# Your summary of benefits

Anthem BlueCross

**Anthem Blue Cross**

**Effective Date:** July 1, 2019

**Your Plan:** UC Medical Residents and Fellows – Modified Premier PPO

**Your Network:** Anthem Prudent Buyer PPO

*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 Certificate of Insurance or Evidence of Coverage (EOC). If there is a difference between this summary and the Certificate of Insurance or Evidence of Coverage (EOC), the Certificate of Insurance or Evidence of Coverage (EOC), will prevail.*

Benefit Lifetime Maximum: Unlimited
A description of the prescription drug coverage is provided separately.

| Covered Medical Benefits | Cost if you use a UCMC Provider | Cost if you use an Anthem Prudent Buyer PPO Provider | Cost if you use a Non-Network Provider |
|---|---|---|---|
| **Benefit Year Deductible**<br>*See notes section to understand how your deductible works. Deductible does not cross accumulate.* | None | $100 individual / $200 family | $200 individual / $500 family |
| **Benefit Year Out-of-Pocket Limit**<br>*When you meet your out-of-pocket limit, you will no longer have to pay costshares during the remainder of your Benefit Year. UCMC, UC and Anthem Prudent Buyer PPO Out-Of-Pocket Maximum amounts cross accumulate. UCMC, UC/Anthem Prudent Buyer PPO and Non-Network Providers Out-of-Pocket Maximums do not cross accumulate. Out-of-Pocket is embedded meaning one family member will contribute no more than the individual amount. See notes section for additional information regarding your out of pocket maximum.* | $1,000 single / $2,000 family | $1,000 individual/ $2,000 family | $2,000 individual / $4,000 family |
| **Doctor Home and Office Services** | | | |
| **Preventive care/screening/immunization**<br>*Deductible does not apply to preventive care under UCMC and Anthem Prudent Buyer Providers.* | No charge | No charge | No charge |
| **Primary care visit to treat an injury or illness**<br>*Deductible does not apply to UCMC, UC or In-Network Providers.* | $15 copay per visit | $15 copay per visit | 30% coinsurance |

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| Covered Medical Benefits | Cost if you use a UCMC Provider | Cost if you use an Anthem Prudent Buyer PPO Provider | Cost if you use a Non-Network Provider |
|---|---|---|---|
| **Specialist care visit**<br>*Deductible does not apply to UCMC, UC or In-Network Providers.* | $15 copay per visit | $15 copay per visit | 30% coinsurance |
| **Prenatal and Post-natal Care**<br>*Deductible does not apply to UCMC, UC or In-Network Providers.* | $15 copay per visit | $15 copay per visit | 30% coinsurance |
| **Other practitioner visits:** | | | |
| Retail health clinic<br>*Deductible does not apply to In-Network providers.* | N/A | $15 copay per visit | 30% coinsurance |
| On-line Visit *(LiveHealth Online. www.livehealthonline.com)*<br>*Deductible does not apply to In-Network providers.* | N/A | $15 copay per visit | N/A |
| Chiropractor services<br>*Coverage for Anthem Prudent Buyer PPO Provider and Non-Network Provider combined is limited to 60 visit limit per Benefit Year. Deductible does not apply to In-Network providers.* | N/A | $15 copay per visit | 30% coinsurance |
| Acupuncture<br>*Coverage for Anthem Prudent Buyer PPO Provider and Non-Network Provider combined is limited to 24 visit limit per Benefit Year. Deductible does not apply to In-Network providers.* | N/A | $15 copay per visit | 30% coinsurance |
| **Other services in an office:** | | | |
| Allergy testing<br>*Deductible does not apply to UCMC or UC In-Network Providers.* | $15 copay per visit | 10% coinsurance | 30% coinsurance |
| Allergy serum purchased separately for treatment *(billed separately from office visit)* | 10% coinsurance | 10% coinsurance | 30% coinsurance |
| Chemo/radiation therapy<br>*Deductible does not apply to UCMC or UC In-Network Providers.* | $15 copay per visit | 10% coinsurance | 30% coinsurance |

