Your summary of benefits

Anthem® Blue Cross and Blue Shield **Xavier University Effective 01/01/2021**

Your Plan: Anthem Blue Connection HMO Option

Your Network: Blue Connection

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
Out-of-Pocket Limit	$2,000 person / $4,000 family	Not covered
The family deductible and out-of-pocket maximum are embedded meaning the cost shares of one family member will be applied to both the individual deductible and individual 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 individual deductible and individual out-of-pocket maximum.		
Preventive Care / Screening / Immunization	No charge	Not covered
Doctor Home and Office Services		
Primary Care Visit	$20 copay per visit deductible does not apply	Not covered
Specialist Care Visit	$40 copay per visit deductible does not apply	Not covered
Prenatal and Post-natal Care	20% coinsurance after deductible is met	Not covered
Other Practitioner Visits:		
Retail Health Clinic	$20 copay per visit deductible does not apply	Not covered
On-line Visit *Includes Mental/Behavioral Health and Substance Abuse*	$10 copay per visit 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
Manipulation Therapy *Coverage is limited to 12 visits per benefit period.*	$40 copay per visit deductible does not apply	Not covered
Acupuncture	$40 copay per visit deductible does not apply	Not covered
Other Services in an Office:		
Allergy Testing	20% coinsurance after deductible is met	Not covered
Chemo/Radiation Therapy - PCP	$20 copay per visit deductible does not apply	Not covered
Chemo/Radiation Therapy - Specialist	$40 copay per visit deductible does not apply	Not covered
Dialysis/Hemodialysis	No charge	Not covered
Prescription Drugs - *Dispensed in the office*	20% coinsurance after deductible is met	Not covered
Diagnostic Services **Lab:**		
Office	No charge	Not covered
Freestanding Lab/Reference Lab	No charge	Not covered
Outpatient Hospital	20% coinsurance after deductible is met	Not covered
X-Ray:		
Office	No charge	Not covered
Freestanding Radiology Center	20% coinsurance after 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 deductible is met	Not covered
Advanced Diagnostic Imaging:		
Office	20% coinsurance after deductible is met	Not covered
Freestanding Radiology Center	20% coinsurance after deductible is met	Not covered
Outpatient Hospital	20% coinsurance after deductible is met	Not covered
Emergency and Urgent Care		
Urgent Care	$35 copay per visit deductible does not apply	Not covered
Emergency Room Facility Services	$150 copay per visit deductible does not apply	Covered as In-Network
Emergency Room Doctor and Other Services	20% coinsurance after deductible is met	Covered as In-Network
Ambulance	20% coinsurance after deductible is met	Covered as In-Network
Outpatient Mental/Behavioral Health and Substance Abuse		
Doctor Office Visit	$20 copay per visit deductible does not apply	Not covered
Facility visit:		
Facility Fees	20% coinsurance after deductible is met	Not covered
Doctor Services	20% coinsurance after 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 Surgery		
Facility Fees:		
Hospital	20% coinsurance after deductible is met	Not covered
Freestanding Surgical Center	20% coinsurance after deductible is met	Not covered
Doctor and Other Services:		
Hospital	20% coinsurance after deductible is met	Not covered
Freestanding Surgical Center	20% coinsurance after deductible is met	Not covered
Hospital (Including Maternity, Mental / Behavioral Health, Substance Abuse):		
Facility fees	20% coinsurance after deductible is met	Not covered
Human Organ and Tissue Transplants *Kidney and Cornea are treated the same as any other illness and subject to the medical benefits.*	No Charge	Not covered
Doctor and other services	20% coinsurance after deductible is met	Not covered
Recovery & Rehabilitation		
Home Health Care *Coverage is limited to 90 visits per benefit period. Limit is combined In-Network and Non-Network.*	20% coinsurance after deductible is met	Not covered
Rehabilitation services:		
Office *Coverage for Occupational Therapy, Physical Therapy and Speech Therapy is limited to 60 visits per benefit period. Limit is combined for rehabilitative and habilitative services.*	$40 copay per visit deductible does not apply	Not covered
Outpatient Hospital *Coverage for Occupational Therapy, Physical Therapy and Speech Therapy is limited to 60 visits per benefit period. Limit is combined for rehabilitative and habilitative services.*	20% coinsurance after deductible is met	Not covered

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Cardiac rehabilitation Office *Coverage is limited to unlimited visits per benefit period.* Outpatient Hospital *Coverage is limited to unlimited visits per benefit period.*	 $40 copay per visit deductible does not apply 20% coinsurance after deductible is met	 Not covered Not covered
Skilled Nursing Care (facility) *Coverage for skilled nursing services is limited to 90 days combined per benefit period. Limit is combined In-Network and Non-Network. Benefit includes coverage for Outpatient Rehabilitation program.*	20% coinsurance after deductible is met	Not covered
Hospice	20% coinsurance after deductible is met	Not covered
Durable Medical Equipment	20% coinsurance after deductible is met	Not covered
Prosthetic Devices	20% coinsurance after deductible is met	Not covered

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Pharmacy Deductible	Not applicable	Not covered
Pharmacy Out of Pocket	Not applicable	Not covered
Prescription Drug Coverage *Essential Drug List* *This product has a 90-day Retail Pharmacy Network available. No coverage for non-formulary drugs.*		
Tier 1 - Typically Generic *30 day supply (retail pharmacy). 90 day supply (home delivery).*	$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 Provider	Cost if you use a Non-Network Provider
Tier 2 – Typically Preferred Brand *30 day supply (retail pharmacy). 90 day supply (home delivery).*	$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)
Tier 3 - Typically Non-Preferred Brand *30 day supply (retail pharmacy). 90 day supply (home delivery).*	$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)
Tier 4 - Typically Specialty (brand and generic) *30 day supply (retail pharmacy). 30 day supply (home delivery).*	25% coinsurance up to $250 per prescription, deductible does not apply (retail and home delivery)	Not covered (retail and home delivery)

Notes:

- Dependent age: to end of the month in which the child attains age 26.
- 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).
- No charge means no deductible/copayment/coinsurance up to the maximum allowable amount. 0% means no coinsurance up to the maximum allowable amount.
- If you have a visit with your Primary Care Physician, Specialist or 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.
  Costs may also 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.
- 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.

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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(TTY/TDD: 711)

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Language Access Services:

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