Your Summary of Benefits

Anthem

University of Dayton - Advantage Plan
Blue Access® (PPO)
Effective 01/01/2015

Please note: As we receive additional guidance and clarification from the U.S. Department of Health and Human Services, we may be required to make additional changes to your benefits.

Covered Benefits	Network	Non-Network
Deductible (Single/Family)	$500/$1,000	$1,000/$2,000
Out-of-Pocket Limit (Single/Family)	$3,000/$6,000	$6,000/$12,000
Physician Home and Office Services (PCP/SCP) Primary Care Physician (PCP)/ Specialty Care Physician (SCP) Including Office Surgeries and allergy serum:	$20/$40	30%
o LiveHealth Online – Online Visit	$10	30%
o allergy injections (PCP and SCP)	$5	30%
o allergy testing	15%	30%
o MRAs, MRIs, PETS, C-Scans, Nuclear Cardiology Imaging Studies, **and non-maternity related Ultrasounds**	15%	30%
Preventive Care Services Services include but are not limited to: Routine Exams, Mammograms, Pelvic Exams, Pap testing, PSA tests, Immunizations[1], Annual diabetic eye exam, Vision and Hearing screenings o Physician Home and Office Visits (PCP/SCP) o Other Outpatient Services @ Hospital/Alternative Care Facility	No copayment/coinsurance	30%
Emergency and Urgent Care		
Emergency Room Services	$250	$250
o **facility/other covered services** (copayment waived if admitted)		
Urgent Care Center Services	$75	30%
o MRAs, MRIs, PETS, C-Scans, Nuclear Cardiology Imaging Studies, **and non-maternity related Ultrasounds**	15%	30%
o Allergy injections	$5	30%
o **Allergy testing**	15%	30%
Inpatient and Outpatient Professional Services Include but are not limited to: o Medical Care visits (1 per day), Intensive Medical Care, Concurrent Care, Consultations, Surgery and administration of general anesthesia and Newborn exams	15%	30%
Blue 4.0 NGF		

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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) • 90 days for skilled nursing facility	15%	30%
Outpatient Surgery Hospital/Alternative Care Facility • Surgery and administration of general anesthesia	15%	30%
Other Outpatient Services (Combined Network & Non-Network limits) including but not limited to: • Non Surgical Outpatient Services for example: MRIs, C-Scans, Chemotherapy, Ultrasounds, and other diagnostic outpatient services. • Home Care Services Unlimited (excludes IV Therapy) • Durable Medical Equipment and Orthotics Unlimited (excluding Prosthetic Devices, Limbs and Medical Supplies) • Prosthetic Devices Unlimited • Prosthetic Limbs Unlimited • Physical Medicine Therapy Day Rehabilitation programs • Hospice Care • Ambulance Services	15% 15% 15%	30% 15% 15%
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: 60 visits • Occupational Therapy: 60 visits • Manipulation Therapy: 12 visits • Speech therapy: 12 visits	 $20/$40 15%	 30% 30%
Accidental Dental: $3,000 limit per Accident (Network and Non Network combined)	*Copayments/Coinsurance based on setting where covered services are received*	30%

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Behavioral Health: **Mental Illness and Substance Abuse[2]** • Inpatient Facility Services • Inpatient Professional Services • Physician Home and Office Visits (PCP/SCP) • Other Outpatient Services. Outpatient Facility @ Hospital/Alternative Care Facility, Outpatient Professional	 15% 15% $20/$20 15%	 30%
Human Organ and Tissue Transplants[3] • Acquisition and transplant procedures, harvest and storage.	No copayment/coinsurance	50%
Prescription Drugs[4] **Network Tier structure equals 1/2/3/4** • **Network Retail Pharmacies:** (30-day supply) Includes diabetic test strip • **Anthem Rx Direct Mail Service:** (90-day supply) Includes diabetic test strip Member may be responsible for additional cost when not selecting the available generic drug. Medicare Rx - Wrap **Specialty Medications** must be obtained via our Specialty Pharmacy network in order to receive network level benefits.	$50 Deductible $10/$40/$60/25% to $200 max $20/$100/$150/25% to $200 max	 50%, min $50[5] Not covered

Notes:

- 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)
- Deductible(s) apply only to covered medical services listed with a percentage (%) coinsurance. However, the deductible does not apply to Emergency Room Services where a percentage (%) coinsurance applies to other covered services and may not apply to some Behavioral Health services where 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 the end of the calendar year which the child attains age 26
- Specialist copayment is applicable to all Specialists excluding General Physicians, Internist, Pediatricians, OB/GYNs and Geriatrics or any other Network Provider as allowed by the plan.
- When allergy injections are rendered with a Physicians Home and Office Visit, only the Office Visit cost share applies.
- No copayment/coinsurance 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.
- PCP is a Network Provider who is a practitioner that specializes in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other Network provider as allowed by the plan.
- SCP is a Network Provider, other than a Primary Care Physician, who provides services within a designated specialty area of practice.
- Certain diabetic and asthmatic supplies have no deductible/copayment/coinsurance up to the maximum allowable amount at network pharmacies except diabetic test strips.
- Benefit period = calendar year
- Mammograms (Diagnostic) are no copayment/coinsurance in Network office and outpatient facility settings.
- 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.
- Private Duty Nursing – limited to 82 visits/Calendar Year and 164 visits/lifetime.

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1 These covered services are not subject to the deductible/copayment if you have a flat dollar copayment and if rendered without an office visit.
2 We encourage you to contact Our Mental Health Subcontractor to assure the use of appropriate procedures, setting and medical necessity. Refer to Schedule of Benefits for limitations. Behavioral Health Services: Mental Health and Substance Abuse benefits provided in accordance with Federal Mental Health parity.
3 Kidney and Cornea are treated the same as any other illness and subject to the medical benefits.
4 If applicable, all prescription drug expenses except tier 1, (Network/Non-network, Retail/Mail-service combined) apply to the per individual deductible. Once the deductible is met, the appropriate copayment applies. Also if applicable, the Prescription Drug out of pocket maximum applies to Network Retail and Mail-Service combined.
5 Rx non-network diabetic/asthmatic supplies not covered except diabetic test strips.

Precertification:
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 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.

Benefit information contained herein is not final, pending approval by the Ohio Department of Insurance
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