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| Covered Medical Benefits | Cost if you use a UCMC Provider | Cost if you use an Anthem Prudent Buyer PPO Provider | Cost if you use a Non-Network Provider |
|---|---|---|---|
| Hemodialysis<br>*Deductible does not apply to UCMC or UC In-Network Providers.* | $15 copay per visit | 10% coinsurance | 30% coinsurance |
| Office based injectable<br>*For the drugs itself dispensed in the office thru infusion/injection.* | 10% coinsurance | 10% coinsurance | 30% coinsurance |
| **Diagnostic Services** | | | |
| **Lab:** | | | |
| Office | No charge | 10% coinsurance | 30% coinsurance |
| Freestanding Lab | No charge | 10% coinsurance | 30% coinsurance |
| Outpatient Hospital<br>*Non-Network Providers are subject to a $350 maximum allowed amount.* | No charge | 10% coinsurance | 30% coinsurance |
| **X-ray:** | | | |
| Office | No charge | 10% coinsurance | 30% coinsurance |
| Freestanding Radiology Center | No charge | 10% coinsurance | 30% coinsurance |
| Outpatient Hospital<br>*Non-Network Providers are subject to a $350 maximum allowed amount.* | No charge | 10% coinsurance | 30% coinsurance |
| **Advanced diagnostic imaging (for example, MRI/PET/CAT scans):** | | | |
| Office | No charge | 10% coinsurance | 30% coinsurance |
| Freestanding Radiology Center | No charge | 10% coinsurance | 30% coinsurance |
| Outpatient Hospital<br>*Non-Network Providers are subject to a $350 maximum allowed amount.* | No charge | 10% coinsurance | 30% coinsurance |

# Your summary of benefits

| Covered Medical Benefits | Cost if you use a UCMC Provider | Cost if you use an Anthem Prudent Buyer PPO Provider | Cost if you use a Non-Network Provider |
|---|---|---|---|
| **Emergency and Urgent Care** | | | |
| **Emergency room facility services**<br>*This is for the hospital/facility charge only. The ER physician charge may be separate.* | No charge | $100 copay | $100 copay |
| **Emergency room doctor and other services** | No charge | No charge | No charge |
| **Ambulance (air and ground)** | N/A | 10% coinsurance | Covered as In-Network |
| **Urgent Care (office setting)**<br>*Deductible does not apply to UCMC, UC or In-Network Providers.* | $15 copay per visit | $15 copay per visit | 30% coinsurance |
| **Outpatient Mental/Behavioral Health and Substance Abuse** | | | |
| **Doctor office visit**<br>*Deductible does not apply to UCMC, UC or In-Network Providers.* | $15 copay per visit | $15 copay per visit | 30% coinsurance |
| **Facility visit:** | | | |
| Facility fees | No charge | 10% coinsurance | 30% coinsurance |
| **Outpatient Surgery** | | | |
| **Facility fees:** | | | |
| Hospital<br>*Non-Network Providers are subject to a $350 maximum allowed amount.* | No charge | 10% coinsurance | 30% coinsurance |
| Freestanding Surgical Center<br>*Non-Network Providers are subject to a $350 maximum allowed amount.* | No charge | 10% coinsurance | 30% coinsurance |
| **Doctor and other services** | No charge | 10% coinsurance | 30% coinsurance |

# Your summary of benefits

| Covered Medical Benefits | Cost if you use a UCMC Provider | Cost if you use an Anthem Prudent Buyer PPO Provider | Cost if you use a Non-Network Provider |
|---|---|---|---|
| **Hospital Stay (all inpatient stays including maternity, mental /behavioral health, and substance abuse)** | | | |
| **Facility fees (for example, room & board)**<br>*An additional copay of $250 if you do not receive preauthorization for Non-Network Providers. Non-Network Providers are subject to a $600 maximum allowed amount. Applies to non-emergency admissions.* | $250 per admission | 10% coinsurance | 30% coinsurance |
| **Facility fees if admitted as emergency** | No charge | No charge | No charge |
| **Doctor and other services** | No charge | 10% coinsurance | 30% coinsurance |
| **Recovery & Rehabilitation** | | | |
| **Home health care**<br>*Coverage for Anthem Prudent Buyer PPO Provider and Non-Network Provider combined is limited to 100 visit limit per Benefit Year. (If pre-authorized, Non-Network will be paid at the Anthem Prudent Buyer PPO coinsurance level.)* | N/A | 10% coinsurance | 30% coinsurance |
| **Rehabilitation services (for example, physical/speech/occupational therapy):** | | | |
| Office<br>*Costs may vary by site of service. Deductible does not apply to UCMC or UC In-Network Providers.* | $15 copay per visit | 10% coinsurance | 30% coinsurance |
| Outpatient hospital<br>*Deductible does not apply to UCMC or UC In-Network Providers.*<br>*Non-Network Providers are subject to a $350 maximum allowed amount.* | $15 copay per visit | 10% coinsurance | 30% coinsurance |
| Habilitation services<br>*Deductible does not apply to UCMC or UC In-Network Providers.* | $15 copay per visit | 10% coinsurance | 30% coinsurance |

