

# Your Summary of Benefits



**Wright State University  
High Deductible Health Plan \$2000/\$4000  
Plan Year 2019**

Covered Benefits	Network	Non-Network
<b>Deductible</b> Family coverage requires the family deductible to be met before coinsurance applies. The single deductible does not apply to family coverage. Network and Non-Network deductibles are combined.	Single: \$2,000 Family: \$4,000	Single: \$4,000 Family: \$8,000
<b>Out-of-Pocket Limit</b>	Single: \$3,000 Family: \$6,000	Single: \$6,000 Family: \$12,000
<b>Physician Home and Office Services (PCP/SCP)</b> <ul style="list-style-type: none"> <li>Including Office Surgeries, allergy serum, allergy injections and allergy testing</li> </ul>	10%	30%
<b>Preventive Care Services</b> Services include but are not limited to: Routine Exams, Mammograms, Pelvic Exams, Pap testing, PSA tests, Immunizations, Annual diabetic eye exam, Routine Vision and Hearing exams <ul style="list-style-type: none"> <li>Physician Home and Office Visits</li> <li>Other Outpatient Services @ Hospital/Alternative Care Facility</li> </ul>	No Cost Share	30%
<b>Emergency and Urgent Care</b> <ul style="list-style-type: none"> <li><b>Emergency Room Services @ Hospital (facility/other covered services)</b> (copayment waived if admitted)</li> <li><b>Urgent Care Center Services</b></li> </ul>	10%	10% or 30% if non-emergency
<b>Inpatient and Outpatient Professional Services</b> Include but are not limited to: <ul style="list-style-type: none"> <li>Medical Care visits (1 per day), Intensive Medical Care, Concurrent Care, Consultations, Surgery and administration of general anesthesia and Newborn exams</li> </ul>	10%	30%
<b>Inpatient Facility Services (Network/Non-Network combined)</b> Unlimited days except for: <ul style="list-style-type: none"> <li>60 days for physical medicine/rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis)</li> <li>Unlimited days In-Network/Non-Network for skilled nursing facility</li> </ul>	10%	30%
<b>Outpatient Surgery Hospital/Alternative Care Facility</b> <ul style="list-style-type: none"> <li>Surgery and administration of general anesthesia</li> </ul>	10%	30%

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<p><b>Other Outpatient Services</b> (Network/Non-network combined) including but not limited to:</p> <ul style="list-style-type: none"> <li>Non Surgical Outpatient Services For example: MRIs, C-Scans, Chemotherapy, Ultrasounds and other diagnostic outpatient services.</li> <li>Home Care Services 100 visits In-Network/ 100 visits Non-Network (excludes IV Therapy)</li> <li>Durable Medical Equipment and Orthotics Network/Non-Network combined</li> <li>Prosthetic Devices &amp; Medical Supplies unlimited benefit maximum</li> <li>Prosthetic Limbs</li> <li>Physical Medicine Therapy Day Rehabilitation programs</li> <li>Hospice Care</li> <li>Ambulance Services</li> </ul>	<p>10%</p> <p>0%</p> <p>0%</p> <p>10%</p>	<p>30%</p> <p>30%</p> <p>0%</p> <p>10%</p>
<p><b>Outpatient Therapy Services</b> (Combined Network &amp; Non-Network limits apply)</p> <ul style="list-style-type: none"> <li>Physician Home and Office Visits (PCP/SCP)</li> <li>Other Outpatient Services @ Hospital/Alternative Care Facility</li> </ul> <p>Limits apply to:</p> <ul style="list-style-type: none"> <li>Cardiac Rehabilitation 36 visits</li> <li>Pulmonary Rehabilitation 20 visits</li> <li>Physical Therapy 30 visits</li> <li>Occupational Therapy 30 visits</li> <li>Manipulation Therapy 12 visits</li> <li>Speech Therapy 20 visits</li> </ul>	<p>10%</p> <p>10%</p>	<p>30%</p> <p>30%</p>
<p><b>Behavioral Health Services:</b> <b>Mental Illness and Substance Abuse<sup>1</sup></b></p> <ul style="list-style-type: none"> <li>Inpatient Facility Services &amp; Inpatient Professional Services</li> <li>Physician Home and Office Visits (PCP/SCP)</li> <li>Other Outpatient Services @ Hospital/Alternative Care Facility</li> </ul>	<p>10%</p> <p>10%</p>	<p>30%</p> <p>30%</p>
<p><b>Human Organ and Tissue Transplants</b></p> <ul style="list-style-type: none"> <li>Acquisition and transplant procedures, harvest and storage.</li> </ul>	<p>0%</p>	<p>30%</p>

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<b>Prescription Drugs</b> <ul style="list-style-type: none"> <li>○ <b>Network Retail Pharmacies:</b> (30-day supply) Includes diabetic test strip</li> <li>○ <b>Anthem Rx Direct Mail Service:</b> (90-day supply) Includes diabetic test strip</li> </ul>	10%  10%	30% <sup>2</sup>  Not covered
<b>Medicare Rx - Wrap</b>		
<b>Lifetime Maximum (Combined Network and Non-network )</b>	Unlimited	Unlimited

## Notes:

- All deductibles. Copayments and coinsurance apply toward the out-of-pocket maximum including prescription drugs. (Excludes Non-network Human Organ and Tissue Transplants).
- Deductible(s) apply to covered services listed with a percentage (%) coinsurance including prescription drugs.
- Deductible applies to all prescription drug expenses. Once the deductible is met the appropriate copayment/coinsurance applies.
- Network and non-network deductibles are separate. Network and non-network coinsurance and out-of-pocket maximums are separate and do not accumulate toward each other.
- Dependent Age: to end of the month which the child attains age 26
- 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.
- Benefit period = calendar year
- Behavioral Health Services: Mental Health and Substance Abuse benefits provided in accordance with Federal Mental Health Parity.
- Preventive Care Services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits are covered.

<sup>1</sup> We encourage you to review the Schedule of Benefits for limitations. .

<sup>2</sup> Rx non-network diabetic/asthmatic supplies not covered except diabetic test strips.

## Precertification:

Many services require precertification; please refer to your plan documents for specifics. Members are encouraged to always obtain prior approval when using non-network providers. Precertification will help avoid any unnecessary reduction in benefits for non-covered or non-medically necessary services.

## Pre-existing Exclusion Period: None

This summary of benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits.