Your summary of benefits

Anthem® Blue Cross and Blue Shield

Your Plan: XAVIER UNIVERSITY:Anthem NonLink Blue Connection HMO

Your Network: Blue Connection

Effective: 1/1/2023

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	$750 person / $1,500 family	Not covered
Overall Out-of-Pocket Limit	$2,000 person / $4,000 family	Not covered
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 toward the out-of-pocket limit(s) (excluding Non-Network Human Organ and Tissue Transplant (HOTT) Services).		
Doctor Visits (virtual and office) *Your plan requires the selection of a Primary Care Physician (PCP).*		
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 medical deductible does not apply.*		
Primary Care (PCP) *virtual and office*	$20 copay per visit medical deductible does not apply	Not covered
Mental Health and Substance Abuse Care *virtual and office*	$20 copay per visit medical deductible does not apply	Not covered
Specialist Care *virtual and office*	$40 copay per visit medical deductible does not apply	Not covered
Other Practitioner Visits		
Routine Maternity Care (Prenatal and Postnatal)	20% coinsurance after medical deductible is met	Not covered

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
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	Not covered
Manipulation Therapy *Coverage is limited to 12 visits per benefit period.*	$40 copay per visit medical deductible does not apply	Not covered
Acupuncture	$40 copay per visit medical deductible does not apply	Not covered
Other Services in an Office		
Allergy Testing *When Allergy injections are billed separately by network providers, the member is responsible for a $5 copay. When billed as part of an office visit, there is no additional cost to the member for the injection.*	20% coinsurance medical deductible does not apply	Not covered
Prescription Drugs *Dispensed in the office*	20% coinsurance after medical deductible is met	Not covered
Surgery	$40 copay per visit medical deductible does not apply‡	Not covered
Preventive care / screenings / immunizations	No charge	Not covered
Preventive Care for Chronic Conditions *per IRS guidelines*	No charge	Not covered
Diagnostic Services **Lab**		
Office	No charge	Not covered
Freestanding Lab/Reference Lab	No charge	Not covered
Outpatient Hospital	20% coinsurance after medical deductible is met	Not covered
X-Ray		
Office	No charge	Not covered
Freestanding Radiology Center	20% coinsurance after medical deductible is met	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
Advanced Diagnostic Imaging *for example: MRI, PET and CAT scans*		
Office	20% coinsurance after medical deductible is met	Not covered
Freestanding Radiology Center	20% coinsurance after medical deductible is met	Not covered
Outpatient Hospital	20% coinsurance after medical deductible is met	Not covered
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	Covered as In-Network
Emergency Room Facility Services *Copay waived if admitted.*	$150 copay per visit medical deductible does not apply	Covered as In-Network
Emergency Room Doctor and Other Services	No charge	Covered as In-Network
Ambulance	20% coinsurance after medical deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Abuse Care at a Facility		
Facility Fees	20% coinsurance after medical deductible is met	Not covered
Doctor Services	20% coinsurance after medical deductible is met	Not covered
Outpatient Surgery		
Facility Fees		
Hospital	20% coinsurance after medical deductible is met	Not covered

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Ambulatory Surgical Center	20% coinsurance after medical deductible is met	Not covered
Doctor and Other Services		
Hospital	20% coinsurance after medical deductible is met	Not covered
Ambulatory Surgical Center	20% coinsurance after medical deductible is met	Not covered
Hospital (Including Maternity, Mental Health and Substance Abuse)		
Facility Fees	20% coinsurance after medical deductible is met	Not covered
Human Organ and Tissue Transplants *Cornea transplants are treated the same as any other illness and subject to the medical benefits.*	No charge	Not covered
Physician and other services *including surgeon fees*	20% coinsurance after medical deductible is met	Not covered
Home Health Care *Coverage is limited to 90 visits per benefit period.* *Private duty nursing limited to 82 visits per benefit period.*	20% coinsurance after medical deductible is met	Not covered
Rehabilitation and Habilitation services *including physical, occupational and speech therapies.* *Coverage for Occupational Therapy, Physical Therapy and Speech Therapy is limited to 60 combined visits per benefit period. Limit is combined for rehabilitative and habilitative services.*		
Office	$40 copay per visit medical deductible does not apply	Not covered
Outpatient Hospital	20% coinsurance after medical deductible is met	Not covered
Pulmonary rehabilitation *Coverage is unlimited visits per benefit period.*		

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Office	$40 copay per visit medical deductible does not apply	Not covered
Outpatient Hospital	20% coinsurance after medical deductible is met	Not covered
Cardiac rehabilitation *Coverage is unlimited visits per benefit period.*		
Office	$40 copay per visit medical deductible does not apply	Not covered
Outpatient Hospital	20% coinsurance after medical deductible is met	Not covered
Dialysis/Hemodialysis		
Office	No charge	Not covered
Outpatient Hospital	20% coinsurance after medical deductible is met	Not covered
Chemo/Radiation Therapy		
Office	$40 copay per visit medical deductible does not apply‡	Not covered
Outpatient Hospital	20% coinsurance after medical deductible is met	Not covered
Skilled Nursing Care (facility) *Coverage for Skilled Nursing is limited to 90 days per benefit period. Inpatient Rehabilitation facility (includes services in an outpatient day rehabilitation program) is limited to 60 days combined per benefit period.*	20% coinsurance after medical deductible is met	Not covered
Inpatient Hospice	20% coinsurance after medical deductible is met	Not covered

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Durable Medical Equipment	20% coinsurance after medical deductible is met	Not covered
Prosthetic Devices *Coverage for wigs is limited to 1 item after cancer treatment per benefit period.*	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
Pharmacy Deductible	Not applicable	Not covered
Pharmacy Out-of-Pocket Limit	Combined with In-Network medical out-of-pocket limit	Not covered
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 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 (IngenioRx will become CarelonRx on January 1, 2023). 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.*		
Tier 1 - Typically Generic	$15 copay per prescription (retail) and $30 copay per prescription (home delivery)	Not covered (retail and home delivery)
Tier 2 – Typically Preferred Brand	$40 copay per prescription (retail) and $100 copay per prescription (home delivery)	Not covered (retail and home delivery)
Tier 3 - Typically Non-Preferred Brand	$60 copay per prescription (retail) and $150 copay per	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
	prescription (home delivery)	
Tier 4 - Typically Specialty (brand and generic)	25% coinsurance up to $250 per prescription (retail and home delivery)	Not covered (retail and home delivery)

Notes:

- Benefit Period: Calendar Year
- 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.
- ‡ Your cost share will be reduced when services are provided in a PCP's office.
- 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.
- Specialty drug Accumulator Program

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 $600/$10/$40/$4000 Rx Tiered $0/$10/$60/$125/$400
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

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

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(TTY/TDD: 711)

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Language Access Services:

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