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| Covered Medical Benefits | Cost if you use a UCMC Provider | Cost if you use an Anthem Prudent Buyer PPO Provider | Cost if you use a Non-Network Provider |
|---|---|---|---|
| **Cardiac rehabilitation** | | | |
| Office<br>*Deductible does not apply to UCMC or UC In-Network Providers.* | $15 copay per visit | 10% coinsurance | 30% coinsurance |
| Outpatient hospital<br>*Deductible does not apply to UCMC or UC In-Network Providers. Non-Network Providers are subject to a $350 maximum allowed amount.* | $15 copay per visit | 10% coinsurance | 30% coinsurance |
| **Skilled nursing care (in a facility)**<br>*Coverage for Anthem Prudent Buyer PPO Provider and Non-Network Provider combined is limited to 100 day limit per Benefit Year. (If pre-authorized, Non-Network will be paid at the Anthem Prudent Buyer PPO coinsurance level.)* | N/A | 10% coinsurance | 30% coinsurance |
| **Hospice**<br>*(If pre-authorized, Non-Network will be paid at the Anthem Prudent Buyer PPO coinsurance level.)* | N/A | 10% coinsurance | 30% coinsurance |
| **Durable Medical Equipment**<br>*Rental or purchase of DME including hearing aids, dialysis equipment, and supplies (hearing aids benefit is available for one hearing aid per ear every three years capped at $2,000; breast pump and supplies are covered under preventive care at no charge – deductible waived).* | N/A | 10% coinsurance | 30% coinsurance |
| **Prosthetic Devices** | N/A | 10% coinsurance | 30% coinsurance |

# Your summary of benefits

**Notes:**

- Unless otherwise specified, copayments/coinsurance are calculated based on allowable amounts. Preferred providers agree to accept Anthem Blue Cross allowable amount plus the plan's and any applicable member's payment as full payment for covered services. Non-Preferred providers can charge more than these amounts. When members use Non-Preferred providers, they must pay the applicable deductibles, copayments or coinsurance plus any amount that exceeds Anthem Blue Cross allowable amount. Charges above the allowable amount do not count toward the benefit-year deductible or out-of-pocket maximum.

- Preventive care services includes physical exam, preventive screenings (including screenings for cancer, HPV, diabetes, cholesterol, blood pressure, hearing and vision, immunization, health education, intervention services, HIV testing) and additional preventive care for women provided for in the guidance supported by Health Resources and Service Administration.
- All medical services subject to a coinsurance are also subject to the annual medical deductible.
- Annual Out-of-Pocket Maximums includes deductible, copays, coinsurance and prescription drug.
- For plans with an office visit copay, the copay applies to the actual office visit and additional cost shares may apply for any other service performed in the office (i.e., X-ray, lab, surgery), after any applicable deductible.
- For Medical Emergency care rendered by a Non-Participating Provider or Non-Contracting Hospital, reimbursement is based on the reasonable and customary value. Members may be responsible for any amount in excess of the reasonable and customary value.
- If your plan includes an emergency room facility copay and you are directly admitted to a hospital, your emergency room facility copay is waived.
- The maximum allowed charges for non-emergency surgery and services performed in a Non-Preferred Ambulatory Surgical Center or outpatient unit of a Non-Preferred hospital is $350 per day. Members are responsible for 50% of this $350 per day, plus all charges in excess of $350.
- Certain services are subject to the utilization review program. Before scheduling services, the member must make sure utilization review is obtained. If utilization review is not obtained, benefits may be reduced or not paid, according to the plan.
- Visit limits start accruing regardless if deductible is met or not.
- Additional visits maybe authorized if medically necessary. Pre-service review must be obtained prior to receiving the additional services.
- Human organ and tissues transplants require precertification and are covered as any other service in your summary of benefits.
- Bariatric surgery covered only when performed at Blue Distinction Center for Specialty Care for Bariatric Surgery.
- Skilled nursing facility day limit does not apply to mental health and substance abuse.
- Freestanding Lab and Radiology Center is defined as services received in a non-hospital based facility.
- Coordination of Benefits: The benefits of this plan may be reduced if the member has any other group health or dental coverage so that the services received from all group coverage do not exceed 100% of the covered expense



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