

WRIGHT STATE UNIVERSITY

SUMMARY OF BENEFITS

Anthem Blue Preferred Primary HMO and Anthem Blue Access PPO

Effective Date: January 1, 2008

ANTHEM BC/BS	ANTHEM BLUE CROSS/BLUE SHIELD	
Blue Preferred Primary (HMO)	Blue Access (PPO)	
Network Benefits Only	NETWORK	NON-NETWORK

BASIC DESCRIPTION OF PLANS

Anthem HMO emphasizes preventative care and wellness care. Benefits are provided by a Primary Care Physician (PCP) that is chosen from the HMO provider directory. If the services of a specialist are needed, you may seek care from any of the specialists in the Dayton and surrounding areas.

A referral from your PCP is NOT required in order for you to receive care from a specialist.

LOCAL NETWORK HOSPITALS:

- Children's Medical Center
- Community Hospital of Springfield & Clark Cc
- Dayton Heart Hospital
- Good Samaritan Hospital
- Grandview Hospital
- Greene Memorial Hospital
- Kettering Medical Center
- Mercy Medical Center
- Miami Valley Hospital
- Middletown Regional Hospital
- Southview Hospital
- Kettering Medical Center - Sycamore
- Upper Valley Medical Center

Plus the Blue Preferred Primary HMO Statewide Network

Anthem Blue Access PPO emphasizes preventive care and wellness care. Benefits are provided primarily by a Primary Care Physician (PCP). If the services of a specialist are needed, you may seek care from any of the specialists in the Dayton and surrounding areas.

A referral from your PCP is NOT required in order for you to receive care from a specialist.

LOCAL NETWORK HOSPITALS:

- Children's Medical Center
- Community Hospital of Springfield & Clark Cc
- Dayton Heart Hospital
- Good Samaritan Hospital
- Grandview Hospital
- Greene Memorial Hospital
- Kettering Medical Center
- Mercy Medical Center
- Miami Valley Hospital
- Middletown Regional Hospital
- Southview Hospital
- Kettering Medical Center - Sycamore
- Upper Valley Medical Center

Plus the Blue Access PPO Statewide Network

Employees and their dependents may choose to receive care from any licensed physician or hospital. If you receive care from a non-network physician non-network benefits apply. Health Care Management features will be included.

Pre-certification for the following services is the responsibility of the employee/dependent:

- * **Elective admissions**
- * **Emergency admissions (Anthem must be notified within 24 hours)**
- * **OB related medical stay, excludes childbirth**
- * **Newborn stays beyond discharge of mother**
- * **Inpatient rehabilitation admissions**
- * **Transplants (Human Organ Tissue Transplants only)**
- * **Inpatient hospice**
- * **Inpatient skilled nursing facility admission**
- * **Transplant services**
- * **Home Health Services**
- * **UPPP surgery (uvulopalatopharyngoplasty)**
- * **Plastic/reconstructive surgeries**
- * **Certain DME/Prosthetics**
- * **Diagnostic Imaging**
- * **Positron Emission Tomography (PET)**

This list is subject to change.

Services not pre-certified may result in denial of coverage. Please consult Anthem's Website (Anthem.com) for additional services requiring pre-certification. In addition, the employee/dependent is responsible for the costs of any services determined to be medically unnecessary.

Covered individuals/family will need to pay the annual deductible and co-payment for covered services. However, services provided by a non-contracting provider are subject to Anthem's maximum allowable amount. After the out-of-pocket is reached, the eligible services are covered at 100% of the maximum allowable charge.

