Your summary of benefits

Anthem® Blue Cross and Blue Shield

Xavier University

Your Plan: Anthem Blue Access Options PPO (3-Tier)

Your Network: Blue Access OH I

Effective Date 1/1/2024

Visits with Virtual Care-Only Providers	Cost through our mobile app and website
Primary Care, and medical services for urgent/acute care	**K Health**: No charge medical deductible does not apply **LiveHealth Online:** $20 copay per visit medical deductible does not apply
Mental Health & Substance Use Disorder Services	$20 copay per visit medical deductible does not apply
Specialist care	$40 copay per visit medical deductible does not apply

Covered Medical Benefits	Cost if you use a Preferred Network Provider	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	$750 person / $1,500 family	$1,250 person / $2,500 family	$2,500 person / $5,000 family
Overall Out-of-Pocket Limit	$2,000 person / $4,000 family	$2,000 person / $4,000 family	$5,000 person / $10,000 family
The family deductible and out-of-pocket limit are embedded, meaning the cost shares of one family member will be applied to the per person deductible and per person out-of-pocket limit; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket limit. No one member will pay more than the per person deductible or per person out-of-pocket limit. All medical and prescription drug deductibles, copayments and coinsurance apply to the out-of-pocket limit (excluding Non-Network Human Organ and Tissue Transplant (HOTT), Cellular and Gene Therapy services). In-Network and Non-Network deductibles and out-of-pocket limit amounts are separate and do not accumulate toward each other. The deductibles for Preferred Network and In-Network cross apply. Satisfying one helps satisfy the other. The out-of-pocket limits for Preferred Network and In-Network cross apply as well.			
Doctor Visits (virtual and office) *You are encouraged to select a Primary Care Physician (PCP).*			
Primary Care (PCP) and Mental Health and Substance Use Disorder Services *virtual and office*	$20 copay per visit medical deductible does not apply	$20 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use a Preferred Network Provider	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Specialist Care *virtual and office*	$40 copay per visit medical deductible does not apply	$40 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Other Practitioner Visits			
Routine Maternity Care (Prenatal and Postnatal)	10% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Retail Health Clinic *for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.*	$20 copay per visit medical deductible does not apply	$40 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Manipulation Therapy *Coverage is limited to 12 visits per benefit period.*	$40 copay per visit medical deductible does not apply	$40 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Other Services in an Office			
Allergy Testing *When Allergy injections are billed separately by network providers, the member is responsible for a $10 copay. When billed as part of an office visit, there is no additional cost to the member for the injection.*	10% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Prescription Drugs *Dispensed in the office*	10% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Surgery	$40 copay per visit medical deductible does not apply‡	$40 copay per visit medical deductible does not apply‡	40% coinsurance after medical deductible is met
Preventive care / screenings / immunizations	No charge	No charge	40% coinsurance after medical deductible is met
Preventive Care for Chronic Conditions *per IRS guidelines*	No charge	No charge	40% coinsurance after medical deductible is met
Diagnostic Services			
Lab			
Office	No charge	No charge	40% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use a Preferred Network Provider	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Outpatient Hospital	10% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
X-Ray			
Office	No charge	No charge	40% coinsurance after medical deductible is met
Outpatient Hospital	10% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Advanced Diagnostic Imaging *for example: MRI, PET and CAT scans*			
Office	10% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Outpatient Hospital	10% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Emergency and Urgent Care			
Urgent Care *includes doctor services. Additional charges may apply depending on the care provided.*	$35 copay per visit medical deductible does not apply	$35 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Emergency Room Facility Services *Your copay will be waived if admitted.*	$150 copay per visit medical deductible does not apply	$150 copay per visit medical deductible does not apply	Covered as In-Network
Emergency Room Doctor and Other Services	No charge	No charge	Covered as In-Network
Ambulance *Authorized Non-Network non-emergency ambulance services are limited to an Anthem maximum payment of $50,000 per trip.*	10% coinsurance after medical deductible is met	10% coinsurance after medical deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Use Disorder Services at a Facility			
Facility Fees	10% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use a Preferred Network Provider	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Doctor Services	10% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Outpatient Surgery **Facility Fees** Hospital **Physician and other services** *including surgeon fees* Hospital	10% coinsurance after medical deductible is met 10% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met 20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met 40% coinsurance after medical deductible is met
Hospital (Including Maternity, Mental Health and Substance Use Disorder Services) **Facility Fees** **Human Organ and Tissue Transplants** *Cornea transplants are treated the same as any other illness and subject to the medical benefits.* **Physician and other services** *including surgeon fees*	10% coinsurance after medical deductible is met 10% coinsurance after medical deductible is met 10% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met 20% coinsurance after medical deductible is met 20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met 40% coinsurance after medical deductible is met 40% coinsurance after medical deductible is met
Home Health Care *Coverage is limited to 90 visits per benefit period. Limits are combined for all home health services.*	10% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Rehabilitation and Habilitation services *including physical, occupational and speech therapies.* *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.* Office	$40 copay per visit medical deductible does not apply	$40 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use a Preferred Network Provider	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Outpatient Hospital	10% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Pulmonary rehabilitation *Coverage is unlimited visits per benefit period.*			
Office	$40 copay per visit medical deductible does not apply	$40 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Outpatient Hospital	10% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Cardiac rehabilitation *Coverage is unlimited per benefit period.*			
Office	$40 copay per visit medical deductible does not apply	$40 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Outpatient Hospital	10% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Dialysis/Hemodialysis			
Office	$40 copay per visit medical deductible does not apply	$40 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Outpatient Hospital	10% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Chemo/Radiation Therapy			
Office	$40 copay per visit medical deductible does not apply‡	$40 copay per visit medical deductible does not apply‡	40% coinsurance after medical deductible is met
Outpatient Hospital	10% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Skilled Nursing Care (facility)	10% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use a Preferred Network Provider	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Coverage for Skilled Nursing and Inpatient Rehabilitation facility (includes services in an outpatient day rehabilitation program) is limited to 90 days combined per benefit period			
Inpatient Hospice	10% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Durable Medical Equipment	10% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Prosthetic Devices *Coverage for wigs is limited to 1 item after cancer treatment per benefit period.*	10% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met

