

Your summary of benefits



Wittenberg University Effective 1/1/2023

Your Plan: Anthem Blue Access PPO HSA

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	\$3,000 person / \$6,000 family	\$5,000 person / \$10,000 family
Overall Out-of-Pocket Limit	\$3,500 person / \$7,000 family	\$7,000 person / \$14,000 family
<p>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.</p> <p>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).</p> <p>In-Network and Non-Network deductibles and out-of-pocket limit amounts are separate and do not accumulate toward each other.</p>		
<p>Doctor Visits (virtual and office) <i>You are encouraged to select a Primary Care Physician (PCP).</i></p>		
<p>Medical Chats and Virtual Visits for Primary Care <i>from our Online Provider K Health, through its affiliated Provider groups are covered at No charge after deductible is met.</i></p>		
<p>Virtual Visits from online provider LiveHealth Online <i>for urgent/acute medical and mental health and substance abuse care via www.livehealthonline.com are covered at 0% coinsurance after deductible is met.</i></p>		
<p>Primary Care (PCP) and Mental Health and Substance Abuse Care <i>virtual and office</i></p> <p>Specialist Care <i>virtual and office</i></p>	<p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p>	<p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p>
<p><u>Other Practitioner Visits</u></p>		
<p>Routine Maternity Care (Prenatal and Postnatal)</p>	<p>0% coinsurance after deductible is met</p>	<p>30% coinsurance after deductible is met</p>
<p>Retail Health Clinic <i>for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.</i></p>	<p>0% coinsurance after deductible is met</p>	<p>30% coinsurance after deductible is met</p>
<p>Manipulation Therapy <i>Coverage is limited to 26 visits per benefit period.</i></p>	<p>0% coinsurance after deductible is met</p>	<p>30% coinsurance after deductible is met</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><u>Other Services in an Office</u></p> <p>Allergy Testing</p> <p>Prescription Drugs <i>Dispensed in the office</i></p> <p>Surgery</p>	<p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p>	<p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p>
<p>Preventive care / screenings / immunizations</p>	<p>No charge</p>	<p>30% coinsurance after deductible is met</p>
<p>Preventive Care for Chronic Conditions <i>per IRS guidelines</i></p>	<p>No charge</p>	<p>30% coinsurance after deductible is met</p>
<p><u>Diagnostic Services</u></p> <p>Lab</p> <p>Office</p> <p>Outpatient Hospital</p>	<p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p>	<p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p>
<p>X-Ray</p> <p>Office</p> <p>Outpatient Hospital</p>	<p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p>	<p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p>
<p>Advanced Diagnostic Imaging <i>for example: MRI, PET and CAT scans</i></p> <p>Office</p> <p>Outpatient Hospital</p>	<p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p>	<p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p>
<p><u>Emergency and Urgent Care</u></p> <p>Urgent Care</p> <p>Emergency Room Facility Services</p> <p>Emergency Room Doctor and Other Services</p>	<p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p>	<p>30% coinsurance after deductible is met</p> <p>Covered as In-Network</p> <p>Covered as In-Network</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Ambulance	0% coinsurance after deductible is met	Covered as In-Network
<u>Outpatient Mental Health and Substance Abuse Care at a Facility</u> Facility Fees Doctor Services	0% coinsurance after deductible is met 0% coinsurance after deductible is met	30% coinsurance after deductible is met 30% coinsurance after deductible is met
<u>Outpatient Surgery</u> Facility Fees Hospital Doctor and Other Services Hospital	0% coinsurance after deductible is met 0% coinsurance after deductible is met	30% coinsurance after deductible is met 30% coinsurance after deductible is met
<u>Hospital (Including Maternity, Mental Health and Substance Abuse)</u> Facility Fees Human Organ and Tissue Transplants <i>Cornea transplants are treated the same as any other illness and subject to the medical benefits.</i> Physician and other services <i>including surgeon fees</i>	0% coinsurance after deductible is met 0% coinsurance after deductible is met 0% coinsurance after deductible is met	30% coinsurance after deductible is met 30% coinsurance after deductible is met 30% coinsurance after deductible is met
Home Health Care <i>Coverage is limited to 100 visits per benefit period. Private Duty Nursing is limited to 82 visits per benefit period.</i>	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Rehabilitation and Habilitation services <i>including physical, occupational and speech therapies.</i> Office Outpatient Hospital	0% coinsurance after deductible is met 0% coinsurance after deductible is met	30% coinsurance after deductible is met 30% coinsurance after deductible is met
Pulmonary rehabilitation <i>office and outpatient hospital</i> <i>Coverage is limited to 20 visits per benefit period.</i>	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
Cardiac rehabilitation office and outpatient hospital <i>Coverage is limited to 36 visits per benefit period.</i>	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Dialysis/Hemodialysis office and outpatient hospital	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Chemo/Radiation Therapy office and outpatient hospital	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Skilled Nursing Care (facility) <i>Coverage for Skilled Nursing is limited to 120 days per benefit period and Inpatient Rehabilitation facility (includes services in an outpatient day rehabilitation program) is limited to 60 days combined per benefit period.</i>	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Inpatient 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 <i>Coverage for wigs is limited to 1 item after cancer treatment per benefit period.</i>	0% coinsurance after deductible is met	30% coinsurance after deductible is met

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Pharmacy Deductible	Combined with In-Network medical deductible	Combined with Non-Network medical deductible
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: Base 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.

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
<p>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.</p> <p>Preventive Drugs Your Pharmacy cost share is 0% pre-deductible for drugs included on the PreventiveRX Plus drug list, a designated list of drugs for the treatment of diabetes, asthma, depression, heart health, high blood pressure, high cholesterol, and osteoporosis.</p>		
Tier 1 - Typically Generic	\$15 copay per prescription after deductible is met (retail) and \$30 copay per prescription after deductible is met (home delivery)	50% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 2 – Typically Preferred Brand	\$30 copay per prescription after deductible is met (retail) and \$60 copay per prescription after deductible is met (home delivery)	50% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand	\$45 copay per prescription after deductible is met (retail) and \$90 copay per prescription after deductible is met (home delivery)	50% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 4 - Typically Specialty (brand and generic)	25% coinsurance up to \$250 per prescription after deductible is met (retail and home delivery)	50% coinsurance after deductible is met (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
<p><i>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.</i></p>		
Children's Vision exam (up to age 19) <i>Limited to 1 exam per benefit period.</i>	No charge	\$0 copayment up to plan's Maximum Allowed Amount
Adult Vision exam (age 19 and older)	No charge	Reimbursed Up to \$42

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<i>Limited to 1 exam per benefit period.</i>		

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.
- 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.
- If you have an office visit with your Primary Care Physician or Specialist at an Outpatient Facility (e.g., Hospital or Ambulatory Surgical Facility), benefits for Covered Services will be paid under “Outpatient Facility Services”.
- Costs may vary by the site of service. Other cost shares may apply depending on services provided. Check your Certificate of Coverage for details.
- Benefit Period – Calendar Year
- 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.

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.