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**ANNUAL DEDUCTIBLES AND
OUT-OF-POCKET MAXIMUMS**

ANTHEM BC/BS	
Blue Preferred Primary (HMO)	
Network Benefits Only	
ANNUAL DEDUCTIBLE	
Per Individual	None
Per Family	None
(including deductible)	
Per Individual	\$500
Per Family	\$1,000

ANTHEM BLUE CROSS/BLUE SHIELD		
Blue Access (PPO)		
NETWORK	NON-NETWORK	
ANNUAL DEDUCTIBLE		
Per Individual	None	
Per Family	None	
COPAYMENTS		
(see description of services pages 3-7)	10%	most services
ANNUAL OUT-OF-POCKET MAXIMUM		
(including deductible)		
Per Individual	\$1,250	
Per Family	\$2,500	
ANNUAL DEDUCTIBLE		
Per Individual	\$250	
Per Family	\$500	
Deductible applies to all covered services		
COPAYMENTS		
(see description of services pages 3-7)	30%	most services
ANNUAL OUT-OF-POCKET MAXIMUM		
(including deductible)		
Per Individual	\$2,250	
Per Family	\$4,500	

1. The out-of-pocket limit applies to all copayments (except prescription drug and human organ and tissue transplants) incurred by a covered person in the same calendar year.
2. Visit limits are applied per calendar year, except where otherwise stated.

1. Copayments DO accumulate toward your annual out-of-pocket maximum (except prescription drug and human organ and tissue transplants).
2. The copayments and deductibles for network and non-network services apply ONLY to their respective out-of-pocket maximums (ex. network services apply to network maximums and non-network services apply to non-network maximums)
3. Expenses associated with Mental Health and Chemical Dependency DO apply to your maximum out-of-pocket limits.
4. Visit limits are applied per calendar year except where otherwise noted
5. Any charges for non-covered health services do not apply to your annual out of pocket maximum
6. Charges that exceed eligible expense do not apply to your annual out of pocket maximum

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DESCRIPTION OF SERVICES			
<u>HOSPITAL CHARGES</u>			
INPATIENT HOSPITAL, INTENSIVE CARE and HOSPITAL ANCILLARY SERVICES	\$250 copayment per confinement; Semi-Private room	Covered, subject to a 10% copayment; Semi-Private Room	Covered, subject to deductible and 30% copayment Semi-Private Room
PRE-ADMISSION TESTING	Covered in full	Covered, subject to a 10% copayment	Covered, subject to deductible and 30% copayment
NEWBORN NURSERY CARE	Covered in full	Covered, subject to a 10% copayment	Covered, subject to deductible and 30% copayment
<u>EMERGENCY ROOM</u>			
Emergency Accident Care	\$75 copayment; waived if admitted to hospital or observation room	\$75 copayment; waived if admitted to hospital or observation room	\$75 copayment; waived if admitted to hospital or observation room
Emergency Medical Care (life threatening)	\$75 copayment; waived if admitted to hospital or observation room	\$75 copayment; waived if admitted to hospital or observation room	\$75 copayment; waived if admitted to hospital or observation room
Urgent Care Centers	\$35 copayment	\$35 copayment	\$35 copayment
DIAGNOSTIC X-RAY & LAB	Covered in full	Covered, subject to a 10% copayment	Covered, subject to deductible and 30% copayment
RADIATION/CHEMOTHERAPY	Covered in full	Covered, subject to a 10% copayment	Covered, subject to deductible and 30% copayment
SKILLED NURSING FACILITY	Covered in full	Covered, subject to a 10% copayment	Covered, subject to deductible and 30% copayment
<u>PHYSICIAN CHARGES</u>			
<u>SURGERY & ANESTHESIA</u>			
Inpatient	Covered in full	Covered, subject to a 10% copayment	Covered, subject to deductible and 30% copayment
Outpatient	Covered in full	Facility charges - 10% copayment Physician's office - \$20 copayment	Covered, subject to deductible and 30% copayment
PHYSICIAN'S VISIT IN HOSPITAL (non-surgical)	Covered in full	Covered, subject to a 10% copayment	Covered, subject to deductible and 30% copayment
ASSISTANT SURGEON (medically necessary)	Covered in full	Covered, subject to a 10% copayment	Covered, subject to deductible and 30% copayment
DIAGNOSTIC X-RAY & LAB	Covered in full	Covered, subject to a 10% copayment	Covered, subject to deductible and 30% copayment

