Your summary of benefits

Anthem

Wittenberg University Effective 01/01/2021

Your Plan: Anthem HDHP with HSA / Essential Rx Formulary on the National w/R90 Network with Optional Home Delivery

Your Network: Anthem Blue Access PPO Network

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	$2,800 person / $5,600 family	$5,000 person / $10,000 family
Out-of-Pocket Limit	$3,500 person / $7,000 family	$7,000 person / $14,000 family
The family deductible and out-of-pocket maximum are embedded meaning the cost shares of one family member will be applied to both the individual deductible and individual out-of-pocket maximum; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket maximum. No one member will pay more than the individual deductible and individual out-of-pocket maximum.		
Preventive Care / Screening / Immunization	No charge	30% coinsurance after deductible is met
Doctor Home and Office Services		
Primary Care Visit	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Specialist Care Visit	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Prenatal and Post-natal Care	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Other Practitioner Visits:		
Retail Health Clinic	0% coinsurance after deductible is met	30% coinsurance after deductible is met
On-line Visit *Includes Mental/Behavioral Health and Substance Abuse*	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Manipulation Therapy *Coverage is limited to 26 visits per benefit period.*	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Other Services in an Office:		

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Allergy Testing	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Chemo/Radiation Therapy	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Dialysis/Hemodialysis	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Prescription Drugs - *Dispensed in the office*	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Diagnostic Services **Lab:**		
Office	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	0% coinsurance after deductible is met	30% coinsurance after deductible is met
X-Ray:		
Office	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Advanced Diagnostic Imaging:		
Office	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Emergency and Urgent Care		
Urgent Care	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Emergency Room Facility Services	0% coinsurance after deductible is met	Covered as In-Network

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Emergency Room Doctor and Other Services	0% coinsurance after deductible is met	Covered as In-Network
Ambulance	0% coinsurance after deductible is met	Covered as In-Network
Outpatient Mental/Behavioral Health and Substance Abuse		
Doctor Office Visit	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Facility Visit:		
Facility Fees	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Doctor Services	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Surgery		
Facility Fees:		
Hospital	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Doctor and Other Services:		
Hospital	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Hospital (Including Maternity, Mental / Behavioral Health, Substance Abuse):		
Facility Fees	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Human Organ and Tissue Transplants *Kidney and Cornea are treated the same as any other illness and subject to the medical benefits.*	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Doctor and other services	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
Recovery & Rehabilitation **Home Health Care** *Coverage is limited to 100 visits per benefit period.*	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Rehabilitation services: Office *Coverage for Occupational Therapy, Physical Therapy and Speech Therapy is unlimited. Limit is combined for rehabilitative and habilitative services.* Outpatient Hospital *Coverage for Occupational Therapy, Physical Therapy and Speech Therapy is unlimited. Limit is combined for rehabilitative and habilitative 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
Cardiac rehabilitation Office *Coverage is limited to 36 visits per benefit period.* Outpatient Hospital *Coverage is limited to 36 visits per benefit period.*	0% coinsurance after deductible is met 0% coinsurance after deductible is met	30% coinsurance after deductible is met 30% coinsurance after deductible is met
Skilled Nursing Care (facility) *Coverage for Skilled Nursing is limited to 120 days per benefit period. Inpatient Rehabilitation facility (includes services in an outpatient day rehabilitation program) is limited to 60 days combined per benefit period.*	0% coinsurance after deductible is met	30% coinsurance after deductible is met
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	0% coinsurance after deductible is met	30% coinsurance after deductible is met

Covered Prescription Drug Benefits	Cost if you use a In- Network Provider	Cost if you use an Non-Network Provider
Pharmacy Deductible	Combined with In-Network medical deductible	Combined with Non- Network medical deductible
Pharmacy Out of Pocket	Combined with In-Network medical	Combined with Non- Network medical
Prescription Drug Coverage *Essential Drug List* *This product has a 90-day Retail Pharmacy Network available. No coverage for non-formulary drugs.*		
Tier 1 - Typically Generic *30 day supply (retail pharmacy). 90 day supply (home delivery).*	$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 day supply (retail pharmacy). 90 day supply (home delivery).*	$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 *30 day supply (retail pharmacy). 90 day supply (home delivery).*	$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) *30 day supply (retail pharmacy). 30 day supply (home delivery).*	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)

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.
- All medical and prescription drug deductibles, copayments and coinsurance apply toward the out-of-pocket maximum (excluding Non-Network Human Organ and Tissue Transplant (HOTT) Services).
- 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 your plan includes out-of-network benefits, In-network and out-of-network deductibles, copayments, coinsurance and out-of-pocket maximum amounts are separate and do not accumulate toward each other.

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.

Your Plan: Anthem Blue Access PPO HSA Option E1 with Rx Option T8
Your Network: Blue Access

This summary of benefits is intended to be a brief outline of coverage. The entire provisions of benefits and exclusions are contained in the Group Contract, Certificate, and Schedule of Benefits. In the event of a conflict between the Group Contract and this description, the terms of the Group Contract will prevail.

By signing this Summary of Benefits, I agree to the benefits for the product selected as of the effective date indicated.

Authorized group signature (if applicable)	Date
Underwriting signature (if applicable)	Date

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