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Your summary of benefits

Anthem

Jefferson Health Plan administering for Shawnee State University Effective 7/1/2022

Your Plan: Anthem Blue Access Options PPO (3-Tier) HSA

Your Network: Blue Access OH I

Covered Medical Benefits	Cost if you use a Preferred Network Provider	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	$3,000 person / $6,000 family	Combined with Tier 1	$6,000 person / $12,000 family
Out-of-Pocket Limit	$6,000 person / $12,000 family	Combined with Tier 1	$12,700 person / $25,400 family
The family deductible and out-of-pocket maximum are embedded, meaning the cost shares of one family member will be applied to both per person deductible and per person 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 per person deductible or per person out-of-pocket maximum. 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). In-network and out-of-network deductibles and out-of-pocket maximum amounts are separate and do not accumulate toward each other. The deductibles for Preferred Network and In-Network are combined, The Out-of-Pocket Maximums for Preferred Network and In-Network are combined as well.			
Preventive Care / Screening / Immunization	No charge	No charge	40% coinsurance after deductible is met
Preventive Care for Chronic Conditions *per IRS guidelines*	No charge	No charge	40% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use a Preferred Network Provider	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Virtual Care (Telemedicine / Telehealth Visits)			
Virtual Visits - Online visits with Doctors who also provide services in person			
Primary Care (PCP)	10% coinsurance after deductible is met	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Mental Health and Substance Abuse care	10% coinsurance after deductible is met	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Specialist	10% coinsurance after deductible is met	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Medical Chats and Virtual (Video) Visits for Primary Care from our Online Provider K Health, through its affiliated Provider groups	0% coinsurance after deductible is met		
Virtual Visits from Online Provider LiveHealth Online *via www.livehealthonline.com; our mobile app, website or Anthem-enabled device*			
Primary Care (PCP) and Mental Health and Substance Abuse	10% coinsurance after deductible is met		
Specialist Care	10% coinsurance after deductible is met		
Visits in an Office			
Primary Care (PCP)	10% coinsurance after deductible is met	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Specialist Care	10% coinsurance after deductible is met	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Other Practitioner Visits			
Routine Maternity Care (Prenatal and Postnatal)	10% coinsurance after deductible is met	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Retail Health Clinic	10% coinsurance after deductible is met	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Manipulation Therapy *Coverage is limited to 30 visits per benefit period.*	10% coinsurance after deductible is met	20% coinsurance after deductible is met	40% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use a Preferred Network Provider	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Other Services in an Office			
Allergy Testing *When Allergy injections are billed separately by network providers, the member is responsible for a $5 copay. When billed as part of an office visit, there is no additional cost to the member for the injection.*	10% coinsurance after deductible is met	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Chemo/Radiation Therapy	10% coinsurance after deductible is met	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Dialysis/Hemodialysis	10% coinsurance after deductible is met	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Prescription Drugs *Dispensed in the office*	10% coinsurance after deductible is met	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Surgery	10% coinsurance after deductible is met	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Diagnostic Services			
Lab			
Office	10% coinsurance after deductible is met	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital	10% coinsurance after deductible is met	20% coinsurance after deductible is met	40% coinsurance after deductible is met
X-Ray			
Office	10% coinsurance after deductible is met	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital	10% coinsurance after deductible is met	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Advanced Diagnostic Imaging *for example: MRI, PET and CAT scans*			
Office	10% coinsurance after deductible is met	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital	10% coinsurance after deductible is met	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Emergency and Urgent Care			
Urgent Care	10% coinsurance after deductible is met	10% coinsurance after deductible is met	40% coinsurance after deductible is met
Emergency Room Facility Services	$75 copay per visit after deductible is met	$75 copay per visit after deductible is met	Covered as In-Network

Covered Medical Benefits	Cost if you use a Preferred Network Provider	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Emergency Room Doctor and Other Services	$75 copay per visit after deductible is met	$75 copay per visit after deductible is met	Covered as In-Network
Ambulance	10% coinsurance after deductible is met	10% coinsurance after deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Abuse			
Doctor Office Visit	10% coinsurance after deductible is met	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Facility Visit			
Facility Fees	10% coinsurance after deductible is met	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Doctor Services	10% coinsurance after deductible is met	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Surgery			
Facility Fees			
Hospital	10% coinsurance after deductible is met	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Doctor and Other Services			
Hospital	10% coinsurance after deductible is met	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Hospital (Including Maternity, Mental Health and Substance Abuse)			
Facility Fees	10% coinsurance after deductible is met	20% coinsurance after deductible is met	40% 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.*	Ded then no charge	Ded then no charge	40% coinsurance after deductible is met
Doctor and other services	10% coinsurance after deductible is met	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Recovery & Rehabilitation			
Home Health Care	10% coinsurance after deductible is met	20% coinsurance after deductible is met	40% coinsurance after deductible is met