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PHYSICAL THERAPY

A. Inpatient	\$250 copayment per confinement; Maximum 60 days per calendar year	Physical Medicine & Rehabilitative medicine 10% copayment; Maximum 60 days per calendar year (combined with Non-Network)	Physical Medicine & Rehabilitative medicine are covered subject to deductible and 30% copayment; Maximum of 60 days per calendar year (combined with network)
B. Outpatient	\$15 copayment; Maximum of 60 visits per calendar year	\$20 copayment; Maximum of 60 visits per calendar year (Combined with Non-Network)	Covered, subject to deductible and 30% copayment; Maximum 60 visits per calendar year (Combined with Network)
CHIROPRACTOR	\$15 copayment per office visit; Maximum of 12 visits for spinal manipulations and subluxations per calendar year	\$20 copayment per office visit; Maximum of 12 visits for spinal manipulations and subluxations per calendar year (combined with Non-Network)	Covered, subject to deductible and 30% copayment; Maximum of 12 visits for spinal manipulations and subluxations per calendar year (combined with Network)

OTHER SERVICES

OFFICE VISITS PRIMARY CARE REFERRALS	\$15 copayment \$15 copayment	\$20 copayment - includes office surgery and pre-conception care	Covered, subject to deductible and 30% copayment; includes office surgery and pre-conception care
ROUTINE PAP TEST	\$15 copayment - office visit	\$20 copayment - office visit	Covered, subject to deductible and 30% copayment
MAMMOGRAM (routine) (No diagnosis)	\$15 copayment - office visit; (Mammograms rendered without an Office Visit are covered in full)	\$20 copayment - office visit; (Mammograms rendered without an Office Visit are covered in full)	Covered, subject to deductible and 30% copayment
ROUTINE PSA TEST	\$15 copayment - office visit; services rendered without an office visit are covered in full	\$20 copayment - office visit; services rendered without an office visit are covered in full	Covered, subject to deductible and 30% copayment
SECOND SURGICAL OPINION	\$15 copayment when authorized by the pre-certification department	\$20 copayment when authorized by the pre-certification department	Covered, subject to deductible and 30% copayment when authorized by pre-certification department

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PRESCRIPTION DRUGS	<u>Member Pharmacies - 30 day supply:</u>		<u>Member Pharmacies - 30 day supply:</u>	
Copayments are:	Retail - \$8 generic - all generic drugs Retail - \$25 brand - formulary Retail - \$40 brand - non-formulary Includes oral contraceptives Diabetic Test Strips subject to drug copayments. Certain other diabetic supplies are covered in full at network pharmacies. Prescriptions written by a dentist are covered.	Retail - \$8 generic - all generic drugs Retail - \$25 brand - formulary Retail - \$40 brand - non-formulary Includes oral contraceptives Diabetic Test Strips subject to drug copayments. Certain other diabetic supplies are covered in full at network pharmacies. Prescriptions written by a dentist are covered.	<u>Non-Member Pharmacies - 30 day supply:</u> 50% copayment at non-member pharmacy Prescriptions written by a dentist are covered.	
	<i>WSU Self Funded Maintenance Drug Program NOT an Anthem BC/BS Plan 90 Day Supply</i>		<i>WSU Self Funded Maintenance Drug Program NOT an Anthem BC/BS Plan 90 Day Supply</i>	
	Copayments are: \$12 generic - all generic drugs 10% (\$22 min) - Brand name drugs with no suitable equivalent generic substitute 10% (\$60 min) - Brand name drugs with a suitable equivalent generic substitute Viagra Pills - limited to 18 per 90 day period Injectable Fertility Medications - 50% copay	Copayments are: \$12 generic - all generic drugs 10% (\$22 min) - Brand name drugs with no suitable equivalent generic substitute 10% (\$60 min) - Brand name drugs with a suitable equivalent generic substitute Viagra Pills - limited to 18 per 90 day period Injectable Fertility Medications - 50% copay		
MATERNITY CARE	All covered persons; \$250 copayment per confinement	All covered persons; 10% copayment	All covered persons; covered subject to deductible and 30% copayment	
AMBULANCE	Covered in full	Covered in full	Covered in full	
ALLERGY SERVICES	Serums/Injections - \$15 copayment (covered in full if rendered without an office visit) Testing/Treatment - \$15 copayment	Serums/Injections - \$20 copayment (covered in full if rendered without an office visit) Testing/Treatment - \$20 copayment	Injections/Serum - subject to deductible and 30% co-payment Testing/Treatment - subject to deductible and 30% co-payment	
PERIODIC ROUTINE PHYSICAL EXAMS	\$15 copayment (not covered if exam is for medical research, employment, school or insurance purposes)	\$20 copayment (not covered if exam is for medical research, employment, school or insurance purposes)	Covered, subject to deductible and 30% copayment (not covered if exam is for medical research, employment school, or insurance purposes)	
BLOOD	Covered in full	Covered in full	Covered, subject to deductible and 30% copayment	
HOME HEALTH CARE	Covered in full	Covered in full	Covered, subject to deductible and 30% copayment; Maximum 30 visits	
HOSPICE	Covered in full	Covered in full	Covered in full	

