# Your summary of benefits

Anthem®

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

Your Plan: Anthem Blue Access PPO HSA with Essential Rx Formulary

Your Network: Blue Access

| Covered Medical Benefits | Cost if you use an In-Network Provider | Cost if you use a Non-Network Provider |
|---|---|---|
| **Overall Deductible** | $3,500 person / $7,000 family | 7,000 person / $14,000 family |
| **Out-of-Pocket Limit** | $3,500 person / $7,000 family | $7,000 person / $14,000 family |
| 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 | 30% coinsurance after deductible is met |
| **Doctor Home and Office Services** | | |
| **Primary Care Visit** | 0% coinsurance after deductible is met | 30% coinsurance after deductible is met |
| **Specialist Care Visit** | 0% coinsurance after deductible is met | 30% coinsurance after deductible is met |
| **Prenatal and Post-natal Care** | 0% coinsurance after deductible is met | 30% coinsurance after deductible is met |
| **Other Practitioner Visits:** | | |
| Retail Health Clinic | 0% coinsurance after deductible is met | 30% coinsurance after deductible is met |
| On-line Visit<br>*Includes Mental/Behavioral Health and Substance Abuse* | 0% coinsurance after deductible is met | 30% coinsurance after deductible is met |
| Manipulation Therapy<br>*Coverage is limited to 12 visits per benefit period.* | 0% coinsurance after deductible is met | 30% coinsurance after deductible is met |
| **Other Services in an Office:** | | |

| Covered Medical Benefits | Cost if you use an In-Network Provider | Cost if you use a Non-Network Provider |
|---|---|---|
| Allergy Testing | 0% coinsurance after deductible is met | 30% coinsurance after deductible is met |
| Chemo/Radiation Therapy | 0% coinsurance after deductible is met | 30% coinsurance after deductible is met |
| Dialysis/Hemodialysis | 0% coinsurance after deductible is met | 30% coinsurance after deductible is met |
| Prescription Drugs - *Dispensed in the office* | 0% coinsurance after deductible is met | 30% coinsurance after deductible is met |
| **Diagnostic Services**<br>**Lab:** | | |
| Office | 0% coinsurance after deductible is met | 30% coinsurance after deductible is met |
| Outpatient Hospital | 0% coinsurance after deductible is met | 30% coinsurance after deductible is met |
| **X-Ray:** | | |
| Office | 0% coinsurance after deductible is met | 30% coinsurance after deductible is met |
| Outpatient Hospital | 0% coinsurance after deductible is met | 30% coinsurance after deductible is met |
| **Advanced Diagnostic Imaging:** | | |
| Office | 0% coinsurance after deductible is met | 30% coinsurance after deductible is met |
| Outpatient Hospital | 0% coinsurance after deductible is met | 30% coinsurance after deductible is met |
| **Emergency and Urgent Care** | | |
| **Urgent Care** | 0% coinsurance after deductible is met | 30% coinsurance after deductible is met |
| **Emergency Room Facility Services** | 0% coinsurance after deductible is met | Covered as In-Network |

| Covered Medical Benefits | Cost if you use an In-Network Provider | Cost if you use a Non-Network Provider |
|---|---|---|
| **Emergency Room Doctor and Other Services** | 0% coinsurance after deductible is met | Covered as In-Network |
| **Ambulance** | 0% coinsurance after deductible is met | Covered as In-Network |
| **Outpatient Mental/Behavioral Health and Substance Abuse** | | |
| **Doctor Office Visit** | 0% coinsurance after deductible is met | 30% coinsurance after deductible is met |
| **Facility visit:** | | |
| Facility Fees | 0% coinsurance after deductible is met | 30% coinsurance after deductible is met |
| Doctor Services | 0% coinsurance after deductible is met | 30% coinsurance after deductible is met |
| **Outpatient Surgery** | | |
| **Facility Fees:** | | |
| Hospital | 0% coinsurance after deductible is met | 30% coinsurance after deductible is met |
| **Doctor and Other Services:** | | |
| Hospital | 0% coinsurance after deductible is met | 30% coinsurance after deductible is met |
| **Hospital (Including Maternity, Mental / Behavioral Health, Substance Abuse):** | | |
| **Facility fees**<br>Coverage for Inpatient physical medicine and rehabilitation including day rehabilitation programs is limited to 60 days combined per benefit period. | 0% coinsurance after deductible is met | 30% coinsurance after deductible is met |
| **Human Organ and Tissue Transplants**<br>*Kidney and Cornea are treated the same as any other illness and subject to the medical benefits.* | 0% coinsurance after deductible is met | 30% coinsurance after deductible is met |
| **Doctor and other services** | 0% coinsurance after deductible is met | 30% coinsurance after deductible is met |

