 copay per visit medical deductible does not apply</p> <p>20% coinsurance after medical deductible is met</p>	<p>Not covered</p> <p>Not covered</p>
<p><b>Cardiac rehabilitation</b></p> <p>Office</p>	\$40 copay per visit medical deductible does not apply	Not covered

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Outpatient Hospital	20% coinsurance after medical deductible is met	Not covered
<b>Skilled Nursing Care (facility)</b> <i>Coverage for Skilled Nursing is limited to 90 days and Inpatient Rehabilitation facility (includes services in an outpatient day rehabilitation program) is limited to 60 days per benefit period.</i>	20% coinsurance after medical deductible is met	Not covered
<b>Hospice</b>	20% coinsurance after medical deductible is met	Not covered
<b>Durable Medical Equipment</b>	20% coinsurance after medical deductible is met	Not covered
<b>Prosthetic Devices</b> <i>Coverage for wigs is limited to 1 item after cancer treatment per benefit period.</i>	20% coinsurance after medical deductible is met	Not covered
Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
<b>Pharmacy Deductible</b>	Not applicable	Not covered
<b>Pharmacy Out-of-Pocket Limit</b>	Not applicable	Not covered
<b>Prescription Drug Coverage</b> <i>Cost shares for drugs included on the Essential drug list appear below. Drugs not included on the Essential drug list will not be covered. Your plan uses the Advantage Network.</i>		
<b>Home Delivery Pharmacy</b> <i>Maintenance medication are available through IngenioRx Home Delivery Pharmacy. You will need to call us on the number on your ID card to sign up when you first use the service.</i>		
<b>Tier 1 - Typically Generic</b> <i>Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).</i>	\$15 copay per prescription, deductible does not apply (retail) and \$30 copay per prescription, deductible does not apply (home delivery)	Not covered (retail and home delivery)

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
<b>Tier 2 – Typically Preferred Brand</b> <i>Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).</i>	\$40 copay per prescription, deductible does not apply (retail) and \$100 copay per prescription, deductible does not apply (home delivery)	Not covered (retail and home delivery)
<b>Tier 3 - Typically Non-Preferred Brand</b> <i>Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).</i>	\$60 copay per prescription, deductible does not apply (retail) and \$150 copay per prescription, deductible does not apply (home delivery)	Not covered (retail and home delivery)
<b>Tier 4 - Typically Specialty (brand and generic)</b> <i>Per 30 day supply (specialty pharmacy).</i>	25% coinsurance up to \$250 per prescription, deductible does not apply (retail and home delivery)	Not covered (retail and home delivery)

**Notes:**

- Your plan requires the selection of a Primary Care Physician (PCP). Choosing a PCP is an important decision. Call us at the number on your ID card and we'll help you pick a doctor.
- Dependent age: to end of the month in which the child attains age 26.
- No charge means no deductible/copayment/coinsurance up to the maximum allowable amount. 0% means no coinsurance up to the maximum allowable amount.
- The Primary Care Physician and Specialist office visit copay applies to both office and facility based office visits for evaluation and management services only.
- Costs may vary by the site of service. Other cost shares may apply depending on services provided. Check your Certificate of Coverage for details.
- If you have receive Urgent Care at an Outpatient Facility (e.g., Hospital or Ambulatory Surgical Facility), benefits for Covered Services will be paid under "Outpatient Facility Services" which is generally coinsurance or coinsurance after your deductible is met.
- ‡ Your cost share will be reduced when services are provided in a PCP's office.
- Benefit Period = Calendar Year.

*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 Certificate of Insurance or Evidence of Coverage (EOC), the Certificate of Insurance or Evidence of Coverage (EOC), will prevail.*

## Your Plan: Anthem NonLink Blue Connection HMO

### Your Network: Blue Connection

This summary of benefits is intended to be a brief outline of coverage. The entire provisions of benefits and exclusions are contained in the Group Contract, Certificate, and Schedule of Benefits. In the event of a conflict between the Group Contract and this description, the terms of the Group Contract will prevail.

By signing this Summary of Benefits, I agree to the benefits for the product selected as of the effective date indicated.

Authorized group signature (if applicable)	Date
Underwriting signature (if applicable)	Date

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Questions: (833) 639-1634 or visit us at [www.anthem.com](http://www.anthem.com)

OH/LG/Anthem NonLink Blue Connection HMO /617N/01-01-2022



## 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 (833) 639-1634

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 (833) 639-1634.

**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՝ (833) 639-1634:

**Chinese(中文):** 如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電(833) 639-1634。

**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 (833) 639-1634 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 (833) 639-1634.

**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 (833) 639-1634.

**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 (833) 639-1634.

**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、(833) 639-1634 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(833) 639-1634로 문의하십시오.

## Language Access Services:

**Navajo (Diné):** Dii naaltsoos biká'ígíí lahgo bina'idiikidgo ná bohónéedzǎ dóó bee ahóót'i' t'áá ni nizaad k'ehǫ́ bee nił hodoonih t'áadoo bááh ilínígóó. Ata' halne'ígíí la' bich'í' hadeesdzih ninizingo kojí' hodíílnih (833) 639-1634.

**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: (833) 639-1634.

**Punjabi (ਪੰਜਾਬੀ):** ਜੇ ਤੁਹਾਡੇ ਇਸ ਦਸਤਾਵੇਜ਼ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹੁੰਦੇ ਹਨ ਤਾਂ ਤੁਹਾਡੇ ਕੋਲ ਮੁਫਤ ਵਿੱਚ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੁੰਦਾ ਹੈ। ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, (833) 639-1634 ਤੇ ਕਾਲ ਕਰੋ।

**Russian (Русский):** Если у вас есть какие-либо вопросы в отношении данного документа, вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы связаться с устным переводчиком, позвоните по тел. (833) 639-1634.

**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 (833) 639-1634.

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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>.