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CARE OF MENTAL HEALTH and/or CHEMICAL DEPENDENCY	<u>MAGELLAN BEHAVIORAL HEALTH</u> Authorized Referral - contact toll free 1-800-788-4003 If Anthem determines the covered person is chronic, not treatable, not significantly responsive to short term treatment or is not compliant to treatment plan, there is no coverage.	<u>MAGELLAN BEHAVIORAL HEALTH</u> Authorized Referral - contact toll free 1-800-788-4003 If Anthem determines the covered person is chronic, not treatable, not significantly responsive to short term treatment or is not compliant to treatment plan, there is no coverage.	<u>ALL LICENSED PSYCHIATRISTS/ QUALIFIED PSYCHOLOGISTS</u> (not coordinated through Magellan Behavioral Health)
	Mental Health (inpatient)	\$250 copayment per confinement; Maximum 60 days/calendar year (Combined with Chemical Dependency inpatient)	10% copayment; Maximum 60 days/calendar year (Combined with Chemical Dependency Inpatient and non-network Mental Health)
Mental Health (out-patient)	\$15 copayment; limited for 60 visits per calendar year (Combined with Chemical Dependency outpatient)	\$20 copayment; Maximum 60 visits per calendar year (combined with Chemical Dependency and non-network Mental Health)	Covered; subject to deductible and 30% co-payment; Maximum 10 visits per calendar year (combined with Chemical Dependency Outpatient and Network Mental Health)
Chemical Dependency (inpatient)	\$250 copayment per confinement; Maximum 60 days/calendar year (Combined with Mental Health inpatient)	10% copayment; Maximum 60 days/calendar year (combined with Mental Health and non-network Chemical Dependency)	Covered; subject to deductible and 30% co-payment; Maximum \$550 per benefit period (Combined with inpatient mental health and network Chemical Dependency)
Chemical Dependency (outpatient)	\$15 copayment; limited to 60 visits per calendar year (Combined with Mental Health outpatient)	\$20 copayment; Maximum 60 visits per calendar year (combined with Mental Health outpatient and non-network Chemical Dependency)	Covered; subject to deductible and 30% co-payment; Maximum \$550 per benefit period. (combined with inpatient & network Chemical Dependency)
	Two inpatient or outpatient substance abuse programs per lifetime per member. Includes detoxification.	Two inpatient or outpatient substance abuse programs per lifetime per member. Includes detoxification.	Two inpatient or outpatient substance abuse programs per lifetime per member. Includes detoxification.
WELL BABY CARE and IMMUNIZATIONS	\$15 copayment	\$20 copayment; immunization covered in full without an office visit	Covered, subject to deductible and 30% copayment
WELL CHILD CARE	\$15 copayment	\$20 copayment; immunization covered in full without an office visit	Covered, subject to deductible and 30% copayment

