Your Summary of Benefits

Anthem BlueCross BlueShield

Wright State University
High Deductible Health Plan $2,000/$4,000
Effective 1/1/2021

Covered Benefits	Network	Non-Network
Deductible (Single/Family) Family coverage requires the family deductible to be met before coinsurance applies. The single deductible does not apply to family coverage.	Single: $2,000 Family: $4,000	Single: $4,000 Family: $8,000
Out-of-Pocket Limit (Single/Family)	Single: $3,000 Family: $6,000	Single: $6,000 Family: $12,000
Physician Home and Office Services (PCP/SCP) • Including Office Surgeries, allergy serum, allergy injections and allergy testing	10%	30%
Preventive Care Services • Services included but not limited to: • Routine medical exams, Mammograms, Pelvic Exams, Pap testing, PSA tests, Immunizations, Annual diabetic eye exam, Routine Vision and Hearing exams • Physicians Home and Office Visits • Other Outpatient Services @ Hospital/Alternative Care Facility	No cost share	30%
Emergency and Urgent Care • Emergency Room Services • facility/other covered services • (copayment waived if admitted) Urgent Care Center Services	10% 10%	10% or 30% if non-emergency 30%
Inpatient and Outpatient Professional Services Include but are not limited to: • Medical Care visits (1 per day), Intensive Medical Care, Concurrent Care, Consultations, Surgery and administration of general anesthesia and Newborn exams	10%	30%
Inpatient Facility Services (Network/Non-Network combined) Unlimited days except for: • 60 days for physical medicine/rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis) • Unlimited days In-Network/Non-Network for skilled nursing facility	10%	30%
Outpatient Surgery Hospital/Alternative Care Facility • Surgery and administration of general anesthesia	10%	30%

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Other Outpatient Services including but not limited to: • Non Surgical Outpatient Services for example: MRIs, C-Scans, Chemotherapy, Ultrasounds, and other diagnostic outpatient services. • Home Care Services 100 visits (excludes IV Therapy) • Durable Medical Equipment, Orthotics Network /Non-Network Combined • Prosthetic Limbs • Physical Medicine Therapy Day Rehabilitation programs • Hospice Care • Ambulance Services	10% 0% 0% 10%	30% 30% 0% 10%
Outpatient Therapy Services (Combined Network & Non-Network limits) • Physician Home and Office Visits (PCP/SCP) • Other Outpatient Services @ Hospital/Alternative Care Facility Limits apply to: • Cardiac Rehabilitation 36 visits • Pulmonary Rehabilitation 20 visits • Physical Therapy: 30 visits • Occupational Therapy: 30 visits • Manipulation Therapy: 12 visits • Speech therapy: 20 visits	 10% 10%	 30% 30%
Behavioral Health: **Mental Illness and Substance Abuse**[1] • Inpatient Facility Services • Physician Home and Office Visits (PCP/SCP) • Other Outpatient Services. Outpatient Facility @ Hospital/Alternative Care Facility, Outpatient Professional	 10% 10%	 30% 30%
Human Organ and Tissue Transplants • Acquisition and transplant procedures, harvest and storage.	0%	30%

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Prescription Drugs – Standard Network Network Tier structure equals: Tier 1 Generic, Tier 2 Brand Formulary, Tier 3 Non Formulary, Tier 4 Specialty		
• Network Retail Pharmacies: (30-day supply) Includes diabetic test strip This plan has a required Rx Maintenance 90-day Retail Pharmacy requirement for select maintenance drugs (via retail or mail order.)	10%	30%[2]
• Home Delivery Service: (90-day supply) Includes diabetic test strip •	10%	Not covered
Member may be responsible for additional cost when not selecting the available generic drug. Specialty Medications are limited up to a 30 day supply and must be obtained thru an Exclusive Specialty Pharmacy		

Notes:

- All deductibles, copayments and coinsurance apply toward the out-of-pocket maximum including prescription drugs. (Excludes Non-Network Human Organ Transplant and Tissue Transplants).
- Deductible(s) apply to covered medical services listed with a percentage (%) coinsurance, including 0%.
- Deductible applies to all prescription drug expenses. Once the deductible is met the appropriate copayments / coinsurance applies.
- Network and Non-network deductibles, copayments, 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.
- Includes Specialty Cost Optimization Program

[1] We encourage you to review the Schedule of Benefits for limitations.
[2] 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.