Covered Prescription Drug Benefits	Cost if you use a Preferred Network Pharmacy	Cost if you use a Non-Network Pharmacy
Pharmacy Deductible	Not applicable	Not applicable
Pharmacy Out-of-Pocket Limit	Combined with In-Network medical out-of-pocket limit	Combined with Non-Network medical out-of-pocket limit
Prescription Drug Coverage **Network: Advantage Network** **Drug List: *Essential*** *Drugs not included on the Essential drug list will not be covered.*		
Day Supply Limits: **Retail Pharmacy** *30 day supply (cost shares noted below)* **Retail 90 Pharmacy** *90 day supply (3 times the 30 day supply cost share(s) charged at Preferred Network and In-Network Retail Pharmacies noted below applies).* **Home Delivery Pharmacy** *90 day supply (maximum cost shares noted below) Maintenance medications are available through CarelonRx Mail. You will need to call us on the number on your ID card to sign up when you first use the service.* **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. Drug cost share assistance programs may be available for certain specialty drugs.*		
Tier 1 - Typically Generic	$15 copay per prescription (retail) and $30 copay per prescription (home delivery)	50% coinsurance (retail) and Not covered (home delivery)
Tier 2 – Typically Preferred Brand	$40 copay per prescription (retail) and $100 copay per prescription (home delivery)	50% coinsurance (retail) and Not covered (home delivery)

Covered Prescription Drug Benefits	Cost if you use a Preferred Network Pharmacy	Cost if you use a Non-Network Pharmacy
Tier 3 - Typically Non-Preferred Brand	$60 copay per prescription (retail) and $150 copay per prescription (home delivery)	50% coinsurance (retail) and Not covered (home delivery)
Tier 4 - Typically Specialty (brand and generic)	25% coinsurance up to $250 per prescription (retail and home delivery)	50% coinsurance (retail) and Not covered (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 exam (up to age 19) *Limited to 1 exam per benefit period.*	No charge	$0 copayment up to plan's Maximum Allowed Amount
Adult Vision exam (age 19 and older) *Limited to 1 exam per benefit period.*	No charge	Reimbursed Up to $42

Notes:

- Dependent Age Limit: to the end of the month in which the child attains age 26.
- 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.
- Network Deductibles Preferred and In-Network commingle towards each other.
- 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.
- 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.
- 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.
- ‡ You will pay the PCP's office visit copay when services are provided in their office.
- If you have received 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.
- Ohio's House Bill 388 and the Federal No Surprises Act establish patient protections including from Out-of-Network Providers' surprise bills ("balance billing") for Emergency Care and other specified items or services. We will comply with these new state and federal requirements including how we process claims from certain Out-of-Network Providers.
- The representations of benefits in this document are subject to Ohio Department of Insurance (ODI) approval and are subject to change.
- 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 Evidence of Coverage (EOC), the Evidence of Coverage (EOC), will prevail.

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

Your Plan: Anthem Blue Access Options PPO (3-Tier) Option 4 with Rx Option T4

Your Network: Blue Access OH I

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

Language Access Services:

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 (فارسي): 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.

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Navajo (Diné): Díí naaltsoos biká'ígíí łahgo bina'idiłkidgo ná bohónéedzą́ dóó bee ahóót'i' t'áá ni nizaad k'ehjí bee nił hodoonih t'áadoo bą́ą́h ílínígóó. Ata' halne'ígíí łą' bich'į' hadeesdzih ninízingo kojį' hodíilnih (833) 639-1634.

Language Access Services:

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.

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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.

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Tagalog (Tagalog): Kung mayroon kang anumang katanungan tungkol sa dokumentong ito, may karapatan kang humingi ng tulong at impormasyon sa iyong wika nang walang bayad. Makipag-usap sa isang tagapagpaliwanag, tawagan ang (833) 639-1634.

Vietnamese (Tiếng Việt): Nếu quý vị có bất kỳ thắc mắc nào về tài liệu này, quý vị có quyền nhận sự trợ giúp và thông tin bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Để trao đổi với một thông dịch viên, hãy gọi (833) 639-1634.

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.