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HUMAN ORGAN TRANSPLANTS (patient meets criteria)	Human Organ Transplant - Covered in full Pre-Certification required. Must receive care through an established transplant network. Tissue Transplants - covered in full Physician's services - \$15 copayment A separate \$1,000,000 lifetime maximum applies to transplant benefits Prescription Drugs are covered under Retail or Maintenance Drug benefits	Human Organ Transplant - Covered in full Pre-Certification required. Must receive care through an established transplant network. Tissue Transplants - covered in full Physician's services - \$20 copayment A separate \$1,000,000 lifetime maximum applies to transplant benefits (combined with non-network) Prescription Drugs are covered under Retail or Maintenance Drug benefits	Covered, subject to deductible and 50% copayment Covered, subject to deductible and 50% copayment A separate \$1,000,000 lifetime maximum applies to transplant benefits (combined with network)
FAMILY PLANNING SERVICES	\$15 copayment - office visit (pre-conception care and education)	See Infertility Services	See Infertility Services
INFERTILITY SERVICES	Not Covered (services to diagnose infertility are covered based on provider setting)	Not Covered (services to diagnose infertility are covered based on provider setting)	Not Covered (services to diagnose infertility are covered based on provider setting)
MEDICAL EQUIPMENT & SUPPLIES	20% copayment	Covered, subject to a 20% copayment	Covered, subject to deductible and 40% copayment
EMERGENCY ACCIDENT DENTAL TREATMENT	Covered (based on provider setting)	Covered (based on provider setting)	Covered, subject to deductible and 30% copayment
TEMPOROMANDIBULAR, MANDIBULAR or ORTHOGNATHIC TREATMENT	Covered if considered medically necessary treatment (based on provider setting)	Covered if considered medically necessary treatment (based on provider setting)	Covered, subject to deductible and 30% copayment if medically necessary treatment
CHRISTIAN SCIENCE PRACTITIONERS	Not Covered	Not Covered	Not Covered
EYE EXAMS	\$15 copayment; one per year	\$20 copayment; one per year	Covered, subject to deductible and 30% copayment
ROUTINE HEARING TESTS	\$15 Copayment per exam	\$20 copayment; one per year	Covered, subject to deductible and 30% copayment

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UNMARRIED DEPENDENT CHILDREN	To Age 19; To Age 25 if IRS Eligible Dependent		To Age 19; To Age 25 if IRS Eligible Dependent	To Age 19; To Age 25 if IRS Eligible Dependent
LIFETIME MAXIMUM	Unlimited		\$5,000,000 per person (combined with Non-Network) \$1,000,000 per person for Human Organ and Tissue Transplants (combined with Non-Network) Two inpatient or outpatient substance abuse programs per lifetime per member. Includes detoxification.	\$5,000,000 per person (combined with Network) \$1,000,000 per person for Human Organ and Tissue Transplants (combined with Network) Two inpatient or outpatient substance abuse programs per lifetime per member. Includes detoxification.
BENEFIT PERIOD	Calendar year		Calendar year	Calendar year
PRE-EXISTING CONDITION LIMITATIONS (for an illness or condition for which you have received medical advice and/or treatment within 6 months prior to your effective date)	No limitations		No limitations	No limitations

CUSTOMER SERVICE:

1-800-826-7987

1-800-826-7987

1-800-826-7987

WEBSITE:

www.anthem.com

www.anthem.com

www.anthem.com

(Select Blue Preferred Primary HMO)

(Select Blue Access PPO)

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This benefit description is intended to be a brief outline of benefits available to you and eligible dependents. It does not include all of the benefits or exclusions. The entire provisions of benefits and exclusions are contained in the Group Certificate Contract. In the event of a conflict between the Group Certificate and this description, the terms of the Certificate will prevail.