| Covered Medical Benefits | Cost if you use an In-Network Provider | Cost if you use a Non-Network Provider |
|---|---|---|
| **Recovery & Rehabilitation**<br>**Home Health Care**<br>*Coverage is limited to 90 visits per benefit period.* | 0% coinsurance after deductible is met | 30% coinsurance after deductible is met |
| **Rehabilitation services:**<br>Office<br>*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.* | 0% coinsurance after deductible is met | 30% coinsurance after deductible is met |
| Outpatient Hospital<br>*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.* | 0% coinsurance after deductible is met | 30% coinsurance after deductible is met |
| **Cardiac rehabilitation**<br>Office<br>*Coverage is limited to unlimited visits per benefit period.* | 0% coinsurance after deductible is met | 30% coinsurance after deductible is met |
| Outpatient Hospital<br>*Coverage is limited to unlimited visits per benefit period.* | 0% coinsurance after deductible is met | 30% coinsurance after deductible is met |
| **Skilled Nursing Care (facility)**<br>*Coverage for skilled nursing services is limited to 90 days combined per benefit period.* | 0% coinsurance after deductible is met | 30% coinsurance after deductible is met |
| **Hospice** | 0% coinsurance after deductible is met | 0% coinsurance after deductible is met |
| **Durable Medical Equipment** | 0% coinsurance after deductible is met | 30% coinsurance after deductible is met |
| **Prosthetic Devices** | 0% coinsurance after deductible is met | 30% coinsurance after deductible is met |

| Covered Prescription Drug Benefits | Cost if you use an In-Network Provider | Cost if you use a Non-Network Provider |
|---|---|---|
| **Pharmacy Deductible** | Combined with In-Network medical deductible | Combined with Non-Network medical deductible |
| **Pharmacy Out of Pocket** | Combined with In-Network medical | Combined with Non-Network medical |
| **Prescription Drug Coverage**<br>*Essential Drug List*<br>*This product has a 90-day Retail Pharmacy Network available. No coverage for non-formulary drugs.* | | |
| **Tier 1 - Typically Generic**<br>*30 day supply (retail pharmacy). 90 day supply (home delivery).* | 0% coinsurance after deductible is met (retail and home delivery) | 30% coinsurance after deductible is met (retail) and Not covered (home delivery) |
| **Tier 2 – Typically Preferred Brand**<br>*30 day supply (retail pharmacy). 90 day supply (home delivery).* | 0% coinsurance after deductible is met (retail and home delivery) | 30% coinsurance after deductible is met (retail) and Not covered (home delivery) |
| **Tier 3 - Typically Non-Preferred Brand**<br>*30 day supply (retail pharmacy). 90 day supply (home delivery).* | 0% coinsurance after deductible is met (retail and home delivery) | 30% coinsurance after deductible is met (retail) and Not covered (home delivery) |
| **Tier 4 - Typically Specialty (brand and generic)**<br>*30 day supply (retail pharmacy). 30 day supply (home delivery).* | 0% coinsurance after deductible is met (retail and home delivery) | 30% coinsurance after deductible is met (retail) and Not covered (home delivery) |

**Notes:**

- Dependent age: to 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.
- 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. However, when choosing a Non-network provider, the member is responsible for any balance due after the plan payment.
- In-network and out-of-network deductibles are combined. In-Network and out-of-network copayments, coinsurance and out-of-pocket maximum amounts are separate and do not accumulate toward each other.
- Specialty Drug Accumulator Program.
- 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 Evidence of Coverage (EOC), the 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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# 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)**

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## Language Access Services:

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