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Covered Medical Benefits	Cost if you use a Preferred Network Provider	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Coverage is limited to 100 visits per benefit period.			
Rehabilitation services *Coverage for Occupational Therapy is limited to 20 visits per benefit period, Physical Therapy is limited to 20 visits per benefit period and Speech Therapy is limited to 20 visits per benefit period. Limit is combined for rehabilitative and habilitative services.*			
Office	10% coinsurance after deductible is met	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital	10% coinsurance after deductible is met	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Cardiac rehabilitation *Coverage is limited to 36 visits per benefit period.*			
Office	10% coinsurance after deductible is met	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital	10% coinsurance after deductible is met	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Pulmonary rehabilitation *Coverage is limited to 20 visits per benefit period.*			
Office	10% coinsurance after deductible is met	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital	10% coinsurance after deductible is met	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Skilled Nursing Care (facility) *Coverage for Skilled Nursing is limited to 100 days and Inpatient Rehabilitation facility (includes services in an outpatient day rehabilitation program) is limited to 60 days combined per benefit period.*	10% coinsurance after deductible is met	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Inpatient Hospice	10% coinsurance after deductible is met	10% coinsurance after deductible is met	40% coinsurance after deductible is met
Durable Medical Equipment	10% coinsurance after deductible is met	20% coinsurance after deductible is met	40% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use a Preferred Network Provider	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Prosthetic Devices *Coverage for wigs is limited to 1 item after cancer treatment per benefit period.*	10% coinsurance after deductible is met	20% coinsurance after deductible is met	40% coinsurance after deductible is met

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Pharmacy Deductible	Combined with In-Network medical deductible	Combined with Non-Network medical deductible
Pharmacy Out-of-Pocket Limit	Combined with In-Network medical out-of-pocket limit	Combined with Non-Network medical deductible
Prescription Drug Coverage *Cost shares for drugs included on the National drug list appear below. Your plan uses the Rx Base Network. You may receive up to a 90 day supply of medication at Retail 90 pharmacies. If you select a brand name drug when a generic drug is available, additional cost sharing amounts may apply.*		
Home Delivery Pharmacy *Maintenance medication are available through IngenioRx Home Delivery Pharmacy. You will need to call us on the number on your ID card to sign up when you first use the service.*		
Tier 1 - Typically Generic *Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).*	$10 copay per prescription after deductible is met (retail) and $20 copay per prescription after deductible is met (home delivery)	40% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 2 – Typically Preferred Brand *Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).*	$35 copay per prescription after deductible is met (retail) and $70 copay per prescription after deductible is met (home delivery)	40% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand *Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).*	$60 copay per prescription after deductible is met (retail) and $120 copay per prescription after deductible is met (home delivery)	40% coinsurance after deductible is met (retail) and Not covered (home delivery)

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Tier 4 - Typically Specialty (brand and generic) *Per 30 day supply (specialty pharmacy).*	25% coinsurance up to $250 per prescription after deductible is met (retail and home delivery)	40% coinsurance after deductible is met (retail) and Not covered (home delivery)

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
This is a brief outline of your vision coverage. Only children's vision services count towards your out of pocket limit.		
Children's Vision (up to age 19) **Child Vision Deductible**	$0 person	$0 person
Vision exam *Limited to 1 exam per benefit period.*	No charge	$0 copayment up to plan's Maximum Allowed Amount
Adult Vision (age 19 and older) **Adult Vision Deductible**	$0 person	$0 person
Vision exam *Limited to 1 exam per benefit period.*	No charge	Reimbursed Up to $42

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.
- Network Deductibles Preferred and In-Network commingle towards each other.
- 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 you have an office visit with your Primary Care Physician or Specialist at an Outpatient Facility (e.g., Hospital or Ambulatory Surgical Facility), benefits for Covered Services will be paid under “Outpatient Facility Services”.
- Costs may vary by the site of service. Other cost shares may apply depending on services provided. Check your Certificate of Coverage for details.
- Benefit Period – Calendar year
- Private Duty Nursing is limited to 82 visits per benefit period.

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- Ohio's House Bill 388 and the Federal No Surprises Act establish patient protections including from Out-of-Network Providers' surprise bills ("balance billing") for Emergency Care and other specified items or services. We will comply with these new state and federal requirements including how we process claims from certain Out-of-Network Providers.

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: Shawnee State University: Anthem Blue Access Options PPO (3-Tier) HSA

Your Network: Blue Access OH I

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) DocuSigned by: 7D11A503105E4DC...	Date 7/11/2022
Underwriting signature (if applicable)	Date

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