Your Summary of Benefits

Anthem

University of Dayton -- Graduates
Blue Preferred®(HMO)
Effective 1/1/2012

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	Coverage
Deductible (Single/Family)	$100/$200
Out-of-Pocket Limit (Single/Family)	$1,500/$3,000
Physician Home and Office Services (PCP/SCP) Primary Care Physician (PCP)/ Specialty Care Physician (SCP) Including Office Surgeries and allergy serum: • allergy injections (PCP and SCP) • allergy testing • MRAs, MRIs, PETS, C-Scans, Nuclear Cardiology Imaging Studies, and non-maternity related Ultrasounds	$25/$50 $5 copayment 10% 10%
Preventive Care Services Services include but are not limited to: Routine Exams, Pelvic Exams, Pap testing, PSA tests, Immunizations[1], Annual diabetic eye exam, Routine Vision and Hearing exams • Physician Home and Office Visits (PCP/SCP) • Other Outpatient Services @ Hospital/Alternative Care Facility	 $25/$50 10%
Emergency and Urgent Care Emergency Room Services • facility/other covered services (copayment waived if admitted) Urgent Care Center Services • Allergy injections	 $100 $75 $5
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%
Blue 3.0	

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Inpatient Facility Services 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	10%
Outpatient Surgery Hospital/Alternative Care Facility • Surgery and administration of general anesthesia	10%
Other Outpatient Services (Limits apply) 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	10% 10% 10%
Outpatient Therapy Services (Limits apply) • 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: 20 visits • Occupational Therapy: 20 visits • Manipulation Therapy: 12 visits • Speech therapy: 20 visits	 $25/$50 10%
Accidental Dental: $3,000 limit	*Copayments/Coinsurance based on setting where covered services are received*
Behavioral Health Services: 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	 10% 10% $25/$25 10%
Human Organ and Tissue Transplants[3] • Acquisition and transplant procedures, harvest and storage.	No copayment/coinsurance

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Prescription Drugs[4] Tier structure equals 1/2/3 • 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.	 $10/$30/$50 $20/$60/$100
Lifetime Maximum	Unlimited

Notes:

- Prescription drug deductibles/copayments/coinsurance and flat dollar copayments for Preventive Care Services, Physician Home and Office Services and Urgent Care are excluded from the Out-of-pocket limits.
- 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 copayment and a percentage (%) coinsurance applies and may not apply to some Behavioral Health services where coinsurance applies.
- Dependent Age: to the end of the calendar year which the child attains age 26[5]
- 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.
- 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
- Behavioral Health Services: Mental Health and Substance Abuse benefits provided in accordance with Federal Mental Health Parity.

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.
5 Dependents that are eligible for employer sponsored health coverage will not be offered benefits under this plan.

Grandfathered Health Plan
We believe this coverage is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator or your Employer.

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.
You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

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.

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