

Your Summary of Benefits



Wright State University
Blue Access® (PPO) 80/20 Plan
Effective 1/1/2022

Covered Benefits	Network	Non-Network
Deductible (Single/Family) Family coverage requires the family deductible to be met before coinsurance applies. One family member or any combination of family members can satisfy it.	\$1,000/\$2,000	\$2,000/\$4,000
Out-of-Pocket Limit (Single/Family) Family coverage requires the family out-of-pocket to be met. One family member or any combination of family members can satisfy it	\$4,000/\$8,000	\$8,000/\$16,000
Physician Home and Office Services (PCP/SCP) Primary Care Physician (PCP)/ Specialty Care Physician (SCP) Including Office Surgeries and allergy serum: <ul style="list-style-type: none"> allergy injections (PCP and SCP) allergy testing MRAs, MRIs, PETS, C-Scans, Nuclear Cardiology Imaging Studies, non-maternity related Ultrasounds and pharmaceutical products 	\$20/\$40 \$5 20% 20%	40% 40% 40% 40%
Preventive Care Services <ul style="list-style-type: none"> Services included but not limited to: Routine medical exams, Mammograms, Pelvic Exams, Pap testing, PSA tests, Immunizations, Annual diabetic eye exam, Hearing screenings and Vision screenings which are limited to Screening tests (i.e. Snellen eye chart) and Ocular Photo screening. 	No cost share	40%
Emergency and Urgent Care Emergency Room Services <ul style="list-style-type: none"> facility/other covered services (copayment waived if admitted) Urgent Care Center Services <ul style="list-style-type: none"> MRAs, MRIs, PETS, C-Scans, Nuclear Cardiology Imaging Studies, Non-maternity related Ultrasounds and pharmaceutical products Allergy injections Allergy testing 	\$300 \$50 20% \$5 20%	\$300 or 40% if non-emergency 40% 40% 40% 40%

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Inpatient and Outpatient Professional Services Include but are not limited to: <ul style="list-style-type: none"> Medical Care visits (1 per day), Intensive Medical Care, Concurrent Care, Consultations, Surgery and administration of general anesthesia and Newborn exams 	20%	40%
Inpatient Facility Services (Network/Non-Network combined) Unlimited days except for: <ul style="list-style-type: none"> 60 days for physical medicine/rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis) 90 days for skilled nursing facility 	20%	40%
Outpatient Surgery Hospital/Alternative Care Facility <ul style="list-style-type: none"> Surgery and administration of general anesthesia 	20%	40%
Other Outpatient Services including but not limited to: <ul style="list-style-type: none"> Non-Surgical Outpatient Services for example: MRIs, C-Scans, Chemotherapy, Ultrasounds, and other diagnostic outpatient services. Home Care Services 100 visits (excludes IV Therapy) (Network/Non-Network combined) Durable Medical Equipment, Orthotics and Prosthetics Physical Medicine Therapy Day Rehabilitation programs Hospice Care Ambulance Services 	20% No cost share 20% 20% No cost share 20%	40% 40% 40% 40% No cost share 20%
Outpatient Therapy Services (Combined Network & Non-Network limits) <ul style="list-style-type: none"> Physician Home and Office Visits (PCP/SCP) Other Outpatient Services @ Hospital/Alternative Care Facility Limits apply to: <ul style="list-style-type: none"> Cardiac Rehabilitation 36 visits Pulmonary Rehabilitation 20 visits Physical Therapy: 30 visits Occupational Therapy: 30 visits Manipulation Therapy: 12 visits Speech therapy: 20 visits 	\$20/\$40 20%	40% 40%
Accidental Dental: \$3,000 per accident (Network and Non-network combined)	Copayments/Coinsurance based on setting where covered services are received	40%

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- Preventive Care Services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits are covered.
- Private Duty Nursing – limited to 82 visits/Calendar Year
- Includes Specialty Cost Optimization Program

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

² Kidney and Cornea are treated the same as any other illness and subject to the medical benefits.

³ Rx non-network diabetic/asthmatic supplies not covered except diabetic test strips.

Recertification:

Many services require recertification; please refer to your plan documents for specifics. Members are encouraged to always obtain prior approval when using non-network providers. Recertification 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.